STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING _____ B. WING _____	C 01/06/2017

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FARMVILLE REHABILITATION & HEALTH CARE CENTER LLC	1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/4/17 through 1/6/17. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 110 at the time of the survey. The survey sample consisted of 19 current resident reviews (Residents # 1 through #19) and 7 closed record reviews (Residents #20 through #26).	F 000	Preparation and submission of this plan of correction by **Farmville Rehabilitation and Health Care Center, LLC**, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF 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. (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. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records,	F 164	**F164** 1. Resident #18's open and unattended MAR was closed on the medication cart by the charge nurse on 1/4/17. The LPN #7 and LPN #5 were reeducated by the Staff Development Coordinator on 1/6/17 related to ensuring that MARs are closed when unattended to maintain confidentiality of records. 2. The Assistant Director of Nursing and the Unit Managers completed an audit on 1/24/17 to ensure confidentiality of the medical records is maintained as required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Demetra Robinson RN DON — TITLE: Director of Nursing — (X6) DATE: 1/27/17

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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F 164	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain confidentiality of records for one of 26 residents in the survey sample, Resident #18. The facility staff left Resident #18 ' s January 2017 MAR (medication administration) open and unattended on the medication cart exposing her medication list. The findings include: Resident #18 was admitted to the facility on 7/18/2013 with diagnoses that included but were not limited to high cholesterol, edema, and high blood pressure. Resident #18's most recent MDS	F 164	3. The nursing staff were reeducated on 1/6/17 by the Staff Development Coordinator related to ensuring that confidentiality of the medical records is maintained as required. 4. The Assistant Director of Nursing or the Unit Managers will complete an audit weekly for 4 weeks and monthly for 2 months to ensure confidentiality of medical records is maintained as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date: 02/03/17	

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(minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/23/16. Resident #18 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #18 was coded as requiring extensive assistance from staff with transfers and dressing; total dependence on staff with hygiene and bathing, and independent with meals.

On 1/4/17 at 7:20 a.m., an observation of a medication cart on wing one was conducted. Resident #18's MAR (Medication Administration record) was observed open and unattended, exposing her medication list, diagnoses; name and DOB (date of birth). The nurse assigned to the cart was not in view of the medication cart. On 1/4/17 at 7:26 a.m., a facility staff member walked by the cart and open MAR. On 1/4/17 at 7:35 a.m., a nursing aide walked by the open MAR on the medication cart. On 1/4/17 at 7:45 a.m., Resident #18's MAR was still left open and no nurse within view of the cart.

Review of Resident #18's January 2017 MAR (medication administration record) revealed that she was on the following medications:

[1] Colace Capsule 100 mg (milligrams) Give 100 mg by mouth two times a day related to constipation.
[2] Imodium A-D Tablet 2 MG (Loperamide HCL) Give 2 mg by mouth as needed for loose stools Give 2 mg by mouth after each loose stool.
[3] Lasix 20 mg- Give 20 mg by mouth one time a day related to Edema.
[4] Lovastin Tablet 40 mg Give 40 mg by mouth in the evening related to Hyperlipidemia (high

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cholesterol)
[5] Robitussin Chest Congestion Syrup (Guaifenesin) Give 200 mg by mouth every 4 hours as needed for cough.
[6] Tylenol Tablet 325 mg (Acetaminophen) Give 650 mg by mouth every 4 hours as needed for HA (headache/Fever)
[7] Vitamin D Tablet- Give 1000 unit by mouth one time a day for Vitamin D deficiency. Give 2 tabs (tablets) every day.

On 1/4/17 at 12:00 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked how staff maintains confidentiality of resident records during medication administration pass, LPN #1 stated that she would either close the Resident's MAR or use a clipboard to cover up the MAR. When asked why it was important to cover the resident's MAR, LPN #1 stated, "Because of HIPAA (The Health Insurance Portability and Accountability Act) [8]. You have to protect their privacy. Their chart belongs to them." When asked if she was Resident #18's nurse, LPN #1 stated, "No. I am not her nurse."

On 1/4/17 at 12:05 p.m., an interview was conducted with LPN #7, the nurse assigned to Resident #18 on that shift. When asked how to maintain confidentiality of resident records during medication administration pass, LPN #7 stated, "Keep the record (MAR) closed because you don't want to see personal information. That would break HIPAA." LPN #7 stated that she was not Resident #18's nurse before 8 a.m. Resident #18 stated, "(Name of Nurse) (LPN #5) stayed later on his shift and was her nurse until I arrived at 8:00 a.m."

On 1/5/17 at approximately 4:30 p.m., an

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F 164	Continued From page 4 interview was conducted with LPN #5, the nurse who was assigned to Resident #18 until 8:00 a.m. on 1/4/17. He denied that he was the nurse working with the resident on that shift. On 1/5/17 at 5:59 p.m., ASM (Administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility policy titled, "HIPAA Security Rules Policy and Procedures Summary" did not address protecting confidential records during medication administration. No further information was presented prior to exit. [1] Colace Capsule-Used to soften the passage of stool. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 442. [2] Imodium -controls symptoms of diarrhea. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=76a976d5-8bee-4158-a94d-7fbfc5544fd4 [3] Lasix 20 mg- used to decrease edema (excess fluid) in patients with heart failure, liver impairment or kidney disease. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 587. [4] Lovastin Tablet-used to decrease cholesterol. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 629.	F 164		

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F 164	Continued From page 5 [5] Robitussin Chest Congestion Syrup (Guaifenesin) - used to clear mucus and phlegm from the chest when you have congestion from the cold or flu. It works by thinning the mucus and phlegm in the lungs. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010512/?report=details. [6] Tylenol Tablet 325 mg (Acetaminophen) - Treats minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details. [7] Vitamin D Tablet- "Vitamin D is a fat-soluble vitamin that is naturally present in very few foods, added to others, and available as a dietary supplement." This information was obtained from The National Institutes of Health. https://ods.od.nih.gov/factsheets/VitaminD-HealthProfessional/. [8] HIPA -The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule is the first comprehensive Federal protection for the privacy of personal health information. This information was obtained from The National Institutes of Health. https://privacyruleandresearch.nih.gov/.	F 164		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State	F 167	**F 167** 1. The survey binder was updated to include three years of survey results on 1/6/17 by the Administrator.	

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F 167	Continued From page 6 surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to post a notice for and failed to ensure that three years of the survey results were available upon request. A Notice was not posted to the residents and responsible parties that the results of the previous three years of survey results, with the plan of corrections, were available for review upon request. Review of the survey results book revealed the book contained the survey results and plan of corrections from the annual survey ending on 1/6/16, an abbreviated survey ending on 1/28/16 and not three years of survey results	F 167	2. The Administrator completed on audit on 1/6/17 to ensure survey binders included three years of survey results as required. 3. The Administrator will be reeducated by the Regional Nurse Consultant on 1/31/17 related to ensuring three years of survey results are maintained in the survey binder as required. 4. The Administrator or Director of Nursing will complete an audit of the facility survey binders weekly for 4 weeks and monthly for 2 months to ensure survey binders continue to include three years of survey results as required. The Administrator will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator will be responsible for monitoring and follow up. Completion date: 02/03/17	

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F 167	Continued From page 7 as required. The findings include: Observation was made of the survey results book in the front lobby on 1/4/17 at 7:00 a.m. The book was located under the sign stating, "Survey Results." The book in the pocket contained the survey results and plan of corrections from the annual survey ending on 1/6/16 and an abbreviated survey ending on 1/28/16. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 1/7/17 at 10:50 a.m. When asked who is responsible for posting the survey results, ASM #1 stated, "The administrator." When asked which surveys were to be posted for the residents and responsible parties, ASM #1 stated, "The last annual and any complaint surveys." When asked if he was aware of the new regulations that went into effect on 11/28/16, ASM #1 stated, "I'm not aware of any new regulations, I have not received any notifications regarding that." A policy on the posting of survey results was requested from ASM #1. He stated, "We don't have one." The administrator and the director of nursing were made aware of the above concern on 1/6/17 at 12:35 p.m. No further information was provided prior to exit.	F 167		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment	F 278		

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F 278	Continued From page 8 must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility failed to complete an accurate MDS (minimum data set) assessment for two of 26 residents in the survey sample, Residents # 10 and # 9.	F 278	**F278** 1. Resident #10 had a pain interview completed by the MDS Coordinator and modified the MDS with ARD of 11/29/16 on 1/23/17. Resident #9's quarterly assessment with ARD 11/11/16 section K was modified by the MDS Coordinator on 1/4/17. 2. The MDS Coordinators will complete an audit of the current resident's MDS by 1/30/17 to ensure MDS assessments are completed accurately as required. 3. The Clinical Reimbursement Specialist will reeducate the MDS Coordinators on 1/27/17 related to ensuring MDS assessments are completed accurately as required. 4. The MDS Coordinators will audit 5 MDS assessments on each unit weekly for 4 weeks and monthly for 2 months to ensure MDS assessments continue to be completed accurately as required. The MDS Coordinators will submit a report to the Quality Assurance Committee monthly for 3 months.	

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F 278	Continued From page 9 1. The facility staff failed to complete the pain interview before the ARD (assessment reference date) on Resident # 10's annual MDS (Minimum Data Set) assessment with an ARD of 11/29/16. 2. The facility staff coded Resident #9 on the quarterly assessment, with an ARD date of 11/11/16, in Section K - Swallowing/Nutritional Concerns, as having a physician prescribed weight loss regimen, when he was having weight loss that was not physician prescribed. The findings include: 1. Resident # 10 was admitted to the facility on 12/6/07 with a readmission on 8/15/16 with diagnoses that included but not limited to: dysphagia (1), anxiety (2), obsessive compulsive disorder (3), aphasia (4), schizophrenia (5), edema (6) diabetes mellitus (7) and convulsions (8). The most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/29/16 coded the resident as scoring a one on the brief interview for mental status (BIMS) of a score of 0 - 15, one being severely impaired of cognition. Resident # 10 was coded as being totally dependent of one staff member for activities of daily living. Section B0700 "Makes Self Understood" coded Resident # 10 as "Sometimes understood" and section B0800 "Able To Understand Others" coded Resident # 10 as "Sometimes understands - responds adequately to simple, direct communication only." Section J0200 "Pain Assessment Interview" of the	F 278	The Director of Nursing will be responsible for monitoring and follow up. Completion date:	02/03/17

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annual MDS assessment with an ARD of 11/29/16 documented, "Should Pain Assessment Interview be Conducted? - Attempt to conduct interview all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)." The box under section J0200 contained a dash (-). Review of sections J0300 "Pain Assessment Interview", J0400 "Pain Frequency", J0500 "Pain Effect on Function" and J0600 "Pain Intensity" revealed dashes in all the boxes in all areas indicating that the interview was not attempted.

On 1/5/17 at 8:55 a.m. an interview was conducted with RN (registered nurse) # 2, the MDS coordinator. RN # 2 was asked to review Section J0200 "Pain Assessment Interview" of Resident # 10's annual MDS assessment with an ARD of 11/29/16. When asked why the interview for Section J0200, "Pain Assessment Interview" was not completed, RN # 2 stated, "The pain assessment should have been completed It was completed by [OSM (other staff member) # 9], clinical reimbursement specialist."

On 1/5/17 at 11:05 a.m. an interview was conducted with OSM (other staff member) # 9, clinical reimbursement specialist. OSM # 9 was asked to review Section J0200 "Pain Assessment Interview" of Resident # 10's annual MDS assessment with an ARD of 11/29/16. When asked why the interview for Section J0200, "Pain Assessment Interview" was not completed, OSM # 9 stated, "I came after the ARD to help out and get the information inputted. At that time there was no pain information to input so I put in dashes. The pain assessment should have been done by the MDS coordinator."

On 1/5/17 at 12:00 a.m. an interview was

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conducted with RN (registered nurse) # 3, MDS coordinator. When asked about the pain interview information that OSM # 9 stated was not done for the pain assessment of Resident # 10's annual MDS, RN # 3 stated, "The interview was completed (OSM # 9) failed to ask for the information." When asked what guidance they follow for completing the MDS assessments, RN # 3 stated, "We use the RAI (resident assessment instrument) manual."

The RAI (Resident Assessment Instrument) manual documented," Steps for Assessment
1. Determine whether the resident is understood at least sometimes. Review Language item (A1100), to determine whether the resident needs or wants an interpreter.
·If an interpreter is needed or requested, every effort should be made to have an interpreter present for the MDS clinical interview. Complete the interview if the resident is at least sometimes understood and an interpreter is present or not required.
·Code 0, no: if the resident is rarely/never understood or an interpreter is required but not available. Skip to Indicators of Pain or Possible Pain item (J0800).
·Code 1, yes: if the resident is at least sometimes understood and an interpreter is present or not required. Continue to Pain Presence item (J0300).

Coding Tips and Special Populations
·If it is not possible for an interpreter to be present during the look-back period, code J0200 = 0 to indicate interview not attempted and complete Staff Assessment of Pain
item (J0800), instead of the Pain Interview items (J0300-J0600).

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F 278	Continued From page 12 Item Rationale Health-related Quality of Life ·The effects of unrelieved pain impact the individual in terms of functional decline, complications of immobility, skin breakdown and infections. ·Pain significantly adversely affects a person ' s quality of life and is tightly linked to depression, diminished self-confidence and self-esteem, as well as an increase in behavior problems, particularly for cognitively-impaired residents. ·Some older adults limit their activities in order to avoid having pain. Their report of lower pain frequency may reflect their avoidance of activity more than it reflects adequate pain management. Planning for Care ·Directly asking the resident about pain rather than relying on the resident to volunteer the information or relying on clinical observation significantly improves the detection of pain. ·Resident self-report is the most reliable means for assessing pain. ·Pain assessment provides a basis for evaluation, treatment need, and response to treatment. ·Assessing whether pain interferes with sleep or activities provides additional understanding of the functional impact of pain and potential care planning implications. ·Assessment of pain provides insight into the need to adjust the timing of pain interventions to better cover sleep or preferred activities. ·Pain assessment prompts discussion about factors that aggravate and alleviate pain. ·Similar pain stimuli can have varying impact on different individuals. ·Consistent use of a standardized pain intensity scale improves the validity and reliability of pain assessment. Using the same scale in different	F 278		

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settings may improve continuity of care.
·Pain intensity scales allow providers to evaluate whether pain is responding to pain medication regimen(s) and/or non-pharmacological intervention(s).

Steps for Assessment: Basic Interview
Instructions for Pain Assessment Interview (J0300-J0600)
1. Interview any resident not screened out by the Should Pain Assessment Interview be Conducted? item (J0200).
2. The Pain Assessment Interview for residents consists of four items: the primary question Pain Presence item (J0300), and three follow-up questions Pain Frequency item (J0400); Pain Effect on Function item (J0500); and Pain Intensity item (J0600). If the resident is unable to answer the primary question on Pain Presence item J0300, skip to the Staff Assessment for Pain beginning with Indicators of Pain or Possible Pain item (J0800).

3. The look-back period on these items is 5 days. Because this item asks the resident to recall pain during the past 5 days, this assessment should be conducted close to the end of the 5- day look-back period; preferably on the day before, or the day of the ARD. This should more accurately capture pain episodes that occur during the 5-day look-back period.
4. Conduct the interview in a private setting.
5. Be sure the resident can hear you.
·Residents with hearing impairment should be tested using their usual communication devices/techniques, as applicable.
·Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.

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F 278	Continued From page 14 ·Minimize background noise. 6. Sit so that the resident can see your face. Minimize glare by directing light sources away from the resident's face. 7. Give an introduction before starting the interview. Suggested language: "I'd like to ask you some questions about pain. The reason I am asking these questions is to understand how often you have pain, how severe it is, and how pain affects your daily activities. This will help us to develop the best plan of care to help manage your pain." 8. Directly ask the resident each item in J0300 through J0600 in the order provided. ·Use other terms for pain or follow-up discussion if the resident seems unsure or hesitant. Some residents avoid use of the term "pain" but may report that they "hurt." Residents may use other terms such as "aching" or "burning" to describe pain. 9. If the resident chooses not to answer a particular item, accept his/her refusal, code 9, and move on to the next item. 10. If the resident is unsure about whether the pain occurred in the 5-day time interval, prompt the resident to think about the most recent episode of pain and try to determine whether it occurred within the look-back period." On 1/5/17 at approximately 6:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit. References: (1) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdi	F 278		

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F 278	Continued From page 15 sorders.html. (2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (3) A common, chronic and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and behaviors (compulsions) that he or she feels the urge to repeat over and over. This information was obtained from the website: http://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd/index.shtml. (4) A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: (5) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm. (6) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html. (7) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 278		

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F 278	Continued From page 16 (8) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm. 2. The facility staff coded Resident #9 on the quarterly assessment, with an ARD of 11/11/16, in Section K - Swallowing/Nutritional Concerns, as having a physician prescribed weight loss regimen, when he was having weight loss that was not physician prescribed. Resident #9 was admitted to the facility on 10/24/12 with diagnoses that included but were not limited to: concussion, hypothyroid, diabetes, depression, anxiety, seizures, high blood pressure and traumatic brain injury with craniotomy and lobectomy. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 11/11/16, coded the resident as scoring a five on the BIMS (brief interview for mental status) scale, indicating he was severely impaired to make daily cognitive decisions. The resident was coded as being totally dependent on one or more staff members for all of his activities of daily living. In Section K - Swallowing/Nutritional Concerns, Resident #9 was coded as having had a weight loss of five percent or more in the last month or a weight loss of 10% or more in last six months. Resident #9 was coded as a "1. Yes, on physician-prescribed weight-loss regimen." The comprehensive care plan dated, 1/3/17,	F 278		

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documented in part, "Focus: I require a therapeutic diet r/t (related to) disease process, risk for impaired nutrition secondary to a hx (history) of swallowing difficulty, recent weight fluctuations, short attention span, aspiration at meals. Family is aware, does not desire TF (tube feeding)."

An interview was conducted with RN (registered nurse) #3, the MDS coordinator, on 1/4/17 at 3:33 p.m. When asked to review Section K on the quarterly MDS assessment, with an ARD of 11/11/16, RN #3 stated, "Well, that was coded in error. He's not on a physician prescribed weight loss program, he's losing weight and his mother doesn't want a tube feeding." When asked what reference she uses to complete the MDS assessments, RN #3 stated, "The RAI (resident assessment instrument) manual."

The RAI manual, October 2016, documented, "Section K - K0300: Code 1, yes on physician-prescribed weight-loss regimen; if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician ' s order. IN cases where a resident has a weight loss of 5% or more in 30 days or 10% or more in 180 days as a results of any physician ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics, K 0300 cane be coded as 1. Code 2, yes, not on physician - prescribed weight-loss regimen; if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician."

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F 278	Continued From page 18 The administrator and director of nursing were made aware of the above concern on 1/4/17 at 4:30 p.m. No further information was provided prior to exit.	F 278		
F 279 SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 279	**F279** 1. Resident #1 was discharged from the facility on 1/17/17 Resident # 2 psychotropic medication care plan from the CAA on 10/25/16 significant change MDS was completed on 1/24/17 by the MDS Coordinator. Resident #25 was discharged on 3/21/16. Resident #15's care plan was updated related to the 10/21/16 incident by the MDS Coordinator on 1/23/17. Resident #8 care plan was reviewed and updated related to the 10/21/16 incident by the MDS Coordinator on 1/23/17.	

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F 279	Continued From page 19 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to develop a comprehensive care plan for five of 26 residents in the survey sample, Resident #1, #2, #25, #15, and #10. 1. The facility staff failed to develop a hospice care plan when Resident #1 was admitted under hospice services on 10/28/16.	F 279	Resident #10 care plan was developed for the CAA triggered area of vision on the annual assessment with ARD 11/29/16 on 1/23/17 by the MDS Coordinator. 2. The MDS Coordinators will complete an audit of the current residents' care plans by 1/30/17 to ensure care plans are developed and updated to reflect the resident's current condition and needs as required. 3. The MDS Coordinators and the interdisciplinary team will be reeducated by the Clinical Reimbursement Specialist on 1/27/17 related to ensuring care plans are developed and updated to reflect the resident's current condition and needs as required. 4. The MDS Coordinators will audit 5 current residents' care plans on each unit weekly for 4 weeks and monthly for 2 months to ensure care plans continue to be developed and updated to reflect the resident's current condition and needs as required.	

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F 279	Continued From page 20 2. The facility staff failed to develop a psychotropic medication care plan from the triggered CAA (care area assessment summary) on Resident #2's 10/25/16 significant change MDS (minimum data set) assessment. 3. The facility staff failed to develop a care plan for discharge planning for Resident #25. 4. The facility staff failed to develop a care plan following the 10/21/16 incident when Resident #15 was kicked by Resident #8. 5. The facility staff failed to develop a care plan for the CAA (care area assessment) triggered area of vision on Resident #10's annual assessment with an ARD (assessment reference date) of 11/29/16. The findings include: 1. The facility staff failed to develop a hospice care plan when Resident #1 was admitted under hospice services on 10/28/16. Resident #1 was admitted to the facility on 4/28/16 with diagnoses that included but were not limited to protein-calorie malnutrition, dysphagia, hypothyroidism, blindness, muscle weakness, and Dementia with Lewy Body [1]. Resident #1's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/10/16. Resident #1 was coded as being severely cognitively impaired in the ability to make daily decisions, scoring 03 out of 15 on the BIMS (Brief Interview for mental status) exam. Resident #1	F 279	A report will be submitted to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date:	02/03/17

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was coded as requiring extensive assistance with bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing.

Review of Resident #1's physician telephone orders revealed an order for Hospice Services on 10/28/16.

Review of Resident #1's clinical record revealed hospice notes and a care plan from the hospice provider.

Review of Resident #1's care plan dated 5/17/16 with a review date of 8/2/16, failed to reveal a hospice care plan from the nursing facility.

On 1/4/17 at approximately 4:33 p.m., Resident #1's hospice care plan was requested at the end of day meeting with ASM (administrative staff member) #1, the administrator and ASM #2 the DON (Director of Nursing).

On 1/5/17 at approximately 8 a.m., a copy of Resident #1's facility hospice care plan was presented with an onset date "Jan/4/2017." Resident #1's hospice care plan documented the following: "Resident is receiving hospice services related to protein calorie malnutrition, Dementia of Behavioral Disturbance, falls, HTN (hypertension), convulsions....Goal/Target date: Hospice nurse/staff and facility staff will provide palliative support and care x 92 days...Effective pain control measures will be provided x (for) 92 days...interventions: Hospice services as ordered. Provide comfort measures every shift. Observe for pain and discomfort each shift. Administer pain medication routinely/as needed as ordered. Provided non-pharmacological interventions for pain. Weight loss and fluid volume deficit may

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experienced. Monitor weight per protocol. Provide appropriate diet, fluids and supplements as ordered. Skin breakdown may occur. Turn and reposition resident q (every) two hours and as needed. Administer laxatives as needed for constipation. Encourage family/resident to talk about death and their feelings about death. Encourage family visit. Social services/Hospice to arrange and provide religious support. Notify MD (medical doctor) as needed."

On 1/6/17 at 8:50 a.m., an interview was conducted with RN (Registered Nurse) #2, the MDS nurse. When asked what would be in the clinical record if a resident was on hospice, RN #2 stated that there should be hospice orders, notes, and a care plan from the hospice provider. RN #2 stated that these documents would be placed under a separate hospice tab in the clinical record. When asked if the nursing facility also creates their own hospice care plan for the resident, RN #2 stated, "We do put a care plan in." When asked what type of interventions would be on the hospice care plan, RN #2 stated that it would look similar to the care plan from the hospice provider. RN #2 stated that the care plan would have interventions addressing pain, weight loss, what to expect etc. When asked who was responsible for creating a hospice care plan when a resident is placed under hospice services, RN #2 stated, "Probably MDS. MDS does it all."

On 1/4/17 at 4:33 p.m., ASM #1, the administrator and ASM #2, the DON were made aware of the concern that a hospice care plan was not developed when Resident #1 was admitted under hospice services on 10/28/16. No further information was presented prior to exit.

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F 279	Continued From page 23 According to "Fundamentals of Nursing Made Incredibly Easy" Lippincott Williams and Wilkins, Philadelphia PA page 65: "A written care plan serves as a communication tool among health care team members that helps ensure the continuity of care...the care plan is developed on admission and includes the most significant problems and is reviewed and revised as necessary..." [1] Lewy Body- "LBD is a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood. LBD is one of the most common causes of dementia, after Alzheimer's disease and vascular disease." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/alzheimers/publication/lewy-body-dementia/basics-lewy-body-dementia. 2. The facility staff failed to develop a psychotropic medication care plan from the triggered CAA (care area assessment summary) on Resident #2's 10/25/16 significant change MDS (minimum data set) assessment. Resident #2 was admitted to the facility on 8/21/15 with diagnoses that included but were not limited to GERD (gastroesophageal reflux disease), major depressive disorder, dementia without behavioral disturbance, high blood pressure, atrial fibrillation, muscle weakness, shortness of breath, and difficulty walking. Resident #2's most recent MDS (minimum data	F 279		

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set) was a quarterly assessment with an ARD (assessment reference date) of 12/4/16. Resident #2 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 (zero) out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #2 was coded as requiring extensive assistance with all ADLS (activities of daily living).

Resident #2's most recent comprehensive MDS was a significant change assessment with an ARD of 10/25/16. "Psychotropic Drug Use" was an area triggered in Section V (CAA) Care Area Assessment Summary of the 10/25/16 MDS. This area was also checked to be on Resident #2's care plan.

Review of Resident #2's care plan dated 9/2/15 and updated 8/23/16 failed to reveal a psychotropic drug use care plan.

Review of Resident #2's December 2016 POS (physician order sheet) revealed that Resident #2 was placed on "Remeron [1] 45 mg (milligrams) by mouth at bedtime related to Major Depressive Disorder." This order was initiated on 11/11/2016.

On 12/28/16 the order for Remeron was decreased to 30 mg po (by mouth) qhs (every night) for depression.

On 1/6/17 at 8:50 a.m., an interview was conducted with RN (registered nurse) #2, the MDS nurse. RN #2 stated that she could not find a psychotropic care plan for Resident #2. When asked why it would be important to have a psychotropic medication care plan, RN #2 stated that it would be important for the care plan to identity signs and symptoms of Remeron use

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F 279	Continued From page 25 (side effects). When asked who was responsible for creating a care plan from the triggered CAAs, RN #2 stated that MDS was responsible for creating the care plan. When asked if Resident #2 should have a psychotropic care plan in place, RN #2 stated, "If the CAA says you are going to care plan, it should be care planned." RN #2 stated, "I know I did one and I thought I attached a black box warning to it." RN #2 stated that she uses the RAI (Resident Assessment Instrument) as a reference when completing a care plan from the triggered CAAs. On 1/6/17 at 1:16 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. The RAI (resident assessment instrument) 3.0 manual documents the following: "The information in the MDS constitutes the core of the required State-specified Resident Assessment Instrument (RAI). Based on assessing the resident, the MDS identifies actual or potential areas of concern. The remainder of the RAI process supports the efforts of nursing home staff, health professionals, and practitioners to further assess these triggered areas of concern in order to identify, to the extent possible, whether the findings represent a problem or risk requiring further intervention, as well as the causes and risk factors related to the triggered care area under assessment. These conclusions then provide the basis for developing an individualized care plan for each resident. CAA documentation.	F 279		

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F 279	Continued From page 26 CAA documentation helps to explain the basis for the care plan by showing how the IDT (interdisciplinary team) determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident; for example, the documentation should indicate the basis for these decisions, why the finding(s) require(s) an intervention, and the rationale(s) for selecting specific interventions. Based on the review of the comprehensive assessment, the IDT and the resident and/or the resident's representative determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan." [1] Remeron- REMERON (mirtazapine) Tablets are indicated for the treatment of major depressive disorder. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=010f9162-9f7f-4b6d-a6e4-4f832f26f38 3. The facility staff failed to develop a care plan for discharge planning for Resident #25. Resident #25 was admitted to the facility on 1/21/16 and discharged on 3/21/16. His diagnoses included but were not limited to: chronic obstructive pulmonary disease, high blood pressure, cerebral infarction, metabolic acidosis, hypothermia, vascular dementia, chronic anemia and atrial fibrillation. The most recent MDS (minimum data set) assessment, a change of therapy assessment, with an assessment reference date of 2/29/16, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive	F 279		

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decisions. He was coded as being independent for bed mobility, transfers, eating and toilet use.

The Care Plan, printed on 2/5/16, was reviewed. There was nothing addressed on the care plan related to discharge planning.

An interview was conducted with other staff member (OSM) #3 on 1/5/17 at 9:50 a.m. OSM #13 was asked when the discharge planning starts for a resident. OSM #3 stated, "It starts during admission. When a resident is admitted, the social work assistant or I contact the family to set up a meeting in 72 hours in person or on the phone." When asked if discharge planning should be on the care plan, OSM #3 stated, "I don't do anything with the care plan." The care plan was reviewed with OSM #3. OSM #3 stated, "I don't see anything on the care plan regarding discharge planning."

An interview was conducted with RN (registered nurse) #3, the MDS coordinator, on 1/5/17 at 10:12 a.m. When asked who is responsible to develop a discharge care plan, RN #3 stated, "I am." When asked if all residents should have a discharge planning care plan, RN #3 stated, "We don't do a care plan if they are going to stay long term care." When asked if it was noted the resident was to stay long term care should that be on the care plan too, RN #3 stated, "If the resident triggers on the MDS for discharging to community, then it is care planned, otherwise I don't do a discharge care plan for staying long term care."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 1/5/17 at 2:55 p.m. When asked if all residents

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should have a discharge care plan, ASM #2 stated, "Yes." When asked even if the resident is staying long term care, ASM #2 stated, "Yes, they should have a care plan for discharge planning."

The administrator and ASM #2 were made aware of the above findings on 1/5/17 at 6:00 p.m.

No further information was provided prior to exit.

4. The facility staff failed to develop a care plan following the 10/21/16 incident when Resident #15 was kicked by Resident #8.
Resident #15 was admitted to the facility on 12/5/13 and readmitted on 7/25/15 with diagnoses that included but were not limited to: pain, diabetes, dementia, high blood pressure and weakness.
The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 11/10/16 coded the resident as having short term and long term memory problems and as moderately impaired cognitively in making daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which coded the resident as independently performed after tray set up.
Review of the facility reported incident dated 10/22/16 documented on 10/21/16 Resident #15 had wheeled his chair in front of Resident #8. Resident #8 kicked Resident #15 in the leg. The residents were separated and Resident #15's leg was assessed. There was no apparent physical injury to the leg.
Review of the social services progress note dated 10/21/16 documented, "SSD (social service director) visited (name of resident [Resident #15]) @ he wandered through the hallway. There were

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no visual signs of distress or trauma. He doesn't understand SSD @ (sic) I asked "Are you okay, Are you afraid of anyone? (") (Name of resident [Resident #15]) reported, I don't know what your (sic) saying. SSD thanked him for his time and exited the area. SSD to follow up on 10/22/16."
Review of the social services progress note dated 10/22/16 documented, "(Name of resident [Resident #15]) continues to wander with disorganized thought process. He has Dx (diagnosis) of Dementia. Resident does not understand boundaries and personal space of others. There are no signs of distress. He is eating, sleeping (per CNA [certified nursing assistant]) and babbling as usual. No changes in his mood/behavior."
Review of the nurse's notes dated 10/21/16 to 10/30/16 did not evidence documentation regarding the incident.
Review of Resident #15's care plan did not evidence documentation regarding the incident.
An interview was conducted on 1/4/16 at 3:45 p.m. with RN (registered nurse) #2, the MDS coordinator. When asked who uses the care plans for the residents, RN #2 stated, "Everybody." RN #2 was then asked when a care plan is updated. RN #2 stated, "Pretty for much for anything." When asked why the care plans were updated, RN #2 stated, "Hopefully we try to find interventions or actual problems to help them from happening again."
An interview was conducted with RN #3, the MDS coordinator. When asked why a resident had a care plan, RN #3 stated, "It dictates the care of the resident." When asked who used the care plan, RN #3 stated, "Anybody taking care of the resident." When asked if a care plan would be developed for a resident to resident altercation, RN #3 stated, "If it's significant yes it should be

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updated."
An interview was conducted with LPN (licensed practical nurse) #3. When asked what process staff when there was a resident to resident altercation, LPN #3 stated, "We check their vital signs (blood pressure, pulse and respirations), give first aid if needed. Notify the RP (responsible party), the doctor and social services."
An interview was conducted on 1/6/17 at 10:50 a.m. with CNA #4. When asked how staff knew if a resident had been struck by another resident, CNA #4 stated, "I would get a report from the nurse." When asked if she was aware of any incidents between Resident #8 and Resident #15, CNA #4 stated she was not but did state, "Some of the residents are afraid of her (Resident #8) so I keep her separated (from the other residents)."
An interview was conducted on 1/6/17 at 11:00 a.m. with CNA #I. When asked how staff knew if there had been a resident to resident altercation, CNA #1 stated, "I would expect that what when on so on my shift I would know what to do." When asked if she was aware that Resident #8 had been aggressive towards Resident #15, CNA #1 stated she was not.
An interview was conducted on 1/6/17 with OSM (other staff member) #3, the social services director. When asked the process staff followed when there was a resident to resident altercation, OSM #3 stated, "Everyone intervenes. We immediately separate the residents and send then to the nurse's station to be assessed (for injury). I check on them for the next day or two to make sure they are not in distress, not in fear of their safety." When asked what behaviors they assess, OSM #3 stated, "Looking for any changes in their behavior, whether or not they had ate (sic) for that day. Any changes in their daily routine." When asked if there would be a

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care plan developed for a resident who had been kicked by another resident, OSM #3 stated, "I have never heard of that. Only do (a care plan) for the aggressor for behavioral management but not the recipient." When asked why a care plan would not be developed for the recipient, OSM #3 stated, "When we talked about care plans as a social worker I'm told I'm supposed to do the discharge care plan only. The MDS coordinator would do that (develop a care plan)." When asked if it would be important to have a care plan for the recipient of an incident, OSM #3 stated, "Yes." When asked about the altercation between Resident #8 and Resident #15, OSM #3 stated, "He doesn't know any better." When asked how staff knew how to keep Resident #15 safe from Resident #8, OSM #3 stated, "We try to redirect (name of Resident #15)."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked what process staff followed when there was an altercation between two residents, ASM #2 stated, "We immediately separate the residents and have them assessed by the licensed nurse for any injury. The nurses monitor the residents for a few days and follow up on their behavior." When asked if there would be a care plan developed for the resident who had been kicked, ASM #2 stated "If the resident had a bruise it would be on there (on the care plan)." When asked how staff would know to keep the resident safe from another resident, ASM #2 stated, "They (the staff) would get it through report."

On 1/6/17 at 11:30 a.m. ASM #1, the administrator and ASM #2 was made aware of the findings.

No further information was provided prior to exit.

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5. The facility staff failed to develop a care plan for the CAA (care area assessment) triggered area of vision on Resident #10's annual assessment with an ARD (assessment reference date) of 11/29/16.

Resident # 10 was admitted to the facility on 12/6/07 with a readmission on 8/15/16 with diagnoses that included but not limited to: dysphagia (1), anxiety (2), obsessive compulsive disorder (3), aphasia (4), schizophrenia (5), edema (6) diabetes mellitus (7) and convulsions (8).

The most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/29/16 coded the resident as scoring a one on the brief interview for mental status (BIMS) of a score of 0 - 15, one being severely impaired of cognition. Resident # 10 was coded as being totally dependent of one staff member for activities of daily living. Review of Section V Care Area Assessment (CAA) Summary revealed, "01. Vision" was coded as "Addressed in Care Plan."

Review of Resident # 10's comprehensive care plan with a review date of 12/01/2016 failed to evidence a care plan to address Resident # 10's vision.

On 1/5/17 at 10:50 a.m., an interview was conducted with ASM # 2, the director of nursing regarding the CAA area of vision being identified for a care plan care plan for Resident # 10. After reviewing the annual MDS assessment with an ARD of 11/29/16 for Resident # 10 and the comprehensive care plan with a review date of

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F 279	Continued From page 33 12/01/2016, ASM # 2 stated, "There isn't a care plan for vision." On 1/5/17 at 12:00 p.m., an interview was conducted with RN (registered nurse) # 3, MDS coordinator regarding the CAA area of vision being identified for a care plan. When asked about the process of developing a care plan from the CAA of an MDS, RN # 3 stated, "If the area triggered on the CAA a care plan should be developed according to the RAI (resident assessment instrument)." After reviewing the annual MDS assessment with an ARD of 11/29/16 for Resident # 10 and the comprehensive care plan dated of 12/1/16, RN # 3 stated, "It's not on the care plan. A care plan should have been developed." The facility's policy "Plans of Care" documented, "1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor) develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS." On 1/5/17 at approximately 6:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit. References: (1) A swallowing disorder. This information was	F 279		

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F 279	Continued From page 34 obtained from the website: <https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html>. (2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (3) A common, chronic and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and behaviors (compulsions) that he or she feels the urge to repeat over and over. This information was obtained from the website: http://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd/index.shtml. (4) A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/aphasia.html>. (5) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm. (6) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html. (7) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:	F 279		

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F 279	Continued From page 35 https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (8) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm.	F 279		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the	F 280	**F280** 1. Resident #6 comprehensive care plan was reviewed by the interdisciplinary team by 1/26/17 to reflect the resident current condition and needs. Resident #9's care plan was revised and reviewed on 1/5/17 by the interdisciplinary team to accurately reflect the type of sleeping arrangements for safety. Resident #14's care plan will be reviewed and revised by the interdisciplinary team by 1/26/17 including the resident altercation and bruised hand.	

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F 280	Continued From page 36 right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 280	Resident #5 comprehensive care plan was reviewed by the interdisciplinary team on 1/26/17 to reflect the resident's current condition and needs. Resident #4 comprehensive care plan was reviewed by the interdisciplinary team on 1/26/17 to reflect the resident's current condition and needs. Resident #12 was discharged on 1/4/17. Resident #11's care plan was reviewed and revised by the MDS Coordinator on 1/13/17 to accurately reflect the use of an AV fistula. Resident #1 was discharged from the facility on 1/7/17. 2. The MDS Coordinator will complete an audit of the current residents' comprehensive care plans by 2/1/17 to ensure care plans have been revised and reviewed by the interdisciplinary team to reflect the resident's current condition needs as required.	

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F 280	Continued From page 37 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 by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for eight of 26 residents in the survey sample, Residents #6, #9, #14, #5, #4, #12, #11 and #1. 1. For Resident #6 the facility staff failed to show evidence that the comprehensive care plan was reviewed at each scheduled assessment. 2. The facility staff failed to revise the care plan to accurately reflect Resident #9's type of sleeping arrangements for safety. 3.a. For Resident #14, the facility staff failed to review and revise the care plan after a resident to resident altercation with Resident #14 the recipient of a bruised hand. b. The facility staff failed to review Resident #14's comprehensive care plan at each scheduled assessment. 4. The facility staff failed to show evidence that	F 280	3. The MDS Coordinators and the interdisciplinary team will be reeducated by the Clinical Reimbursement Specialist by 1/27/17 related to ensuring comprehensive care plans are reviewed and revised as required. 4. The MDS Coordinators will audit 5 comprehensive care plans on each unit weekly for 4 weeks and monthly for 2 months to ensure comprehensive care plans continue to reviewed and revised as required. The MDS Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion Date:	02/03/17

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the comprehensive care plan was reviewed quarterly for Resident #5.

5. The facility staff failed to show evidence that the comprehensive care plan was reviewed quarterly for Resident #4.

6. The facility staff failed to show evidence that the comprehensive care plan was reviewed quarterly for Resident #12.

7. The facility staff failed to revise Resident 11's care plan for the use of an AV fistula (1) for dialysis (2).

8. For Resident #1, facility staff failed to revise and update the care plan to include multiple falls and interventions implemented after each fall.

The findings include:

1. For Resident #6 the facility staff failed to review the comprehensive care plan at each scheduled assessment.

Resident #6 was admitted to the facility on 10/13/09 with a recent readmission on 9/16/16, with diagnoses that included but were not limited to: multiple sclerosis (MS) (a progressive disease in which nerve fibers of the brain and spinal cord lose their myelin cover) (1), dysphagia, peripheral vascular disease, high blood pressure, and neurogenic bladder.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/14/16, coded the resident as scoring a 13 on the BIMS (brief

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interview for mental status) score, indicating that she was cognitively intact to make daily decisions. The resident was coded as requiring extensive to being totally dependent upon the staff for most of her activities of daily living. She was coded as independent after set up assistance was provided for eating.

The following assessments were completed:
1/22/16 - quarterly assessment
4/13/16 - annual assessment
5/11/16 - significant change assessment
8/1/16 - quarterly assessment
9/23/16 - Medicare 90 assessment.

The active comprehensive care plan documented the following: "Problem/Need: I have chosen FULL CODE STATUS. Problem onset: 10/05/15. Goal & Target Date: My decision for FULL CODE status will be honored x (times) 92 days. Cont. (continue) goals." There were no dates documented under goals.
"Problem/Need: Impaired skin integrity, r/t (related to) Rt (right) great toes arterial wound, and LFT (left) middle finger open area. Problem onset: 10/04/15. Goal & Target Date: Will show healing of arterial ulcer thru next 30 days. Will show signs of healing of LFT middle finger open area thru next 2 weeks. Cont. goals." There were no dates documented under goals.
"Problem/Need: Impaired thought process r/t episodes of confusion noted at times, i.e. thinks she is still working at a job, hands around papers stating that she is signing people up for better work and pay (however has an appropriate BIMS score), HX (history) of MS. Problem onset: 10/15/12. Goal & Target Date: Resident will continue to be alert to person and time thru next 92 days. Cont. goals." There were no dates

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documented under goals.
"Problem/Need: Risk for falls and injury r/t decreased mobility, SE (side effects) of psychotropic medications, side rail use, resident has MS requires staff assistance with transfers, decreased vision at times (double vision). Goal & Target date: 11/03/09. Resident will not fall or sustain injury that requires hospitalization r/t to the same thru next 92 days. Cont. goals." There were no dates documented under goals.
Problem/Need: Self-care deficit r/t decreased mobility secondary to MS. Problem onset: 11/03/09. Goal & Target Date: Resident will continue to attend activities of choice daily thru next 92 days. Cont. goals. Resident will be able to wash her hands and face each day thru next 92 days. Cont. goals. Resident will continue to choice (sic) clothing daily thru next 92 days. Cont. goals. There were no dated documented under goals.
Problem/Need: Risk for anaphylactic reaction r/t hypersensitivity to HCTZ (hydrochlorothiazide - used to treat high blood pressure (2)) and Propranolol (used to treat high blood pressure (3)). Problem onset: 11/03/09. Goal & Target date: Resident will not experience an allergic reaction aeb (as exhibited by) no s/s (signs and symptoms) of respiratory distress thru next 92 days. Cont. goals." There were no dated documented under goals.
Problem/Need: Risk for infection (UTI - urinary tract infection) r/t indwelling catheter. Problem onset: 10/28/09. Goal & Target date: Resident will be without S&S (signs and symptoms) of UTI i.e.; fever, chills flank pain thru next 92 days. Cont. goals." There were no dated documented under goals.
Problem/Need: Risk for Impaired elimination (constipation) r/t impaired mobility. Problem

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onset: 10/28/09. Goal & Target date: Resident will have a soft formed stool q (every) 2-3 days thru next 92 days. Cont. goals." There were no dated documented under goals.
Problem/Need: Risk for impaired comfort r/t pain secondary to the disease process. Problem onset: 10/28/10. Goal & Target date: Will have no complaints of pain aeb statement of no pain or no facial grimacing or other symptoms of pain each shift through next 92 days. Resident will state pain level less than 2 on a scale of 1-10 after intervention for pain within 30 min (minutes) to 1 hour thru next 90 days. Cont. goals." There were no dated documented under goals.
Problem/Need: Risk for further impaired skin integrity r/t suprapubic catheter present, decreased mobility secondary to MS, and incontinence of bowel. Problem onset: 11/03/09. Goal & Target date: 11/03/09. Resident will have no skin breakdown aeb documentation on weekly body audit thru next 92 days. Cont. goals." There were no dated documented under goals.
Problem/Need: Risk for side effects r/t use of psychotropic medications. Problem onset: 2/9/15. Goal & Target date: Resident will be free from injury from use of psychotropic medications. Cont. Goals." There were no dated documented under goals.
Problem/Need: Risk for imbalanced nutrition r/t resident may leave food uneaten at times, recent weight loss. Goal & Target date: Resident will consume at least 75% of her meal each day thru next 92 days. Cont. goals. Will not lose any weight thru next 30 days. Cont. goals." There were no dated documented under goals.

The care plan documented on page four, "C.P. (care plan) meeting, 4/21/16." It documented four staff members' signatures. The care plan

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documented under "Signatures," the signatures of three staff members and was dated, 2/20/15.

An interview was conducted with RN (registered nurse) #3 on 1/5/17 at approximately 2:00 p.m. When asked how often the care plans are reviewed, RN #3 stated, "They are reviewed with each assessment and updated as needed." RN #3 was asked to review the active care plan for Resident #6. Once reviewed, RN #3 was asked how it is documented that the care plan was reviewed. RN #3 stated, "By the dates documented on it." When asked if the goals for each resident should have documented date instead of 'continue goals,' RN #3 stated, "That is an inside issue. Somewhere back we were told to write continue goals. I agree there is no date that it was reviewed but we have reviewed the care plan." When asked what continue goals indicated, RN #3 stated, "a continue goal is to be there until it changes or goal is resolved or needs revision." When asked where it is documented that the care plan was reviewed, RN #3 stated, "Here on the care plan." She pointed to the dates of signatures on 2/20/15 and 4/21/16. When asked if that was with each scheduled assessment, RN #3 just shook her head.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/5/17 at approximately 2:30 p.m. ASM #2 was asked when resident care plans are reviewed. ASM #2 stated, "Care plans are review quarterly and PRN (as needed). If there is a new change we update the care plan." When asked where the quarterly review of the care plan is documented, "It's on a signature sheet." Resident #6's care plans with no documented dates under the goals were reviewed with ASM #2. When

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asked if the goals should have dates documented, ASM #2 stated, "Yes, there should be dates there."

The facility policy, "Care Plans" documented, "Policy: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental psychological needs is developed for each resident. Guidelines: 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identified the highest level of functioning the resident may be expected to attain. 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to the MDS. 3. Identifying problem areas and their causes and developing interventions that are targeted to the resident are interdisciplinary processes. 4. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS).
5. Assessments of the residents are ongoing and care plans are revised as information about the resident and the resident's condition change. 6. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans."

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates

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nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

The administrator, ASM #1 and ASM #2 were made aware of the above findings on 1/5/17 at 6:00 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 380.
(2) This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010584/?report=details
(3) This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011873/?report=details

2. The facility staff failed to revise the care plan to accurately reflect Resident #9's type of sleeping arrangements for safety.

Resident #9 was admitted to the facility on 10/24/12 with diagnoses that included but were not limited to: concussion, hypothyroid, diabetes, depression, anxiety, seizures, high blood

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pressure and traumatic brain injury with craniotomy and lobectomy.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 11/11/16, coded the resident as scoring a five on the BIMS (brief interview for mental status) scale, indicating he was severely impaired to make daily cognitive decisions. The resident was coded as being totally dependent on one or more staff members for all of his activities of daily living.

The comprehensive care plan dated, 1/3/17, documented, "Focus: I am at risk for falls/injuries r/t (related to) hx (history) of falls, with multiple interventions, I become agitated easily, I can be aggressive with staff at times, I use psychotropic meds (medications), I have decreased vision, hx of TBI (traumatic brain injury) and poor decision making skills and poor safety awareness, and hx of depression." The "Interventions" documented in part, "Low Bed with side mats."

Observation was made of Resident #9 on 1/4/17 at 7:20 a.m. There was no bed frame in the resident's room. The resident was observed sitting on a mattress that was at ground level. There was no sort of bed frame under the mattress. Under the mattress was noted to be foam mats approximately 24 by 24 inches that connected to each other. The mattress was up against the wall lengthwise. There was a fall mat next to the mattress on the floor, lengthwise.

The review of the physician orders dated, 1/1/17, did not reveal a physician order for a type of bed.

An interview was conducted with RN (registered

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nurse) #3, the MDS coordinator, on 1/5/17 at 1:13 p.m. When asked if an unusual sleeping arrangement should be placed on the care plan, RN #3 stated, "We've always called it a low bed." When asked if it is a "bed," RN #3 stated, "It's a mattress on the floor with mats underneath it." When asked the purpose of the care plan, RN #3 stated, "It's used to care for the residents with their goals and interventions in place." When asked if the care plan truly reflects the resident's sleeping arrangements for his safety, RN #3 stated, "That's what we've been told to call it."

An interview was conducted with LPN (licensed practical nurse) #2, on 1/5/17 at 1:32 p.m. When asked what kind of sleeping arrangements are in place for (Resident #9), LPN #2 stated, "He has a low bed with protective padding." When asked if that is considered a bed, LPN #2 stated, "That's what we've called it."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/5/17 at approximately 2:30 p.m. When asked about Resident #9's sleeping arrangements, ASM #2 stated, "He has a low bed." When asked if there was a bed frame, for Resident #9, ASM #2 stated, "There is a mattress that lies on foam mats underneath it." When asked if the care plan should reflect this, ASM #2 stated, "I guess it's a wording issue, but I see where you are coming from."

The administrator, ASM #1 and ASM #2 were made aware of the above findings on 1/5/17 at 6:00 p.m.

No further information was provided prior to exit.

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3.a. For Resident #14, the facility staff failed to review and revise the care plan after a resident to resident altercation with Resident #14 the recipient of a bruised hand.

Resident #14 was admitted to the facility on 8/27/09 with diagnoses that included but were not limited to: hemiplegia, peripheral vascular disease, pain in left shoulder, malaise, chronic obstructive pulmonary disease, stroke and high blood pressure.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/18/16, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring limited to extensive assistance of one or more staff members for all of her activities of daily living except eating and locomotion on the unit as the resident was independent with supervision only.

The facility reported incident (FRI) dated, 7/8/16, documented, "Resident outside on patio and got into altercation. (Name of other resident) obtaining scratch to right arm and (Resident #14) obtained bruise to left hand. Residents were separated. RP/MD (responsible party/medical doctor) aware. Treatments initiated." The follow up letter dated, 7/13/16, documented in part, "On July 8th 2016 (Name of other resident) and (Resident #14) were outside on the patio when they got into a verbal and physical altercation. (Name of other resident) hit (Resident #!4) on the hand resulting into a bruise and (Resident #14) scratched (Name of other resident) on the right

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arm.....Upon interview (Name of other resident) stated she was upset she didn't have any cigarettes and (Resident #14) wouldn't give her one of hers. (Resident #14) stated that (Name of other resident) was trying to be rude and cut in front of her to go inside bumping her chair....Both residents were monitored and no there (sic) altercations occurred. Social Services met with both resident and no changes in mood or behavior were noted. Social Services will continue to monitor both residents and follow up with the physician as needed."

The "Nurse's Notes" dated, 7/8/16, documented, "Resident assaulted and hit by another resident on patio. Noted L (left) hand injury, swollen bruised. Tx (treatment) started to monitor. MD (medical doctor) called made aware, message left for (name of responsible party)." There were no further nursing notes until 7/18/16.

The "Social Service Progress Notes" dated, 7/8/16, documented, "CNA (certified nursing assistant) reported that another resident had struck resident (Resident #14) on her hand. SSD (social services director) visited resident (Resident #14) to inquire about the incident. Resident reported, "I was trying to come in the building from the patio and so was she; she struck my hand several times for no reason. Resident (Resident#14) showed her hand to SSD. SSD observed a bruise on resident's hand. SSD then apologized for other resident's behavior. SSD escorted resident to DON (director of nursing) office. DON then spoke with resident (Resident #14)." A "Social Service Progress Notes" dated, 7/11/16, documented, "SSD visited with resident (Resident #14) in her room today; she was watching television. SSD

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asked her how was she feeling today and whether or not she had any concerns. Resident reported 'No I'm doing fine. I'm just watching TV.' SSD thanked her for her time. There was no distress observed." No further social services notes until 8/25/16.

The active comprehensive care plan dated, 12/21/11, was reviewed. There was no documentation related to the incident of 7/8/16 or of the bruise on the left hand sustained on 7/8/16. The care plan dated, 12/21/11, documented, "Problem/Need: Risk for ineffective protection r/t (related to) treatment (platelet inhibitor/blood thinner)."

An interview was conducted with RN (registered nurse) #2, the MDS coordinator, on 1/6/17 at 9:45 a.m. When asked if there is a resident to resident altercation should the care plan be updated to protect the recipient, RN #2 didn't respond. When asked if the care plan should have the bruise received to monitor for healing, RN #2 stated, "That should be on the care plan and yes, it's not there." When asked what was put into place to protect this resident, RN #2 stated, "I'm sure we separated them and we probably updated the care plan of the aggressor."

An interview was conducted with other staff member (OSM) #3, the director of social services, on 1/6/17 at 11:25 a.m. When asked should the care plan be updated for the recipient of a resident to resident altercation, OSM #3 stated, "I've never heard of that. We usually update the care plan for the aggressor but not the recipient."

An interview was conducted with ASM (administrative staff member) #2, the director of

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F 280	Continued From page 50 nursing, on 1/6/17 at 12:21 a.m. When asked if the care plan should be updated for a resident to resident altercation if there is an injury such as a bruise, ASM #2 stated, "I would expect to see a follow up note in the clinical record." When asked should it be in the care plan, ASM #2 stated, "I guess it should be." The administrator and ASM #2 were made aware of the above findings on 1/6/17 at 12:35 p.m. No further information was provided prior to exit. b. The facility staff failed to review Resident #14's comprehensive care plan at each scheduled assessment. Resident #14 had the following MDS assessments: 2/16/16 - quarterly assessment. 5/8/16 - quarterly assessment. 7/18/16 - quarterly assessment. 10/18/16 - quarterly assessment. The active comprehensive care plan printed on 3/8/16, documented the following: Problem/Need: Smoking - Potential for safety hazard, injury related to smoking. Potential for health improvement related to smoking cessation. Problem onset: 05/29/13. Goal & Target date: Will not cause injury to self or others, or damage to property related to smoking. Will discuss resident's desire for possibility of smoking cessation at each care plan meeting." There was nothing documented and no dates documented for this care plan.	F 280		

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F 280	Continued From page 51 Problem/Need: I have decreased hearing. Problem onset: 2/21/16. Goal & Target date: Allow me to demonstrate ability to hear by answering questions appropriately daily through next 90 days." There was nothing documented and no dates documented for this care plan. Problem/Need: I want to return to my home. Problem onset: 2/17/15. Goal & Target date: I will return to my home with supportive services." There was nothing documented and no dates documented for this care plan. Problem/Need: Risk for impaired comfort; pain r/t (related to) c/o (complaint of) pain, late effects of CVA (cerebrovascular accident - stroke) disease. Problem onset: 12/21/11. Goal & Target date: Resident will state or show relief in 30 minutes to 1 hour after interventions was introduced thru next 90 days. There was nothing documented and no dates documented for this care plan. Problem/Need: Risk for contractures r/t late effects of CVA with hemiparesis, impaired mobility and impaired cognitive function with muscle disuse. Problem onset: 12/21/11. Goal & Target Date: Will show no evidence of decline in current ROM (range of motion) AEB (as exhibited by) ability to continue ADL (activities of daily living) as currently noted on MDS through next 90 days." There was nothing documented and no dates documented for this care plan. Problem/Need: Risk for impaired skin integrity r/t decreased bed mobility, episodes of incontinence, hemiparesis, sitting in hover round most of the day with legs crossed. Problem onset: 12/21/11. Goal & Target date: Will not have any areas of impaired skin aeb documentation on weekly body audit thru next 90days." There was nothing documented and no dates documented for this care plan. Problem/Need: self-care deficit; toileting,	F 280		

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F 280	Continued From page 52 dressing, bathing, personal hygiene, ambulation, bed mobility, transfers r/t to decline in health status; extensive hemiparesis, hx (history) of previous stroke, Resident feels she can be more independent that she is. Problem onset: 12/21/11. Goal & Target date: Resident will continue to participate in self-care by brushing hair, washing face, and brushing teeth daily thru review." There was nothing documented and no dates documented for this care plan. Problem/Need: Risk for further falls/injury r/t hx of falls, hemiparesis, decreased mobility, uses electric hover round as primary mode of locomotion, and leans to the left side especially her head with c/o (complaints of) neck pain. Problem onset: 12/21/11. Goal & Target date: Resident will have no injury from fall that requires hospitalization aeb no hospitalization for such thru next 90 days. There was nothing documented and no dates documented for this care plan. Problem/Need: Risk for ineffective protection r/t treatment (platelet inhibitor/blood thinner). Problem onset: 12/21/11. Goal & Target date: Resident will have no evidence of new bleeding such as hematuria, bleeding gums, hematomas, bruises thru next review." There was nothing documented and no dates documented for this care plan. Problem/Need: Risk for vascular congestion r/t vascular insufficiency (HTN - high blood pressure). Problem onset: 12/21/11. Goal & Target date: Resident will have no signs or symptoms of HTN; headache, bloody nose or confusion, thru next 90 days." There was nothing documented and no dates documented for this care plan. Problem/Need: Risk for metabolic imbalance r/t thyroid insufficiency. Problem onset: 12/21/11. Goal & Target date: Resident will have no	F 280		

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complications r/t hypothyroidism or synthroid (drug used to treat hypothyroidism (1)) such as c/o cold, weight gain, GI (gastrointestinal) intolerance thru next 90 days." There was nothing documented and no dates documented for this care plan.
Problem/Need: DNR (do not resuscitate). Problem onset: 12/21/11. Goal & Target date: Resident will have all available necessary medical care withheld in the event of cardiac or respiratory arrest should occur thru next 90 days." There was nothing documented and no dates documented for this care plan.
Problem/Need: Risk for impaired adjustment r/t loss of independence. Problem onset: 12/21/11. Goal & Target date: Resident will interact with other resident at least 3 times a week during the next 90 days." There was nothing documented and no dates documented for this care plan.

There was one page with spaces for signatures. The one signature, the assistant director of nursing, was dated, 5/17/16. Attached to the care plan was a "Care Plan Attendance Record." This form was dated 10/27/16. The top of the form documented, "Resident's discharge plan has been reviewed with resident/responsible party. The resident/responsible party desires discharge plan to be home/assisted living/another skilled nursing facility/remain in this facility/other." There were two signatures, the MDS coordinator and the social work assistant. At the bottom of the page was documented, "Care plan reviewed and updated by: _____ on: _____." This was not filled out.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/5/17 at approximately 2:30 p.m.

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When asked how often care plans are reviewed, ASM #2 stated, "They are reviewed with each assessment and PRN (as needed) for any change in the resident's treatment or condition."

An interview was conducted with RN (registered nurse) #2, the MDS coordinator, on 1/6/17 at 9:45 a.m. When asked how often the care plan is reviewed, RN #2 stated, "With each assessment and as needed." When asked where it was documented that the care plan has been reviewed, RN #2 stated, "It's on the care plan or we just started using a new form, so we don't have to write a nurse's note, where everyone signs." The "Care Plan Attendance Record" was reviewed with RN #2. The top paragraph of the discharge plan was discussed and then the bottom sentence that states the care plan had been reviewed and updated. When shown the bottom of the form, RN #2 stated, "I didn't see that, I guess I better read the form we are using."

The administrator and ASM #2 were made aware of the above findings on 1/6/17 at 12:35 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010926/?report=details

4. The facility staff failed to show evidence that the comprehensive care plan was reviewed quarterly for Resident #5.

Resident # 5 was admitted to the facility on 1/2/09 and most recently on 3/26/16 with diagnoses including, but not limited to: anemia, atrial

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fibrillation, hypertension, coronary artery disease, benign prostatic hypertrophy, diabetes, hyperlipidemia, arthritis, bi-polar (1), and schizophrenia (2). On the most recent MDS (minimum data set), an annual assessment with ARD (assessment reference date) of 12/14/16, Resident # 4 was coded as scoring an 8 out of a possible 15 on the BIMS (brief interview of mental status) indicating that he was cognitively impaired.

The following list of completed MDS assessments was provided by RN # 3:

1/28/16 - Annual Assessment
4/26/16 - Quarterly Assessment
7/20/16 - Quarterly Assessment
10/20/16 - Quarterly Assessment
12/14/16 - Annual Assessment

Review of Resident # 5's active comprehensive care plan documented the following:

Under Problem Onset: 07/07/2015 I am at moderate constipation risk related to use of medications. For this problem it was documented under Goal & Target Date: I will have soft formed stool every two or three days and verbalize or indicate freedom from discomfort. Hand written under Goal & Target Date: "cont. (continue) goals"

Under Problem Onset: 09/05/2012 Risk for impaired comfort. For this problem it was documented under Goal & Target Date: Resident will state decrease in pain of at least one point on the pain scale within one hour of interventions through next 90 days. Hand written under Goal & Target Date: "cont. goals"

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F 280	Continued From page 56 Under Problem Onset: 06/08/2013 Risk for ineffective protection r/t (related to) to anticoagulation therapy. For this problem it was documented under Goal & Target Date: I will not be hospitalized for occult bleeding, thru next 92 days. Hand written under Goal & Target Date: "cont. goals" Under Problem Onset: 09/05/2012 Self-Care Deficit r/t lack of coordination, easily fatigued, and poor balance, recent decline in health. For this problem it was documented under Goal & Target Date: Resident will continue to comb my hair daily thru next 92 days. Hand written under Goal & Target Date: "cont. goals" Under Problem Onset: 09/05/2012 Risk for impaired Skin Integrity...For this problem it was documented under Goal & Target Date: Resident will have no skin breakdown thru next 92 days (r/t pressure). Hand written under Goal & Target Date: "cont. goals" Under Problem Onset: 06/08/2013 Hydration: Risk for alteration in hydration r/t hx (history) of UTI (urinary tract infection). For this problem it was documented under Goal & Target Date: Will continue to self access fluids as needed. AND Will show no signs of dehydration AEB (as evidenced by) a moist mouth daily. Hand written under both goals -- Goal & Target Date: "cont. goals" Under Problem Onset: 09/05/2012 Risk for alteration in Nutrition ... For this problem it was documented under Goal & Target Date: Will remain consume at least 50 to 75% of each meal thru next 92 days. Hand written under Goal &	F 280		

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F 280	Continued From page 57 Target Date: "cont. goals" Under Problem Onset: 06/08/2013 I have cognition and memory impairment poor decision skills, with receptive and expressive communication deficits. For this problem it was documented under Goal & Target Date: I will make appropriate/positive/safe decisions through next review period. AND I will make a choice when offered through the next 92 days. Hand written under both -- Goal & Target Date: "cont. goals" Under Problem Onset: 09/05/2012 Risk for injury, r/t hx of falls...For this problem it was documented under Goal & Target Date: Resident will have no more than 2 falls per month aeb (AEB) documentation thru next 90 days. Hand written under Goal & Target Date: "cont. goals" Under Problem Onset: 06/08/2013 Risk for ineffective protection r/t to anticoagulation therapy. For this problem it was documented under Goal & Target Date: I will not be hospitalized for occult bleeding, thru next 92 days. Hand written under Goal & Target Date: "cont. goals" Under Problem Onset: 09/05/2012 Risk for Decreased Cardiac Output r/t cardiac dysfunction...For this problem it was documented under Goal & Target Date: Resident will have no s/s (signs and symptoms) of hypertension; headache, bloody nose or confusion thru next 92 days. Hand written under Goal & Target Date: "cont. goals" Under Problem Onset: 01/01/2015At risk for adverse effects r/t use of psychotropic	F 280		

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medications. For this problem it was documented under Goal & Target Date: Resident will be free of adverse effects from use of psychotropic medications, thru next 92 days. Nothing was written under Goal & Target.

During an interview on 1/5/17 at 11:40 a.m. with RN (Registered Nurse) # 1, the assistant director of nurses, care plans were discussed. RN # 1 stated that it is important to date when the care plan is reviewed. RN # 1 further stated, "If not documented then not done."

During an interview on 1/5/17 at 2:24 p.m. with RN # 3, one of the MDS (minimum data set) coordinators, RN # 3 was asked about the quarterly review of care plans. RN # 3 stated, "They are reviewed with each assessment and updated as needed." RN # 3 reviewed a resident care plan and was asked how it is documented that the care plan was reviewed. RN # 3 stated, "By the dates documented on it." When asked if the goals for each resident should have a date documented on it instead of 'continue goals' RN # 3 stated that at one time they did put a date on the care plan when it was reviewed but sometime ago they were told to write 'continue goals'. RN # 3 agreed that there was no date to indicate when the care plan was reviewed. When RN # 3 was asked about the hand written 'continue goals', RN # 3 stated that (continue goals) indicated that the goal is still good until there is a notation that there is a goal change or that the problem is resolved. When asked how one would know when the care plan was resolved since there is no date, RN # 3 agreed that there is no date so staff cannot tell when it was reviewed. RN # 3 further stated that the care plans are a work in progress - they are changing over to the computer and educating

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F 280	Continued From page 59 nurses. During an interview on 1/5/17 at 4:30 p.m. with ASM (Administrative Staff Member) # 2, the Director of Nurses, ASM # 2 was asked how often care plans should be reviewed. ASM # 2 stated that staff should review the care plans quarterly and as needed. When asked how this review should be documented, ASM # 2 stated that the care plan should have signatures of who reviewed the care plan and the date that it was done. When asked what the purpose of the care plan was, ASM # 2 stated, "The purpose is that all know how to take care of residents." During the end of day interview on 1/5/17 at 6:00 p.m. with ASM # 1, the Administrator, and ASM # 2, the concern about the missing care plan review dates was revealed. Prior to exit no further information was provided. Notes: (1) Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml <http://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml> (2) Schizophrenia is a chronic and severe mental disorder that affects how a person thinks, feels, and behaves. www.nimh.nih.gov/health/topics/schizophrenia/index.shtml	F 280		

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5. The facility staff failed to show evidence that the comprehensive care plan was reviewed quarterly for Resident #4.

Resident # 4 was admitted to the facility on 8/26/15 with diagnoses including, but not limited to: hypertension, pressure ulcer, and polyneuropathy. On the most recent MDS (minimum data set), a quarterly assessment with ARD (assessment reference date) of 12/16/16, Resident # 4 was coded as scoring a 15 out of a possible 15 on the BIMS (brief interview of mental status) indicating that she was cognitively intact.

The following list of completed MDS assessments was provided by RN # 2:

2/8/16 - Quarterly Assessment
5/12/16 - Quarterly Assessment
8/2/16 - Annual Assessment
11/2/16 - Quarterly Assessment
12/16/16 - Quarterly Assessment

Review of Resident # 4's active comprehensive care plan documented

Under Problem Onset: 08/28/2015 I am at risk for alteration in comfort/pain. For this problem it was documented under Goal & Target Date: Will have demonstrate (sic) a decrease in pain level of at least one point on the cognitively impaired scale within one hour of interventions used including non-pharmaceutical and/or medication administration as needed. There were no dates documented under goals.

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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 280	Continued From page 61 Under Problem Onset: 09/10/2015 Risk for impaired skin integrity r/t incontinent of B & B (bowel & bladder) for this problem it was documented under Goal & Target Date: Will maintain intact skin or not develop any new skin issues through next 92 days. There were no dates documented under goals. Under Problem Onset: 09/10/2015 Behavior - Resistant to Care Giver...For this problem it was documented under Goal & Target Date: Resident will receive ADL (activities of daily living) care without resistant behaviors by 30 days. There were no dates documented under goals. Under Problem Onset: 09/10/2015 Risk for falls/injury r/t hx of falls, requires assistance with transfers via Hoyer Lift. For this problem it was documented under Goal & Target Date: Will have no falls with significant injury AEB (as evidenced by) no hospitalizations for same. There were no dates documented under goals. Under Problem Onset: 09/10/2015, I am at risk for alteration in bowel pattern related to constipation with use of narcotics. For this problem it was documented under Goal & Target Date: I will be free from constipation and have regular BM (bowel movement) q (every) 3 days aeb documentation (sic) through next 90 days. There were no dates documented under goals. Under Problem Onset: 08/27/2015 I have chosen DO NOT RESUSCITATE STATUS. For this problem it was documented under Goal & Target Date: My advanced directive for DNR (DO NOT RESUSCITATE) will be honored x 92 days. This goal was reviewed on 2/16/16 at the care	F 280		

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plan meeting but there were no other dates documented under goals.

Under Problem Onset: 09/10/2015 I require staff assistance to maintain personal hygiene, transfers via Hoyer lift with nursing, toileting, bathing, dressing, and grooming due to functional limitations related to amputation and pain. For this problem it was documented under Goal & Target Date: I will be clean, dry, odor free and dressed appropriately for season, place and time of day through next 90 days. There were no dates documented under goals.

Under Problem Onset: 09/10/2015 Risk for imbalanced nutrition related to refusals, therapeutic diet, increase need for caloric intake d/t (due to) pressure ulcer...For this problem it was documented under Goal & Target Date: Resident will consume 75% of two meals daily thru next 30 days. This goal was reviewed on 12/1/15 at the care plan meeting but there were no other dates documented under goals.

During an interview on 1/5/17 at 11:40 a.m. with RN (Registered Nurse) # 1, the assistant director of nurses, care plans were discussed. RN # 1 stated that it is important to date when the care plan is reviewed. RN # 1 further stated, "If not documented then not done."

During an interview on 1/5/17 at 2:46 p.m. with RN # 2, an MDS coordinator, this care plan was discussed. RN # 2 stated that each care plan is reviewed with each assessment. RN # 2 further stated that there are signature sheets that document each review. RN # 2 stated that she would look for the signature sheets and present

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F 280	Continued From page 63 them. Review of the "Care Plan Attendance Record" documented at the bottom revealed the following: Care plan reviewed and updated by: _____. On: _____. For all forms presented the signature and date were blank. During an interview on 1/5/17 at 4:30 p.m. with ASM (Administrative Staff Member) # 2, the Director of Nurses, ASM # 2 was asked how often care plans should be reviewed. ASM # 2 stated that staff should review the care plans quarterly and as needed. When asked how this review should be documented, ASM # 2 stated that the care plan should have signatures of who reviewed the care plan and the date that it was done. When asked what the purpose of the care plan was, ASM # 2 stated, "The purpose is that all know how to take care of residents." During the end of day interview on 1/5/17 at 6:00 p.m. with ASM # 1, the Administrator, and ASM # 2, the concern about the missing care plan review dates was revealed. Prior to exit no further information was provided. 6. The facility staff failed to show evidence that the comprehensive care plan was reviewed quarterly for Resident #12. Resident # 12 was admitted to the facility on	F 280		

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F 280	Continued From page 64 4/30/13 with diagnoses including, but not limited to: hypertension, diabetes, hyperlipidemia, anxiety, depression, and fibromyalgia (1). On the most recent MDS (minimum data set), a quarterly assessment with ARD (assessment reference date) of 10/3/16, Resident # 12 was coded as scoring a 15 out of a possible 15 on the BIMS (brief interview of mental status) indicating that she was cognitively intact. The following list of completed MDS assessments was provided by RN # 2: 1/7/16 - Quarterly Assessment 2/13/16 - Annual Assessment 5/5/16 - Quarterly Assessment 7/11/16 - Quarterly Assessment 10/3/16 - Quarterly Assessment Review of Resident # 12's active comprehensive care plan documented Under Problem Onset: 08/21/2015 I am at risk for hyper/hypoglycemia related to diagnosis of diabetes mellitus. For this problem it was documented under Goal & Target Date: I will not exhibit any s/s (signs & symptoms) of hyper/hypoglycemia thru next 90 days. There were no dates documented under goals. Under Problem Onset: 05/05/2014 Social Isolation: Risk for r/t absence of contact with daughter & friends and prefers to stay in room. For this problem it was documented under Goal & Target Date: Resident will be out of the room to attend at least 1 activity per week thru next 30 days. AND Resident will establish friendship with at least one other individual by day 92. There were no dates documented under goals.	F 280		

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F 280	Continued From page 65 Under Problem Onset: 05/05/2014 I am resistant to daily care: refuses care...For this problem it was documented under Goal & Target Date: I will allow staff to assist with my care and resist assistance x (times) 3 a week There were no dates documented under goals. Under Problem Onset: 05/05/2014 Risk for impaired skin integrity...For this problem it was documented under Goal & Target Date: Will maintain intact skin or not develop any new skin issues through next 92 days. There were no dates documented under goals. Under Problem Onset: 05/05/2014 I am feeling down depressed or hopeless. For this problem it was documented under Goal & Target Date: I will express desire to increase my OOR (out of room) activity by coming OOR daily and socializing. There were no dates documented under goals. Under Problem Onset: 10/06/2015 I have chosen FULL CODE STATUS. For this problem it was documented under Goal & Target Date: My decision for FULL CODE status will be honored x 92 days. There were no dates documented under goals. Under Problem Onset: 04/30/2013 Impaired Comfort, r/t (related to) pain secondary to an hx of fibromyalgia. For this problem it was documented under Goal & Target Date: Will have demonstrate (sic) a decrease in pain level of at least one point on the cognitively impaired scale within one hour of interventions used including non-pharmaceutical and/or medication administration as needed. There were no dates documented under goals.	F 280		

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Under Problem Onset: 04/30/2013, I am at risk for falls/injury...For this problem it was documented under Goal & Target Date: I will be free from significant injury resulting from falls aeb no hospitalization for such thru next 90 days. There were no dates documented under goals.

Under Problem Onset: 04/30/2013 I require staff intervention or assistance to maintain personal hygiene due to functional limitations...For this problem it was documented under Goal & Target Date: I will be able to wash my hands and face each shift thru the next 92 days. There were no dates documented under goals.

Under Problem Onset: 04/30/2013 I am at moderate nutritional risk related to my noncompliance with my diet ...For this problem it was documented under Goal & Target Date: I will allow my weight to be measured at least every other month thru next 90 days. AND I will maintain my current weight +/- (plus or minus) < (less than) 3 pounds by or through next 92 days. This goal was reviewed on 5/17/16 at the care plan meeting but there were no other dates documented under goals.

During an interview on 1/5/17 at 11:40 a.m. with RN (Registered Nurse) # 1, the assistant director of nurses, care plans were discussed. RN # 1 stated that it is important to date when the care plan is reviewed. RN # 1 further stated, "If not documented then not done."

During an interview on 1/5/17 at 2:46 p.m. with RN # 2, an MDS coordinator, this care plan was discussed. RN # 2 stated that each care plan is reviewed with each assessment. RN # 2 further

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F 280	Continued From page 67 stated that there are signature sheets that document each review. RN # 2 stated that she would look for the signature sheets and present them. Review of the "Care Plan Attendance Record" documented at the bottom revealed the following: Care plan reviewed and updated by: _____. On: _____. For all forms presented the signature and date were blank. During an interview on 1/5/17 at 4:30 p.m. with ASM (Administrative Staff Member) # 2, the Director of Nurses, ASM # 2 was asked how often care plans should be reviewed. ASM # 2 stated that staff should review the care plans quarterly and as needed. When asked how this review should be documented, ASM # 2 stated that the care plan should have signatures of who reviewed the care plan and the date that it was done. When asked what the purpose of the care plan was, ASM # 2 stated, "The purpose is that all know how to take care of residents." During the end of day interview on 1/5/17 at 6:00 p.m. with ASM # 1, the Administrator, and ASM # 2, the concern about the missing care plan review dates was revealed. Prior to exit no further information was provided. NOTES: (1) Fibromyalgia: Fibromyalgia is a disorder that	F 280		

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causes muscle pain and fatigue. People with fibromyalgia have "tender points" on the body. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=fibromy

7. The facility staff failed to revise Resident 11's care plan for the use of an AV fistula (1) port for dialysis (2).

Resident # 11 was admitted to the facility on 3/22/16 with diagnoses that included but were not limited to: hypertension (1), gastroesophageal reflux disease (2), diabetes mellitus (3), convulsions (4), end stage renal disease (5) and depression.

Resident # 11's most recent MDS (minimum dada set) a significant change assessment with an ARD (assessment reference date) of 10/5/16 coded the resident as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 being cognitively intact for daily decision making. Resident # 11 was coded as requiring limited assistance of one staff member for activities of daily living.

The "(Name of Dialysis Center) Dialysis Access management Application" for Resident # 11 documented, "Access type: AV Fistula." Under "Surgical Information" it documented, "Date Placed: 06/23/2016. Location: Left. Site: Above Elbow."

The POS (physician's order sheet) dated 1/1/2017 for Resident # 11 documented, "Monitor dialysis shunt to left arm every shift. Assess for bruit/thrill every shift. Notify MD (medical doctor) of any changes. If bleeding should occur apply

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F 280	Continued From page 69 direct pressure & (and) notify MD. Start Date; 11/18/16." The comprehensive care plan for Resident # 11 dated 3/22/2016 documented, "Problem/Need: I require renal dialysis related to ESRD (end stage renal disease)." Under the heading "Approaches" it documented, "Resident to attend dialysis on MON-WED-FRI (Monday-Wednesday-Friday) at (Name of Dialysis) with (Name of Physician); Coordinate my transportation to the dialysis center as scheduled; Monitor my fluid intake and Monitor my RT (right) upper CX (chest) wall perma-cath (8)." Further review of the care plan failed to document the use of the AV Fistula in Resident # 11's left upper arm. On 1/5/17 at 9:30 a.m. an interview was conducted with ASM (administrative staff member) # 2, director of nursing. After reviewing the comprehensive care plan for Resident # 11 dated 3/22/2016, ASM # 2 was asked if the use and monitoring of Resident # 11's AV fistula should be part of the interventions on the comprehensive care plan. ASM # 2 stated, "It should be part of the interventions on the care plan." According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when	F 280		

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there are changes in condition, treatments, and with new orders..." (1)

(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

On 1/5/17 at approximately 6:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:

(1) An AV fistula is a connection, made by a vascular surgeon, of an artery to a vein. Arteries carry blood from the heart to the body, while veins carry blood from the body back to the heart. <http://nkdep.nih.gov/living/kidney-failure/dialysis.shtml>

(2) Dialysis is a treatment to filter wastes and water from your blood, allowing people with kidney failure to feel better and continue doing the things they enjoy <http://nkdep.nih.gov/living/kidney-failure/dialysis.shtml>

(3) Low blood pressure. This information was taken from the website: https://medlineplus.gov/lowbloodpressure.html.

(4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

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F 280	Continued From page 71 (5) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (6) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm. (7) The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm. (8) A permacath is a long, flexible tube that is inserted into a vein most commonly in the neck (internal jugular vein) and less commonly in the groin (femoral vein). This type of ventral venous catheter is tunneled under the skin for a few centimeters usually on the chest before it enters the neck vein. Permacath, better known as the dialysis catheter or hemodialysis catheter is used in a variety of cases. Here are a few indications; Regular hemodialysis to treat kidney failure-permacath avoids multiple catheter insertions and serves as a permanent catheter for dialysis; Route for plasmapheresis; frequent blood sampling; Administration of drugs and fluids during long-term treatment; Administration of caustic medications (chemotherapy) that may harm peripheral veins; a route for TPN and blood products in special cases. This information was obtained from the website:	F 280		

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F 280	Continued From page 72 http://lavascular.com/permcath/. 8. For Resident #1, facility staff failed to revise and update the care plan to include multiple falls and interventions implemented after each fall. Resident #1 was admitted to the facility on 4/28/16 with diagnoses that included but were not limited to protein-calorie malnutrition, dysphagia, hypothyroidism, blindness, muscle weakness, and Dementia with Lewy Body [1]. Resident #1's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/10/16. Resident #1 was coded as being severely cognitively impaired in the ability to make daily decisions, scoring 03 out of 15 on the BIMS (Brief Interview for mental status) exam. Resident #1 was coded as requiring extensive assistance with bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing. Review of Resident #1's incident/accident reports revealed the first fall documented on 4/28/16. The following was documented: "4/28/16 at 11:15 p.m....Resident was found sitting on floor at bedside, no injuries or wounds at this time...Describe anything unusual that may have contributed to the incident? New resident unfamiliar with facility...Additional comment and/or steps taken to prevent reoccurrence: Floor mats." Review of Resident #1's fall care plan revealed that it was not initiated until 5/17/16. There was no evidence of a fall care plan on Resident #1's interim care plan. There was no evidence that fall mats made it to the care plan after it was initiated	F 280		

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The next documented fall was dated 5/11/16. The following was documented: Resident was sitting in w/c (wheelchair) at nurses station and slid out of w/c (wheelchair)....Additional comments/or steps taken to prevent recurrence: Dycem." Review of Resident #1's fall care plan revealed that it was not initiated until 5/17/16. The dycem cushion was not placed on the care plan after the care plan was initiated on 5/17/16.

The next fall was documented on 5/13/16. The incident report documented the following: " 5/13/16 at 1:30 p.m....Resident non-compliant to safety, attempted to stand unassist (sic) then sat to floor...Additional comments and/or steps taken to prevent future recurrence: Provide q (every) 15 min (minute) checks monitoring q shift." Review of Resident #1's fall care plan revealed 15 minute checks and monitoring q (every) shift did not make it to the 5/17/16 care plan after it was initiated.

The next fall was documented on 5/27/16. The following was documented in the incident report: "Resident was in dining room seated in wheelchair, then sat self on floor and scooted self a few feet from wheelchair. Chair alarm intact and functioning properly...Additional comments/steps taken to prevent reoccurrence: Resident was incontinent of bowel and bladder. Plan: Increase ADL (activity of daily living) rounds/toileting rounds." Review of Resident #1's care plan dated 5/17/16 revealed that it was not updated after this fall. The chair alarm was placed on the 5/17/16 care plan.

The next two falls were documented on 8/3/16

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and 8/10/16. The care plan was updated after each of these falls. The following was documented: "8/3/16 Increase rest breaks if resident allows 8/10/16 B & B (Bowel and Bladder) trial program."

The next fall was documented on 8/21/16. The following was documented: "Resident noted on floor at nsg (nursing) station in front of w/c (wheelchair) at nsg station...Type of injury: Laceration...Additional comments: ...Sent to ER (emergency room) for evaluation." The care plan was not updated after the 8/21/16 fall. The laceration and treatment provided was not updated on the care plan.

The last fall was documented on 10/29/16. The following was documented: "Resident was found by therapy on floor mat on knees, Res (resident) was assessed. 0 (zero) injury noted....Additional comments/or steps taken to prevent recurrence: "high traffic area." This intervention did not make it to the care plan dated 5/17/16.

On 1/5/17 at approximately 4:00 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked when the care plan was updated, LPN #3 stated that first an interim care plan would be created on admission that addressed issues such as code status and pain. LPN #3 stated that a fall care plan would not necessarily be on the interim care plan; it would be placed on the comprehensive care plan. She stated this was completed within 14 days of admission. LPN #3 stated that all care plans should be personalized to fit each resident's needs. LPN #3 stated that care plans must be updated after each change in care or condition such as falls, antibiotics etc. LPN #3 stated that

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the nurse caring for the resident at the time of a fall, the unit manager or the charge nurse would be responsible for updating the care plan after a fall. LPN #3 agreed that she could not locate where the care plan was updated or reviewed after each of the above falls. LPN #3 stated that interventions were put in place but the care plan was not updated.

On 1/5/17 at 4:36 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked when the care plan was reviewed or revised, ASM #2 stated that care plan was reviewed and revised quarterly and prn (as needed) for any new changes. When asked the purpose of the care plan, ASM #2 stated that the purpose of the care plan was to make sure how to take care of each resident. ASM #2 stated that the care plan should identify each problem, goal, and interventions needed to meet each goal. ASM #2 stated that the care plan should be updated or at least reviewed after each fall.

On 1/5/17 at 5:59 p.m., ASM #1, the administrator and ASM #2 the DON were made aware of the above findings.

Facility policy titled, "Care Plans," documents in part, the following: "...5. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change."

No further information was presented prior to exit.

[1] Lewy Body- "LBD is a disease associated with abnormal deposits of a protein called

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F 280	Continued From page 76 alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood. LBD is one of the most common causes of dementia, after Alzheimer's disease and vascular disease." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/alzheimers/publication/lewy-body-dementia/basics-lewy-body-dementia.	F 280		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that facility staff failed to provide services in accordance with the written plan of care for four of 26 residents in the survey sample, Residents # 10, # 17, # 6 and #7 and failed to provide care by qualified personnel for one of 26 residents in the survey sample, Resident # 7. 1. The facility staff failed to monitor and document Resident # 10's behaviors according to the resident's plan of care. 2. The facility staff failed to monitor and document Resident # 17's behaviors according to	F 282	**F282** 1. Resident #10's behavior monitoring record will be reviewed and updated by the Assistant Director of Nursing or the Director of Nursing by 2/1/17 to ensure behaviors have been documented according to the resident's plan of care. Resident #17 behavior monitoring record will be reviewed and updated by the Assistant Director of Nursing or the Director of Nursing by 2/1/17 to ensure behaviors have been documented according to the resident's plan of care. The licensed nurses will be reeducated on resident #6 comprehensive care plan for pain by 2/1/17 by the Director of Nursing to ensure the pain care plan is followed as required.	

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F 282	Continued From page 77 the resident's plan of care. 3. The facility staff failed to follow the comprehensive care plan for pain for Resident #6. 4. a. The facility staff failed to follow Resident #7's care plan to medicate the resident for pain one half hour prior to treatments or care. b. The facility staff failed to have a licensed nurse connect and turn on the oxygen for Resident #7. The findings include: 1. The facility staff failed to monitor and document Resident # 10's behaviors according to the resident's plan of care. Resident # 10 was admitted to the facility on 12/6/07 with a readmission on 8/15/16 with diagnoses that included but not limited to: dysphagia (1), anxiety (2), obsessive compulsive disorder (3), aphasia (4), schizophrenia (5), edema (6) diabetes mellitus (7) and convulsions (8). The most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/29/16 coded the resident as scoring a one on the brief interview for mental status (BIMS) of a score of 0 - 15, one being severely impaired of cognition. Resident # 10 was coded as being totally dependent of one staff member for activities of daily living. Resident # 10's care plan with a review date of	F 282	Resident #7 was discharged on 1/19/17.	

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F 282	Continued From page 78 12/1/16 was reviewed. Under "Problem/Need" it documented, "At risk for adverse effects r/t (related to) use of psychotropic medications." Under "Approaches" it documented, "Monitor and record target behaviors and inform MD (medical doctor) of increase in frequency for possible medication adjustments." The "Physician's Order Sheet" (POS) dated 12/1/16 for Resident # 10 and signed by the physician on 12/21/16 documented, "Seroquel (10) 100 MG (milligram). Give one (1) tablet via PEG (percutaneous endoscopic gastrostomy)-tube (9) at bedtime related to schizophrenia. Start Date 10/19/16." The MARs (medication administration records) for Resident # 10 dated November 1, 2016 through January 4, 2017 documented, "Seroquel 100 MG. Give 1 tablet via PEG-tube at bedtime related to schizophrenia." Further review of the MARs revealed Resident # 10 received one Seroquel tablet each evening for 65 of 65 opportunities. The "Behavior Monthly Flow Sheets" for Resident # 10 dated November 1, 2016 through January 4, 2017 failed to document behavior monitoring for the use of Seroquel for 195 of 195 opportunities. On 1/5/17 at 3:20 p.m. an interview was conducted with LPN (licensed practical nurse) # 1. When asked about the purpose of the care plan, LPN # 1 stated, "To know how to take care of the resident and what we need to do to help them get better." LPN # 1 was then asked to review the current care plan and behavior monitoring sheets dated November 1, 2016 through January 4, 2017 for Resident # 10. When asked about the blanks on the behavior	F 282	2. The Assistant Director of Nursing and the Director of Nursing will audit the behavior monitoring record of the current residents by 2/1/17 to ensure behaviors have been documented according to the resident's plan of care. The Assistant Director and the Unit Manager will audit the current residents' pain management programs by 2/1/17 to ensure the nursing staff are following the resident's pain plan of care as required. The Assistant Director of Nursing and the Unit Manager will review the current residents that are currently receiving oxygen by 2/1/17 to ensure licensed nurses are connecting and turning on oxygen as required. 3. The Staff Development Coordinator will reeducated the licensed nurses by 2/1/17 related to ensuring behavior monitoring records are completed and behaviors documented and resident pain management programs are followed.	

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F 282	Continued From page 79 monitoring sheets, LPN # 1 stated, "If it wasn't documented I can't say it was done." When asked about following the care plan LPN # 1 stated that it wasn't being followed. On 1/5/17 at 4:30 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked about the purpose of the care plan, ASM # 2 stated, "It tells how to take care of the resident." ASM # 2 was then asked to review Resident # 10's current care plan and behavior monitoring sheets dated November 1, 2016 through January 4, 2017 for Resident # 10. When asked about the blanks on the behavior monitoring sheets, ASM # 2 stated, "If it wasn't documented it wasn't done." When asked about following the care plan ASM # 2 stated that it wasn't being followed. On 1/5/17 at approximately 6:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit. References: (1) A swallowing disorder. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html>. (2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (3) A common, chronic and long-lasting disorder	F 282	The Staff Development Coordinator will reeducate the nursing staff by 2/1/17 related to ensuring oxygen is connected and turned on by a licensed nurse. 4. The Director of Nursing or Assistant Director of Nursing will complete audits weekly for 4 weeks and monthly for 2 months to ensure the behavior monitoring records, the behavior documentation, the pain management documentation and the resident's receiving oxygen to ensure plan of care continues to be follow as required The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion Date: 02/03/17	

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in which a person has uncontrollable, reoccurring thoughts (obsessions) and behaviors (compulsions) that he or she feels the urge to repeat over and over. This information was obtained from the website: http://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd/index.shtml.

(4) A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/aphasia.html>.

(5) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm.

(6) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html.

(7) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(8) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm.

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(9) Feeding tubes are needed when you are unable to eat or drink. This may be due to stroke or other brain injury, problems with the esophagus, surgery of the head and neck, or other conditions. This information was obtained from the website: <https://medlineplus.gov/ency/patientinstructions/000900.htm>.

(10) Used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html.

2. The facility staff failed to monitor and document Resident # 17's behaviors according to the resident's plan of care.

Resident # 17 was admitted to the facility on 5/2/12 with a readmission on 5/5/16 with diagnoses that included but not limited to: hypertension (1), peripheral vascular disease (2), diabetes mellitus (3), dementia (4), seizure (5), and asthma (6).

The most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/15/16 coded the resident as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 being moderately impaired of cognition for daily decision making. Resident # 17 was coded as requiring extensive assistance of one staff

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F 282	Continued From page 82 member for activities of daily living. Resident # 17's care plan with a review date of 11/22/16 was reviewed. Under "Problem/Need" it documented, "At risk for adverse effects r/t (related to) use of psychotropic medications." Under "Approaches" it documented, "Monitor and record target behaviors and inform MD (medical doctor) of increase in frequency for possible medication adjustments." The "Physician's Order Sheet" (POS) dated 11/1/16 for Resident # 17 and signed by the physician on 11/2/16 documented, "Seroquel. Give 25 MG (milligram) by mouth two times a day. Start Date 11/1/16." The MARs (medication administration records) for Resident # 17 dated November 1, 2016 through January 4, 2017 documented, "Seroquel. Give 25 MG (milligram) by mouth two times a day. Start Date 11/1/16." Further review of the MARs revealed Resident # 17 received two Seroquel tablets each day for 129 of 129 opportunities. The "Behavior Monthly Flow Sheets" for Resident # 17 dated November 1, 2016 through January 4, 2017 failed to document behavior monitoring for the use of Seroquel on 317 of 573 opportunities. On 1/6/17 at 11:05 a.m. an interview was conducted with LPN (licensed practical nurse) # 7. When asked about the purpose of the care plan LPN # 1 stated, "To know how to take care of the resident." LPN # 7 was then asked to review Resident # 17's current care plan and behavior monitoring sheets dated November 1, 2016 through January 4, 2017. When asked	F 282		

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about the blanks on the behavior monitoring sheets LPN # 7 stated, "If it wasn't documented it was done." When asked about following the care plan LPN # 7 stated that it wasn't being followed.

On 1/6/17 at 1:10 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked about the purpose of the care plan ASM # 2 stated, "It tells how to take care of the resident." ASM # 2 was then asked to review Resident # 17's current care plan and behavior monitoring sheets dated November 1, 2016 through January 4, 2017. When asked about the blanks on the behavior monitoring sheets ASM # 2 stated, "If it wasn't documented it wasn't done." When asked about following the care plan ASM # 2 stated that it wasn't being followed.

On 1/6/17 at approximately 12:35 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(2) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing

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bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.

(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(4) A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html.

(5) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.

(6) A disease that causes the airways of the lungs to swell and narrow. It leads to wheezing, shortness of breath, chest tightness, and coughing. Information was obtained from the website: https://medlineplus.gov/ency/article/000141.htm.

3. The facility staff failed to follow the comprehensive care plan for pain management and assessment for Resident #6.

Resident #6 was admitted to the facility on 10/13/09 with a recent readmission on 9/16/16, with diagnoses that included but were not limited

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to: multiple sclerosis (MS) (a progressive disease in which nerve fibers of the brain and spinal cord lose their myelin cover (1)), dysphagia, peripheral vascular disease, high blood pressure, and neurogenic bladder.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/14/16, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating that she was cognitively intact to make daily decisions. The resident was coded as requiring extensive to being totally dependent upon the staff for most of her activities of daily living. She was coded as independent after set up assistance was provided for eating. In Section J - Health Conditions, the resident was coded as having received scheduled pain medication, as needed pain medication and received non-medication interventions for pain. Resident #6 was coded as having frequent pain on a scale of five out of zero - ten, ten being the worse pain ever in.

The Care Plan dated, 10/28/10 and reprinted on 11/2/15, documented, "Problem/Need: Risk for impaired comfort r/t (related to) pain secondary to the disease process." The "Goals & Target date" documented, "Resident will state pain level less than 2 on a scale of 1 -10 after intervention for pain within 30 min (minutes) to 1 hour. Thru next 90 days." The "Approaches" documented, "Assess for pain quarterly. Administer pain medications PRN (as needed). Monitor for effectiveness of interventions for pain. Assess for pain each shift and prn."

An interview was conducted with Resident #6 on

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1/5/17 at 1:22 p.m. Resident #6 was asked when she requests pain medication does the staff asks her to rate her pain on a scale. Resident #6 stated, "Yes." Resident #6 was asked if staff come back and ask her to rate her pain again on a scale, after they give her the pain medication. Resident #6 stated, "No they don't." On 1/5/17 at 1:41 p.m. Resident #6 was asked if staff offers to reposition her, give her a snack or anything to relieve the pain without medication, when she asks for pain medication. Resident #6 stated, "No, no one does that."

The physician orders dated 1/1/17, documented, "Percocet (used to treat moderate to severe pain) (2) 5/325 one po (by mouth) Q (every) 6 hrs (hours) PRN (as needed)."

Review of the November 2016 MAR (medication administration record) revealed the documentation of the administration of the Percocet 34 times. The reverse side of the MAR did not document a pain level and only documented nothing or "helpful or a plus sign" under the column, "Results or Response."

The December 2016 MAR revealed the documentation of the administration of the Percocet 15 times. The reverse side of the MAR did not document a pain level and only documented, "Eff (effective)" or a plus sign with "results voiced."

A review of the nurse's notes did not document anything related to pain except one nurse's note dated, 12/16/16 at 9:00 p.m. that documented, "Res (resident) rec'd (received) PRN Percocet at 6:10 p.m. for c/o (complaint of) wound pain after repositioning was ineffective. (A plus sign) results

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F 282	Continued From page 87 noted." An interview was conducted with RN (registered nurse) #5, the unit manager, on 1/5/17 at 11:30 a.m. RN #5 was asked what is expected of the nurse, if the care plan goal documents a resident will state pain level less than 2 on a scale of 1 -10 after interventions for pain within 30 minutes or 1 hour. RN #5 stated, "We should be asking the pain scale again and document it." An interview was conducted with LPN (licensed practical nurse) #1, the nurse caring for Resident #6; on 1/5/17 at 1:25 p.m. LPN #1 was asked about the process staff follows when a resident complains of pain. LPN #1 stated, "First I assess where the pain is, assess the pain level by using the pain scale or watch facial grimacing. I offer repositioning or offer a snack, if that doesn't work then ! will give the pain medication." When asked if she went back to reassess the residents pain, LPN #1 stated, "I go back and reassess. Ask if it was effective, sometimes I just ask if they can tell me if it's better or gone. I write helpful or effective." Resident #6's care plan was reviewed with LPN #1. When asked what staff should be doing, LPN #1 stated, "I should be asking the pain scale after I give her pain medication. That's not anywhere on her MAR." When asked the purpose of the care plan, LPN #1 stated, "It's to know how to care for a resident. What we need to do to care for them." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 1/5/17 at approximately 2:30 p.m. When asked the purpose of the care plan, ASM #2 stated, "The care plan tells us how to take care of the resident. How to do it, what goal and	F 282		

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interventions on how to reach that goal." The care plan for Resident #6's pain was reviewed with ASM #2. When asked if the care plan should be followed, ASM #2 stated, "Yes, it should be."

The facility policy, "Pain Assessment" documented in part, "7. Reassess and document the resident's pain scale each time pain medication is used, when the dose changes or when the drug changes."

The facility policy, "Care Plans" documented in part, "1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identified the highest level of functioning the resident may be expected to attain."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

The administrator and ASM #2 were made aware of the above findings on 1/5/17 at 6:00 p.m.

No further information was provided prior to exit.

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F 282	Continued From page 89 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 380. (2) This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011543/?report=details#uses. 4. a. The facility staff failed to follow Resident #7's care plan to medicate the resident for pain one half hour prior to treatments or care. Resident #7 was admitted to the facility on 12/26/16 and readmitted on 12/30/16 with diagnoses that included but were not limited to: respiratory failure, chronic lung disease, high blood pressure, arthritis and chronic pain. The most recent MDS was in progress and not available for review. The admission nurse's note dated 12/30/16 at 4:00 p.m. documented, "...Resident is alert/orient (sic) x (times) 3 (knows name, date and where she is).... 1 assist needed for ADL (activities of daily living) care." Review of the physician's orders documented, "Percocet (1) 5/325 mg (milligrams) 1 tab (tablet) po (by mouth) q (every) 4 hr (hours) prn (as needed) pain." Review of the medication administration record (MAR) documented, "Percocet 5/325 mg 1 tab po Q4Hrs prn pain. It was documented that Resident #7 received pain medication on 1/1/17 at 4:45 p.m.; 1/2/17 at 3:15 a.m.; 1/4/17 at 7:10 a.m., 1/5/17 at 2:30 a.m. and 1/5/17 at 9:55 a.m. Review of the care plan initiated on 1/4/17	F 282		

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documented, "Focus. The resident is at risk for alteration in comfort: pain r/t (related to) disease process. Interventions. Administer analgesia as per orders. Give 1/2 hour before treatments or care."

Review of the clinical record documented that the resident received physical therapy twice a day. There was no documentation that the resident received pain medication one half hour prior to therapy.

An interview was conducted on 1/6/17 at 9:50 a.m. with LPN (licensed practical nurse) #8. When asked when Resident #7 was given pain medication, LPN #8 stated, "When she asks for it." When asked what she would do if there was a care plan intervention to medicate the resident prior to treatments or care such as therapy, LPN #8 stated, "I would coordinate it with therapy because they have a schedule." When asked if she had coordinated giving Resident #7 pain medication with physical therapy, LPN #8 stated she had not.

On 1/6/17 at 11:30 a.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

An interview was conducted on 1/6/17 at 1:30 p.m. with OSM (other staff member) #8, the physical therapist. When asked what times Resident #7 had therapy, OSM #8 stated, "It's at different times. She's already had therapy today."

No further information was provided prior to exit.

(1) Percocet -- A narcotic pain reliever that treats

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moderate to severe pain. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011543/.

b. The facility staff failed to have a licensed nurse connect and turn on the oxygen for Resident #7.

An observation was made on 1/4/16 at 3:05 p.m. of Resident #7. The resident was sitting up in the wheelchair. She had oxygen on via nasal cannula (soft prongs that fit in the nose to deliver oxygen). The resident requested her oxygen be changed from the portable tank on the wheelchair to the oxygen machine in her room. A nurse and a CNA (certified nursing assistant) were in the room at the time. The nurse left the room and CNA #2 unhooked the oxygen from the portable tank, turned on the oxygen machine and stood looking at the machine. CNA #2 did not know how to connect the oxygen tubing to the machine and asked the resident how it was attached. The resident showed CNA #2 where to connect the tubing to the machine. The oxygen was set at 3 1/2 liters. Resident #7 stated, "I'm on 4 liters."

Review of the physician's orders dated 12/30/16 documented, "O2 (oxygen)." There was no liter flow ordered.

Review of the MAR (medication administration record) documented, "O2 at 2L/m (liters/minute) continuous.

An interview was conducted on 1/4/16 at 3:55 p.m. with CNA #2. When asked if CNAs normally applied oxygen to the residents, CNA #2 stated, "Normally it's not the CNA, it's just the nurses. If

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they're busy I do it. I didn't put it on anything, it went to 4 (liters)." CNA #2 was told that the oxygen had been observed set at 3 1/2 liters. When asked if she knew that oxygen was a medication, CNA #2 stated, "No." When asked if CNAs were allowed to administer medications, CNA #2 stated, "No."

An interview was conducted on 1/4/16 at 4:00 p.m. with LPN #4. When asked who could put oxygen on the residents, LPN #4 stated, "Just the nurses here." When asked why only nurses could put on oxygen, LPN #4 stated, "The correct answer is because it's considered a medication."

An interview was conducted on 1/4/16 at 4:05 p.m. with CNA #3. When asked who could put oxygen on the residents, CNA #3 stated, "The doctor prescribes it and the nurse puts it on." When asked if CNAs put oxygen on the residents, CNA #3 stated, "Yes, I hook up (the resident) to the oxygen and ask what liter it's on." When asked if she knew oxygen was a medication, CNA #3 stated, "Yes." When asked if CNAs were allowed to administer medications stated, "No."

On 1/4/16 at 4:45 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "OXYGEN THERAPY" documented, Policy: To administer oxygen when indicated to provide adequate gas exchanges. A physician's order is required and shall include liter flow rate and administration divide (i.e. nasal cannula, mask etc.)." The policy was from the nursing policies and procedures manual revised 7/2007.

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F 282	Continued From page 93 No further information was provided prior to exit.	F 282		
F 284 SS=D	483.21(c)(1)(2)(iv) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN (c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the	F 284	**F284** 1. Resident #25 was discharged from the facility on 3/21/16 2. Social Services will audit the current residents' clinical record by 2/1/17 to ensure discharge plans have been developed as required. 3. The Administrator will reeducated Social Service staff by 1/27/17 to ensure discharge plans are developed for residents as required. 4. The Social Service Coordinator or the Social Service Assistant will audit 5 current residents' clinical record weekly for 4 weeks and monthly for 2 months to ensure discharge plans continue to be developed as required. The Social Service Coordinator will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator will to responsible for monitoring and follow up. Completion Date:	02/03/17

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discharge plan and inform the resident and resident representative of the final plan.

(vi) Address the resident's goals of care and treatment preferences.

(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.

(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.

(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.

(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment

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F 284	Continued From page 95 preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. (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: (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 staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to develop a discharge plan for one of 26 residents in the survey sample, Resident #25. The facility staff failed to develop a discharge plan for Resident #25.	F 284		

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F 284	Continued From page 96 The findings include: Resident #25 was admitted to the facility on 1/21/16 and discharged on 3/21/16. His diagnoses included but were not limited to: chronic obstructive pulmonary disease (COPD), high blood pressure, cerebral infarction, metabolic acidosis, hypothermia, vascular dementia, chronic an email and atrial fibrillation. The most recent MDS (minimum data set) assessment, a change of therapy assessment, with an assessment reference date of 2/29/16, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions. He was coded as being independent for bed mobility, transfers, eating and toilet use. The "Social Service Progress Notes" dated, 1/21/16, documented, "82 year old African American male admitted to (Initials of facility) with DX (diagnosis) of COPD and hypertension (high blood pressure). Resident is alert, oriented X 3 (oriented to person, place and time). He is very pleasant but adamant about leaving soon to get home. Resident is a Full Code status. He has a disposition to home. The phone number listed on the face sheet does not work therefore 72 hour meeting has to be scheduled via letter." The "Social Service Progress Notes" dated, 2/2/16, documented, "SSD (social service director) spoke with resident's daughter to schedule a meeting about her father's disposition. (Resident #25) requesting to go home. He left the facility with a visitor on Saturday (1/30/16). Resident was returned to facility by his daughter.	F 284		

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F 284	Continued From page 97 A meeting has been set for Thursday 2/4/16 at 5:30 p.m." The "Social Service Progress Notes" dated, 2/9/16, documented, "SSD called to advise R/P (responsible party) that resident will have an admission care plan tomorrow 2/10/16 @ (at) 2:00 p.m. SSD left message encouraging attendance via telephone or in person. SSD asked R/P (responsible party) to please return call. Resident (Resident #25) was also invited to attend." The "Social Service Progress Notes" dated, 2/29/16, documented, "SSD called and spoke to R/P to tell her that resident (last name of resident)'s last covered day for therapy will be 3/9/16. She has the option to take the resident home or private pay. Resident requires supervision due to memory deficits. R/P requesting the name of the business office manager. She was provided with (OSM #4)'s mane and contact information." The "Social Service Progress Notes" dated, 3/4/16, documented, "SSD called and left a message for R/P of resident (last name of resident) to please return my call in reference to setting of a d/c (discharge) meeting for (Resident #25). Resident have (sic) a d/c date of 3/10/16. Resident will become private pay. SSD advised R/P to please return call to myself of (OSM #4) to set up d/c meeting or paperwork." The "Social Service Progress Notes" dated, 3/8/16, documented, "SSD called R/P (name of RP) to discuss her father (Resident #25). Per R/P (Resident #25) will be staying @ (initials of facility name) long term. One of her other siblings	F 284		

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F 284	Continued From page 98 will be calling today or tomorrow to set up finances with BOM (business office manager." There were no further social services notes. Review of the nurse's note did not reveal any documentation of discharge planning until the note of 3/21/16 at 12:00 p.m. that documented, "Resident D/C (discharged) out of facility to (Name of facility). Left facility with his daughters in stable condition. Left at 11:00 a.m. This writer explained all medication to RP along with diagnosis and times given. RP voiced understanding. All personal property was present and accounted for with RP signing paperwork." The Care Plan, printed on 2/5/16, was reviewed. There was nothing addressed on the care plan related to discharge planning. An interview was conducted with other staff member (OSM) #3 on 1/5/17 at 8:35 a.m. When asked the process for discharging a resident, OSM #3 stated, "The clinical team which includes the social worker, therapy and nursing. They discuss the plan to go home. The therapist gives the date of discharge. Nursing them has input if there is any medical reasons not to be discharged. Then nursing and social services plan a discharge date. We then set up a discharge meeting with the family and loved ones." When asked how much notice is given to the resident and family of impending discharge, OSM #3 stated, "Usually if they are on skilled services (Medicare) we give two weeks' notice unless they are not performing in therapy and if that is the case then that can sometimes be abrupt."	F 284		

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An interview was conducted with OSM #7, the director of therapy, on 1/5/17 at 8:50 a.m. When asked to discuss Resident #25, OSM #7 stated she couldn't recall anything and went to her office to locate any paperwork on him. OSM #7 returned at 9:11 a.m. stating she had no records on his discharge. I would have written it on my schedule. Sadly, I don't recall if I had a record of it. I slightly recall my conversation with the daughter. I recall speaking to her regarding his function ability. Based on our documentation, I doubt that she would have said he could go home alone. All of our documentation shows confusion couldn't read a clock or calendar. All of his therapy goals except one long term goal had been met. He could function at home with supervision." OSM #7 stated that all therapy documentation indicated that he would stay long term in the facility. The speech therapist had planned long term goals in the event he was taken home but needed 'full time care.' When asked if she was involved with his discharge planning, OSM #7 stated, "I treated him for a week so yes." When asked if any discharge planning or care plan meetings were held, OSM #7 stated, "I can't recall but normally we do a 72 hour meeting to discuss the plan for the resident. If not held in 72 hours, it's held as soon as the family is available."

An interview was conducted with OSM #5, the admission director, on 1/5/17 at 9:30 a.m. When asked when the discharge process is starting, OSM #5 stated, "It starts with admission. We evaluate the resident in 72 hours and the family is involved from the get go." When asked who's involved in the planning of the resident's discharge, OSM #5 stated, "Therapy, social worker and the MDS coordinator." When asked

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how much notice is given to the family of a discharge, OSM #5 stated, "We have a 10 -14 day window where the discharge plan is set with the interdisciplinary team and the family." When asked if she had any recollection of conversations with Resident #25's daughter, OSM #5 stated, "Any conversation I have is on the front end prior to admission." When asked how the information she obtains prior to admission regarding discharge is passed on to the social worker or therapy staff, OSM #5 stated, "Unless someone gets back to me, it doesn't get passed down until was determined what the plan is. The social worker is not involved. The business office manager takes care of the Medicaid application and financial process with the families." When asked again if the social worker is involved in discharge planning, OSM #5 stated, "Not usually." When asked about the resident being transfers to a veteran's facility, OSM #5 stated, "We didn't know he had VA (veteran's affairs) benefits."

An interview was conducted with OSM #4, the business office manager, on 1/5/17 at 9:42 a.m. When asked her involvement in the discharge of a resident, OSM #4 stated, "I'm usually in the 72 hour meeting where discharge planning starts. I don't have any notes for that meeting so I must not have been in it." OSM #4 was asked to provide any documentation she has related to Resident #25's discharge or plan to stay at the facility.

A second interview was conducted with OSM #3, the social services director, on 1/5/17 at 9:50 a.m. When asked if she could find any documentation of the discharge plan to send the resident to a VA facility, OSM #3 stated, "The only documentation regarding his transfer was the nurse's note of

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F 284	Continued From page 101 3/21/16 of his transfer to (Name of facility)." When asked when the discharge planning starts, OSM #3 stated, "It starts during the admission process. My assistant or I call to set up a 72 hour meeting in person or speaker phone." When asked who's responsible for discharge planning, OSM #3 stated, "Primarily it should be the social worker." When asked if she was told of Resident #25's desire to stay long term care, OSM #3 stated, "I should have been told, many times it's not communicated to me the information from admissions." When asked if the 72 hour meeting took place, OSM #3 stated, "I can't find any documentation that it did." When asked why it took two weeks, after the resident eloped, for the facility to reach out and contact the family regarding discharge planning, OSM #3 stated, "We sent a letter." A copy of the letter was requested at this time. OSM #3 was then asked why there was no follow up for a meeting 72 hours after admission, if the facility is stating that a 72 hour meeting is to take place for all residents being admitted. OSM #3 stated, "I don't know. I take responsibility of no documentation in the clinical record regarding the discharge but the daughter initiated the transfer to (Name of facility)." When asked if the social worker should be informed of any impending discharge, OSM #3 stated, "I should have been but wasn't. The admissions office had communication with the RP." A copy of any communication was requested. When asked why there was no documentation of the resident's impending transfer to another facility in the clinical record, OSM #3 stated, "I wasn't involved with it." An interview was conducted with RN (registered nurse) #3, the MDS coordinator, on 1/5/17 at 10:12 a.m. When asked if all residents should	F 284		

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have a discharge care plan, RN #3 stated, "No, if they plan to stay long term care then I don't care plan discharge." When asked the process for discharge planning, RN #3 stated, "The social worker starts the discharge process within 72 hours of admission. We have a meeting with therapy, social services and nursing." When asked if Resident #25 had a 72 hour meeting, RN #3 stated, "I don't recall. We had a meeting with her on the phone after he eloped (previously investigated during another complaint investigation) but we didn't discuss discharge, we were talking about keeping him safe." When asked where the documentation of that meeting was, RN #3 stated she would have to look for it." RN #3 stated, "I remember this family, the family didn't want him to go home but didn't want to private pay."

On 1/5/17 at 10:46 a.m. OSM #4, the business office manager returned and presented notes that she keeps on file. The note of 3/8/16 documented, "Skilled resident admitted and no secondary payer. Plan is STC (short term care) and return to home."

The social worker returned on 1/5/17 at approximately 1:30 p.m. and presented documentation of a care plan meeting on 2/4/16 at 5:46 p.m. Also presented email communication from the RP and the admissions director (OSM #5). The email dated 3/18/16 documented, "I received a call from (name and contact number) that they has been trying to get a CURRENT medications list for my father (Resident #25). And he is having difficulty getting that information. What is being faxed to him is the ADMISSION med list. He needs the CURRENT med list. I know my father's medications have been

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F 284	Continued From page 103 changed since his admission to (name of facility). Would you please assist? The fax number for (name of facility and number)." An interview was conducted with the administrator, administrative staff member (ASM) #1 and the director of nursing, ASM #2, on 1/5/17 at 2:55 p.m. ASM #1 and ASM #2 were asked when discharge planning for residents starts. ASM #2 stated, "Upon admission." When asked if the resident should have a care plan for discharge planning, ASM #2 stated, "Yes." When asked if a discharge care plan would be done if the resident is planning to stay long term care. ASM #2 stated, "Yes." When asked for any documentation regarding the planning of the discharge of Resident #25 to another facility, ASM #1 stated he wasn't in the building at that time. ASM #1 stated they could not locate the letter the family was sent for the 72 hour meeting. ASM #1 confirmed that only one care plan meeting was held on 2/4/16 over the phone with the RP after the resident had eloped from the facility and no discharge planning was done at that meeting. ASM #1 was shown the email communication from the admissions director to the responsible party on 3/18/16, and was asked, for any documentation of the social workers involvement in the discharge planning, and communication with the other facility. ASM #1 stated, "The daughter initiated the transfer." When asked if that negated the facility's responsibility to ensure a safe discharge, ASM #1 stated, "No." The administrator and ASM #2 were made aware of the above concern on 1/5/17 at 6:00 p.m. No further information was provided prior to exit.	F 284		

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F 284	Continued From page 104 Complaint Deficiency F 309 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that that facility staff failed to provide care and services to maintain the highest practicable well-being for five of 26 residents in the survey sample, Resident #7, Resident #3, Resident #6, Resident #1 and	F 284 F 309	**F309** 1. Resident #7 was discharged from the facility on 1/9/17. Resident #3's physician was notified by the Director of Nursing that the 7 facial treatments, 8 abdominal skin treatments, and 2 right third toe wound care were not documented on the December 2016 medical records. Resident #3's facial areas, abdominal skin areas, and right third toe wound were reassessed by the licensed nurse on 1/6/17 and no decline were noted. Resident #6 was reassessed for pain on 1/6/17 by the Unit Manager. The Licensed nurses will be reeducated by the Staff Development Coordinator by 2/1/17 related to ensuring non pharmacological interventions are attempt prior to the administration of as needed pain medication and the effectiveness of the administered pain medication is assessed using a pain scale. Resident #1 was discharged from the facility on 1/7/17.	

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F 309	Continued From page 105 Resident #11. 1. The facility staff failed to assess Resident #7's pain prior to administering as needed pain medication. 2. The facility staff failed to provide the physician ordered facial treatments on seven occasions out of 62 opportunities in December 2016; physician ordered abdominal skin treatments on eight occasions out of 62 opportunities in December 2016; and physician ordered right third toe wound care on two occasions out of 31 occasions in December 2016 for Resident #3. 3. The facility staff failed to attempt non pharmacological interventions prior to the administration of as needed pain medication and failed to assess the effectiveness of the medication administered using a pain scale for Resident #6. 4. For Resident #1, facility staff failed to attempt non-pharmacological interventions prior to the administration of prn (as needed) pain medication. The facility staff failed to assess and monitor pain prior to the administration of pain medication and failed to monitor effectiveness of prn pain medication. 5. The facility staff failed to monitor Resident # 11's AV fistula (1) (arterial - venous) fistula for dialysis (2). The findings include: 1. Facility staff failed to assess Resident #7's pain prior to administering as needed pain medication.	F 309	Resident #11's AV fistula was assessed on 1/6/17 by the Registered Nurse with no concerns noted. 2. The Assistant Director of Nursing and the Director of Nursing will audit the current resident's treatment records by 2/1/17 to ensure treatments have been documented as required. The Assistant Director of Nursing and the Director of Nursing will audit the current residents' medical record by 2/1/17 to ensure non pharmacological interventions are attempted prior to the administration of as needed pain medications and the effectiveness of the administered pain medication is assessed using a pain scale. The Assistant Director of Nursing will audit the current dialysis residents' by 2/1/17 to ensure AV fistula and shunt are assessed and monitored as required.	

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F 309	Continued From page 106 Resident #7 was admitted to the facility on 12/26/16 and readmitted on 12/30/16 with diagnoses that included but were not limited to: respiratory failure, chronic lung disease, high blood pressure, arthritis and chronic pain. The most recent MDS was in progress and not available to review. The admission nurse's note dated 12/30/16 at 4:00 p.m. documented, "...Resident is alert/orient (sic) x (times) 3 (knows name, date and where she is).... 1 assist needed for ADL (activities of daily living) care." Review of the care plan initiated on 1/4/17 documented, "Focus. The resident is at risk for alteration in comfort: pain r/t (related to) disease process. Interventions. Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition." Review of the physician's orders documented, "Percocet (1) 5/325 mg (milligrams) 1 tab (tablet) po (by mouth) q (every) 4 hr (hours) prn (as needed) pain." Review of the medication administration record (MAR) documented, "Percocet 5/325 mg 1 tab po Q4Hrs prn pain. It was documented that Resident #7 received pain medication on 1/1/17 at 4:45 p.m.; 1/2/17 at 3:15 a.m.; 1/4/17 at 7:10 a.m., 1/5/17 at 2:30 a.m. and 1/5/17 at 9:55 a.m. There was no documentation of the resident's pain rating prior to administration of the pain medication. There was documentation that the pain medication was effective.	F 309	3. The Licensed nurses will be reeducated by the Staff Development Coordinator by 2/1/17 related to ensuring treatments are documented as required, dialysis AV fistula and shunts are assessed and monitored as required, and non pharmacological interventions are attempted prior to the administration of as needed pain medications and the effectiveness of the administered pain medication is assessed using a pain scale. 4. The Director of Nursing or Assistant Director of Nursing will audit 5 current resident's medical record on each unit weekly for 4 weeks and monthly for 2 months to ensure treatments continue to be documented as required, dialysis AV fistula and shunts continue to be assessed and monitored and non-pharmacological interventions continue to be attempted prior to the administration of as needed pain medications and the effectiveness of the administered pain medication continues to be assessed using a pain scale. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months.	

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F 309	Continued From page 107 Review of the nurse's notes on 1/1/17, 1/2/17 and 1/5/17 did not evidence documentation of a pain assessment prior to the administration of the pain medication. There was a pain assessment completed on 1/14/17. An interview was conducted on 1/5/16 at 11:30 a.m. with RN (registered nurse) #5 regarding the process staff follows to assess a resident's pain. RN #5 stated, "Ask the pain scale or if not cognitively intact we use facial expressions. We look at the MAR and see if there are parameters and offer interventions before giving the pain medication and follow up after (to see if the medication was effective)." When asked if the pain scale was documented, RN #5 stated it was documented on the MAR. An interview was conducted on 1/5/16 at 11:35 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked how staff assessed a resident's pain, ASM #2 stated, "We get a baseline on their pain level." When asked if this was documented, ASM #2 stated, "Yes, on the back of the MAR." An interview was conducted on 1/5/16 at 11:45 a.m. with LPN (licensed practical nurse) #3. When asked how staff assesses a resident's pain, LPN #3 stated, "Where (is the pain), how long (have they had it)....ask them the pain scale of zero pain to ten being the worst pain ever." When asked if this was documented, LPN #3 stated, "Yes, on the MAR." LPN #3 was asked to review Resident #7's MAR for the Percocet. When asked if there was a pain rating documented, LPN 3 stated, "No. I would put it in my nurse's note." LPN #3 was asked to review the nurse's notes for Resident #7 for 1/1/17 and	F 309	The Director of Nursing will be responsible for monitoring and follow up. Completion Date:	02/03/17

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F 309	Continued From page 108 1/2/17 for pain assessment, LPN #3 stated, "It's not there." On 1/5/16 at 6:10 p.m. ASM #1, the administration and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "PAIN ASSESSMENT" documented, "Policy: An in-depth pain assessment will be completed for each resident who presents with acute or chronic; unrelieved pain symptoms. The comprehensive pain assessment includes: origin, location, severity, exacerbating and alleviating factors, and current treatment and response to treatment. Procedure: 7. Reassess and document the resident's pain using the pain scale each time pain medication is used, when the dose changes or when the drug changes." No further information was provided prior to exit. (1) Percocet -- Treats moderate to moderately severe pain. This medicine is a narcotic pain reliever. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=percocet 2. The facility staff failed to provide the physician ordered facial treatments on seven occasions out of 62 opportunities in December 2016; physician ordered abdominal skin treatments on eight occasions out of 62 opportunities in December 2016; and physician ordered right third toe wound care on two occasions out of 31 occasions in December 2016 for Resident #3. Resident #3 was admitted to the facility on	F 309		

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11/27/09 and readmitted on 10/19/16 with Resident #3 was admitted to the facility on 11/27/09 and readmitted on 10/19/16 with diagnoses that included but were not limited to: fracture left thigh bone, pain, anxiety, high blood pressure and bladder cancer.

The most recent MDS (minimum data set, a thirty day assessment, with an ARD (assessment reference date) of 12/3/16 coded the resident as having scored seven out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring the assistance from staff for all activities of daily living. The resident was coded as being at risk for developing pressure ulcers. The resident was coded as having one or more unhealed pressure ulcers.

Review of the physician orders dated 12/30/16 documented:
- "Cleanse face with water only and apply hydrocortisone (1) 0.1% to red areas on face BID two times a day. Start date. 10/19/16."
- Cleanse skin to abdominal fold with normal saline, pat dry apply nystatin (2) 1000,000 units/gram topical powder bid two times a day for treatment. Start date. 10/19/16."
- Cleanse right 3rd toe with normal saline, apply xeroform (3) gauze, cover with 4x4 gauze, wrap with kling and secure daily every day shift. Start date. 10/20/16."

Review of the December 2016 treatment administration record (TAR) documented:
- "Cleanse face with water only and apply hydrocortisone 0.1% to red areas on face BID two times a day." Review of the TAR did not evidence documentation that the treatment had

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been provided as ordered on: 12/2/16 at 9:00 a.m. or 6:00 p.m.; 12/7/16 at 9:00 a.m.; 12/13/16 at 9:00 a.m.; 12/16/16 at 6:00 p.m.; 12/21/16 at 6:00 p.m. and 12/26/16 at 6:00 p.m. The treatment was not provided a total of seven times out of 62 opportunities.
- "Cleanse skin to abdominal fold with normal saline, pat dry apply nystatin 1000,000 units/gram topical powder bid two times a day for treatment. Start date. 10/19/16."Review of the TAR did not evidence documentation that the treatment had been provided as ordered on: 12/2/16 at 9:00 a.m. or 6:00 p.m.; 12/3/16 at 6:00 p.m.; 12/13/16 at 9:00 a.m.; 12/16/16 at 6:00 p.m.; 12/21/16 at 9:00 a.m. or 6:00 p.m.; 12/26/16 at 6:00 p.m. The treatment was not provided a total of eight times out of 62 opportunities.
- "Cleanse right 3rd toe with normal saline, apply xeroform gauze, cover with 4x4 gauze, wrap with kling and secure daily every day shift. Start date. 10/20/16."
Review of the TAR did not evidence documentation that the therapy had been provided on 12/7/16 and 12/13/16. The treatment was not provided a total of two times out of 31 opportunities.

Review of Resident #3's care plan initiated on 5/26/15 and revised on 12/10/16 documented, "Problem. Arterial (arterial wound) toe, with risk for further damage r/t (related to tghe (sic) disease process."

Review of the weekly non-pressure skin condition report dated 11/15/16 documented, "SITE/LOCATION: abdominal fold. CONDITION IS: MASD (moisture associated skin damage). Tx (treatment) continues area free of erythema

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F 309	Continued From page 111 (redness and (no) broken skin." On 1/4/17 a request was made to ASM (administrative staff member) #2, the director of nursing to observe the wound care for Resident #3. A request was also made for all wound care sheets for the resident from October 2016 to the present date. On 1/5/17 at 8:30 a.m. ASM #2 stated that the wound care had been already been completed around 5:00 a.m. but she would facilitate an observation of wound care. Wound care was not made available for observation on 1/5/17. An interview was conducted on 1/5/17 at 11:45 a.m. with LPN (licensed practical nurse) #3 was asked what blank spaces on the TAR meant. LPN #3 stated, "If it isn't documented it didn't happen." An interview was conducted on 1/5/17 at 12:15 a.m. with LPN #1. When asked what it meant when there were blank spaces on the TAR, LPN #1 stated, "It means it wasn't done." On 1/5/17 at 6:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. A request was made for the weekly body audit tool. The tool was not provided during the survey. A request was made to speak to the nurses who worked the shifts when the treatments were not provided. The nurses were not made available for interview during the survey. A repeat request to observe wound care for Resident #3 was again made. On 1/6/17 at 10:30 a.m. a request to observe Resident #3's wound care again to ASM #2. ASM	F 309		

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F 309	Continued From page 112 #2 stated she would make sure it occurred. On 1/6/17 at 11:45 a.m. a request to observe Resident #3's wounds was made to ASM #2. ASM #2 again stated that she would make sure that occurred. On 1/6/17 at 12:50 a.m. a final request was made to ASM #2 to observe Resident #3's wounds. Wound care was not made available prior to exit. Review of the facility's policy titled, "Physician Medication Orders" did not specifically address administering medications as ordered. No further information was provided prior to exit. (1) Hydrocortisone cream -- Topical corticosteroids share anti-inflammatory, anti-pruritic and vasoconstrictive actions. The mechanism of anti-inflammatory activity of the topical corticosteroids is unclear. This information was obtained from: <https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?id=60265> (2) Nystatin - Treats infections caused by fungus. This information was obtained from: <https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011455/?report=details> (3) Xeroform --Commercial silver-impregnated occlusive dressings (such as Aquacel Ag Surgical wound dressing) have been touted as antimicrobial dressings. This information was obtained from: <https://www.ncbi.nlm.nih.gov/pubmed/27776905>	F 309		

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3. The facility staff failed to attempt non pharmacological interventions prior to the administration of as needed pain medication and failed to assess the effectiveness of the medication administered using a pain scale for Resident #6.

Resident #6 was admitted to the facility on 10/13/09 with a recent readmission on 9/16/16, with diagnoses that included but were not limited to: multiple sclerosis (MS) (a progressive disease in which nerve fibers of the brain and spinal cord lose their myelin cover (1)), dysphagia, peripheral vascular disease, high blood pressure, and neurogenic bladder.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/14/16, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating that she was cognitively intact to make daily decisions. The resident was coded as requiring extensive to being totally dependent upon the staff for most of her activities of daily living. She was coded as independent after set up assistance was provided for eating. In Section J - Health Conditions, the resident was coded as having received scheduled pain medication, as needed pain medication and received non-medication interventions for pain. Resident #6 was coded as having frequent pain on a scale of five out of zero - ten, ten being the worse pain ever in.

The physician orders dated 1/1/17, documented, "Percocet (used to treat moderate to severe pain (2)) 5/325 one po (by mouth) Q (every) 6 hrs

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(hours) PRN (as needed)."

Review of the November 2016 MAR (medication administration record) revealed the documentation of the administration of the Percocet 34 times. The reverse side of the MAR did not document a pain level and documented nothing or "helpful or a plus sign" under the column, "Results or Response."

The December 2016 MAR revealed the documentation of the administration of the Percocet 15 times. The reverse side of the MAR did not document a pain level and only documented, "Eff (effective)" or a plus sign with "results voiced."

A review of the nurse's notes did not document anything related to pain except one nurse's note dated, 12/16/16 at 9:00 p.m. that documented, "Res (resident) rec'd (received) PRN Percocet at 6:10 p.m. for c/o (complaint of) wound pain after repositioning was ineffective. (A plus sign) results noted."

The Care Plan dated, 10/28/10 and reprinted on 11/2/15, documented, "Problem/Need: Risk for impaired comfort r/t (related to) pain secondary to the disease process." The "Goals & Target date" documented, "Resident will state pain level less than 2 on a scale of 1 -10 after intervention for pain within 30 min (minutes) to 1 hour. Thru next 90 days." The "Approaches" documented, "Assess for pain quarterly. Administer pain medications PRN (as needed). Monitor for effectiveness of interventions for pain. Assess for pain each shift and prn."

The "Pain Evaluation" form located in the clinical

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record was dated, 9/16/16. The form documented, "11/15/16 - (A zero with a line through it indication 'no') pain interventions necessary at this time (A zero with a line through it indication 'no') increased c/o (complaints of) pain."

An interview was conducted with RN (registered nurse) #1, the assistant director of nursing, on 1/5/17 at 11:45 a.m., regarding the process staff follows for administering pain medications. RN #1 stated, "First you assess where the pain is. If the resident is capable, you ask the pain scale rating, try non-pharmacological interventions, and if they aren't effective, you go to the medications and administer medications. After you give the medications, you go back and reassess the resident to see if the medication was effective." RN #1 was asked if staff ask residents' the pain scale rating again on reassessment. RN #1 stated, "Yes, you do." When asked where the assessment using the pain scale, non-pharmacological interventions implemented and the reassessment using the pain scale is documented, RN #1 stated, "In the nurses notes."

An interview was conducted with Resident #6 on 1/5/17 at 1:22 p.m. Resident #6 was asked when she requests pain medication does the staff asks her to rate her pain on a scale. Resident #6 stated, "Yes." Resident #6 was asked if staff come back and ask her to rate her pain again on a scale, after they give her the pain medication. Resident #6 stated, "No they don't." On 1/5/17 at 1:41 p.m. Resident #6 was asked if staff offers to reposition her, give her a snack or anything to relieve the pain without medication, when she asks for pain medication. Resident #6 stated, "No, no one does that."

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An interview was conducted with LPN (licensed practical nurse) #1, the nurse caring for Resident #6; on 1/5/17 at 1:25 p.m. LPN #1 was asked about the process staff follows when a resident complains of pain. LPN #1 stated, "First I assess where the pain is, assess the pain level by using the pain scale or watch facial grimacing. I offer repositioning or offer a snack, if that doesn't work then I will give the pain medication." When asked if she went back to reassess the residents pain, LPN #1 stated, "I go back and reassess. Ask if it was effective, sometimes I just ask if they can tell me if it's better or gone. I write helpful or effective." LPN #1 was asked where interventions offered prior to the administration medication and the pain scale rating assessment is documented. LPN #1 stated, "We had pain flow sheets. We were told to use them then told not to use them." LPN #1 left to look at the MAR to determine if she had a flow sheet. LPN #1 returned and stated she couldn't find any old pain flow sheets and stated, "I guess it should be in the nurse's notes then."

An interview with ASM (administrative staff member) #2, the director of nursing on 1/5/17 at approximately 2:30 p.m., regarding the process staff follows for resident complaints of pain. ASM #2 stated, "First you ask the resident to rate the pain and location of the pain. You try interventions first, if they don't help, you go the medications. Then you go back and evaluate if the medication worked, you ask the pain scale once again." When asked where the interventions attempted prior to medication and the pain scale assessment and rating are documented, ASM #2 stated, "In the nurse's

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F 309	Continued From page 117 notes." The facility policy, "Pain Assessment" documented in part, "4. Non pharmacological interventions are used to provide pain relieve (sic) in conjunction with medication use. Interventions can include: positioning, physical therapy modalities, relaxation techniques, etc....7. Reassess and document the resident's pain using the pain scale each time pain medication is used, when the dose changes or when the drug changes. 8. If pain medication is provided as part of a pain management program, the Pain Management Flow Sheet should be used to assess pain each time pain medication is provided. This record should be kept with the MAR." Fundamentals of Nursing, 6th Edition, Potter and Perry, 2005, pages 1239-1287, "Nurses need to approach pain management systematically to understand a client's pain and to provide appropriate intervention....it is necessary to monitor pain on a consistent basis....Assessment of common characteristics of pain helps the nurse form an understanding of the type of pain, its pattern, and types of interventions that may bring relief....Onset and duration....Location....Intensity....Quality....Pain Pattern....Relief Measures....Contributing Symptoms....Pain therapy requires an individualized approach....Nurses administer and monitor interventions ordered by physicians for pain relief and independently use pain-relief measures that complement those prescribed by a physician....Effective communication of a client's assessment of pain and his or her response to intervention is facilitated by accurate and thorough documentation. This communication	F 309		

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F 309	Continued From page 118 needs to transpire from nurse to nurse, shift to shift, and nurse to other health care providers. It is the professional responsibility of the nurse caring for the client to report what has been effective for managing the client's pain. The client is not responsible for ensuring that this information is accurately transmitted. A variety of tools such as a pain flow sheet or diary will help centralize the information about pain management. The administrator and ASM #2 were made aware of the above findings on 1/5/17 at 6:00 p.m. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 380. (2) This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011543/?report=details#uses. 4. For Resident #1, facility staff failed to attempt non-pharmacological interventions prior to the administration of prn (as needed) pain medication. The facility staff failed to assess and monitor pain prior to the administration of pain medication and failed to monitor effectiveness of prn pain medication. Resident #1 was admitted to the facility on 4/28/16 with diagnoses that included but were not limited to protein-calorie malnutrition, dysphagia, hypothyroidism, blindness, muscle weakness, and Dementia with Lewy Body [1]. Resident #1's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/10/16. Resident #1 was	F 309		

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coded as being severely cognitively impaired in the ability to make daily decisions, scoring 03 out of 15 on the BIMS (Brief Interview for mental status) exam. Resident #1 was coded as requiring extensive assistance with bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing.

Review of Resident #1's November 2016 MAR (medication administration record) revealed the following orders initiated on 10/28/16:

"Lortab Tablet [2] 5-325 mg (milligrams) Give 1 tablet po (by mouth) as needed for PAIN.

Lortab Tablet 5-325 mg Give 1 tablet po (by mouth) at bedtime." This order was discontinued on 12/23/16.

Review of the November 2016 MAR revealed that PRN (as needed) Lortab was documented one time on 11/12/16 as being administered. Documentation in the nursing notes was found regarding the administration of the Lortab, non-pharmacological interventions attempted prior to the administration, and effectiveness of the Lortab.

Review of Resident #1's Narcotic sheet revealed that Resident #1 was also administered PRN (as needed) Lortab on 11/1/16 at 3 p.m., 11/3/16 at 9 a.m., 11/5/16 at 2 p.m., 11/10/16 at 8:30 a.m., 11/16/16 at 11 a.m., 11/20/16 at 11 a.m., and 11/25/16 at 8 a.m.

No documentation could be found regarding the resident's pain level at the above administered times, non-pharmacological interventions prior to the administration of Lortab, or effectiveness of

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F 309	Continued From page 120 the Lortab. Review of Resident #1's December 2016 MAR (medication administration record) revealed the following orders initiated on 10/28/16: "Lortab Tablet 5-325 mg (milligrams) Give 1 tablet po (by mouth) as needed for PAIN." Lortab Tablet 5-325 mg Give 1 tablet po (by mouth) at bedtime." This order was discontinued on 12/23/16. Review of the December MAR revealed that PRN (as needed) Lortab was not signed out or documented as being administered for that month. Review of the Narcotic log sheet for "Hydrocodone/APAP (acetaminophen) 5 -325 mg" revealed that nursing was dispensing the scheduled and PRN Lortab from the same narcotic pack. The following was documented: "Hydrocodone/APAP (Lortab) 5-325 mg Tablet Take 1 TAB (tablet) by mouth at bedtime scheduled." Review of this narcotic log sheet revealed that PRN (as needed) Lortab was administered on 12/27/16 at 8 p.m., 12/28/16 at 8 p.m., and 12/29/16 at 8 p.m. No documentation could be found regarding the resident's pain level at the above administered times, non-pharmacological interventions prior to the administration of Lortab, or effectiveness of the Lortab. On 1/5/17 at 11:40 a.m., an interview was	F 309		

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conducted with RN (Registered Nurse) #1. RN #1 was asked about the process staff follows prior to administering prn (as needed) pain medication to a resident, RN #1 stated that she would ask the resident the pain scale, attempt non-pharmacological interventions before giving pain medication, and then administer prn pain medications if non-pharmacological interventions were not effective. She stated that she would write the resident's pain level on the back of the MAR or in a nursing note. RN #1 stated that she would check back to see if the pain medication was effective and document the new pain level on the back of the MAR or in a nursing note.

On 1/5/17 at 4:30 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 was asked about the process staff follows prior to administering prn (as needed) pain medication to a resident, ASM #2 stated that she would rate the pain, try non-pharmacological interventions first, medicate if the pain is not relieved by non-pharmacological interventions, and then go back to evaluation medication effectiveness. When asked where this process is documented, ASM #2 stated that it should be documented in a nurse ' s narrative. ASM #2 stated that a pain scale should also be documented on the back of the MAR (medication administration record).

On 1/5/17 at 5:59 p.m., ASM #1, the administrator, and ASM #2 the DON were made aware of the above findings.

Facility policy titled, "Pain Assessment," documents in part, the following: "1. When pain is

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identified through the MDS process, the initial nursing assessment, or the resident has complaints of pain not relieved for prolong periods of time, initiate the pain assessment tool to further assess the type, frequency. Location, and other factors or causes related to the resident's pain...4. Non-pharmacological interventions are used are used to provide pain relieve in conjunction with medication use. Interventions can include: positioning, physical therapy modalities, relaxation techniques, etc."

No further information was presented prior to exit.

[1] Lewy Body- "LBD is a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood. LBD is one of the most common causes of dementia, after Alzheimer's disease and vascular disease." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/alzheimers/publication/lewy-body-dementia/basics-lewy-body-dementia.

[2] Lortab- Hydrocodone and Acetaminophen combination used to relieve moderate to severe pain. This information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/.

5. The facility staff failed to monitor Resident # 11's AV fistula (1) (arterial - venous) fistula port for

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F 309	Continued From page 123 dialysis (2). Resident # 11 was admitted to the facility on 3/22/16 with diagnoses that included but were not limited to: hypertension (3), gastroesophageal reflux disease (4), diabetes mellitus (5), convulsions (6), end stage renal disease (7) and depression. Resident # 11's most recent MDS (minimum dada set) a significant change assessment with an ARD (assessment reference date) of 10/5/16 coded the resident as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 being cognitively intact for daily decision making. Resident # 11 was coded as requiring limited assistance of one staff member for activities of daily living. The "(Name of Dialysis Center) Dialysis Access management Application" for Resident # 11 documented, "Access type: AV Fistula." Under "Surgical Information" it documented, "Date Placed: 06/23/2016. Location: Left. Site: Above Elbow." The POS (physician's order sheet) dated 1/1/2017 for Resident # 11 documented, "Monitor dialysis shunt to left arm every shift. Assess for bruit/thrill (9) every shift. Notify MD (medical doctor) of any changes. If bleeding should occur apply direct pressure & (and) notify MD. Start Date; 11/18/16." The comprehensive care plan for Resident # 11 dated 3/22/2016 documented, "Problem/Need: I require renal dialysis related to ESRD (end stage renal disease). Under the heading "Approaches" it failed to document the use of the AV Fistula in	F 309		

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F 309	Continued From page 124 Resident # 11's left upper arm. Review of the clinical record for Resident # 11 which included the MARs (medication administration records) dated November 18, 2016 through December 31, 2016, the nurse's "Progress Notes" dated November 18, 2016 through December 30, 2016 and the "Hemodialysis Communication" sheets revealed monitoring of the AV fistula for only 54 out of 132 opportunities. On 1/5/17 at 3:40 p.m. an interview was conducted with LPN (licensed practical nurse) # 1. When asked if Resident # 11 went to the dialysis center, LPN # 1 stated Resident # 11 went to dialysis every Monday, Wednesday and Friday. When asked about Resident # 11's dialysis access site, LPN # 1 stated that the access site was located on Resident # 11's left upper arm. When asked to describe the procedure staff follows regarding Resident # 11's dialysis site, LPN # 1 stated, "Check it every day for bleeding and soreness around the site." When asked about documenting on the MAR that a procedure was done, LPN # 1 stated that the nurse would check the box and initial it. LPN # 1 was asked to review Resident # 11's MARs dated November 2016 through December 2016 regarding the bruit and thrill. When asked about the blanks on the MAR, LPN # 1 stated that if it wasn't checked it wasn't done. On 6/11/15 at 8:30 a.m. an interview was conducted with the ASM (administrative staff member) # 2, director of nursing. When asked about the procedure followed regarding Resident # 11's dialysis site, ASM # 2 stated, "Need to monitor the bruit and thrill every shift every day."	F 309		

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F 309	Continued From page 125 ASM # 2 was asked to review Resident # 11's MARs dated November 2016 through December 2016 regarding the bruit and thrill. When asked about the blanks on the MAR, ASM # 2 stated, "I can't say it was done." The facility policy "Protocol for Dialysis" documented,"5. Check for bruit and thrill in the AV shunt, fistula, or graft site Q (every) shift per physician's order." According to Medical Surgical Nursing made Incredibly Easy, Lippincott Williams & Wilkins copyright 2004 page 565 Dialysis Monitoring and Aftercare: "At least four times per day, assess circulation at the access site by auscultating for the presence of bruits and palpating for thrills. Unlike most other circulatory assessments, bruits and thrills should be present here. Lack of a bruit at a venous access site during dialysis may indicate a blood clot requiring immediate surgical attention." On 1/5/17 at approximately 6:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit. References: (1) An AV fistula is a connection, made by a vascular surgeon, of an artery to a vein. Arteries carry blood from the heart to the body, while veins carry blood from the body back to the heart. <http://nkdep.nih.gov/living/kidney-failure/dialysis.shtml>	F 309		

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(2) Dialysis is a treatment to filter wastes and water from your blood, allowing people with kidney failure to feel better and continue doing the things they enjoy <http://nkdep.nih.gov/living/kidney-failure/dialysis.shtml>

(3) Low blood pressure. This information was taken from the website: https://medlineplus.gov/lowbloodpressure.html.

(4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(5) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(6) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm.

(7) The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.

(8) A permacath is a long, flexible tube that is inserted into a vein most commonly in the neck (internal jugular vein) and less commonly in the

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F 309	Continued From page 127 groin (femoral vein). This type of ventral venous catheter is tunneled under the skin for a few centimeters usually on the chest before it enters the neck vein. Permacath, better known as the dialysis catheter or hemodialysis catheter is used in a variety of cases. Here are a few indications; Regular hemodialysis to treat kidney failure-permacath avoids multiple catheter insertions and serves as a permanent catheter for dialysis; Route for plasmapheresis; frequent blood sampling; Administration of drugs and fluids during long-term treatment; Administration of caustic medications (chemotherapy) that may harm peripheral veins; a route for TPN and blood products in special cases. This information was obtained from the website: <http://lavascular.com/permcath/>. (9) A bruit is an audible vascular sound associated with turbulent blood flow. Although usually heard with a stethoscope such sounds may occasionally also be palpated as a thrill. <http://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=thrill>	F 309		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and	F 328	**F328** 1. Resident #3's respiratory status was assessed on 1/6/17 by the Assistant Director of Nursing with no respiratory distress noted.	

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F 328	Continued From page 128 arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (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. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional	F 328	Resident #3 oxygen flow rate was adjusted to 2 liters per minute by LPN #2 on 1/4/17. LPN #2 was reeducated on 1/6/17 by Staff Development Coordinator related to ensuring oxygen is administer as ordered. Resident #3's physician was notified on 1/6/17 by Director of Nursing related to the 81 pulse oximetry omissions in December 2016 on medication record. Resident #7 was discharged from the facility on 1/7/17. 2. The Assistant Director of Nursing and Director of Nursing will complete an audit by 2/1/17 to ensure current residents' pulse oximetry is completed as ordered, resident have completed oxygen orders that include the flow rate, and oxygen is administer per physician's orders.	

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F 328	Continued From page 129 standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility policy review and clinical record review, it was determined that facility staff failed to administer oxygen as prescribed by the physician. 1. a. Facility staff failed to administer the physician prescribed oxygen flow rate of 2 liters per minute to Resident #3. b. Facility staff failed to obtain physician ordered pulse oximetry every shift for 81 times out of 93 opportunities in December 2016 for Resident #3. 2. The facility staff administered oxygen to Resident #7 without a physician prescribed flow rate and failed to clarify the physicians order. The findings include: 1. Resident #3 was admitted to the facility on 11/27/09 and readmitted on 10/19/16 with diagnoses that included but were not limited to: fracture left thigh bone, pain, anxiety, high blood pressure and bladder cancer. The most recent MDS (minimum data set, a thirty day assessment, with an ARD (assessment reference date) of 12/3/16 coded the resident as have seven out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was	F 328	3. The Licensed Nurses will be reeducated by the Staff Development Coordinator by 2/1/17 related to ensuring oxygen is administer as ordered, resident have completed oxygen orders that include the flow rate, and pulse oximetry is completed as ordered. 4. The Director of Nursing or Assistant Director of Nursing will complete an audit of 5 current residents on each unit weekly for 4 weeks and monthly for 2 months to ensure oxygen continues to be administered as ordered, residents continue to have completed oxygen orders that include the flow rate, and pulse oximetry continue to be completed as ordered.	

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F 328	Continued From page 130 coded as requiring the assistance from staff for all activities of daily living. The resident was coded as requiring oxygen therapy. An observation was made on 1/4/16 at 3:00 p.m. of Resident #3. The resident was lying in bed with her eyes closed; she was wearing an oxygen nasal cannula. The oxygen was set at two and 1/2 (a half) liters. An observation was made on 1/4/16 at 4:30 p.m. of Resident #3. The resident was lying in bed. She was wearing a nasal cannula and her oxygen was set a two and 1/2 liters. On 1/4/16 at 4:35 p.m. LPN (licensed practical nurse) #2, the resident's nurse, and this surveyor made an observation of the oxygen flow rate for Resident #3. LPN #2 stated, "It's on two and 1/2 liters. It should be on two liters." LPN #2 was asked when staff checked the oxygen rate. LPN #2 stated they checked the rate when the resident was assessed. When asked how staff knew if the oxygen had been correctly set for Resident #3, LPN #2 stated, "The metal ball will be right in the middle of the line." LPN #2 set the oxygen to two liters as ordered by the physician. Review of the physician's orders dated 10/19/16 documented, "Oxygen at 2L/m (liters per minute) via nasal cannula (soft prongs that fit in the nose to deliver oxygen) continuous, pulse ox (oximetry) checks Q (every) shift." Review of the December 2016 MAR (medication administration record) documented, "Oxygen at 2L/m (liters per minute) via nasal cannula (soft prongs that fit in the nose to deliver oxygen) continuous, pulse ox (oximetry) checks Q (every)	F 328	The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date:	02/03/17

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F 328	Continued From page 131 shift." An interview was conducted on 1/5/16 at 11:30 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked if there were any risks involved in administering oxygen, ASM #2 stated, "We don't want to over oxygenate someone with chronic lung disease." An interview was conducted on 1/5/16 at 11:45 a.m. with LPN (licensed practical nurse) #3, the resident's nurse. When asked if it was important to know the oxygen rate for the residents, LPN #3 stated, "You have to know how much. It can cause more harm than good if you give too much." On 1/5/16 at 6:10 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "OXYGEN THERAPY" documented, Policy: To administer oxygen when indicated to provide adequate gas exchanges. A physician's order is required and shall include liter flow rate and administration device (i.e. nasal cannula, mask etc.)." The policy was from the nursing policies and procedures manual revised 7/2007. Review of the oxygen machine's manufacturer's manual documented, "Chapter 1: Introduction....DO NOT change the flow setting unless your health care professional tell you to do so. (page 3). Operating Instructions: 5. Adjust the flow to the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line marking the specific flow rate. (page 6)."	F 328		

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No further information was provided prior to exit.

b. Review of the physician's orders dated 10/19/16 documented, "Oxygen at 2L/m (liters per minute) via nasal cannula (soft prongs that fit in the nose to deliver oxygen) continuous, pulse ox (oximetry) checks Q (every) shift."

Review of the December 2016 MAR (medication administration record) documented, "Oxygen at 2L/m (liters per minute) via nasal cannula (soft prongs that fit in the nose to deliver oxygen) continuous, pulse ox (oximetry) checks (oxygen levels) Q (every) shift." There were no pulse oximetry results documented.

Review of the nurse's notes for December 2016 did not evidence documentation of the pulse oximetry results for 81 shifts out of 93 shifts.

An interview was conducted on 1/5/17 at 11:45 a.m. with LPN #3. When asked to review the December 2016 MAR for the pulse oximetry results, LPN #3 stated, "If it wasn't documented it wasn't done."

An interview was conducted on 1/5/17 at 12:15 p.m. with LPN #1. When asked to review the December 2016 MAR for the pulse oximetry results, LPN #1 stated, "I see what you're saying there should be a number in there." When asked why staff would not follow the physician's order, LPN #1 stated there was no reason not to follow the order. When asked why a pulse oximetry was done on a resident, LPN #1 stated, "It's the most important thing to see what level of oxygen they have."

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F 328	Continued From page 133 On 1/5/16 at 6:10 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "OXYGEN THERAPY" documented, "KEY STEPS: 5. Monitor the resident's response to oxygen therapy. If appropriate, use pulse oximetry to assess resident stability." 2. The facility staff administered oxygen to Resident #7 without a physician prescribed flow rate and failed to clarify the physicians order. Resident #7 was admitted to the facility on 12/26/16 and readmitted on 12/30/16 with diagnoses that included but were not limited to: respiratory failure, chronic lung disease, high blood pressure, arthritis and chronic pain. The most recent MDS was in progress and not available to review. The admission nurse's note dated 12/30/16 at 4:00 p.m. documented, "...Resident is alert/orient (sic) x (times) 3 (knows name, date and where she is).... 1 assist needed for ADL (activities of daily living) care." An observation was made on 1/4/16 at 7:10 a.m. of Resident #7. The resident was sitting up in a wheelchair with oxygen on via nasal cannula (soft prongs that fit in the nose to deliver oxygen). The oxygen was observed set at 3 1/2 liters/minute. An observation was made on 1/4/16 at 3:05 p.m. of Resident #7. The resident was sitting up in a wheelchair in the room with the oxygen on via nasal cannula. The oxygen was observed set at 3	F 328		

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1/4 liters/minute.

Resident #7 was asked if she ever adjusted the oxygen flow rate, Resident #7 stated, "Never." When asked how much oxygen she was to be on, Resident #7 stated, "Four liters."

An observation of Resident #7's oxygen was made on 1/4/16 at 3:40 p.m. with LPN #10, the resident's nurse. LPN #10 stated, "Looks like three and 1/2 liters, should be four liters." LPN #10 was asked when staff checked the resident's oxygen rate. LPN #10 stated, "When we assess them. I just got here and I haven't assessed her yet."

Review of the physician's orders dated 12/30/16 documented, "O2 (oxygen)." There was no liter flow rate ordered.

Review of the December 2016 MAR (medication administration record) documented, "O2 at 2L/m (liters/minute) continuous.

Review of the January 2017 MAR documented, "O2 @ 4LPM (liters per minute) via nc (nasal cannula)." There were nurse's initials documented for each shift from 1/1/17 to 1/5/17.

Review of the nurse's notes dated 1/1/17 at 10:00 p.m. documented, "O2 on @ 2L PER CANNULA."

Review of the nurse's notes dated 1/2/17 at 7:00 a.m. documented, "Up in w/c (wheelchair) O2 @ 4L PER CANNULA."

Review of the nurse's notes dated 1/3/17 at 9:00 a.m. documented, "O2 4L via n/c..."

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F 328	Continued From page 135 Review of the nurse's notes date 1/4/17 at 10:35 a.m. at 10:35 documented, "O2 @ 4 LPM." Review of the physician's orders dated 1/4/17 (time unknown) documented, "Clarification order O2 @ 4 LPM...." An interview was conducted on 1/5/16 at 11:30 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked to review Resident #7's oxygen order, ASM #2 stated, "Actually I don't see it on here. It just has O2. It doesn't have a liter." When asked how staff would know how much oxygen the resident was to receive, ASM #2 stated, "Without an order? I can't answer that." When asked if the oxygen order should have been clarified, ASM #2 stated, "Definitely. I would expect that prior to her coming in." When asked if there were any risks involved in administering oxygen, ASM #2 stated, "We don't want to over oxygenate someone with chronic lung disease." An interview was conducted on 1/5/16 at 11:45 a.m. with LPN (licensed practical nurse) #3, the resident's nurse. When asked to review Resident #7's oxygen order, LPN #3 stated, "They should have clarified it, the amount, when I review the admission orders I would have called the hospital back." When asked if it was important to know the oxygen rate, LPN #3 stated, "You have to know how much. It can cause more harm than good if you give too much." On 1/5/16 at 6:10 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "OXYGEN	F 328		

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F 328	Continued From page 136 THERAPY" documented, Policy: To administer oxygen when indicated to provide adequate gas exchanges. A physician's order is required and shall include liter flow rate and administration device (i.e. nasal cannula, mask etc.)." The policy was from the nursing policies and procedures manual revised 7/2007. No further information was provided prior to exit.	F 328		
F 329 SS=E	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review facility staff failed to ensure residents were free from unnecessary medications for two of 26 residents	F 329	**F329** 1. Resident #10's behaviors for the use of Seroquel are being monitor by the licensed nurse as of 01/19/17 on the behavior monitoring sheet as required. Resident #17's behaviors for the use of Seroquel are being monitor by the licensed nurse as of 01/19/17 on the behavior monitoring sheet as required. 2. The Assistant Director of Nursing and Unit Manager will audit current residents' behavior monitoring sheets by 2/1/17 to ensure behavior are being monitored and documented as required.	

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F 329	Continued From page 137 in survey sample, Residents #10 and # 17. 1. The facility staff failed to monitor behaviors for Resident # 10's use of Seroquel (10). 2. The facility staff failed to monitor behaviors for Resident # 17's use of Seroquel. The findings include: 1. The facility staff failed to monitor behaviors for Resident # 10's use of Seroquel (10). Resident # 10 was admitted to the facility on 12/6/07 with a readmission on 8/15/16 with diagnoses that included but not limited to: dysphagia (1), anxiety (2), obsessive compulsive disorder (3), aphasia (4), schizophrenia (5), edema (6) diabetes mellitus (7) and convulsions (8). The most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/29/16 coded the resident as scoring a one on the brief interview for mental status (BIMS) of a score of 0 - 15, one being severely impaired of cognition. Resident # 10 was coded as being totally dependent of one staff member for activities of daily living. Resident # 10's care plan with a review date of 12/1/16 was reviewed. Under "Problem/Need" it documented, "At risk for adverse effects r/t (related to) use of psychotropic medications." Under "Approaches" it documented, "Monitor and record target behaviors and inform MD (medical doctor) of increase in frequency for possible medication adjustments."	F 329	3. The Licensed Nurses will be reeducated by the Staff Development Coordinator by 2/1/17 to ensure behavior monitoring sheets are in place and being completed as required. 4. The Director of Nursing or Assistant Director of Nursing will complete an audit on 5 residents from each unit weekly for 4 weeks and monthly for 2 months to ensure behavior monitoring sheets continue to be completed and documented as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date: 02/03/17	

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The "Physician's Order Sheet" (POS) dated 12/1/16 for Resident # 10 and signed by the physician on 12/21/16 documented, "Seroquel (10) 100 MG (milligram). Give one (1) tablet via PEG (percutaneous endoscopic gastrostomy)-tube (9) at bedtime related to schizophrenia. Start Date 10/19/16."

The MARs (medication administration records) for Resident # 10 dated November 1, 2016 through January 4, 2017 documented, "Seroquel 100 MG. Give 1 tablet via PEG-tube at bedtime related to schizophrenia." Further review of the MARs revealed Resident # 10 received one Seroquel tablet each evening for 65 of 65 opportunities.

The "Behavior Monthly Flow Sheets" for Resident # 10 dated November 1, 2016 through January 4, 2017 failed to document behavior monitoring for the use of Seroquel for 195 of 195 opportunities.

On 1/5/17 at 3:20 p.m. an interview was conducted with LPN (licensed practical nurse) # 1. LPN # 1 was then asked to review the behavior monitoring sheets dated November 1, 2016 through January 4, 2017 for Resident # 10. When asked about the blanks on the behavior monitoring sheets, LPN # 1 stated, "If it wasn't documented I can't say it was done."

On 1/5/17 at 4:30 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. ASM # 2 was then asked to review Resident # 10's behavior monitoring sheets dated November 1, 2016 through January 4, 2017 for Resident # 10. When asked about the blanks on the behavior

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F 329	Continued From page 139 monitoring sheets ASM # 2 stated, "If it wasn't documented it wasn't done." On 1/5/17 at approximately 6:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit. References: (1) A swallowing disorder. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/swallowing disorders.html>. (2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (3) A common, chronic and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and behaviors (compulsions) that he or she feels the urge to repeat over and over. This information was obtained from the website: http://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd/index.shtml. (4) A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/aphasia.html>.	F 329		

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F 329	Continued From page 140 (5) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm. (6) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html. (7) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (8) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm. (9) Feeding tubes are needed when you are unable to eat or drink. This may be due to stroke or other brain injury, problems with the esophagus, surgery of the head and neck, or other conditions. This information was obtained from the website: <https://medlineplus.gov/ency/patientinstructions/000900.htm>. (10) Used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.h	F 329		

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F 329	Continued From page 141 tml. 2. The facility staff failed to monitor behaviors for Resident # 17's use of Seroquel. Resident # 17 was admitted to the facility on 5/2/12 with a readmission on 5/5/16 with diagnoses that included but not limited to: hypertension (1), peripheral vascular disease (2), diabetes mellitus (3), dementia (4), seizure (5), and asthma (6). The most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/15/16 coded the resident as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 being moderately impaired of cognition for daily decision making. Resident # 17 was coded as requiring extensive assistance of one staff member for activities of daily living. Resident # 17's care plan with a review date of 11/22/16 was reviewed. Under "Problem/Need" it documented, "At risk for adverse effects r/t (related to) use of psychotropic medications." Under "Approaches" it documented, "Monitor and record target behaviors and inform MD (medical doctor) of increase in frequency for possible medication adjustments." The "Physician's Order Sheet" (POS) dated 11/1/16 for Resident # 17 and signed by the physician on 11/2/16 documented, "Seroquel. Give 25 MG (milligram) by mouth two times a day. Start Date 11/1/16."	F 329		

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The MARs (medication administration records) for Resident # 17 dated November 1, 2016 through January 4, 2017 documented, "Seroquel. Give 25 MG (milligram) by mouth two times a day. Start Date 11/1/16." Further review of the MARs revealed Resident # 17 received two Seroquel tablet each day for 129 of 129 opportunities.

The "Behavior Monthly Flow Sheets" for Resident # 17 dated November 1, 2016 through January 4, 2017 were reviewed. The "Behavior Monthly Flow Sheets" failed to document behavior monitoring for the use of Seroquel for 317 of 573 opportunities.

On 1/6/17 at 11:05 a.m. an interview was conducted with LPN (licensed practical nurse) # 7. LPN # 7 was then asked to review Resident # 17's behavior monitoring sheets dated November 1, 2016 through January 4, 2017. When asked about the blanks on the behavior monitoring sheets LPN # 7 stated, "If it wasn't documented it was done."

On 1/6/17 at 1:10 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. ASM # 2 was then asked to review Resident # 17's behavior monitoring sheets dated November 1, 2016 through January 4, 2017. When asked about the blanks on the behavior monitoring sheets, ASM # 2 stated, "If it wasn't documented it wasn't done."

On 1/6/17 at approximately 12:35 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing,

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were made aware of the findings.

No further information was provided prior to exit.

References:
(1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(2) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.

(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(4) A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html.

(5) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.ht

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F 329	Continued From page 144 ml. (6) A disease that causes the airways of the lungs to swell and narrow. It leads to wheezing, shortness of breath, chest tightness, and coughing. Information was obtained from the website: https://medlineplus.gov/ency/article/000141.htm.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly 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. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility	F 371	**F371** 1. The meat slicer blade and produce table was cleaned and sanitized on 1/4/17 by the dietary manager. 2. The Dietary Manager inspected the dietary equipment and food preparation areas on 1/9/17 to ensure the kitchen remains clean and sanitized. 3. The Administrator will reeducate the Dietary Manager and Dietary staff by 1/27/17 related to ensuring the kitchen which include the kitchen equipment and the food preparation areas remain clean and sanitized.	

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F 371	Continued From page 145 document review, it was determined that the facility staff failed to prepare and serve food in a sanitary manner. The meat slicer blade and product table was observed to have food debris on it. The findings include: Observation of the kitchen was conducted on 1/4/17 at approximately 7:05 a.m. with OSM (other staff member) # 11, cook. The following was observed: Observation of the food preparation table revealed a meat slicer. When asked if the meat slicer was cleaned and ready for use OSM # 11 stated, "Yes." Observation of the meat slicer revealed the blade and product table was observed to have food debris on it. OSM # 11 agreed with the findings. During an interview with OSM # 2, the dietary manager on 1/4/17 at 1:45 p.m. OSM # 2 stated that the meat slicer was taken apart and rewashed. The facility's policy "Cleaning and Sanitizing" documented, "To prevent illness or death caused by the spread of food-borne pathogens, it is important to properly clean and sanitize the entire slicer as any surface of the slicer can become contaminated. It is the responsibility of the slicer/owner/operator to follow all guidelines, instructions, and laws as established by your local and state health departments and the manufactures of chemical sanitizers." On 1/5/17 at approximately 6:00 p.m. ASM	F 371	4. The Dietary Manager or Administrator will complete a kitchen audit weekly for 4 weeks and monthly for 2 months to ensure the kitchen continues to be maintained in a clean and sanitary condition including the kitchen equipment and the food preparation areas as required. The Dietary Manager will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator will be responsible for monitoring and follow up. Completion date: 02/03/17	

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F 371	Continued From page 146 (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit.	F 371		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 441	**F 441** 1. The infection control logs from March, April, May, June, and September through December 2016 will be updated to include the causative organisms for cultures obtained by the Infection Control Nurse by 2/2/17. 2. The current infection control logs will be audited by 2/2/17 by the Infection Control Nurse to ensure the logs are updated to include the causative organisms for cultures and the logs are completed as required. 3. The Director of Nursing will reeducate the Infection Control Nurse by 2/2/17 related to ensuring causative organisms for cultures are included on the log and the infection control log is completed as required.	

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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 441	Continued From page 147 to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of facility documentation, it was determined that facility staff failed to maintain a complete infection control program as evidenced by incomplete infection control tracking logs for March, April,	F 441	4. The Director of Nursing or Assistant Director of Nursing will review the infection control logs weekly for 4 weeks and monthly for 2 months to ensure infection control logs continue to be updated to include the causative organisms for cultures as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date:	02/03/17

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F 441	Continued From page 148 May, June, September through December 2016. The infection control log did not evidence the causative organisms for cultures obtained from residents during the months of March, April, May, June, September, through December 2016. The findings include: Review of the facility's March 2016 infection control log documented that there were eight cultures obtained and all cultures were positive for an infection. A respiratory culture obtained on 3/18/16 did not evidence documentation of the organism. Review of the May 2016 infection control log documented that there were five cultures that were positive for infection. Two urine cultures were obtained on 5/23/16 from two different residents. The cultures were documented as being positive for infection there was no evidence of documentation of the organisms. Review of the June 2016 infection control log documented that there were four cultures that were positive for infection. A urine culture was obtained on 6/8/16. The culture was documented as being positive for infection; there was no evidence of documentation of the organism. A skin culture was obtained on 6/22/16 and 6/30/16 from two different residents. The cultures were documented as being positive for infection; there was no evidence of documentation of the organisms. Review of the September 2016 infection control log documented that there were six cultures	F 441		

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F 441	Continued From page 149	F 441		

positive for infection. A urine culture obtained on 8/24/16 (documented on the September report) was documented as being positive for infection. There was no evidence of documentation of the organism.

Review of the October 2016 infection control log documented that there were seven cultures positive for infection. A urine culture obtained on 10/19/16 and 9/28/16 on two different residents were documented as being positive for infection. There was no evidence of documentation of the organisms.

Review of the November 2016 infection control log documented that there were three cultures positive for infection. A urine infection obtained on 11/11/16 was documented as being positive. There was no evidence of documentation of the organism.

Review of the December 2016 infection control log documented that there were two cultures positive for infection. A urine culture obtained on 12/9/16 was documented as being positive. There was no evidence of documentation of the organism.

An interview was conducted on 1/5/17 at 4:10 p.m. with RN (registered nurse) #4, the infection control nurse. When asked if the culture results were to be documented on the infection control logs, RN #4 stated, "They should be, yes." When asked why the cultures were documented, RN #4 stated, "Because in our case something's require isolation. They can be on a round of an antibiotic and may need something else. It helps us track and trend so we know if we need to education our staff on the floor. It's part of our surveillance."

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F 441	Continued From page 150 On 1/5/17 at 6:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was obtained prior to exit.	F 441		
F 503 SS=D	483.50(a)(i)-(iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT (a) Laboratory Services (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. (ii) If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in part 493 of this chapter. (iii) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. (iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to ensure	F 503	**F 503** 1. The identified expired blood draw tubes on the two nursing units were discarded on 1/6/17 by the Assistant Director of Nursing. 2. The two nursing units were checked on 1/6/17 by the Assistant Director of nursing to ensure expired laboratory supplies and other medical supplies have been discarded as required. 3. The Licensed Nurses will be reeducated by the Staff Development Coordinator by 2/2/17 related to ensuring laboratory and other medical supplies are checked for expiration and discarded as required.	

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F 503	Continued From page 151 laboratory supplies were not expired on two of two nursing units. One hundred and one blood drawing tubes were expired on two of two nursing units. The findings include: Observation was made on 1/5/17 at 1:50 p.m. on the West Nursing Unit. The following laboratory tubes were expired: Green top tubes: 3 ML (milliliter) - 60 expired in 10/2016 Observation was made on 1/5/17 at 3:50 p.m. on the North Nursing Unit. The following laboratory tubes were expired: Green top tubes: 3 ML (milliliter) - 24 expired in 12/2016 Blue top tubes: 2.7 ML - 17 expired in 12/2016 During an interview on 1/5/17 at 1:50 p.m. with LPN (licensed practical nurse) # 1, LPN # 1 stated that they do not use the green tubes that often that is probably why they are expired. LPN # 1 further stated that the nurses usually use the gold tubes - since they are larger. During an interview on 1/5/17 at 3:59 p.m. with LPN # 9, LPN # 9 confirmed that the tubes were expired and stated that the supervisors are the ones that use the tubes to draw blood. During the end of day interview on 1/5/17 at 6:00 p.m. with ASM (Administrative Staff Member) # 1, the administrator, and ASM # 2 this concern was discussed. A copy of the facility policy on storing	F 503	4. The Assistant Director of Nursing and Unit Manager will complete audits weekly for 4 weeks and monthly for 2 months to ensure expired laboratory and other medical supplies continue to be discarded as required. The Director of Nursing will submit a report to the Quality Assurance Committee for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date: 02/03/17	

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F 503	Continued From page 152 laboratory supplies was requested at this time. During an interview on 1/6/17 at 8:25 a.m. with ASM # 2, ASM # 2 stated that there was no policy and procedure for the use of blood draw tubes. When asked about who draws blood, ASM # 2 stated, "The nurses draw blood." ASM # 2 continued by saying that the facility no longer uses the blue tubes. A request was made at this time for documentation as to what laboratory test each color tube is used for. According to applicable requirements for laboratories specified in Part 493 of this chapter: § 493.1252 Standard: Test systems, equipment, instruments, reagents, materials, and supplies.(4) (d) Reagents, solutions, culture media, control materials, calibration materials, and other supplies must not be used when they have exceeded their expiration date, have deteriorated, or are of substandard quality. No further information was provided prior to exit.	F 503		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 514	**F 514** 1. Resident #1 was discharge from the facility on 1/7/17.	

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F 514	Continued From page 153 (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review it was determined that facility staff failed to maintain a complete and accurate clinical record for five of 26 residents in the survey sample, Resident #1, #6, #3, #7, and #20. 1a. For Resident #1, facility staff failed to document that prn (as needed) pain medication was administered on her November and December 2016 MARS (Medication Administration Record) on several occasions. b. For Resident #1, facility staff failed to file wound documentation on the clinical record.	F 514	Resident #6 Pressure ulcer tracking form was updated on 1/7/17 by Assistant Director of Nursing to include the stage of the pressure ulcer. Resident #3 Pressure ulcer tracking form was updated on 1/7/17 by the Assistant Director of Nursing to include the stage of the pressure ulcer. Resident #7's Percocet administration record, nursing notes and narcotic count sheets were reviewed on 1/6/17 by the Director of Nursing. Resident #20 was discharged from the facility on 12/9/16.	

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F 514	Continued From page 154 2. The facility staff failed to document the stage of Resident #6's pressure ulcer on the pressure ulcer tracking forms. 3. The facility staff failed to document the stage Resident #3's pressure ulcers. 4. The facility staff failed to document Resident #7's Percocet (1) medication administration on the medication administration record (MAR) or the nurse's notes on two out of nine opportunities. 5. The facility staff failed to include the hospice records on the facility chart for Resident # 20. The findings include: 1a. For Resident #1, facility staff failed to document that prn (as needed) pain medication was administered on her November and December 2016 MARS (Medication Administration Record) on several occasions. Resident #1 was admitted to the facility on 4/28/16 with diagnoses that included but were not limited to protein-calorie malnutrition, dysphagia, hypothyroidism, blindness, muscle weakness, and Dementia with Lewy Body [1]. Resident #1's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/10/16. Resident #1 was coded as being severely cognitively impaired in the ability to make daily decisions, scoring 03 out of 15 on the BIMS (Brief Interview for mental status) exam. Resident #1 was coded as requiring extensive assistance with bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing.	F 514	2. The Assistant Director of Nursing, the Unit Manager and the Director of Nursing will complete an audit on the current residents' medical records by 2/2/17 to ensure medical records are complete including staging of pressure ulcers and documentation of medication administration as required. 3. The Staff Development Coordinator will have re-educated the licensed nurses by 2/2/17 related to the requirements of documenting the staging of pressure ulcers and documenting the administration of medications. 4. The Director of Nursing or Assistant Director of Nursing will complete an audit of 5 clinical records from each unit weekly for 4 weeks and monthly for 2 months to ensure pressure ulcer staging and documentation of medication administration continues to be completed as required. The Director of nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of nursing will be responsible for monitoring and follow up.	

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F 514	Continued From page 155 Review of Resident #1's November 2016 MAR (medication administration record) revealed the following orders initiated on 10/28/16: "Lortab Tablet [2] 5-325 mg (milligrams) Give 1 tablet po (by mouth) as needed for PAIN. Lortab Tablet 5-325 mg Give 1 tablet po (by mouth) at bedtime." This order was discontinued on 12/23/16. Review of the November 2016 MAR revealed that PRN (as needed) Lortab was documented one time on 11/12/16 as being administered. Review of Resident #1's Narcotic sheet revealed that Resident #1 was also administered PRN (as needed) Lortab on 11/1/16 at 3 p.m., 11/3/16 at 9 a.m., 11/5/16 at 2 p.m., 11/10/16 at 8:30 a.m., 11/16/16 at 11 a.m., 11/20/16 at 11 a.m., and 11/25/16 at 8 a.m. These administration times were not documented on Resident #1's November 2016 MAR. Nursing notes could not be found regarding the administration of Lortab at these times. Review of Resident #1's December 2016 MAR (medication administration record) revealed the following orders initiated on 10/28/16: "Lortab Tablet 5-325 mg (milligrams) Give 1 tablet po (by mouth) as needed for PAIN." Lortab Tablet 5-325 mg Give 1 tablet po (by mouth) at bedtime." This order was discontinued on 12/23/16. Review of the December 2016 MAR revealed that PRN (as needed) Lortab was not signed out or documented as being administered for that	F 514	Completion date:	02/03/17

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F 514	Continued From page 156 month. Review of the Narcotic log sheet for "Hydrocodone/APAP (acetaminophen) (Lortab) 5-325 mg" revealed that nursing was dispensing the scheduled and PRN Lortab from the same narcotic pack. The following was documented: "Hydrocodone/APAP (Lortab) 5-325 mg Tablet Take 1 TAB (tablet) by mouth at bedtime scheduled." Review of this narcotic log sheet revealed that PRN (as needed) Lortab was administered on 12/27/16 at 8 p.m., 12/28/16 at 8 p.m., and 12/29/16 at 8 p.m. On 1/5/17 at 11:40 a.m., an interview was conducted with RN (Registered Nurse) #1. When asked the process of administering prn (as needed) pain medication to a resident, RN #1 stated that she would ask the resident the pain scale, attempt non-pharmacological interventions before giving pain medication, and then administer prn pain medications if non-pharmacological interventions were not effective. She stated that she would write the resident's pain level on the back of the MAR or in a nursing note. RN #1 stated that she would check back to see if the pain medication was effective and document the new pain level on the back of the MAR or in a nursing note. When asked where she would document that pain medication was administered, RN #2 stated that prn medications should always be signed out on the MAR every time they are given. RN #2 stated that if the pain medication is a narcotic, it would also be signed out of the narcotic log. When asked if the narcotic log was part of the clinical record, RN #2 stated, that it was not.	F 514		

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F 514	Continued From page 157 On 1/5/17 at 5:59 p.m., ASM (administrative staff member) #1 and ASM #2, DON (Director of Nursing), were made aware of the above concerns. Facility policy titled, "LTC Facilities Receiving Pharmacy Products and Services from Pharmacy" did not address signing out prn pain medication. No further information was presented prior to exit. The following information is provided in Basic Nursing, Essentials for Practice, 6th edition (Potter and Perry, 2007, pages 349-360) was used as a reference for medication administration. To ensure safe medication administration, be aware of the six rights of medication administration. 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation [1] Lewy Body- "LBD is a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood. LBD is one of the most common causes of dementia, after Alzheimer's disease and vascular disease." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/alzheimers/publication/lewy-body-dementia/basics-lewy-body-dementia.	F 514		

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F 514	Continued From page 158 [2] Lortab- Hydrocodone and Acetaminophen combination used to relieve moderate to severe pain. This information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/. b. For Resident #1, facility staff failed to file wound documentation on the clinical record. Review of Resident #1's clinical record revealed the following SBAR (situation, background, appearance and review) form dated 7/17/16 that documented in part, the following: "Open area to Coccyx...This started on 7/17/16...Appearance-Open area partial thickness pink center, macerated edges, no drainage, 0 (zero) odor..." Review of this form revealed that the MD (medical doctor) was notified on 7/17/16 at 11:55 a.m. The following nursing note was documented on 7/19/16: "Wound note: Res (Resident) observed with 0.4 cm x 0.2 cm open area to coccyx. No drainage or odor noted. edges intact with wound bed of pink granulation tissue. Tx (treatment) order continues for foam dressing q 3 (every) days." Review Resident #1's skin/pressure care plan dated 5/17/2016 revealed that it was updated on 7/17/16 with the following problem area: " 7/17/16 open area partial thickness coccyx/sac (sacral)...Goal/Target date: Res (Resident) will show signs of healing x 90 days...7/17 Tx (treatment as ordered)."	F 514		

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F 514	Continued From page 159 Review of Resident #1's skin/pressure care plan dated 5/17/16 revealed that skin interventions were put into place prior to the development of the 7/17/16 pressure sore. Review of Resident #1's physician orders revealed that different treatments were put into place in attempts to heal the wound after the discovery of Resident #1's pressure area. Review of Resident #1's clinical record revealed weekly body audit sheets. The last body audit sheet in the clinical record was dated 6/13/16 before the discovery of the open area on 7/17/16. Resident #1's 6/13/16 body audit report documented the following: "No new areas noted." Body audit sheets for 6/20/16, 6/27/16, 7/4/16 and 7/11/16 could not be found in the clinical record. Review of the June 2016 and July 2016 nursing notes did not reveal any skin issues prior to the development of the 7/17/16 pressure sore. Further review of Resident #1's clinical record revealed wound sheets from October 2016 through January 2017, documenting measurements, stages, and appearance of the wound. Wound sheets from 7/17/16 (when the wound was discovered) through September 2016 could not be found in the clinical record. On 1/4/17 at 4:33 p.m., wound sheets for Resident #1 were requested at the end of day meeting with ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (Director of Nursing).	F 514		

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F 514	Continued From page 160 On 1/5/17 at 10:47 a.m., wound sheets for Resident #1 were requested for the second time. On 1/6/17 at 8: 20 a.m., wound sheets from 7/21/16 through 9/30/16 were presented by the DON (Director of Nursing) to this writer. When asked where the wound documentation was found, ASM #2 stated that wound documentation was found in the ADON's (assistant director of nursing) office in a file. When asked if this documentation should have been in the Resident's clinical record, ASM #2 stated, "Yes." ASM #2 stated that she could not find the missing weekly body audit sheets but knows they were completed. ASM #2 stated that she did not have a policy on maintaining a complete clinical record. The wound documentation presented was written on a weekly body audit report rather than a pressure ulcer report. The first weekly audit body report after the discovery of the 7/17/16 wound was dated 7/21/16. The 7/21/16 body audit report documented the following: "Comments: Res (Resident) continues with coccyx Stg (Stage) II (two) measuring 0.4 cm x 0.9 cm. (zero) depth noted. Wound is without odor with small amount of drainage. Tx (treatment) foam dressing continues as prescribed." No further information was presented prior to exit. The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to	F 514		

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retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients."

2. The facility staff failed to document the stage of Resident #6's pressure ulcer on the pressure ulcer tracking forms.

Resident #6 was admitted to the facility on 10/13/09 with a recent readmission on 9/16/16, with diagnoses that included but were not limited to: multiple sclerosis (MS) (a progressive disease in which nerve fibers of the brain and spinal cord lose their myelin cover (1)), dysphagia, peripheral vascular disease, high blood pressure, and neurogenic bladder.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/14/16, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating that she was cognitively intact to make daily decisions. The resident was coded as requiring extensive to being totally dependent upon the staff for most of her activities of daily living. She was coded as independent after set up assistance was provided for eating. In Section M - Skin Conditions, Resident #6 was coded as having a Stage 4 pressure ulcer that measured 0.8 cm (centimeters) in length, 0.5 cm in width, and 2.8 cm in depth. Section M0900 documented the pressure ulcer was present on the previous assessment.

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F 514	Continued From page 162 Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (2) The "Weekly Pressure Ulcer Record" was located in the clinical record. The report documented the onset of the pressure ulcer on the right buttock as 1/12/16. The form documented on 11/3/16, 11/10/16, 11/17/16, 11/23/16 and 11/29/16, that the pressure ulcer wound was a Stage IV (four) pressure ulcer. The "Weekly Pressure Ulcer Record" dated, 12/8/16, 12/12/16, 12/19/16, 12/26/16 and 1/2/17 did not document the stage of the pressure ulcer on the right buttock. The space for "Stage" was left blank on all of the above mentioned dates. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/5/17 at 11:00 a.m. When asked who stages the pressure ulcers, ASM #2 stated, "The wound care nurse." When asked if the form has a place for the stage, should it be documented, ASM #2 stated, "Yes, the form should be complete. If it's asking for a stage on the form then a stage should be there." An interview was conducted with RN (registered nurse) #1, who documented the wound on 12/19/16, 12/26/16 and 1/2/17, on 1/5/17 at 11:20 a.m. When asked how she documents the stages of a pressure ulcer, RN #1 stated, "I don't	F 514		

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downstage. We should carry the stage the highest stage until it is healed." The "Weekly Pressure Ulcer Record" form was reviewed with RN #1. RN #1 stated, "I forgot to carry over the stage."

An interview was conducted with RN #5, who documented on the wound on 12/8/16 and 12/12/16, on 1/5/17 at 11:24 a.m. When asked how she documents the stages of a pressure ulcer, RN #5 stated, "Once the wound care nurse stages the wound, I carry it over until it is healed. I don't downstage any wound." The "Weekly Pressure Ulcer Record" form was reviewed with RN #5. RN #5 stated, "I forgot to document the stage." When asked if she should have documented the stage, RN #5 stated, "Yes."

The administrator and ASM #2 were made aware of the above findings on 1/5/17 at 6:00 p.m. A policy on the documentation of wound or completing the weekly pressure ulcer record was requested on 1/5/17. No policy was received prior to exit.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 380
(2)
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

3. The facility staff failed to document the stage Resident #3's pressure ulcers.

Resident #3 was admitted to the facility on 11/27/09 and readmitted on 10/19/16 with

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F 514	Continued From page 164 diagnoses that included but were not limited to: fracture left thigh bone, pain, anxiety, high blood pressure and bladder cancer. The most recent MDS (minimum data set, a thirty day assessment, with an ARD (assessment reference date) of 12/3/16 coded the resident as have seven out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring the assistance from staff for all activities of daily living. The resident was coded as being at risk for developing pressure ulcers. In section M "Skin Conditions" the resident was coded as having one stage 2 pressure ulcer and six stage 3 pressure ulcers. Review of the weekly non-pressure skin condition report dated 10/26/16 documented that the resident had a burn/abrasion to the right lower lateral leg measuring 12 cm. (centimeters) by three cm. and right inner ankle measuring 6 cm by 2 cm. "Tx (treatment) ordered for Silvasorb patch to be applied." Review of the weekly non-pressure skin condition report dated 11/5/16 documented that the resident had a moisture associated skin condition on the abdomen measuring 0.5 cm by 1.0 cm. Review of the weekly non-pressure skin condition report dated 11/3/16 documented that the resident had tissue loss to 2nd toe on R (right) foot measuring 0.9 cm. x 1.3 cm., outer aspect of R great toe and scratches to other phalanges. There was no documentation regarding the location of all of the wounds and the staging of any of the wounds.	F 514		

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F 514	Continued From page 165 Review of the care plan initiated on 5/26/15 and revised on 12/30/16 documented, "Impaired skin integrity...Stage III. (R) [right] leg. (R) ankle. Top (R) foot. (R) lateral foot. Stag (stage) II sacrum, rt lateral leg." A request was made to ASM (administrative staff member) #2 on 1/4/16 at 4:45 p.m. for documentation regarding Resident #3's wounds and staging. On 1/5/17 no documentation was obtained. On 1/6/16 at 8:30 a.m. a note was attached to Resident #3's weekly non-pressure skin condition report documented, "Documentation issue. Used the wrong sheet. Wound care nurse change over...etc." Another request was made to ASM #2 on 1/6/17 at 11:30 a.m. for documentation regarding the staging of Resident #3's wounds. Review of the facility's weekly pressure ulcer log on 10/20/16 documented, "Site. Sacrum. Stage II." Review of the facility's weekly pressure ulcer log on 11/17/16 documented, "Sacrum. Stage II. Right ankle. Stage II. Right lat (lateral) leg. Stage III." An interview was conducted on 1/6/17 at 11:30 a.m. with ASM #2. When asked if wound staging was to be documented in the clinical record she stated it should be. When asked if the facility's weekly pressure ulcer log was part of the resident's clinical record, ASM #2 stated it was	F 514		

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F 514	Continued From page 166 not. Review of the facility's policy on wound care did not address documentation of wound staging. No further information was provided prior to exit. 4. Facility staff failed to document Resident #7's Percocet (1) medication administration on the medication administration record (MAR) or the nurse's notes on two out of nine opportunities. Resident #7 was admitted to the facility on 12/26/16 and readmitted on 12/30/16 with diagnoses that included but were not limited to: respiratory failure, chronic lung disease, high blood pressure, arthritis and chronic pain. The most recent MDS was in progress and not available to review. The admission nurse's note dated 12/30/16 at 4:00 p.m. documented, "...Resident is alert/orient (sic) x (times) 3 (knows name, date and where she is).... 1 assist needed for ADL (activities of daily living) care." Review of the physician's orders documented, "Percocet (1) 5/325 mg (milligrams) 1 tab (tablet) po (by mouth) q (every) 4 hr (hours) prn (as needed) pain." Review of the nurse's notes dated 1/5/17 at 6:00 a.m. documented, "Percocet 5/325/mg (milligram) i (one) PO (by mouth)." Review of the January 2017 MAR (medication administration record) documented that Resident #7 received Percocet on 1/1/17 at 4:45 p.m.;	F 514		

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F 514	Continued From page 167 1/2/17 at 3:15 a.m.; 1/4/17 at 10:00 p.m..; 1/5/17 at 2:30 a.m. ad 1/5/17 at 9:55 a.m. There was no documentation that the resident had received Percocet on 1/5/17 at 6:00 a.m. Review of Resident #7's narcotic sheets documented that the resident received Percocet 1/1/17 at 4:45 p.m.; 1/2/17 at 3:15 a.m.; 1/2/17 at 1:20 p.m.; 1/3/17 12:00 p.m.; 1/4/17 2:45 a.m.; 1/4/17 10:00 a.m.; 1/4/17 9:00 p.m.; 1/5/17 2:30 a.m.; 1/5/17 9:50 a.m. and 1/5/17 at 2:00 p.m. a total of ten doses of Percocet were given with only five doses documented on the MAR. An interview was conducted on 1/5/17 at 12:20 p.m. with LPN (licensed practical nurse) #1.When asked if staff documented that a resident received pain medication, LPN #1 stated, "Yes, we put it on the MAR or when I write my note I usually put it in there." An interview was conducted on 1/5/16 at 11:30 a.m. with ASM #2. When asked where staff documented that a resident received a pain medication, ASM #2 stated, "On the MAR." When asked if the narcotic record was part of the permanent record, ASM #2 stated it was not. On 1/5/16 at 6:10 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "PAIN ASSESSMENT" documented, "Procedure: 8. If pain medication is provided as part of a pain management program, the Pain Management Flow Sheet should be used to assess pain each time pain medication is provided. This record should be kept with the MAR."	F 514		

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No further information was provided prior to exit.

(1) Percocet -- Treats moderate to moderately severe pain. This medicine is a narcotic pain reliever. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=percocet

5. The facility staff failed to include the hospice records on the facility chart for Resident # 20.

Resident # 20 was admitted to the facility on 12/1/15 and readmitted on 7/27/16 with diagnoses including, but not limited to: anemia, coronary disease, hypertension, diabetes, hyperlipidemia, dementia, and schizophrenia (1). On the most recent MDS (minimum data set), a significant change assessment with assessment reference date 10/6/16, Resident # 20 was coded as scoring a 2 out of a possible 15 on the BIMS (brief interview of mental status) indicating that she was severely cognitively impaired. She was coded as receiving hospice services.

A review of the clinical record for Resident # 20 revealed a nurse's note dated order dated 12/8/2016 1114 pm (11:14 p.m.) that documented, "@ (at) 1040 pm, (10:40 p.m.) resident observed (symbol for with) cool, clammy skin. Dyspnea noted upon assessment. Pupils non-reactive to light ...call placed to (name of hospice provider) on-call nurse as well as RP (responsible party) and made aware of resident's serious decline in status. Spoke (symbol for with) on-call nurse who states she is enroute (sic) facility. RP is also enroute (sic) to facility. Res

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(resident) observed @ this time (symbol for without) pulse or respirations. (Symbol for no) apical pulse auscultated (symbol for after) 1 full minute. Unable to obtain a blood pressure. MD aware. (Name of hospice provider) aware." Signed by LPN (licensed practical nurse) # 3.

A review of the clinical record, including the "Hospice section" failed to reveal any evidence of any other documentation of the hospice nurse's assessment of Resident # 20.

During an interview on 1/5/17 at approximately 2:00 p.m. with ASM (Administrative staff member) # 2, the director of nurses, a request was made for any documentation from the hospice nurse in regards her final assessment of Resident # 20.

During an interview on 1/5/17 at 3:30 p.m. with ASM # 2, ASM # 2 stated, "My nurses documented in the clinical record - there is no note from the hospice nurse in the record. I'm waiting for (name of hospice provider) to fax a copy of the note to me."

A faxed copy of the note (faxed on 1/5/17 at 15:48:54) was provided. The faxed copy documented a copy of the note signed electronically by the hospice nurse on 12/09/16 02:44 PM. The note documented the following: "Call received from nurse (name of nurse) at (name of facility) reporting PT (patient -- Resident # 20) had expired. Writer received PT lying in bed unresponsive. No signs of Respirations nor (sic) breath sounds auscultated. No carotid pulse nor heartbeat auscultated. Pupils fixed and dilated. Skin cool to touch. No signs of life noted. PT was pronounced at 1:50 A.M." Signed by RN (registered nurse) # 6.

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F 514	Continued From page 170 During the end of day interview on 1/5/17 at 6:00 p.m. with ASM # 1, the administrator, and ASM # 2 this concern was again discussed. A copy of the facility policy on complete and accurate records was requested at this time. During an interview on 1/6/17 at 8:25 a.m. with ASM # 2, ASM # 2 stated that there was no policy and procedure for the having a complete and accurate clinical record. No further information was provided prior to exit. NOTES: (1) Schizophrenia is a chronic and severe mental disorder that affects how a person thinks, feels, and behaves. www.nimh.nih.gov/health/topics/schizophrenia/index.shtml	F 514		