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	495240	A. BUILDING ______ B. WING ______	05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted on 5/24/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal law.	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives. The findings include: On 5/24/18 at 9:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator, and OSM (other	E 035	1. Maintenance Director posted location of the emergency preparedness plan in the corridor bulletin cabinet, where pertinent facility notices and licenses are located on 5/24/18 at 4:30PM. The emergency plan is located at the receptionist desk where residents, families, or representatives can view them. 2. Residents who reside in facility are at risk for same deficient practice. 3. Administrator informed residents at Resident Council Meeting of location of Emergency Preparedness plan on June 12, 2018. Maintenance Director added location of Emergency Preparedness plan to facility television information station on May 29, 2018. The information station plays throughout the facility in resident rooms and also in the main lobby television.	

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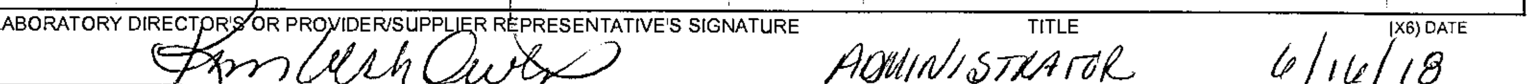

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE ADMINISTRATOR | (X6) DATE 6/16/18

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

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E 035	Continued From page 1 staff member) #1, the director of maintenance. Review of the facility's emergency preparedness plan failed to demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives. ASM # 1 stated the emergency preparedness binders were at the front desk along with the survey results binder. When asked if families and residents know about the facility's emergency preparedness plan and know to look in the binder for additional information, ASM #1 stated no. OSM #1 stated that maybe they needed to add information about the plan in their admission packet. On 5/24/18 at approximately 11:45 a.m., ASM (administrative staff member) # 1 was made aware of the above concerns. No further information was provided prior to exit.	E 035	4. Administrator will review Emergency Preparedness Plan and share location with Quality Assurance Performance Committee (QAPI) during next month QAPI and ensure posting is available in main corridor ongoing.	6/26/18
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/23/18 through 5/25/18. 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 177 certified bed facility was 104 at the time of the survey. The survey sample consisted of 34 current resident reviews (Residents #73, #8, #34, #23, #52, #82, #30, #108, #37, #64, #51, #46, #12, #38, #58, #35, #69, #18, #4, #11, #95, #93, #79, #9, #15, #99, #75, #27, #67, #70, #262, #19, #14, and #90) and 3 closed record reviews (Residents #219, #112, and #80.)	F 000	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal law.	

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F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550	1. CNA #1 was re-educated on ensuring residents are provided with dignity during meals regarding Resident #18 & Resident #27, including the use of napkins when assisting with meals and ensuring residents are seated facing the table during meals. 2. Residents who reside in facility are at risk for same deficient practice. 3. Staff will be re-educated on residents rights to ensure residents are provided with dignity, including ensure they have a dignified dining experience. Department heads will observe 5 meals per week for 4 weeks to ensure residents are provided a dignified dining experience. Issues identified will be corrected immediately. 4. Results of rounds will be reviewed in the monthly QAPI meeting. Trends identified will be addressed as needed.	6/26/18

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exercise of his or her rights as required under this subpart.
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 provide dignity for two of 37 residents in the survey sample, Residents #18 and #27.

1. The facility staff failed to provide a dignified dining experience for Resident #18. While feeding Resident #18, CNA (certified nursing assistant) #1 was observed scraping food from the resident's chin and feeding the food to the resident.

2. The facility staff failed to feed Resident #27 in a dignified manner in the bistro dining room.

The findings include:

1. The facility staff failed to provide a dignified dining experience for Resident #18. While feeding Resident #18, CNA (certified nursing assistant) #1 was observed scraping food from the resident's chin and feeding the food to the resident.

Resident #18 was admitted to the facility on 9/15/14. Resident #18's diagnoses included but were not limited to Huntington's disease (1), pain and difficulty swallowing. Resident #18's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/6/18, coded the resident's cognition as severely impaired. Section G coded Resident #18 as requiring limited assistance of one staff

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with eating. Resident #18's comprehensive care plan dated 9/18/14 documented "(Name of Resident #18) is at risk for imbalanced nutrition & hydration RT (related to) hx (history) of dysphagia (difficulty swallowing), edentulous (lacking teeth) with refusal to wear dentures, resident experiencing constant body movements/tremors as evidenced by resident needing altered consistency diet, hx sig (significant) wt (weight) change, need for adaptive equipment, occasionally refuses assistance with meals...Assist resident with meals as needed & as tolerated..."

On 5/23/18 at 12:57 p.m., CNA #1 was observed feeding Resident #18 a pureed meal in the bistro dining area. While feeding the resident, food was observed on the resident's chin. CNA #1 was then observed scraping the food in an upward motion from the resident's chin with a spoon and then placing the spoon containing the food in Resident #18's mouth. This was observed four times during the meal.

On 5/23/18 at 2:40 p.m., an interview was conducted with CNA #2. CNA #2 was asked what she does when feeding a resident and the food falls on the resident's chin. CNA #2 stated, "Take a napkin and go to their face and wipe it off and make sure he isn't pocketing (holding food in the mouth)." CAN #2 was asked if staff should scrape food from a resident's chin and then place the food in his/her mouth, CNA #2 stated, "That's not something I would do. To me it's not sanitary." When asked how she would feel if that was done to her, CNA #2 stated, "Like a baby."

On 5/23/18 at 2:45 p.m., an interview was conducted with CNA #1. CNA #1 was asked what

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she does when feeding a resident and the food falls on the resident's chin. CNA #1 stated, "I usually just take the spoon and get it off." When asked if she uses a napkin, CNA #1 stated, "Um. No." When asked if she viewed removing food from a resident's chin with the spoon then placing the food in the resident's mouth as a dignity issue, CNA #1 stated, "No." When asked how she would feel if that was done to her, CNA #1 stated, "I couldn't really tell you. I'm just used to feeding him (Resident #18) like that. I don't know."

On 5/24/18 at 3:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked what she should do when feeding a resident and the food falls on the resident's chin. LPN #4 stated, "Get a napkin." When asked how she would feel if someone scraped food from her chin and placed the food into her mouth, LPN #4 stated, "No. I wouldn't want food scraped off me."

On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "YOUR RESIDENT RIGHTS AND PROTECTIONS UNDER STATE AND FEDERAL LAW" documented, "Dignity and Respect. You have the right to be treated with consideration, dignity and respect in full recognition of your individuality."

No further information was presented prior to exit.

(1) "Huntington's disease (HD) is an inherited disease that causes certain nerve cells in the

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brain to waste away. People are born with the defective gene, but symptoms usually don't appear until middle age. Early symptoms of HD may include uncontrolled movements, clumsiness, and balance problems. Later, HD can take away the ability to walk, talk, and swallow. Some people stop recognizing family members. Others are aware of their environment and are able to express emotions." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=huntington%27s+disease&_ga=2.232040607.1046050702.1527592979-139120270.1477942321

2. The facility staff failed to feed Resident #27 in a dignified manner in the bistro dining room.

Resident #27 was admitted to the facility on 6/18/07 and readmitted on 8/1/12 with diagnoses that included but were not limited to: difficulty swallowing, psychosis, lack of coordination and falls.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 3/13/18 coded the resident as having scored a zero out of 15 on the brief interview for mental status indicting the resident was severely impaired cognitively. The resident was coded as usually able to make self-understood and sometimes understanding others. The resident was coded as requiring assistance for all activities of daily living including eating.

An observation was made on 5/23/18 at 12:30 p.m. of the lunch service in the bistro dining

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room. Resident #27 was sitting with her back to a table where three other residents were sitting. CNA (certified nursing assistant) #1 was sitting to the right of the resident facing the table while feeding the resident.

An observation was made on 5/24/18 at 1:00 p.m. of the lunch service in the bistro dining room. Resident #27 was sitting with her back to the table where two other residents were sitting. CNA #1 was sitting to the right of the resident facing the table while feeding the resident.

An interview was conducted on 5/24/18 at 1:17 p.m. with CNA #1. When asked why the resident was fed with her back to the table while other residents sat at the table and ate their meals, CNA #1 stated, "It's so much easier." When asked whom it was easier for, CNA #1 stated, "For us. We can have eye contact." When asked if the resident was having a dignified dining experience, CNA #1 stated, "No."

An interview was conducted on 5/24/18 at 3:55 p.m. with LPN (licensed practical nurse) #2. When asked about feeding a resident with their back to the table where other residents were eating, LPN #2 stated, "I wouldn't do it. You'd think they could give you a reason for it." When asked why she wouldn't feed the resident in this manner, LPN #2 stated, "Because the other residents are eating, I wouldn't go out to a meal and turn my back on the table." When asked if this was a dignified way to be fed, LPN #2 stated, "No."

On 5/25/18 at 1:20 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the

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F 550	Continued From page 8 findings. Review of the facility's document titled, "YOUR RESIDENT RIGHTS AND PROTECTIONS UNDER STATE AND FEDERAL LAW" documented, "QUALITY OF LIFE A nursing home must care for you in manner and environment that promotes the maintenance and enhancement of your quality of life. Dignity and Respect. You have the right to be treated with consideration, dignity and respect in full recognition of your individuality." No further information provided prior to exit.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580	1. MD notified of Resident 82's Blood pressure readings on 6/14/18. MD reviewed B/P history from May 2018 to current. MD notified of 15's Blood sugar readings on 6/14/18. MD reviewed resident 15s blood sugar history from April 2018 to current. 2. Residents who reside in this facility are at risk for same deficient practice.	

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F 580	Continued From page 9 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician of a change in condition and/or a possible need to alter treatment for two of 37 residents in the survey sample, Residents #82 and #15. 1. The facility staff failed to notify the nurse practitioner/physician of Resident #82's blood pressures when they were below the physician ordered parameter for blood pressure medication	F 580	3. Nursing staff will be re-educated on notification of MD/RP for changes, including notification when call parameters are outside specific orders. DON or designee will audit Medication Administration Records (MARs) to ensure MD/RP notification is made according to parameter call instructions. Audit will include 3 residents' records 2 x week x 4 weeks to ensure notification is made. Issues identified will be corrected immediately. 4. Results of audits will be reviewed in the monthly QAPI meeting. Trends and issues will be identified and addressed as needed.	6/26/18

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administration.

2. The facility staff failed to notify the doctor/nurse practitioner of elevated blood sugars for Resident #15.

The findings include:

1. The facility staff failed to notify the nurse practitioner/physician of Resident #82's blood pressures when they were below the physician ordered parameter for blood pressure medication administration.

Resident #82 was admitted to the facility on 10/31/17. Resident #82's diagnoses included but were not limited to diabetes, high blood pressure and anxiety disorder. Resident #82's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/24/18, coded the resident as being cognitively intact.

Review of Resident #82's clinical record revealed a physician's order dated 12/5/17 that documented to give clonidine (1) 0.1 mg (milligrams) by mouth every morning and at bedtime and to hold the medication if the resident's blood pressure is less than 120/70.

Review of Resident #82's May 2018 eMAR (electronic medication administration record) revealed:
-On 5/9/18 at 6:00 a.m., the resident's blood pressure was 113/68 and clonidine was administered (as evidenced by a check mark and a nurse's initials).
-On 5/19/18 at 6:00 a.m., the resident's blood

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pressure was 110/68 and clonidine was administered (however, an interview with the nurse who administered the medication stated she held it).

Further review of Resident #82's clinical record (including the May 2018 eMAR and nurses' notes dated 5/9/18 and 5/19/18) failed to reveal the nurse practitioner or physician was made aware of the resident's above blood pressures.

Resident #82's comprehensive care plan dated 10/18/16 documented, "Impaired Cardiovascular status related to: dx (diagnosis) of anemia and Hypertension (high blood pressure) and hx (history) of chest pain and hypokalemia (low potassium), PVD (peripheral vascular disease)...Interventions: Medications as ordered by physician and Observe use and effectiveness..."

On 5/24/18 at 3:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked how nurses document an administered medication. LPN #4 stated she checks and initials the MAR (medication administration record). LPN #4 was asked how nurses document a held medication. LPN #4 stated she checks the number "3" on the MAR, which indicates, "Hold/See nurses note" and by coding a "3", a page comes up on the computer for her to document a progress note. LPN #4 was shown Resident #82's physician order for clonidine and asked what should be done if the resident's blood pressure is below 120/70. LPN #4 stated she would not give the medication and she would let the nurse practitioner or doctor know. When asked why, LPN #4 stated, "Because they need to know if we are not giving a

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medication so they can adjust whatever they need to adjust."

On 5/24/18 at 4:31 p.m., an interview was conducted with LPN #6 (the nurse who checked and initialed clonidine administration to Resident #82 on 5/9/18 at 6:00 a.m. and 5/19/18 at 6:00 a.m.) LPN #6 was asked how she documents that a medication is administered and how she documents that a medication is held. LPN #6 stated she signs the medication off when she administers it and there is an option in the computer system to document when a medication is held. LPN #6 was asked if she ever had to hold any of Resident #82's medications in May 2018. LPN #6 stated there were times where she documented the resident's blood pressure medication was given but she actually held the medication. When asked if she administered or held Resident #82's blood pressure medication on 5/9/18, LPN #6 stated she could not remember but she knew she held the medication on 5/19/18. When asked if she would notify the physician or nurse practitioner when a blood pressure medication is held, LPN #6 stated, "I don't think I'm supposed to do that unless it's critically low."

On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

On 5/25/18 at 9:40 a.m., an interview was conducted with ASM #3 (the nurse practitioner). ASM #3 was made aware Resident #82 has a physician's order for clonidine with parameters to hold the medication if the resident's blood pressure is less than 120/70. ASM #3 was asked

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if the nurses should notify her if they have to hold the medication due to the resident's blood pressure being below the ordered parameter. ASM #3 stated, "Yeah they should because if it's running low consistently we need to make changes. Decrease or dc (discontinue). He fluctuates." When asked if nurses should notify her even if they only have to hold the medication once, ASM #3 stated, "Yes."

The facility document titled, "Medication Administration General Guidelines" documented, "2. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (for example, the resident is not in the nursing care center at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN (as needed) documentation. If two consecutive doses of a vital medication are withheld or refused, the physician is notified..."

No further information was presented prior to exit.

(1) Clonidine is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682243.html

2. The facility staff failed to notify the doctor/nurse practitioner of elevated blood sugars for Resident #15.

Resident #15 was admitted to the facility on 4/6/16 with a recent readmission on 4/27/17, with diagnoses that included but were not limited to:

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diabetes (a complex and chronic disorder of metabolism due either to partial or total lack of insulin secretion by the pancreas or to the inability of insulin to function normally in the body) (1) , COPD (chronic obstructive pulmonary disease [general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis]) (2), high blood pressure, heart failure, pain, and difficulty walking.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 2/27/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she is capable of making cognitive daily decisions. Resident #15 was coded as requiring supervision with set up assistance for all of her activities of daily living.

The physician order dated, 11/10/17, documented, "Humalog Solution Insulin Lispro (HUMALOG is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. (3)) inject as per sliding scale if (blood sugar) 150 - 199 = 6 unit, less than 70 = 0 units, Follow hypoglycemic protocol and call MD (medical doctor); 200 - 249 = 8 units, greater than 500 call MD, 250 - 299 = 10 units, 300 - 349 = 12 units; 350 - 399 = 14 units, 400 - 450 = 16 units, 451 - 500 = 20 units., subcutaneously before meals and at bedtime related to diabetes mellitus due to underlying condition with unspecified complications. Call MD if less than 70 and greater than 400, patient may check her BS (blood sugar) and report number to staff for insulin coverage."

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The April 2018 MAR (medication administration record) documented, "Humalog Solution Insulin Lispro, inject as per sliding scale if (blood sugar) 150 - 199 = 6 unit, less than 70 = 0 units, Follow hypoglycemic protocol and call MD; 200 - 249 = 8 units, greater than 500 call MD, 250 - 299 = 10 units, 300 - 349 = 12 units; 350 - 399 = 14 units, 400 - 450 = 16 units, 451 - 500 = 20 units., subcutaneously before meals and at bedtime related to diabetes mellitus due to underlying condition with unspecified complications. Call MD if less than 70 and greater than 400, patient may check her BS and report number to staff for insulin coverage." Resident #15's documented blood sugars were as follows:
4/2/18 at 9:00 p.m. = 419
4/4/18 at 6:30 a.m. = 412
4/8/18 at 9:00 p.m. = 423
4/11/18 at 11:30 a.m. = 422
4/13/18 at 9:00 p.m. = 423
4/18/18 at 9:00 p.m. = 410
4/21/18 at 9:00 p.m. = 425
4/22/18 at 11:30 a.m. = 432
4/22/18 at 9:00 p.m. = 431
4/25/18 at 9:00 p.m. = 445
4/29/18 at 4:30 p.m. = 406
4/29/18 at 9:00 p.m. = 408

Review of the nurse's notes for April 2018 failed to evidence any documented notification to the physician for the recorded blood sugars documented above.

The May 2018 MAR documented, "Humalog Solution Insulin Lispro, inject as per sliding scale if (blood sugar) 150 - 199 = 6 unit, less than 70 = 0 units, Follow hypoglycemic protocol and call MD; 200 - 249 = 8 units, greater than 500 call

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MD, 250 - 299 = 10 units, 300 - 349 = 12 units; 350 - 399 = 14 units, 400 - 450 = 16 units, 451 - 500 = 20 units., subcutaneously before meals and at bedtime related to diabetes mellitus due to underlying condition with unspecified complications. Call MD if less than 70 and greater than 400, patient may check her BS and report number to staff for insulin coverage."
Resident #15's documented blood sugars were as follows:
5/1/18 at 9:00 p.m. = 455
5/4/18 at 4:30 p.m. = 485
5/5/18 at 9:00 p.m. = 421
5/10/18 at 4:30 p.m. = 414
5/10/18 at 9:00 p.m. = 417
5/12/18 at 9:00 p.m. = 437
5/15/18 at 11:30 a.m. = 412
5/15/18 at 9:00 p.m. = 439
5/23/18 at 9:00 p.m. = 439

Review of the nurse's notes for May 2018 failed to evidence any documented notification to the physician for the recorded blood sugars documented above.

The comprehensive care plan dated, 4/22/16 and revised on 3/7/18, documented in part, "Focus: I am at Risk for Metabolic Complications due to: Diabetes Mellitus. I have episodes of hyperglycemia at times." The "Interventions" documented in part, "Labs (laboratory tests) and blood sugar check per physician order and PRN (as needed) for change in condition/manifestation of clinical signs or symptoms. Resident may assist or complete her own accuchecks (glucometer machine used for obtaining blood sugar readings to monitor blood sugars) and show nursing the results. Observed for high blood sugar symptoms - increased thirst, increased

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hunger, increased urinary output."

An interview was conducted with LPN (licensed practical nurse) #4 on 5/24/18 at 2:21 p.m. LPN #4 reviewed the above order for Humalog insulin. When asked what staff should do, per the order, if the resident's blood sugar is greater than 400, LPN #4 stated, "We should notify the doctor/nurse practitioner." When asked where staff document that notification, LPN #4 stated, "It should be in the nurse's notes."

An interview was conducted with ASM (administrative staff member) #3, the nurse practitioner; on 5/24/18 at 3:22 p.m. ASM #3 reviewed the physician order above for the Humalog insulin sliding scale. ASM #3 was then asked what is the nurses should do when the resident's blood sugar is greater than 400, ASM #3 stated, "I would expect them to notify me or the doctor." When asked why it is important to notify the doctor of elevated blood sugars, ASM #3 stated, "I would need to adjust her insulin and elevated blood sugars can cause medical complications."

The administrator, ASM #1 was made aware of the above concern on 5/24/18 at 5:26 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 163.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(3) This information was obtained from the following website:

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F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.	F 582	1. Resident #219 discharged from facility. 2. Residents who reside at this facility are at risk for same deficient practice. 3. Social service director and Business Office Manager were re-educated on requirements for Notice of Medicare Non-Coverage and their right to appeal on June 13, 2018. Administrator or designee will audit 3 resident records pending discharge weekly for 4 weeks, to ensure resident are provided notice of coverage liability and appeal rights. Issues identified will be corrected immediately. 4. Results of audits will be reviewed in the monthly QAPI meeting. Trends identified will be addressed as needed.	6/26/18

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(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to evidence that one of 37 sampled residents, (Resident #219) or their resident representative was provided with a Notice of Medicare Non-Coverage and their right to appeal. Resident #219 was admitted on 4/13/18, and discharged on 4/19/18, and had used seven of 100 Medicare days.

The findings include:

Resident #219 was admitted on 4/13/18 with the diagnoses of but not limited to right knee replacement, high blood pressure, and polyosteoarthritis. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 4/19/18. The resident was coded as cognitively intact in ability to make daily

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life decisions. The resident was coded as requiring total care for bathing; supervision for bed mobility, ambulation, and toileting; as independent for transfers, dressing, eating, and hygiene; and as continent of bowel and bladder.

A review of the clinical record revealed a note dated 4/17/18 which documented, "Please note that a TCM (treatment care meeting)/discharge meeting was held with the resident, his family, and the IDT (Interdisciplinary team). The resident is alert and oriented and is able to make his needs known to staff. He has not presented with any mood or behavior concerns. His family visits often and is very supportive. PT (physical therapy): The resident's ROM (range of motion) is good...he is able to bend his knee. They are working on getting it straight. Therapy is also working on strengthening...his bed mobility and walking are great. Nursing: The resident's test results revealed he does not have a blood clot in his leg. He does complain of occasional pain in his leg. There is a follow-up appointment scheduled for Thursday, April 26, 2018 at 1pm. Social Services: The resident will be discharging home on Thursday, April 19, 2018 with a referral for home health with (name of home health agency) for PT. The resident has no DME (durable medical equipment) needs. He and his family are very excited about his discharge and are looking forward to him returning home. Please continue POC (plan of care)."

The above discharge note did not document that the resident or their representative was provided with the Notice of Medicare Non-Coverage form and the resident's right to appeal being discharged.

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A review of the Notice of Medicare Non-Coverage for the resident documented that "Services Will End: 4/18/17." The date portion was hand-written in.

The notice documents the following: "Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current services after the effective date indicated above. You may have to pay for any services you receive after the above date. YOUR RIGHT TO APPEAL THIS DECISION: You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal. If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish. If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal. If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above; Neither Medicare nor your plan will pay for these services after that date. If you stop services no later than the effective date indicated above, you will avoid financial responsibility....HOW TO ASK FOR AN IMMEDIATE APPEAL: You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services. Your request for

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an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above. The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO will generally notify you of its decision by the effective date of this notice......"

At the end of the above notice, is the following statement: "Please sign below to indicate you received and understood this notice. I have been notified that coverage of my services will end on the effective date on this notice and that I may appeal this decision by contacting my QIO." There was a blank for a signature and a blank for a date. The date of 4/17/18 was hand-written in, matching the handwriting of the "Services Will End" date at the begriming of the notice. The blank for the signature was not completed. There was no signature of the resident or their representative, indicating that they ever received this notice of the right to appeal.

On 5/24/18 at 3:22 p.m., in an interview with ASM #1 (Administrative Staff Member, the Administrator) she stated that this notice was reviewed at the meeting documented in the above TCM/Discharge meeting note, but that the facility forgot to have the resident or their representative sign it. The above referenced note did not document that the appeal process was offered or reviewed with the resident and/or their representative.

A review of the facility policy, "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN [skilled

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F 582	Continued From page 23 nursing facility advanced beneficiary notice]) documented, "....The SNF ABN provides information to the beneficiary so that s/he (she/he) can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility....The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice." No further information was provided by the end of the survey.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584	1. Resident # 35s over bed table was removed from the room and discarded on 5/24/18. Resident #35 was provided a new over bed table by the maintenance director. 2. An environmental audit of resident rooms was completed by Maintenance Director and Administrator on 5/29/18. Furniture was replaced as needed. 3. Staff will be re-educated on reporting and/or removing furniture, if indicated, to maintenance for repair. Department heads will complete Care Keeper rounds Monday thru Friday to observe for environmental issues or concerns needing attention or corrective actions. Care keeper rounds are completed in the morning to correct and/or report to the appropriate department for corrections.	

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F 584	Continued From page 24 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that the facility staff failed to maintain the resident's furniture in good repair for one of 37 residents in the survey sample, Resident # 35. The facility staff failed to maintain Resident # 35's over the bed table was in good repair. The findings include: Resident # 35 was admitted to the facility on 11/01/06 with a readmission of 06/04/07 with diagnoses that included but were not limited to Alzheimer's disease (1), dysphagia (2), osteoporosis (3) heart failure, and hypertension (4). Resident # 35's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/20/18, coded	F 584	Care keeper rounds are reviewed monthly by the administrator or designee. Care keeper rounds is an ongoing quality assurance performance improvement process. 4. Results of care keeper rounds are reviewed monthly in the QAPI meeting. Trends identified will be addressed as needed.	6/26/18

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Resident # 35 as scoring a 2 (two) on the brief interview for mental status (BIMS) of a score of 0 - 15, 2 (two) - being severely impaired of cognition for making daily decisions. Resident # 35 was coded as requiring extensive assistance of one staff member for activities of daily living.

On 05/23/18 at approximately 10:19 a.m., Resident # 35's over the bed table was observed. The edges were chipped and peeling, a hole was gouged out in the middle of the top of the table approximately size of a person's thumb and the trim surrounding the edges of the table was separated from the table exposes the bare wood fiber edges.

On 05/23/18 at approximately 9:00 a.m., Resident # 35's over the bed table was observed. The edges were chipped and peeling, a hole was gouged out in the middle of the top of the table approximately size of a person's thumb and the trim surrounding the edges of the table was separated from the table exposes the bare wood fiber edges.

On 05/24/18 at approximately 2:05 p.m., Resident # 35's over the bed table was observed. The edges were chipped and peeling, a hole was gouged out in the middle of the top of the table approximately size of a person's thumb and the trim surrounding the edges of the table was separated from the table exposes the bare wood fiber edges.

On 05/24/18 at approximately 2:27 p.m., an interview was conducted with CNAs (certified nursing assistants) # 3 and # 9, regarding the procedure staff follow when resident's damaged furniture is identified. CNA # 3 stated, "Remove

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the damaged item from the resident's room if possible. I record it in a maintenance log at the nurse's station and notify my nurse the unit manager and maintenance when I see them but as soon as possible." When asked how often they observe the resident's furniture to ensure it is in good repair, CNA # 3 stated, "I try to observe things when in the resident's room." At this time, CNA # 3 and # 9 observed Resident # 35's bedside table. CNA # 3 agreed the table was not in good repair. CNA # 3 stated due to the chipped edge, hole in the middle of the table and the trim falling off the edge, the table could not be cleaned or disinfected properly. When asked if the table was recorded in the maintenance log CNA # 3 stated, "No, I didn't notice the table earlier today."

On 05/24/18 at approximately 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) # 8. When asked to describe the procedure staff follows when resident's damaged furniture is identified, the LPN # 8 stated, "It is removed from the room, write it down in the maintenance log and call maintenance." LPN # 8 stated she was not aware of the condition of Resident # 35's over the bed table.

Review of the maintenance logs from 05/01/18 through 05/24/18 for the East 2 unit failed to evidence a "Maintenance Request Form" for Resident # 35's over the bed table.

On 05/24/18 at 3:00 p.m., an interview was conducted with OSM (other staff member) # 1, maintenance director. When asked to describe the procedure staff follows when resident's damaged furniture is identified, OSM # 1 stated, "When something is broken or in need of repair,

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nursing should write it down in the maintenance log. We check the log frequently throughout the day." When asked about Resident # 35's bedside table, OSM # 1 stated, "I was already informed about it and we just replaced it. It was not in serviceable condition."

On 05/24/18 at approximately 5:55 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 brain disorder that seriously affects a person's ability to carry out daily activities). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

(2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(3) Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.

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

F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		

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§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health

1. Resident # 73 was transferred to hospital on 2/7/18 and report to hospital emergency room nurse was called at 7:15pm by facility charge nurse. Resident 73 was readmitted on 2/12/18 with resumption of plan of care. On 2/7/18 at 5:45pm, Resident #73's Infectious Disease (ID) physician called facility with orders to send resident to hospital for evaluation and treatment of febrile illness [elevated temperature]. Resident #58 was transferred to the hospital emergency department following (Nurse Practitioner) NP examination related to injury sustained during fall on 1/26/18 at 7:40pm. Resident returned from hospital emergency department on 1/27/18 at 1:50am with resumption of care. Resident # 262 was transferred to the hospital per NP order due to critical lab results on 4/17/18. Resident #4 was transferred to hospital for evaluation following a fall per NP on 4/28/18 at 11:30am. Resident # 30 was transferred to the hospital on 4/25/18 at 12:51 AM per NP due to fall and change in condition. Resident # 75 was examined by NP on 3/20/18 at 7:37pm. NP consulted with Responsible Party (RP) and ordered transfer to the hospital for further evaluation.

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F 622	Continued From page 29 or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for	F 622	2. Residents residing in this facility are at risk for the same deficient practice. 3. Nursing staff, attending physicians, and NPs will be re-educated on documentation requirements for transfers and discharges to ensure appropriate documentation is provided to the receiving health care institution or provider. Director of Nursing or designee will review 24 hour report during morning meeting to ensure residents transferred or discharge have documentation of appropriate notices to the receiving facility and physician/NP documentation supports transfer. DON or designee will audit 3 residents' records weekly for 4 weeks. 4. Results of audits will be reviewed in the monthly QAPI meeting. Trends identified will be addressed as needed.	6/26/18

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F 622	Continued From page 30 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, it was determined that the facility staff failed to meet the appropriate transfer requirements for six of 42 residents in the survey sample, Residents # 73, 58, 262, 30, 4 , and 75. 1a. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 02/07/18 for Resident # 73. 1b. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 73 for a facility initiated transfer. 2. The facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 01/26/18 for Resident # 58. 3a. The facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 04/17/18 for Resident # 262.	F 622		

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3b. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 262 for a facility initiated transfer on 04/17/18.

4. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet and failed to provide a copy of Resident #30's care plan goals for a facility initiated transfer to the hospital on 4/25/18.

5. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet and failed to provide a copy of Resident #4's care plan goals to the receiving facility for a facility initiated transfer to the hospital on 4/28/18.

6. The facility staff failed to evidence that the required documentation and information was provided to the receiving facility when Resident #75 was transferred to the hospital on 3/20/18.

The findings include:

1a. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 02/07/18 for Resident # 73.

Resident # 73 was admitted to the facility on 05/21/13 with a readmission of 02/12/18 with

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diagnoses that included but were not limited to human immunodeficiency virus (1), gastroesophageal reflux disease (2), convulsions (3), myelopathy disease (4), dementia (5) and encephalopathy (6).

Resident # 73 was admitted to the facility on 05/21/13 with a readmission of 02/12/18 with diagnoses that included but were not limited to human immunodeficiency virus (1), gastroesophageal reflux disease (2), convulsions (3), myelopathy disease (4), dementia (5) and encephalopathy (6).

Resident # 73's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/24/18, coded Resident # 73 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being cognitively for making daily decisions. Resident # 73 was coded as requiring limited to extensive assistance of one staff member for activities of daily living.

The nurse's "Progress Notes," dated 2/7/2018 23:41 (11:41 p.m.) for Resident # 73 documented in part, "Looses rattling NPC (nonproductive cough) and clear nasal drainage. Medicated with Tylenol and Mucinex at that time and FNP (facility nurse practitioner) was notified. RP (responsible party) notified and a Flu swab was obtained. Temperature 100.8 F (Fahrenheit) at 6 p.m. (6:00 p.m.) and a new order has been rec'd (received) to send resident to (Name of Hospital) ER (emergency room) for eval/tx (evaluation and treatment) of febrile (fever) illness per direction of (Name of Physician). Report was called to ER charge nurse and transportation was arranged Via (by) (Name of Transportation Company).

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Sister / RP to meet at hospital. Resident was transported to ER (at) 7:15 p.m. A f/u (follow up) with ER staff @ (at) 23:00 (11:00 p.m.) and resident is still in the examination area and there has been no determination."

The nurse's "Progress Notes," dated 02/12/2018 for Resident # 73 documented in part, "17:48 (5:48 p.m.) Resident readmitted into facility at 2:55 p.m. from (Name of Hospital) (by) (Name of Transportation Company) accompanied by EMT (emergency medical technician) personnel (by) stretcher ..."
On 05/25/18 at approximately 9:21 a.m., an interview was conducted with LPN (licensed practical nurse) # 3, regarding information provided to the receiving facility for a facility-initiated transfer. LPN # 3 stated, "The face sheet, code status, vitals, medication orders and treatments." When asked if they send the resident care plan goals, LPN # 3 stated, "I don't believe so."

Review of resident # 73's clinical record failed to evidence the receiving facility received a copy of Resident # 73's care plan goals.

On 05/25/18 at approximately 1:10 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) HIV stands for human immunodeficiency virus. It harms your immune system by destroying the white blood cells that fight infection. This puts you at risk for serious infections and certain

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cancers. AIDS stands for acquired immunodeficiency syndrome. It is the final stage of infection with HIV. Not everyone with HIV develops AIDS. HIV most often spreads through unprotected sex with an infected person. It may also spread by sharing drug needles or through contact with the blood of an infected person. Women can give it to their babies during pregnancy or childbirth. This information was obtained from the website: https://medlineplus.gov/hivaids.html.

(2) 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.

(3) 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.

(4) Any functional disturbance or pathological change in the spinal cord; often used to denote nonspecific lesions, as opposed to myelitis. 2. pathological bone marrow changes. adj., adj myelopath´ic. This information was obtained from the website: https: https://medical-dictionary.thefreedictionary.com/myelopathy.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

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(6) A term for any diffuse disease of the brain that alters brain function or structure. This information was obtained from the website: http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm.

1b. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 73 for a facility initiated transfer.

The nurse's "Progress Notes," dated 2/7/2018 23:41 (11:41 p.m.) for Resident # 73 documented in part, "Looses rattling NPC (nonproductive cough) and clear nasal drainage. Medicated with Tylenol and Mucinex at that time and FNP (facility nurse practitioner) was notified. RP (responsible party) notified and a Flu swab was obtained. Temperature 100.8 F (Fahrenheit) at 6 p.m. (6:00 p.m.) and a new order has been rec'd (received) to send resident to (Name of Hospital) ER (emergency room) for eval/tx (evaluation and treatment) of febrile (fever) illness per direction of (Name of Physician). Report was called to ER charge nurse and transportation was arranged Via (by) (Name of Transportation Company). Sister / RP to meet at hospital. Resident was transported to ER (at) 7:15 p.m. A f/u (follow up) with ER staff @ (at) 23:00 (11:00 p.m.) and resident is still in the examination area and there has been no determination."

The nurse's "Progress Notes," dated 02/12/2018

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for Resident # 73 documented in part, "17:48 (5:48 p.m.) Resident readmitted into facility at 2:55 p.m. from (Name of Hospital) (by) (Name of Transportation Company) accompanied by EMT (emergency medical technician) personnel (by) stretcher ..."

Review of the physician's most recent progress notes dated February 2018 through May 2018 failed to evidence documentation of the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 73 for the facility initiated hospital transfer on 2/7/18.

On 05/25/18 at 1:58 p.m., an interview was conducted with ASM (administrative staff member) # 3, the nurse practitioner. When asked if they document the specific needs the facility could not meet, facility's efforts to meet those needs and the specific needs the receiving facility could provide to meet the needs of the resident ASM # 3 stated, "No."

On 05/25/18 at approximately 1:10 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.

2. The facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 01/26/18 for Resident # 58.

Resident # 58 was admitted to the facility on

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F 622	Continued From page 37 01/01/16 with diagnoses that included but were not limited to anoxic brain damage (1), anxiety (2), seizures (3), depressive disorder (4), dementia (5) and muscle weakness. Resident #58's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/17/18, coded Resident # 58 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 58 was coded as requiring limited to extensive assistance of one staff member for activities of daily living. The nurse's "Progress Notes," dated 01/26/18 for Resident # 58 documented, "20:19 (8:19 p.m.) Resident was found sitting on the floor in his room @ (at) 7:40 p.m. He was alert and talkative. Reported having a headache at that time. Bleeding observed on face, clothes and on the floor. A large laceration was noted on the posterior scalp. FNP (facility nurse practitioner) in to examine resident and an order was rec'd (received) to send (Resident # 58) to (Name of Hospital) ER (emergency room) for evaluation and tx (treatment) of head injury. (Name of Transportation Company) was arranged a voice message was left for sister/RP (responsible party) (Name of Sister) in regards to this event ..." The nurse's "Progress Notes," dated 01/27/18 at 01:54 (1:54 a.m.) for Resident # 58 documented, "Resident returned from ER with brother 6 (six) staples to the parietal area of his head no active bleeding noted vital signs within normal limits." On 05/25/18 at approximately 9:21 a.m., an	F 622		

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interview was conducted with LPN (licensed practical nurse) # 3, regarding information provided to the receiving facility for a facility-initiated transfer. LPN # 3 stated, "The face sheet, code status, vitals, medication orders and treatments." When asked if they send the care plan LPN # 3 stated, "I don't believe so."

Review of resident # 58's clinical record failed to evidence the receiving facility received a copy of Resident # 58's care plan goals.

On 05/25/18 at approximately 1:10 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) Not enough oxygen getting to the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001435.htm

(2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(3) 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.

(4) Depression may be described as feeling sad,

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blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

3a. The facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 04/17/18 for Resident # 262.

Resident # 262 was admitted to the facility on 12/24/17 with a readmission of 05/01/18 with diagnoses that included but were not limited to sepsis (1), dysarthria (2), aphasia (3), depressive disorder (4), dementia (5) and cerebral infarction (6).

Resident #262's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/17/18, coded Resident # 262 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 262 was coded as requiring limited to extensive assistance of one staff member for activities of daily living.

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The nurse's "Progress Notes," dated 04/17/18 at 17:49 (5:49 a.m.) for Resident # 262 documented in part, "(Name of Hospital) lab (laboratory) called with critical hemoglobin results at 5.8. NP (nurse practitioner) in facility. NON (new order now) to send (Name of Hospital) ER (emergency room) ..."

The nurse's "Progress Notes," dated 05/01/18 at 12:54 p.m., for Resident # 262 documented in part, "Resident was brought to the facility by (Name of Transportation Company) and put in bed ..."

Review of resident # 262's clinical record failed to evidence the receiving facility received a copy of Resident # 262's care plan goals.

On 05/25/18 at approximately 9:21 a.m., an interview was conducted with LPN (licensed practical nurse) # 3, regarding information provided to the receiving facility for a facility-initiated transfer. LPN # 3 stated, "The face sheet, code status, vitals, medication orders and treatments." When asked if they send the care plan goals, LPN # 3 stated, "I don't believe so

On 05/25/18 at approximately 1:10 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) Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or

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other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm.

(2) A condition in which you have difficulty saying words because of problems with the muscles that help you talk). This information was obtained from the website: https://medlineplus.gov/ency/article/007470.htm.

(3) 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.htm l

(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(6) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain

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attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm .

3b. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 262 for a facility initiated transfer.

Resident #262's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/17/18, coded Resident # 262 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 262 was coded as requiring limited to extensive assistance of one staff member for activities of daily living.

The nurse's "Progress Notes," dated 04/17/18 at 17:49 (5:49 a.m.) for Resident # 262 documented in part, "(Name of Hospital) lab (laboratory) called with critical hemoglobin results at 5.8. NP (nurse practitioner) in facility. NON (new order now) to send (Name of Hospital) ER (emergency room) ..."

Review of the physician's most recent progress notes dated February 2018 through May 2018 failed to evidence documentation of the specific

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needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 262 for facility initiated hospital transfer on 4/17/18.

On 05/25/18 at 1:58 p.m., an interview was conducted with ASM (administrative staff member) # 3, the nurse practitioner. When asked if they document the specific needs the facility could not meet, facility's efforts to meet those needs and the specific needs the receiving facility could provide to meet the needs of the resident for facility initiated transfers, ASM # 3 stated, "No."

On 05/25/18 at approximately 1:10 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.
4. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet and failed to provide a copy of Resident #30's care plan goals for a facility initiated transfer to the hospital on 4/25/18.

Resident #30 was admitted to the facility on 8/27/18 and readmitted on 5/3/18 with diagnoses that included but were not limited to: kidney disease, depression, dementia, low blood pressure and chronic pain.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 3/13/18 coded the resident as having scored a 13 out of 15 on the brief

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interview for mental status indicating the resident was cognitively intact to make daily decisions.

Review of the clinical record revealed a nurses note dated 4/25/18 at 12:51 a.m. that documented, "Resident was found sitting on the floor on the mat in front of his bed at 11:25 (p.m.) by CNA (certified nursing assistant)....Nurse practitioner was contacted. Order to send him to (name of hospital) were given."

Review of the April and May 2018 physician's notes and clinical record failed to evidence documentation for the reason the resident required a facility initiated transfer to the hospital and the specific needs that could not be met at the facility for Resident #30's 4/25/18 facility initiated transfer.

Review of the clinical record did not evidence any documentation that the care plan goals were sent with the resident to the receiving facility for the 4/25/18 facility initiated transfer.

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An interview was conducted on 5/24/18 at 2:06 p.m. with RN (registered nurse) #1. When asked about the process staff follow when a resident was sent to the hospital, RN #1 stated, "We have to have a doctor's order. First we do an assessment, if the doctor says to send to them to the hospital we the notify family." When asked what paperwork was sent to the hospital with the resident, RN #1 stated, "The doctor's orders, the medication list." When asked if the resident's care plan goals are sent, RN #1 stated, "No."

An interview was conducted on 5/25/18 at 9:20 a.m. with LPN (licensed practical nurse) #3, the

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unit manager, regarding the process staff follow when a resident was sent to the hospital. LPN #3 stated, "We notify the MD/NP (medical doctor/nurse practitioner) to see how they would like to proceed. The family is notified." When asked what paperwork was sent to the hospital, LPN #3 stated, "A face sheet, copy of medications, code status, recent set of vitals (blood pressure, pulse, temperature and respirations) and what's going on with the resident." When asked if the care plan goals are sent, LPN #3 stated, "I don't believe so."

An interview was conducted on 5/25/18 at 9:43 a.m. with ASM (administrative staff member) #3, the nurse practitioner. When asked what information was documented when a resident was transferred to the hospital, ASM #3 stated, "If I see them I dictate a note for why I send them out. If I don't see them I don't document it. I will see them when they come back."

On 5/25/18 at 1:20 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 provided prior to exit.

5. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet and failed to provide a copy of Resident #4's care plan goals to the receiving facility for a facility initiated transfer to the hospital on 4/28/18.

Resident #4 was admitted to the facility on 7/1/17 and readmitted on 5/6/18 with diagnoses that included but were not limited to: diabetes, blood

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infection, depression and anemia.

The most recent MDS, a quarterly assessment, with an ARD of 5/15/18 coded the resident as having scored a 13 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions.

Review of the nurse's notes dated 4/28/18 at 2:08 p.m. documented, "At 1130 (11:30 a.m.) resident was found on floor lying on her right side. Asked resident what had happened she stated "I walked to my closet from the bathroom to get something out. I was walking to my bed when I fell and head hit the bedside table.....Notified (name of nurse practitioner) she gave order to send out to ER (emergency room) for evaluation."

Review of the April and May 2018 physician's notes and clinical record failed to evidence documentation for the reason the resident required a facility initiated transfer to the hospital and the specific needs that could not be met at the facility for Resident #4's 4/28/18 facility initiated transfer to the hospital.

An interview was conducted on 5/24/18 at 2:06 p.m. with RN (registered nurse) #1. When asked about the process staff follow when a resident was sent to the hospital, RN #1 stated, "We have to have a doctor's order. First we do an assessment, if the doctor says to send to them to the hospital we the notify family." When asked what paperwork was sent to the hospital with the resident, RN #1 stated, "The doctor's orders, the medication list." When asked if the resident's care plan goals are sent, RN #1 stated, "No."

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An interview was conducted on 5/25/18 at 9:20 a.m. with LPN (licensed practical nurse) #3, the unit manager, regarding the process staff follow when a resident was sent to the hospital. LPN #3 stated, "We notify the MD/NP (medical doctor/nurse practitioner) to see how they would like to proceed. The family is notified." When asked what paperwork was sent to the hospital, LPN #3 stated, "A face sheet, copy of medications, code status, recent set of vitals (blood pressure, pulse, temperature and respirations) and what's going on with the resident." When asked if the care plan goals are sent, LPN #3 stated, "I don't believe so."

An interview was conducted on 5/25/18 at 9:43 a.m. with ASM (administrative staff member) #3, the nurse practitioner. When asked what information was documented when a resident was transferred to the hospital, ASM #3 stated, "If I see them I dictate a note for why I send them out. If I don't see them I don't document it. I will see them when they come back."

On 5/25/18 at 1:20 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 provided prior to exit.

6. The facility staff failed to evidence that the required documentation and information was provided to the receiving facility when Resident #75 was transferred to the hospital on 3/20/18.

Resident #75 was admitted to the facility on 3/13/18 with the diagnoses of but not limited to heart failure, osteomyelitis, angina, peripheral

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vascular disease, respiratory failure, Alzheimer's disease, high blood pressure, diabetes, atrial fibrillation, cerebrovascular disease, chronic embolism and thrombosis, and dysphagia. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 4/18/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions, scoring a 2 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

A review of the clinical record revealed the following: A nurse's note dated 3/20/18 documented, "NP (nurse practitioner) reviewed and assess resident. RP (responsible party) (the RP's name) called and was updated on resident's condition and was in agreement with treatment. (name of hospital) ER (emergency room) updated on resident's condition and why resident was being transferred." A second nurse's note dated 3/20/18 documented, "Resident was transported to (name of hospital) via (name of ambulance transport company) at 2030pm (8:30 p.m.), alert and responsive. (Name of hospital) was updated on transport and reason for transfer."

On 5/25/18 at 9:20 a.m., in an interview with LPN #3 (Licensed Practical Nurse), she stated that when a resident is sent to the hospital, that the hospital is provided with the face sheet, code status, medication list, vital signs, a report of what was going on with the resident. LPN #3 stated that care plan goals are not sent to the hospital.

On 5/25/18 at 1:10 p.m., the ASM #1 (the Administrator - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 49 survey.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F 623	1. Resident #73 Responsible Party (RP) requested resident transfer to hospital by phone to the charge nurse on 2/7/18 at 5:06PM due to change in condition. Resident #58 RP was notified by phone of MD order to transfer to the hospital on 1/26/18 at 7:40 PM. Resident #262s RP was notified by phone on 4/17/18 at 5:49pm by charge nurse. Resident #30 RP was notified by phone of transfer to the hospital on 4/25/18 at 12:51 AM by the charge nurse. Resident #4 RP was notified by phone of transfer to the hospital on 4/28/18 at 11:30 AM by the charge nurse. Resident #75 RR was notified by phone of transfer to the hospital on 3/20/18 at 7:37 PM. 2. Residents residing at this facility are at risk for the same deficient practice. 3. Nursing staff will be re-educated on notice requirements before transfer or discharge, including ensuring a copy of notices sent are maintained on the resident's medical record. Director of Nursing or designee will review 24 hour report during morning meeting to ensure residents transferred or discharge have	

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F 623	Continued From page 50 (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 623	documentation of appropriate notices sent. DON or designee will audit 3 residents' records weekly for 4 weeks. 4. Results of audits will be reviewed in the monthly QAPI meeting. Trends identified will be addressed as needed.	6/26/18

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for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written documentation of the transfer to the responsible party for six of 42 residents in the survey sample, Residents # 73, 58, 262, 30, 4 , and 75.

1. The facility staff failed to provide written notification to Resident # 73's responsible party (RP) for a facility initiated transfer to the hospital on 02/07/18.

2. The facility staff failed to provide written notification to Resident # 58's responsible party (RP) for a facility initiated transfer to the hospital on 01/26/18.

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3. The facility staff failed to provide written notification to Resident # 262's responsible party (RP) for a facility initiated transfer to the hospital on 04/17/18.

4. The facility staff failed to provide Resident #30 or the resident's representative written notification prior to a facility initiated transfer to the hospital on 4/25/18.

5. The facility staff failed to provide Resident #4 or the resident's representative written notification prior to a facility initiated transfer to the hospital on 4/28/18.

6. The facility staff failed to evidence that Resident #75's resident representative (RR) was provided with written notification of the hospital transfer when the resident went to the hospital on 3/20/18.

The findings include:

1. The facility staff failed to provide written notification to Resident # 73's responsible party (RP) for a facility initiated transfer to the hospital on 02/07/18.

Resident # 73 was admitted to the facility on 05/21/13 with a readmission of 02/12/18 with diagnoses that included but were not limited to human immunodeficiency virus (1), gastroesophageal reflux disease (2), convulsions (3), myelopathy disease (4), dementia (5) and encephalopathy (6).

Resident # 73's most recent MDS (minimum data set), a quarterly assessment with an ARD

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(assessment reference date) of 04/24/18, coded Resident # 73 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being cognitively for making daily decisions. Resident # 73 was coded as requiring limited to extensive assistance of one staff member for activities of daily living.

The nurse's "Progress Notes," dated 2/7/2018 23:41 (11:41 p.m.) for Resident # 73 documented in part, "Looses rattling NPC (nonproductive cough) and clear nasal drainage. Medicated with Tylenol and Mucinex at that time and FNP (facility nurse practitioner) was notified. RP (responsible party) notified and a Flu swab was obtained. Temperature 100.8 F (Fahrenheit) at 6 p.m. (6:00 p.m.) and a new order has been rec'd (received) to send resident to (Name of Hospital) ER (emergency room) for eval/tx (evaluation and treatment) of febrile (fever) illness per direction of (Name of Physician). Report was called to ER charge nurse and transportation was arranged Via (by) (Name of Transportation Company). Sister / RP to meet at hospital. Resident was transported to ER (at) 7:15 p.m. A f/u (follow up) with ER staff @ (at) 23:00 (11:00 p.m.) and resident is still in the examination area and there has been no determination."

The nurse's "Progress Notes," dated 02/12/2018 for Resident # 73 documented in part, "17:48 (5:48 p.m.) Resident readmitted into facility at 2:55 p.m. from (Name of Hospital) (by) (Name of Transportation Company) accompanied by EMT (emergency medical technician) personnel (by) stretcher ..."

On 05/25/18 at approximately 9:21 a.m., an interview was conducted with LPN (licensed

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practical nurse) # 3, regarding information provided to the responsible party (RP).. When asked how the notification for transfer to the hospital to the family is conducted, LPN # 3 stated, "Notification to family is over the phone." When asked if staff provide any written information to family, LPN # 3 stated, "Only if they request it."

Review of Resident # 73's clinical record failed to evidence the RP received a written notification of Resident # 73's facility initiated transfer to the hospital on 2/7/18

On 05/25/18 at approximately 1:10 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) HIV stands for human immunodeficiency virus. It harms your immune system by destroying the white blood cells that fight infection. This puts you at risk for serious infections and certain cancers. AIDS stands for acquired immunodeficiency syndrome. It is the final stage of infection with HIV. Not everyone with HIV develops AIDS. HIV most often spreads through unprotected sex with an infected person. It may also spread by sharing drug needles or through contact with the blood of an infected person. Women can give it to their babies during pregnancy or childbirth. This information was obtained from the website: https://medlineplus.gov/hivaids.html.

(2) Stomach contents to leak back, or reflux, into

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the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(3) 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.

(4) Any functional disturbance or pathological change in the spinal cord; often used to denote nonspecific lesions, as opposed to myelitis. 2. pathological bone marrow changes. adj., adj myelopath´ic. This information was obtained from the website: https: https://medical-dictionary.thefreedictionary.com/myelopathy.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(6) A term for any diffuse disease of the brain that alters brain function or structure. This information was obtained from the website: http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm.

2. The facility staff failed to provide written notification to Resident # 58's responsible party (RP) for a facility initiated transfer to the hospital on 01/26/18.

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Resident # 58 was admitted to the facility on 01/01/16 with diagnoses that included but were not limited to anoxic brain damage (1), anxiety (2), seizures (3), depressive disorder (4), dementia (5) and muscle weakness.

Resident #58's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/17/18, coded Resident # 58 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 58 was coded as requiring limited to extensive assistance of one staff member for activities of daily living.

The nurse's "Progress Notes," dated 01/26/18 for Resident # 58 documented, "20:19 (8:19 p.m.)Resident was found sitting on the floor in his room @ (at) 7;40 p.m. He was alert and talkative. Reported having a headache at that time. Bleeding observed on face, clothes and on the floor. A large laceration was noted on the posterior scalp. FNP (facility nurse practitioner) in to examine resident and an order was rec'd (received) to send (Resident # 58) to (Name of Hospital) ER (emergency room) for evaluation and tx (treatment) of head injury. (Name of Transportation Company) was arranged a voice message was left for sister/RP (responsible party) (Name of Sister) in regards to this event ..."

The nurse's "Progress Notes," dated 01/27/18 at 01:54 (1:54 a.m.) for Resident # 58 documented, "Resident returned from ER with brother 6 (six) staples to the parietal area of his head no active bleeding noted vital signs within normal limits."

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On 05/25/18 at approximately 9:21 a.m., an interview was conducted with LPN (licensed practical nurse) # 3, regarding information provided to the responsible party (RP).. When asked how the notification to the family is conducted LPN # 3 stated, "Notification to family is over the phone." When asked if they provide any written information to family LPN # 3 stated, "Only if they request it."

Review of Resident # 73's clinical record failed to evidence the RP received a written notification of Resident # 73's transfer.

On 05/25/18 at approximately 1:10 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) Not enough oxygen getting to the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001435.htm

(2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(3) 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.

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(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

3. The facility staff failed to provide written notification to the responsible party (RP) of a facility initiated transfer to the hospital on 04/17/18 for Resident # 262.

Resident # 262 was admitted to the facility on 12/24/17 with a readmission of 05/01/18 with diagnoses that included but were not limited to sepsis (1), dysarthria (2), aphasia (3), depressive disorder (4), dementia (5) and cerebral infarction (6).

Resident #262's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/17/18, coded Resident # 262 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 262 was coded as requiring limited to extensive assistance of one staff member for activities of daily living.

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The nurse's "Progress Notes," dated 04/17/18 at 17:49 (5:49 a.m.) for Resident # 262 documented in part, "(Name of Hospital) lab (laboratory) called with critical hemoglobin results at 5.8. NP (nurse practitioner) in facility. NON (new order now) to send (Name of Hospital) ER (emergency room) ..."

The nurse's "Progress Notes," dated 05/01/18 at 12:54 p.m., for Resident # 262 documented in part, "Resident was brought to the facility by (Name of Transportation Company) and put in bed ..."

On 05/25/18 at approximately 9:21 a.m., an interview was conducted with LPN (licensed practical nurse) # 3, regarding information provided to the responsible party (RP).. When asked how the notification to the family is conducted LPN # 3 stated, "Notification to family is over the phone." When asked if they provide any written information to family LPN # 3 stated, "Only if they request it."

Review of Resident # 73's clinical record failed to evidence the RP received a written notification of Resident # 73's transfer.

On 05/25/18 at approximately 1:10 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) Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not

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caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm.

(2) A condition in which you have difficulty saying words because of problems with the muscles that help you talk). This information was obtained from the website: https://medlineplus.gov/ency/article/007470.htm.

(3) 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.htm l

(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(6) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a

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few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm .
4. The facility staff failed to provide the resident or resident's representative written notification prior to a facility initiated transfer to the hospital for Resident #30.

Resident #30 was admitted to the facility on 8/27/18 and readmitted on 5/3/18 with diagnoses that included but were not limited to: kidney disease, depression, dementia, low blood pressure and chronic pain.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 3/13/18 coded the resident as having scored a 13 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions.

Review of the clinical record revealed a nurses note dated 4/25/18 at 12:51 a.m. that documented, "Resident was found sitting on the floor on the mat in front of his bed at 11:25 (p.m.) by CNA (certified nursing assistant)....Nurse practitioner was contacted. Order to send him to (name of hospital) were given."

Review of the clinical record failed to evidence that written documentation for the need of the transfer was given to the resident or resident's representative for the facility initiated hospital transfer on 4/25/18.

An interview was conducted on 5/24/18 at 2:06 p.m. with RN (registered nurse) #1 regarding how

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the family is notified of a hospital transfer. , RN #1 stated, "We talk to them." When asked if there any written notification is given to the family, RN #1 stated, "No."

An interview was conducted on 5/25/18 at 9:20 a.m. with LPN (licensed practical nurse) #3, the unit manager, regarding how the family is notified of a transfer to the hospital. LPN #3 stated, "We call them." When asked if the family is given written notification of the transfer, LPN #3 stated they did not.

On 5/25/18 at 1:20 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 provided prior to exit.

5. The facility staff failed to provide the resident or resident's representative written notification prior to a facility initiated transfer to the hospital for Resident #4.

Resident #4 was admitted to the facility on 7/1/17 and readmitted on 5/6/18 with diagnoses that included but were not limited to: diabetes, blood infection, depression and anemia.

The most recent MDS, a quarterly assessment, with an ARD of 5/15/18 coded the resident as having scored 13 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions.

Review of the nurse's notes dated 4/28/18 at 2:08 p.m. documented, "At 1130 (11:30 a.m.) resident was found on floor lying on her right side. Asked

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resident what had happened she stated, "I walked to my closet from the bathroom to get something out. I was walking to my bed when I fell and head hit the bedside table.....Notified (name of nurse practitioner) she gave order to send out to ER (emergency room) for evaluation."

Review of the clinical record failed to evidence that written documentation regarding transfer was given to the resident or resident's representative for the facility initiated hospital transfer on 4/28/18.

An interview was conducted on 5/24/18 at 2:06 p.m. with RN (registered nurse) #1 regarding how the family is notified of a hospital transfer. , RN #1 stated, "We talk to them." When asked if there any written notification is given to the family, RN #1 stated, "No."

An interview was conducted on 5/25/18 at 9:20 a.m. with LPN (licensed practical nurse) #3, the unit manager, regarding how the family is notified of a transfer to the hospital. LPN #3 stated, "We call them." When asked if the family is given written notification of the transfer, LPN #3 stated they did not.

On 5/25/18 at 1:20 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 provided prior to exit.

6. The facility staff failed to evidence that Resident #75's resident representative (RR) was provided with written notification of the hospital transfer when the resident went to the hospital on

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3/20/18.

Resident #75 was admitted to the facility on 3/13/18 with the diagnoses of but not limited to heart failure, osteomyelitis, angina, peripheral vascular disease, respiratory failure, Alzheimer's disease, high blood pressure, diabetes, atrial fibrillation, cerebrovascular disease, chronic embolism and thrombosis, and dysphagia. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 4/18/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions, scoring a 2 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

A review of the clinical record revealed the following: A nurse's note dated 3/20/18 documented, "NP (nurse practitioner) reviewed and assess resident. RP (responsible party) (the RP's name) called and was updated on resident's condition and was in agreement with treatment. (name of hospital) ER (emergency room) updated on resident's condition and why resident was being transferred." A second nurse's note dated 3/20/18 documented, "Resident was transported to (name of hospital) via (name of ambulance transport company) at 2030pm (8:30 p.m.), alert and responsive. (Name of hospital) was updated on transport and reason for transfer."

On 5/25/18 at 9:08 a.m., in an interview with OSM #3 (Other Staff Member, the social worker) she stated that when a resident is sent to the hospital, she does not provide a written notification to the resident representative. She stated that nursing does that.

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F 623	Continued From page 65 On 5/25/18 at 9:20 a.m., in an interview with LPN #3 (Licensed Practical Nurse), she stated that when a resident is sent to the hospital, that the resident representative is notified via phone. She stated that a written notification might be sent if it was necessary, but that usually it was not. On 5/25/18 at 1:10 p.m., the ASM #1 (the Administrator - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for	F 625	1. Residents # 73, 58, 262, 30, 4, and 75 were provided a copy of facility bed hold policy upon admission. 2. Residents residing in this facility are at risk for the same deficient practice. 3. Nursing staff, social services, and admission director will be re-educated on Bed Hold Policy to ensure residents received a written copy of the notice before/upon transfer. Director of Nursing or designee will review 24 hour report during morning meeting to ensure residents transferred or discharge have documentation of appropriate notices sent. DON or designee will audit 3 residents' records weekly for 4 weeks.	

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F 625	Continued From page 66 hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, it was determined that facility staff failed to provide the bed hold policy for six of 42 residents in the survey sample, Residents # 73, 58, 262, 30, 4 , and 75. 1. The facility staff failed to provide Resident # 73's representative written notification of the bed hold policy when the resident was transferred to hospital on 02/07/18. 2. The facility staff failed to provide Resident # 58's representative written notification of the bed hold policy when the resident was transferred to hospital on 01/26/18. 3. The facility staff failed to provide Resident # 262's representative written notification of the bed hold policy when the resident was transferred to hospital on 04/17/18. 4. The facility staff failed to provide the resident or resident's representative a bed-hold notification prior to a facility initiated transfer to the hospital for Resident #30 on 4/25/18. 5. The facility staff failed to provide the resident or resident's representative a bed-hold notification prior to a facility initiated transfer to the hospital for Resident #4 on 4/28/18. 6. The facility staff failed to evidence that	F 625	4. Results of audits will be reviewed in the monthly QAPI meeting. Trends identified will be addressed as needed.	6/26/18

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Resident #75's resident representative was provided with written notification of the of the bed hold policy when the resident was transferred to the hospital on 3/20/18.

The findings include:

1. The facility staff failed to provide Resident # 73's representative written notification of the bed hold policy when the resident was transferred to hospital on 02/07/18.

Resident # 73 was admitted to the facility on 05/21/13 with a readmission of 02/12/18 with diagnoses that included but were not limited to human immunodeficiency virus (1), gastroesophageal reflux disease (2), convulsions (3), myelopathy disease (4), dementia (5) and encephalopathy (6).

Resident # 73's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/24/18, coded Resident # 73 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being cognitively for making daily decisions. Resident # 73 was coded as requiring limited to extensive assistance of one staff member for activities of daily living.

The nurse's "Progress Notes," dated 2/7/2018 23:41 (11:41 p.m.) for Resident # 73 documented in part, "Looses rattling NPC (nonproductive cough) and clear nasal drainage. Medicated with Tylenol and Mucinex at that time and FNP (facility nurse practitioner) was notified. RP (responsible party) notified and a Flu swab was obtained. Temperature 100.8 F (Fahrenheit) at 6 p.m. (6:00

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p.m.) and a new order has been rec'd (received) to send resident to (Name of Hospital) ER (emergency room) for eval/tx (evaluation and treatment) of febrile (fever) illness per direction of (Name of Physician). Report was called to ER charge nurse and transportation was arranged Via (by) (Name of Transportation Company). Sister / RP to meet at hospital. Resident was transported to ER (at) 7:15 p.m. A f/u (follow up) with ER staff @ (at) 23:00 (11:00 p.m.) and resident is still in the examination area and there has been no determination."

The nurse's "Progress Notes," dated 02/12/2018 for Resident # 73 documented in part, "17:48 (5:48 p.m.) Resident readmitted into facility at 2:55 p.m. from (Name of Hospital) (by) (Name of Transportation Company) accompanied by EMT (emergency medical technician) personnel (by) stretcher ..."
Further review of Resident # 73's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident #73"s representative.

On 05/25/18 at 9:01 a.m., an interview was conducted with OSM (other staff member) # 2, admissions director regarding the bed hold policy. When asked about the bed hold policy, OSM # 2 stated, "The bed hold policy is given in the admission packet. When a resident is transferred, I call the family and ask if they want a bed hold. I don't document it. The nurse is supposed to give the resident and/or family a copy of the bed hold policy at the time of transfer. We follow up with the phone call."

On 05/25/18 at 9:08 a.m., an interview was conducted with OSM # 3, the social worker

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regarding the bed hold policy. When asked if the responsible party is given written notification of the bed hold policy at the time of the transfer, OSM # 3 stated, "No."

On 05/25/18 at approximately 1:10 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) HIV stands for human immunodeficiency virus. It harms your immune system by destroying the white blood cells that fight infection. This puts you at risk for serious infections and certain cancers. AIDS stands for acquired immunodeficiency syndrome. It is the final stage of infection with HIV. Not everyone with HIV develops AIDS. HIV most often spreads through unprotected sex with an infected person. It may also spread by sharing drug needles or through contact with the blood of an infected person. Women can give it to their babies during pregnancy or childbirth. This information was obtained from the website: https://medlineplus.gov/hivaids.html.

(2) 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.

(3) 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

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obtained from the website: https://medlineplus.gov/ency/article/003200.htm.

(4) Any functional disturbance or pathological change in the spinal cord; often used to denote nonspecific lesions, as opposed to myelitis. 2. pathological bone marrow changes. adj., adj myelopath´ic. This information was obtained from the website: https: https://medical-dictionary.thefreedictionary.com/myelopathy.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(6) A term for any diffuse disease of the brain that alters brain function or structure. This information was obtained from the website: http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm.

2. The facility staff failed to provide Resident # 58's representative written notification of the bed hold policy when the resident was transferred to hospital on 01/26/18.

Resident # 58 was admitted to the facility on 01/01/16 with diagnoses that included but were not limited to anoxic brain damage (1), anxiety (2), seizures (3), depressive disorder (4), dementia (5) and muscle weakness.

Resident #58's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/17/18, coded

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Resident # 58 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 58 was coded as requiring limited to extensive assistance of one staff member for activities of daily living.

The nurse's "Progress Notes," dated 01/26/18 for Resident # 58 documented, "20:19 (8:19 p.m.) Resident was found sitting on the floor in his room @ (at) 7:40 p.m. He was alert and talkative. Reported having a headache at that time. Bleeding observed on face, clothes and on the floor. A large laceration was noted on the posterior scalp. FNP (facility nurse practitioner) in to examine resident and an order was rec'd (received) to send (Resident # 58) to (Name of Hospital) ER (emergency room) for evaluation and tx (treatment) of head injury. (Name of Transportation Company) was arranged a voice message was left for sister/RP (responsible party) (Name of Sister) in regards to this event ..."

The nurse's "Progress Notes," dated 01/27/18 at 01:54 (1:54 a.m.) for Resident # 58 documented, "Resident returned from ER with brother 6 (six) staples to the parietal area of his head no active bleeding noted vital signs within normal limits."

Further review of Resident # 58's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident #58's representative.

On 05/25/18 at 9:01 a.m., an interview was conducted with OSM (other staff member) # 2, admissions director regarding the bed hold policy. When asked about the bed hold policy, OSM # 2

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stated, "The bed hold policy is given in the admission packet. When a resident is transferred, I call the family and ask if they want a bed hold. I don't document it. The nurse is supposed to give the resident and/or family a copy of the bed hold policy at the time of transfer. We follow up with the phone call."

On 05/25/18 at 9:08 a.m., an interview was conducted with OSM # 3, the social worker regarding the bed hold policy. When asked if the responsible party is given written notification of the bed hold policy at the time of the transfer, OSM # 3 stated, "No."

On 05/25/18 at approximately 1:10 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) Not enough oxygen getting to the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001435.htm

(2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(3) 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.

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(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

3. The facility staff failed to provide Resident # 262's representative written notification of the bed hold policy when the resident was transferred to hospital on 04/17/18.

Resident # 262 was admitted to the facility on 12/24/17 with a readmission of 05/01/18 with diagnoses that included but were not limited to sepsis (1), dysarthria (2), aphasia (3), depressive disorder (4), dementia (5) and cerebral infarction (6).

Resident #262's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/17/18, coded Resident # 262 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 262 was coded as requiring limited to extensive

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assistance of one staff member for activities of daily living.

The nurse's "Progress Notes," dated 04/17/18 at 17:49 (5:49 a.m.) for Resident # 262 documented in part, "(Name of Hospital) lab (laboratory) called with critical hemoglobin results at 5.8. NP (nurse practitioner) in facility. NON (new order now) to send (Name of Hospital) ER (emergency room) ..."

The nurse's "Progress Notes," dated 05/01/18 at 12:54 p.m., for Resident # 262 documented in part, "Resident was brought to the facility by (Name of Transportation Company) and put in bed ..."

Further review of Resident # 262's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident # 262's representative.

On 05/25/18 at 9:01 a.m., an interview was conducted with OSM (other staff member) # 2, admissions director regarding the bed hold policy. When asked about the bed hold policy, OSM # 2 stated, "The bed hold policy is given in the admission packet. When a resident is transferred, I call the family and ask if they want a bed hold. I don't document it. The nurse is supposed to give the resident and/or family a copy of the bed hold policy at the time of transfer. We follow up with the phone call."

On 05/25/18 at 9:08 a.m., an interview was conducted with OSM # 3, the social worker regarding the bed hold policy. When asked if the responsible party is given written notification of the bed hold policy at the time of the transfer,

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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
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OSM # 3 stated, "No."

On 05/25/18 at approximately 1:10 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) Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm.

(2) A condition in which you have difficulty saying words because of problems with the muscles that help you talk). This information was obtained from the website:
https://medlineplus.gov/ency/article/007470.htm.

(3) 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.htm l

(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the

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website:
https://medlineplus.gov/ency/article/003213.htm.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website:
https://medlineplus.gov/ency/article/000739.htm.

(6) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website:
https://medlineplus.gov/ency/article/000726.htm.
4. The facility staff failed to provide the resident or resident's representative a bed-hold notification prior to a facility initiated transfer to the hospital for Resident #30 on 4/25/18.

Resident #30 was admitted to the facility on 8/27/18 and readmitted on 5/3/18 with diagnoses that included but were not limited to: kidney disease, depression, dementia, low blood pressure and chronic pain.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 3/13/18 coded the resident as having scored a 13 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions.

Review of the clinical record revealed a nurses note dated 4/25/18 at 12:51 a.m. that documented, "Resident was found sitting on the floor on the mat in front of his bed at 11:25 (p.m.)

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F 625	Continued From page 77 by CNA (certified nursing assistant)....Nurse practitioner was contacted. Order to send him to (name of hospital) were given." Review of the clinical record failed to evidence documentation that Resident #30 or the resident representative were provided a bed-hold notification prior to the facility initiated transfer to the hospital for Resident #30 on 4/25/18. An interview was conducted on 5/24/18 at 2:06 p.m. with RN (registered nurse) #1. When asked if a bed-hold notification is given to the resident or resident representative prior to or at the time of transfer, RN #1 stated, "I believe admissions does." An interview was conducted on 5/25/18 at 9:01 a.m. with OSM (other staff member) #2, the admissions director. When asked if a bed-hold notice is given to the family at the time of transfer, OSM #2 stated, "The nurse is supposed to give the bed-hold policy." When asked what her role was, OSM #2 stated, "We follow up with the resident. We call the family and ask if they want to do a bed hold." An interview was conducted on 5/25/18 at 9:08 a.m. with OSM #3, the social worker. When asked if a bed-hold notification is given to the resident or resident representative prior to or at the time of transfer to the hospital, OSM #3 stated that social workers did not provide that. An interview was conducted on 5/25/18 at 9:20 a.m. with LPN (licensed practical nurse) #3, the unit manager. When asked if a bed-hold notification is given to the resident or resident	F 625		

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representative prior to or at the time of transfer to the hospital, LPN #3 stated, "The social worker does that."

On 5/25/18 at 1:20 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 provided prior to exit.

5. The facility staff failed to provide the resident or resident's representative a bed-hold notification prior to a facility initiated transfer to the hospital for Resident #4 on 4/28/18.

Resident #4 was admitted to the facility on 7/1/17 and readmitted on 5/6/18 with diagnoses that included but were not limited to: diabetes, blood infection, depression and anemia.

The most recent MDS, a quarterly assessment, with an ARD of 5/15/18 coded the resident as having scored 13 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions.

Review of the nurse's notes dated 4/28/18 at 2:08 p.m. documented, "At 1130 (11:30 a.m.) resident was found on floor lying on her right side. Asked resident what had happened she stated, "I walked to my closet from the bathroom to get something out. I was walking to my bed when I fell and head hit the bedside table.....Notified (name of nurse practitioner) she gave order to send out to ER (emergency room) for evaluation."

An interview was conducted on 5/24/18 at 2:06 p.m. with RN (registered nurse) #1. When asked

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if a bed-hold notification is given to the resident or resident representative prior to or at the time of transfer, RN #1 stated, "I believe admissions does."

An interview was conducted on 5/25/18 at 9:01 a.m. with OSM (other staff member) #2, the admissions director. When asked if a bed-hold notice is given to the family at the time of transfer, OSM #2 stated, "The nurse is supposed to give the bed-hold policy." When asked what her role was, OSM #2 stated, "We follow up with the resident. We call the family and ask if they want to do a bed hold."

An interview was conducted on 5/25/18 at 9:08 a.m. with OSM #3, the social worker. When asked if a bed-hold notification is given to the resident or resident representative prior to or at the time of transfer to the hospital, OSM #3 stated that social workers did not provide that.

An interview was conducted on 5/25/18 at 9:20 a.m. with LPN (licensed practical nurse) #3, the unit manager. When asked if a bed-hold notification is given to the resident or resident representative prior to or at the time of transfer to the hospital, LPN #3 stated, "The social worker does that."

On 5/25/18 at 1:20 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 provided prior to exit.

6. The facility staff failed to evidence that Resident #75's resident representative was

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F 625	Continued From page 80 provided with written notification of the of the bed hold policy when the resident was transferred to the hospital on 3/20/18. Resident #75 was admitted to the facility on 3/13/18 with the diagnoses of but not limited to heart failure, osteomyelitis, angina, peripheral vascular disease, respiratory failure, Alzheimer's disease, high blood pressure, diabetes, atrial fibrillation, cerebrovascular disease, chronic embolism and thrombosis, and dysphagia. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 4/18/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions, scoring a 2 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. A review of the clinical record revealed the following: A nurse's note dated 3/20/18 documented, "NP (nurse practitioner) reviewed and assess resident. RP (responsible party) (the RP's name) called and was updated on resident's condition and was in agreement with treatment. (name of hospital) ER (emergency room) updated on resident's condition and why resident was being transferred." A second nurse's note dated 3/20/18 documented, "Resident was transported to (name of hospital) via (name of ambulance transport company) at 2030pm (8:30 p.m.), alert and responsive. (Name of hospital) was updated on transport and reason for transfer." On 5/25/18 at 9:03 a.m., in an interview with OSM #2 (Other Staff Member, Admissions), she stated that nurses are supposed to provide a written bed-hold notice when the resident goes to the	F 625		

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F 625	Continued From page 81 hospital. OSM #2 stated that she follows up with a phone call to find out if the resident or resident representative wants the bed-hold or not. OSM #2 stated she does not document that the bed-hold was offered/provided. On 5/25/18 at 9:20 a.m., in an interview with LPN #3 (Licensed Practical Nurse), she stated that when a resident is sent to the hospital, the social worker provides the bed-hold. LPN #3 stated that nursing does not. On 5/25/18 at approximately 11:00 a.m., in an interview with OSM #3 (Other Staff Member, the social worker) she stated that when a resident is sent to the hospital, she does not provide a written bed-hold notice to the resident or the resident representative. On 5/25/18 at 1:10 p.m., the ASM #1 (the Administrator - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655	1. Resident #90 RP provided and reviewed facility base line care plan summary on 6/14/18. 2. An audit of admitted residents in the past 45 days will be completed by DON/designee to ensure baseline care plans were provided to resident and/or resident representative.	

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F 655	Continued From page 82 (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide a care plan summary to the resident representative for one resident (Resident #90) of 37 sampled residents.	F 655	3. An audit of resident care plans that were admitted within the last 30 days was completed on 6/15/18. Nursing staff will be re-educated on policy and procedure to ensure resident and/or representative provided a care plan summary within 48 hours of admission. . Director of Nursing or designee will review 24 hour report during morning meeting to ensure new admissions were provided a base line care plan summary to the resident and/or RP . DON or designee will audit 3 residents' records per week for 4 weeks. 4. Results of audits will be reviewed in the monthly QAPI meeting. Trends identified will be addressed and re-education provided as needed.	6/26/18

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The findings include:

Resident #90 was admitted to the facility on 4/26/18 with the diagnoses of but not limited to respiratory failure, Alzheimer's disease, and adult failure to thrive. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 5/3/18. The resident was coded as being in a persistent vegetative state and as requiring total care for all areas of activities of daily living.

A review of the clinical record revealed a "Baseline Care Plan Summary" form. This form was a multi-copy form (a white original layer and a yellow copy layer). The form was intact with both copies, as of the date of survey on 5/25/18, approximately one month after the resident was admitted.

Further review of the form revealed an area titled "Acknowledgement of Receipt." This area documented, "I acknowledge that I have received this summary of my Baseline Care Plan and my care has been explained to me. I understand that I may ask questions at any time and request changes as I feel are necessary." There were lines for the resident, resident representative, and facility representative to sign and date. None of the lines contained any signatures to indicate that the resident representative was provided with the Baseline Care Plan Summary.

On 5/25/18 at 12:05 p.m., in an interview with LPN #10 (Licensed Practical Nurse), she stated "the Baseline Care Plan Summary has to be provided sometime during the admission period

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F 655	Continued From page 84 but I don't know the time frame." When asked, if the time frame had passed since Resident #90 was admitted on 4/26/18 and it was now 5/25/18 (date of survey), LPN #10 stated, "yes, it should have been provided by now." A review of the facility policy, "Care Plan Preparation" did not include any direction for providing the resident representative with a summary of the care plan. On 5/25/18 at 1:10 p.m., the ASM #1 (the Administrator - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656	1. Resident #37 is discharged from facility. Resident #46 was re-assessed for hot liquids and plan of care updated with appropriate interventions. MD/RP notified of Resident #11's wound care interventions not followed as ordered on 6/14/18. MD notified of Resident # 15 wound care interventions not followed as ordered on 6/14/18. MD/RP notified of Resident #19s weight not obtained as ordered on 6/14/18. MD/RP notified of Resident #82 cardiovascular medication administration interventions not followed as ordered on 6/14/18. MD/RP notified of Resident #95 interventions for no shoe to right foot not followed as ordered on 6/14/18. Resident #35 no longer resides at facility.	

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F 656	Continued From page 85 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 observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop and implement the comprehensive care plan for eight of 37 residents in the survey sample, Residents #37, 46, 11, 15, 19, 82, 95 and 35. 1. The facility staff failed to develop and implement a comprehensive care plan for hot liquid precautions as documented on the hot liquid assessment for Resident #37. 2. The facility staff failed to develop and implement a comprehensive care plan for hot liquid precautions as documented on the hot	F 656	2. Residents residing in this facility are at risk for the same deficient practice. 3. Nursing staff will be re-educated on implementation and provision of resident care plans to ensure interventions are followed. Director of nursing or designee will audit 3 resident care plans per week for 4 weeks to ensure resident care plans are followed. 4. Results of audits will be reviewed in the monthly QAPI meeting. Trends identified will be addressed and re-education provided as needed.	6/26/18

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liquid assessment for Resident #46.

3. The facility staff failed to implement Resident #11's comprehensive care plan for the provision of wound treatments as ordered by the physician.

4. The facility staff failed to implement Resident #15's comprehensive care plan for the provision of wound treatments as ordered by the physician.

5. The facility staff failed to implement Resident #19's care plan for obtaining weights.

6. The facility staff failed to implement Resident #82's care plan for cardiovascular medication administration per physician's orders.

7. The facility staff failed to implement Resident #95's care plan for no shoe to the right foot.

8. The facility staff failed to implement Resident # 35's care plan for the use of two fall mats and a low bed.

The findings include:

1. Resident #37 was admitted to the facility on 1/24/13 and readmitted on 10/25/17 with diagnoses that included but were not limited to: lung disease, depression, high cholesterol, psychosis and muscle weakness.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 3/20/18 coded the resident as having scored a seven out of 15 on the brief interview for mental status indicating the resident was severely impaired cognitively. The resident

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was coded as requiring assistance for bed mobility, dressing and toileting. The resident was coded as requiring set up assistance with the meal tray.

An observation was made on 5/24/18 at 8:35 a.m. of Resident #37. The resident was lying in bed. The breakfast tray was on the over bed table next to the bed. The coffee cup was on the tray without a lid.

Review of the hot liquid safety evaluation dated 10/15/17 documented, "A. Safety Evaluation. This assessment identifies if the resident is at risk for injury while handling and drinking hot liquids. Place a check mark if the following apply to the resident being assessed: 1. (box checked) Has a cognitive impairment or drowsiness that impacts the resident's perception and awareness to hot liquids and safety measures including but not limited to: altered comprehension and/or memory impairment. 4. Altered muscle strength (hands was checked). 8. (box checked) Episodes of behavior which could cause injury if occurring while the resident is handling hot liquids.11. (box checked) 1. Cup with lid or other adaptive cup. (box checked) 2. Staff assistance. 4. To drink hot liquids at table only."

Review of the resident's comprehensive care plan initiated on 10/7/17 did not evidence documentation regarding a hot liquid safety plan of care.

An interview was conducted on 5/24/18 at 12:57 p.m. with RN (registered nurse) #2, the MDS coordinator. When asked why residents had care plans, RN #2 stated, "To care for the resident, the care plans are patient driven. It's to inform others

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on how to care for the resident." When asked who used the care plan, RN #2 stated, "Everyone who is involved with the resident's care. The patients actually have to sign their care plan; the patient is highly involved in their care plan." When asked what would be care planned, RN #2 stated, "What I typically do, I work off the CAA (care area assessment) worksheet, according to the guidelines. The things I make sure of is that everyone has a care plan for pain, ADLS (activities of daily living), mobility and what they are able to do. I'm looking at their diagnoses and medications to pull together a picture on how to care for the patient." When asked if a care plan would be developed for a resident who had been assessed as a safety risk from hot liquids, RN #2 stated, "Yes because they are at high risk for burns if not supervised."

An interview was conducted on 5/25/18 at 8:11 a.m. with LPN (licensed practical nurse) #8, the unit manager. When asked why residents had care plans, LPN #8 stated, "In order to communicate to the other disciplines." When asked if a care plan would be developed if a resident were assessed to be a safety risk from hot liquids, LPN #8 stated, "Yes."

An interview was conducted on 5/25/18 at 8:20 a.m. with CNA (certified nursing assistant) #3, the resident's aide. When asked how she knew what care a resident needed, CNA stated, "We look at the care plan or the kardex at the nurse's station. It'll tell us how they eat, how they ambulate." When asked if a care plan or kardex would have information if a resident were a safety risk from hot liquids, CNA #3 stated, "It should be." When asked if she had any residents who were a safety risk for hot liquids, CNA #3 stated, "No."

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Review of the resident's CNA kardex did not evidence documentation regarding hot liquids precautions.

On 5/25/18 at 1:20 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's document titled, "CARE PLAN PREPARATION" documented, "A care plan directs the patient's nursing care from admission to discharge. The written action plan is based on nursing diagnoses that have been formulated after reviewing assessment findings, and it embodies the components of the nursing process...Nurses update and revise the plan through-out the patient's stay, and the document becomes part of the permanent patient record."

No further information was provided prior to exit.

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..." (1)

(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia

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pages 65-77.

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 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."

2. The facility staff failed to develop and implement a comprehensive care plan for hot liquid precautions as documented on the hot liquid assessment for Resident #46.

Resident #46 was admitted to the facility on 1/24/13 and readmitted on 10/25/17 with diagnoses that included but were not limited to: lung disease, anxiety, insomnia, heart failure and muscle weakness.

The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 5/15/18 coded the resident as having scored a 14 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance for all activities of daily living. The resident was

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coded as requiring assistance with meals.

An observation was made on 5/24/18 at 8:30 a.m., of Resident #46. The resident was sitting up in bed eating breakfast. The coffee cup did not have a lid on it.

An observation was made on 5/25/18 at 8:01 a.m., of Resident #46. The resident was sitting up in bed eating breakfast. The resident was observed drinking from a coffee cup. The cup did not have a lid on it.

Review of the hot liquid safety evaluation dated 5/20/17 documented, "A. Safety Evaluation. This assessment identifies if the resident is at risk for injury while handling and drinking hot liquids. Place a check mark if the following apply to the resident being assessed: 4. Altered muscle strength (hands was checked). 11. 1. Cup with lid or other adaptive cup. (box checked) 2. Staff assistance. (box checked)."

Review of the resident's care plan initiated on 5/22/17 did not evidence documentation regarding a hot liquid safety plan of care.

An interview was conducted on 5/24/18 at 12:57 p.m. with RN (registered nurse) #2, the MDS coordinator. When asked if a care plan would be developed for a resident who had been assessed as a safety risk from hot liquids, RN #2 stated, "Yes because they are at high risk for burns if not supervised."

An interview was conducted on 5/25/18 at 8:11 a.m. with LPN (licensed practical nurse) #8, the unit manager. When asked why residents had care plans, LPN #8 stated, "In order to

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communicate to the other disciplines." When asked if a care plan would be developed if a resident were assessed to be a safety risk from hot liquids, LPN #8 stated, "Yes."

An interview was conducted on 5/25/18 at 8:20 a.m. with CNA (certified nursing assistant) #3, the resident's aide. When asked how she knew what care a resident needed, CNA stated, "We look at the care plan or the kardex at the nurse's station. It'll tell us how they eat, how they ambulate." When asked if a care plan or kardex would have information if a resident was a safety risk from hot liquids, CNA #3 stated, "It should be." When asked if she had any residents who were a safety risk for hot liquids, CNA #3 stated, "No."

Review of the resident's CNA kardex did not evidence documentation regarding hot liquids precautions.

On 5/25/18 at 1:20 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 provided prior to exit.

3. The facility staff failed to implement Resident #11's comprehensive care plan for the provision of wound treatments as ordered by the physician.

Resident #11 was admitted to the facility on 2/5/15 with a readmission on 12/21/17 with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in which wastes and impurities are removed from the blood by a special machine) (1), depression, dementia, high blood

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pressure, and asthma.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 2/27/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. Resident #11 was coded are requiring extensive assistance of one staff member for most of her activities of daily living.

The comprehensive care plan dated, 4/2/18, documented in part, "Focus: I am at risk for alteration in skin integrity/pressure ulcers related to occasional bowel and bladder incontinence and requires assistance with bed mobility, history of pressure ulcers. I have shear wounds at this time." The "Interventions" documented in part, "Treatments as ordered."

On 5/23/18 at 4:21 p.m., Administrative staff member (ASM) #4, the wound care doctor, accompanied this writer and an observation of the wound on Resident #11's right upper buttock was conducted. The wound was described as a "shear" wound and not a pressure ulcer. The area was .9 cm (centimeters) by .5 cm. The dressing removed from the wound by ASM #4 was a hydrocolloid dressing. The hydrocolloid dressing was in the shape of a butterfly and covered both sides of the buttocks. ASM #4 stated he didn't think he had ordered that kind of dressing. There was no date on the dressing. After the wound care, ASM #4 reviewed his orders for the wound, and stated he had not ordered the hydrocolloid dressing but had ordered medi-honey and a protective dressing.

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The physician order dated, 5/18/18, documented, "Right Upper Buttock; cleanse with NS (normal saline), apply medi-honey (a certified medical honey used to treat wounds and inhibit infections) (2), cover with dry protective dressing, three days per week, every evening shift every Mon, Wed, Fri."

An interview was conducted with LPN (licensed practical nurse) #3, on 5/25/18 at 11:46 a.m. When asked the purpose of the care plan, LPN #3 stated, "It's the individualized plan of care on how to take care of the resident, what their needs are, what their goals are while they are here. It helps to assist how we take care of them, transfers, meals." When asked who has access to the care plan, LPN #3 stated, "Everyone, social workers, nursing and administration." When asked if the care plan should be followed, LPN #3 stated, "Yes." When asked why it should be followed, LPN #3 stated, "It's resident specific and it give the best care for the resident."

The administrator (ASM [administrative staff member]) #1 and ASM #2, the director of nursing were made aware of the above findings on 5/25/18 at 1:10 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 266.
(2) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2686636/

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4. The facility staff failed to implement Resident #15's comprehensive care plan for the provision of wound treatments as ordered by the physician.

Resident #15 was admitted to the facility on 4/6/16 with a recent readmission on 4/27/17, with diagnoses that included but were not limited to: diabetes (a complex and chronic disorder of metabolism due either to partial or total lack of insulin secretion by the pancreas or to the inability of insulin to function normally in the body) (1), COPD (chronic obstructive pulmonary disease [general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis]) (2), high blood pressure, heart failure, pain, and difficulty walking.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 2/27/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she is capable of making cognitive daily decisions. Resident #15 was coded as requiring supervision with set up assistance for all of her activities of daily living.

The comprehensive care plan dated, 6/21/17 and revised on 3/7/18, documented in part, "Focus: I have the potential for impaired skin integrity due to: diabetes, obesity, recurring edema to bilateral lower extremities. I have altered skin integrity with areas noted on toes and heels." The "Interventions" documented in part, "Treatments as ordered."

Observation was made of Resident #15's left foot

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on 5/23/18 at 10:41 a.m. The dressing on the resident's foot was dated 5/21/18. Resident #15 was interviewed at this time. The resident stated the dressing is supposed to be changed every day but it's not done every day. The nurse told her she would return to do the dressing last night but never came back. Resident #15 stated that she has had the toe wound for over four years and the callus on the heel has split open.

The physician orders dated, 3/20/18 documented, "Left heel cleanse with NS (normal saline). Pat dry, apply silver hydrogel (Hydrogel Dressing is intended for the management of wounds and to provide an antimicrobial barrier (3)) and dry dsg (dressing) daily every evening shift. Left plantar Second toe - cleanse with NS, pat dry, apply medi-honey (a certified medical honey used to treat wounds and inhibit infections (4)) and dry dsg daily every evening shift."

The May 2018 TAR (treatment administration record) documented the dressing had been completed as ordered on 5/22/18.

An interview was conducted with LPN (licensed practical nurse) #1, the nurse who documented the wound as completed on 5/22/18, on 5/24/18 at 4:55 p.m. When asked if she completed the dressing on 5/22/18, LPN #1 stated, "If I signed it off I did it." The observation of the dressing on 5/23/18 with the date of 5/21/18 was shared with LPN #1. LPN #1 stated, "I got distracted. I was calling the nurse who was supposed to relieve me. I told the resident I would be back to do the dressing. I guess I never went back." When asked why she would document that she did the treatment when she did not do it, LPN #1 stated, "I don't know."

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An interview was conducted with LPN (licensed practical nurse) #3, on 5/25/18 at 11:46 a.m. When asked the purpose of the care plan, LPN #3 stated, "It's the individualized plan of care on how to take care of the resident, what their needs are. What their goals are while they are here. It helps to assist how we take care of them, transfers, meals." When asked who has access to the care plan, LPN #3 stated, "Everyone, social workers, nursing and administration." When asked if the care plan should be followed, LPN #3 stated, "Yes." When asked why it should be followed, LPN #3 stated, "It's resident specific and it give the best care for the resident."

The administrator (ASM [administrative staff member]) #1 and ASM #2, the director of nursing were made aware of the above findings on 5/25/18 at 1:10 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 163.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(3) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=91244d66-ed63-4a70-a1ce-e2b77a6b09e1.
(4) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2686636/

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5. The facility staff failed to implement Resident #19's care plan for obtaining weights.

Resident #19 was admitted to the facility on 3/17/17. Resident #19's diagnoses included but were not limited to Huntington's disease (1), major depressive disorder and high cholesterol. Resident #19's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/6/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section K coded Resident #19 as having a weight gain of five percent or more in the last month or ten percent or more in the last six months.

Review of Resident #19's clinical record revealed a physician's order dated 2/22/18 for weekly weights. Resident #19's comprehensive care plan dated 3/24/17 documented, "(Name of Resident #19) is at risk for imbalanced nutrition r/t (related to) dx (diagnosis) dependence on PEG (2) for nutrition & hydration, hx (history) sig (significant) wt (weight) change, dx huntingtons (sic.) dx...Weigh per protocol..."

Review of Resident #19's weights revealed a weight obtained on 4/24/18 was 130.2 pounds. The next weight was not obtained until 5/9/18 (15 days later) and was 133.8 pounds.

On 5/24/18 at 3:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked the purpose of the care plan. LPN #4 stated "To keep knowledgeable and it's an updated calendar of what's going on with the patient and to have goals that are to be met by the plans you put in according to what problems

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they may have." When asked how staff ensures residents' care plans are implemented, LPN #4 stated, "It should be on the orders." LPN #4 was asked when physician ordered weekly weights should be obtained. LPN #4 stated the unit managers' hand out weekly weights when they are due and it is within a week. When asked to clarify, LPN #4 stated the weight should be obtained within seven days or sooner. Resident #19's physician order for weekly weights and the resident's weights as documented above were shown to LPN #4. LPN #4 confirmed another weight should have been obtained between 4/24/18 and 5/9/18.

On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) "Huntington's disease (HD) is an inherited disease that causes certain nerve cells in the brain to waste away. People are born with the defective gene, but symptoms usually don't appear until middle age. Early symptoms of HD may include uncontrolled movements, clumsiness, and balance problems. Later, HD can take away the ability to walk, talk, and swallow. Some people stop recognizing family members. Others are aware of their environment and are able to express emotions." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=huntington%27s+disease&_ga=2.232040607.1046050702.1527592979-139120270.1477942321

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(2) "PEG stands for percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and esophagus." This information was obtained from the website: https://www.asge.org/home/for-patients/patient-information/understanding-peg

6. The facility staff failed to implement Resident #82's care plan for cardiovascular medication administration per physician's orders.

Resident #82 was admitted to the facility on 10/31/17. Resident #82's diagnoses included but were not limited to diabetes, high blood pressure and anxiety disorder. Resident #82's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/24/18, coded the resident as being cognitively intact.

Resident #82's comprehensive care plan dated 10/18/16 documented, "Impaired Cardiovascular status related to: dx (diagnosis) of anemia and Hypertension (high blood pressure) and hx (history) of chest pain and hypokalemia (low potassium), PVD (peripheral vascular disease)...Interventions: Medications as ordered by physician and Observe use and effectiveness..."

Review of Resident #82' clinical record revealed a physician's order dated 12/5/17 that documented to give clonidine (1) 0.1 mg (milligrams) by mouth

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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 656	Continued From page 101 every morning and at bedtime and to hold the medication if the resident's blood pressure is less than 120/70. Review of Resident #82's May 2018 eMAR (electronic medication administration record) revealed on 5/9/18 at 6:00 a.m., the resident's blood pressure was 113/68 and clonidine was administered (as evidenced by a check mark and a nurse's initials). Further review of the eMAR and review of nurses' notes dated 5/9/18 failed to reveal documentation that the 5/9/18 6:00 a.m. dose of clonidine was held. On 5/24/18 at 3:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked the purpose of the care plan. LPN #4 stated "To keep knowledgeable and it's an updated calendar of what's going on with the patient and to have goals that are to be met by the plans you put in according to what problems they may have." When asked how staff ensures implementation of residents' care plans, LPN #4 stated, "It should be on the orders." LPN #4 was asked how nurse's document administered medication. LPN #4 stated she checks and initials the MAR (medication administration record). LPN #4 was asked how nurses document a held medication. LPN #4 stated she checks the number "3" on the MAR, which indicates, "Hold/See nurses note" and by coding a "3", a page comes up on the computer for her to document a progress note. LPN #4 was shown Resident #82's physician order for clonidine and asked what should be done if the resident's blood pressure is below 120/70. LPN #4 stated she would not give the medication and she would let the nurse practitioner or doctor know. LPN #4 confirmed it looked like clonidine was administered to Resident #82, when it should have been held on 5/9/18.	F 656		

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On 5/24/18 at 4:31 p.m., an interview was conducted with LPN #6 (the nurse who checked and initialed clonidine administration to Resident #82 on 5/9/18 at 6:00 a.m.) LPN #6 was asked how she documents that a medication is administered and how she documents that a medication is held. LPN #6 stated she signs the medication off when she administers it and there is an option in the computer system to document when a medication is held. LPN #6 was asked if she ever had to hold any of Resident #82's medications in May 2018. LPN #6 stated there were times where she documented the resident's blood pressure medication was given but she actually held the medication. When asked if she administered or held Resident #82's blood pressure medication on 5/9/18, LPN #6 stated she could not remember.

On 5/25/18 at 10:13 a.m., ASM (administrative staff member) #2 (the director of nursing) was made aware of the above concern. On 5/25/18 at 10:20 a.m., ASM #1 (the administrator) was made aware of the above concern.

No further information was presented prior to exit.

(1) Clonidine is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682243.html

7. The facility staff failed to implement Resident #95's care plan for no shoe to the right foot.

Resident #95 was admitted to the facility on

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7/12/17. Resident #95's diagnoses included but were not limited to diabetes, morbid obesity and difficulty swallowing. Resident #95's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/1/18, coded the resident's cognition as severely impaired. Section G coded Resident #95 as requiring extensive assistance of one staff with bed mobility, locomotion on the unit and dressing.

Resident #95's comprehensive care plan dated 2/14/18 documented, "(Name of Resident #95) is at risk for ALTERATION IN SKIN INTEGRITY/PRESSURE ULCERS due to: Assistance required in bed mobility, Bowel incontinence, Obesity. (Name of Resident #95) has open areas to lower extremities r/t (related to) trauma...Interventions: No shoe to right foot..."

Review of Resident #95's clinical record revealed a physician's order dated 7/26/17 that documented, "No shoe to Right Foot every shift." Resident #95's May 2018 eTAR (electronic treatment administration record) documented, "No shoe to Right Foot every shift."

A note signed by the wound care physician on 5/9/18 documented a wound on the right second toe that was 0.5 centimeters (length) by 0.6 centimeters (width). The note documented a treatment order and a recommendation to off-load the wound.

On 5/23/18 at approximately 8:15 a.m., 5/23/18 at approximately 11:00 a.m. and 5/24/18 at approximately 8:45 a.m., Resident #95 was observed in a wheelchair in the bedroom. A shoe was observed on the resident's right foot. A sign on Resident #95's closet documented, "(Name of

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Resident #95). NO Shoe to Right Foot."

On 5/24/18 at 3:09 p.m., an interview was conducted with CNA (certified nursing assistant) #1 (the CNA caring for Resident #95). CNA #1 was asked if Resident #95 had any footwear restrictions. CNA #1 stated, "He's not supposed to have a shoe on his right foot." When asked why, CNA #1 stated, "I believe he has a sore on his toe." CNA #1 was made aware this surveyor observed a shoe on Resident #95's right foot this morning. CNA #1 stated she put a shoe on the resident's foot as a safety precaution while transferring the resident with a sit to stand lift and forgot to remove the shoe. CNA #1 was made aware this surveyor observed a shoe on Resident #95's right foot during the previous morning. CNA #1 stated she thought the restorative staff also puts a shoe on the resident's foot to complete exercises.

On 5/24/18 at 3:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked the purpose of the care plan. LPN #4 stated "To keep knowledgeable and it's an updated calendar of what's going on with the patient and to have goals that are to be met by the plans you put in according to what problems they may have." When asked how staff ensures residents' care plans are implemented, LPN #4 stated, "It should be on the orders." LPN #4 was asked why Resident #95 had a physician's order for no shoe to the right foot. LPN #4 stated Resident #95 had scrapes on his toes and the thought was that his shoes were irritating his toes. When asked if Resident #95 was supposed to have a shoe on the right foot when sitting in the wheelchair, LPN #4 stated the resident should have a slipper sock or soft slipper as opposed to

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a hard shoe.

On 5/24/18 at 4:20 p.m., this surveyor showed LPN #4 the shoe that had been on Resident #95's right foot. LPN #4 stated she would have preferred a slipper to be on the resident's right foot.

On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

8. The facility staff failed to implement Resident # 35's care plan for the use of two fall mats and a low bed.

Resident # 35 was admitted to the facility on 11/01/06 with a readmission of 06/04/07 with diagnoses that included but were not limited to Alzheimer's disease (1), dysphagia (2), osteoporosis (3) heart failure, and hypertension (4).

Resident # 35's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/20/18, coded Resident # 35 as scoring a 2 (two) on the brief interview for mental status (BIMS) of a score of 0 - 15, 2 (two) - being severely impaired of cognition for making daily decisions. Resident # 35 was coded as requiring extensive assistance of one staff member for activities of daily living.

On 05/23/18 at 9:10 a.m., an observation of Resident # 35 revealed she was lying in her bed.

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Further observation revealed a fall mat on floor next to the right side of the bed.

On 05/23/18 at 10:24 a.m., an observation of Resident # 35 revealed she was lying in her bed. Further observation revealed a fall mat on floor next to the right side of the bed.

On 05/23/18 at approximately 10:28 a.m., a CNA (certified nursing assistant) and a staff member from the maintenance department arrived at Resident # 35's room. The maintenance staff member was carrying a fall mat. The CNA and maintenance staff entered Resident # 35's room and placed the fall mat down on the floor to the left side of the bed.

On 05/23/18 at 5:15 p.m., an observation and measurement was made of Resident # 35's bed. Resident # 35 was lying in bed. Using a standard carpenter's ruler Resident # 35's bed height was measured. Measuring from the floor to the surface of the mattress the height of the bed measured 29 and a half inches.

On 05/24/18 at 1:15 p.m., an observation and measurement was made of Resident # 35's bed. Resident # 35 was lying in bed. Using a standard carpenter's ruler Resident # 35's bed height was measured. Measuring from the floor to the surface of the mattress the height of the bed measured 19.

The care plan for Resident # 35 dated 03/28/18 documented, "Focus: (Resident # 35) is at risk for falls related to use of antidepressant medication, Dx (diagnoses) of Alzheimer's Dementia and Psychosis. Demonstrates cognitive loss and poor safety awareness. Has history of falls." Under

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"Interventions" it documented, "Bed in lowest position while in bed related to history of falls. Date initiated 10/18/2016" and "Fall mats at bedside while in bed. Date initiated: 05/23/18."

On 05/23/18 at 1:30 p.m., interview and observation of resident # 35's bed was conducted with CNA (certified nursing assistant) # 3. Upon entering the resident's room and observing the height of the bed CNA # 3 was asked if the bed was in the lowest position. CNA # 3 stated, "I think it can go lower." Upon measuring the height of the bed CNA # 3 agreed it measured 19 inches from the floor. CNA # 3 then picked up the remote control for the bed and lowered the bed. Upon measuring the height of the bed from the floor to the surface of the mattress it measured 15 inches. CNA # 3 looked at the ruler and confirmed the measurement., When asked who was responsible for ensuring the bed was in the lowest position CNA # 3 stated, "The nurse and myself." When asked how often the height of the bed is checked CNA # 3 stated, "Everytime someone goes into the room." When asked when the last time she was in Resident # 35's room CNA # 3 # stated, "About 15 minutes ago. I repositioned (Resident # 35)." When asked if she checked the height of the bed CNA # 3 stated, "No, I picked up her tray and repositioned her. It was overlooked."

On 05/23/18 at 1:47 p.m., an interview with RN registered nurse) # 1. When asked to describe the purpose of the care plan RN # 1 stated, "It is the individual's plan of care. It tells you how to take care of the patient. If it is on the care plan it should be followed." After being informed of the observations of the fall mat and bed height and reviewing the care plan for Resident # 35, RN # 1

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stated, "The care plan was not followed."

On 05/24/18 at 1:35 p.m., an interview was conducted with LPN (licensed practical nurse) # 9, unit manager. When asked to describe the purpose of the care plan LPN # 9 stated, "It is the individual's plan of care. It tells you how to take care of the patient. If it is on the care plan it should be followed." After being informed of the observations of the fall mat and bed height and reviewing the care plan for Resident # 35, LPN #9 stated, "The care plan was not followed."

On 05/24/18 at approximately 5:55 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 brain disorder that seriously affects a person's ability to carry out daily activities). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

(2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(3) Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.

(4) High blood pressure. This information was

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F 656	Continued From page 109 obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan	F 657	1. Care plan was revised for Resident #58 on 6/13/18 with fall interventions as indicated. 2. Residents residing in facility are at risk for same deficient practice. 3. DON or designee will re-educate nursing staff on the care plan process, including interventions related to falls. During morning meeting, DON or designee will review 24 hour report to ensure current changes are reviewed and/or updated on residents care plan. An audit of 5 resident care plans per week for 4 weeks will be completed by DON or designee, to ensure care plans are reviewed or revised as indicated. 4. Results of audits will be reviewed in the monthly QAPI meeting. Trends identified will be addressed and re-education provided as needed.	6/26/18

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for one of 37 residents in the survey sample, Resident #58.

The facility staff failed to review and/or revise Resident # 58's comprehensive care plan following a fall.

The findings include:

Resident # 58 was admitted to the facility on 01/01/16 with diagnoses that included but were not limited to anoxic brain damage (1), anxiety (2), seizures (3), depressive disorder (4), dementia (5) and muscle weakness.

Resident #58's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/17/18, coded Resident # 58 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 58 was coded as requiring limited to extensive assistance of one staff member for activities of daily living.

The clinical record for Resident # 58 revealed a fall on 02/24/18.

The facility's "Fall Investigation" dated 2/24/18 for Resident # 58 documented, "What was resident doing prior to fall? Got up to go to the bathroom, What may have caused the accident? Ambulation without assist (assistance), Did resident sustain injury? Yes RT (right) shin 3in x 1in (three inches by one inch)." The "Fall Investigation" revealed the physician was notified on 02/24/18 at 7:00 a.m., and a message left for the family on

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02/24/18 at 7:10 a.m. Further review of the "Fall Investigation" documented that the care plan was updated.

The comprehensive care plan for Resident # 58 documented, "Focus: Resident has had actual fall and continues to be at risk for further fall related injury related to: History of falls, use of antidepressants, and pain medication, Parkinson's, Brain damage, Dementia and Seizure. Date Initiated 11/14/2017. Further review of the fall care plan failed to evidence documentation of a review or revision of the care plan following the fall on 02/24/18.

On 05/25/18 at 8:31 a.m., an interview was conducted with RN (registered nurse) # 2, the assessment coordinator. When asked to describe the process for reviewing or revising the resident's care plan, RN # 2 stated, "If there is an event, the nurse on that shift is responsible for updating the care plan. For a fall it may take a day or to update the care plan because of the investigation time and develop the appropriate intervention for the resident." When asked about Resident # 58's care plan being updated regarding Resident # 58's fall on 2/24/18. RN # 2 stated she would check the care plan." On 05/25/18 at 8:52 a.m., RN # 2 stated, "The care plan was not updated and it should have been with the appropriate intervention."

On 05/24/18 at approximately 5:55 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.

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References:
(1) Not enough oxygen getting to the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001435.htm

(2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(3) 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.

(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

F 658 SS=E Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) F 658

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility,

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F 658	Continued From page 113 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to follow professional standards of practice for four of 37 residents in the survey sample, Residents #9, #15, #95, and #70. 1. a. The facility staff failed to clarify if Resident #9 could receive her medications by mouth versus by feeding tube. The medication orders documented by mouth for some medications and via feeding tube for other medications. 1. b. The facility staff failed to clarify Resident #9's physician order for Tylenol. Resident #9's physician ordered Tylenol for fever over 100 degrees F (Fahrenheit). The April 2018 MAR (medication administration record documented the Tylenol the staff was administering the medication for pain. 2. a. The facility staff failed to clarify the order for notification of elevated blood sugars for Resident #15. 2. b. The facility staff failed provide education and assess Resident #15's ability to do her own blood glucose (sugar) monitoring. 3. The facility staff failed to clarify a physician's order to include the settings for Resident #95's CPAP (continuous positive airway pressure) machine.	F 658	1. Resident # 9 medication orders were clarified by physician on 5/25/18 to be administered by mouth. RP made aware. Resident # 9's Tylenol medication order was clarified by physician on 5/25/18. Resident # 15's order for notification parameters of blood sugars was clarified on 6/14/18. Resident #15 was provided education assessed for the ability to monitor her own blood glucose (sugar). Resident #95 order for CPAP machine settings was clarified on 6/11/18. Facility clarified daily fluid consumption for Resident #70 on 5/18/18. 2. Residents residing in facility are at risk for same deficient practice. 3. DON or designee will re-educate nursing staff on clarifying physician orders, providing resident education and self-administration assessments for residents, and process to monitor residents with fluid restriction.	

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4. The facility staff failed to document the amount of fluid consumed while Resident #70 was on a physician ordered fluid restriction.

The findings include:

1. a. The facility staff failed to clarify if Resident #9 could receive her medications by mouth versus by feeding tube. The medication orders documented by mouth for some medications and via feeding tube for other medications.

Resident #9 was admitted to the facility on 5/5/17 with diagnoses that included but were not limited to: dementia, contractures, feeding tube, anemia, Parkinson's disease (a slowly progressive disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and must weakness, sometimes with emotional instability (1)), insomnia, asthma, and adult failure to thrive (a geriatric syndrome termed "failure to thrive" has been described, consisting of weight loss, decreased appetite, poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low serum cholesterol. Failure
to thrive occurs in both acute and chronic forms, leading to impaired functional status, morbidity from infection, pressure sores, and increased mortality (2)).

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/2/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive

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DON/designee will review new admissions and residents with new orders daily in the morning meeting and also the stand down meeting in the afternoon. In addition, a 24 hour chart check will be completed by 11-7 shift and any changes needed will be verified at that time. An audit will be completed 2 x week on 10 resident records x 4 weeks to ensure physician orders are followed and/or clarified as indicated. An audit of resident who self-administer medications or treatments will be completed to ensure residents receive education and are assessed with ability to perform tasks.

4. Results of audits will be reviewed in the monthly QAPI meeting. Trends identified will be addressed and re-education provided as needed

6/26/18

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F 658	Continued From page 115 daily decisions. The resident was coded as being totally dependent upon one or more staff members for all of her activities of daily living. In Section K - Nutrition/Swallowing, the resident was coded as having both a feeding tube and a mechanically altered diet. Under K0710, the resident was coded as receiving 25% or less of her nutrition via the artificial route (feeding tube). The physician orders dated, 5/5/17, documented: "Metoprolol Tartrate Tablet (used to treat high blood pressure (3)) 50 mg (milligrams); give 1 tablet via G-Tube (gastrostomy tube otherwise known as a feeding tube (14)) two times a day related to hypertension (high blood pressure). Pravachol Tablet 20 mg (used to treat elevated cholesterol and triglycerides (4)); Give 20 mg via G-tube one time a day." The physician orders dated, 5/25/17, documented, "Amlodipine Besylate Tablet (used to treat high blood pressure and heart disease (5)), Give 1 tablet via G-tube one time a day related to hypertensive." The physician order dated, 5/26/17, documented, "Carbidopa-Levodopa Tablet (used to treat Parkinson's disease (6)) 25-100 mg; give 1 tablet via G-tube three times a day." The physician order dated, 6/16/17, documented, "Baclofen Tablet (used to relax certain muscles in the body (7)) 10 mg, Give 5 mg via G-tube every 8 hours for spasms." The physician order dated, 9/27/17, documented, "Thera-M Tablet (multiple vitamins and minerals); give 1 tablet by mouth one time a day for supplement. Do not give in PEG (Percutaneous	F 658		

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endoscopic gastrostomy feeding (14)) tube."

The physician order dated, 10/2/17, documented, "Pepcid tablet (used to treat gastroesophageal reflux disease (8)) via PEG-tube at bedtime related to gastroesophageal reflux disease."

The physician order dated, 10/9/17, documented, "Potassium Chloride Packet 20 mEq (milli-equivalent) (used to replace potassium in the bloodstream (9)) Give 1 packet via Peg-tube one time a day."

The physician order dated, 12/14/18, documented, "Vitamin C (Vitamin C is an antioxidant. It is important for your skin, bones, and connective tissue. It promotes healing and helps the body absorb iron (10)), tablet 500 mg; give 1 tablet by mouth two times a day for supplement."

The physician order dated, 1/31/18, documented, "Remeron Tablet (Mirtazapine) (used to treat depression (11)) Give 7.5 mg by mouth at bedtime related to adult failure to thrive."

The physician order dated, 2/28/18, documented, "Ferrous Sulfate Liquid 220 mg/ml (milligrams per milliliter); (used to treat iron deficiency anemia (12)), Give 220 mg via PEG-tube in the morning related to anemia."

The comprehensive care plan dated, 10/18/17, and revised on 5/17/18, documented in part, "Focus: (Resident #90 has potential for imbalanced nutrition...presence of PEG with flushes only."

An interview was conducted with LPN (licensed

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practical nurse) #4 on 5/24/18 at 2:08 p.m. LPN #4 was asked how Resident #9 takes her medications. LPN #4 stated, "She takes her pills by mouth but we still flush her peg." The orders above were reviewed with LPN #4. LPN #4 stated, "They all don't say the same thing." LPN #4 was asked how long the resident had been receiving all of her medications by mouth. LPN #4 stated, "One to two months." LPN #4 was asked if the physician orders for medications should coincide with how the medications are being administered. LPN #4 stated, "Yes." When asked if these orders need to be clarified, LPN #4 stated, "Yes."

On 5/24/18 at 3:19 p.m. An interview was conducted with administrative staff member (ASM) #3, the nurse practitioner. ASM #3 was asked how Resident #9 receives her medications. ASM #3 stated, "Through her PEG tube." The orders above were reviewed with ASM #3, and ASM #3 confirmed that half the medication orders instructed for medications to be given via the feeding tube and half the medication orders documented by mouth. ASM #3 was informed the nurse LPN #4 stated she gives all of Resident #9's medications by mouth, ASM #3 stated, "We need to clarify those orders."

The facility policy, "Medication Orders" documented in part, 2. Any dose or order that appears inappropriate considering the resident's age, condition, allergies or diagnosis is verified by nursing with the prescriber."

"Always clarify with the prescriber any medication order that is unclear or seems inappropriate." (13)

The administrator was made aware of the above

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concerns on 5/24/18 at 5:26 p.m.

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References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.
(2) This information was obtained from the following website: https://grants.nih.gov/grants/guide/pa-files/PA-93-022.html.
(3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011186/?report=details.
(4) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=897AD8B7-921D-EB02-A61C-3419E662A2DA.
(5) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008948/?report=details.
(6) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=abff005f-23fc-4d1e-b469-88aa07589a43.
(7) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009200/?report=details.
(8) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010262/?report=details
(9) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf

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m?setid=af7ef02a-1a51-4747-b4a0-7e270136f16 1.
(10) This information was obtained from the following website: https://medlineplus.gov/vitaminc.html.
(11) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?id=62223.
(12) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a017eb78-8c70-4b59-b7c0-22ec6945c1a1
(13) This information was obtained from Fundamentals of Nursing, 5th edition, Lippincott, Williams & Wilkins, page 553.
(14) This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm

1. b. The facility staff failed to clarify Resident #9's physician order for Tylenol. Resident #9's physician ordered Tylenol for fever over 100 degrees F (Fahrenheit). The April 2018 MAR (medication administration record documented the Tylenol the staff was administering the medication for pain.

The physician order dated, 5/25/17, documented, "Acetaminophen Tablet (Tylenol - used to treat fever and mild pain (1)) 325 mg; give 2 tablets via PEG-tube (Percutaneous endoscopic gastrostomy or feeding tube (2)) every 4 hours as needed for fever over 100 degrees F (Fahrenheit). Take two tablets to equal 650 mg via peg tube for fever over 100 degrees."

The April 2018 medication administration record

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(MAR) documented, "Acetaminophen Tablet 325 mg; give 2 tablets via PEG-tube every 4 hours as needed for fever over 100 degrees F. Take two tablets to equal 650 mg via peg tube for fever over 100 degrees F." It was documented on 4/1/18 as having been administered at 2:22 p.m.

The nurse's note dated, 4/1/18 at 2:22 p.m. documented, "Resident c/o (complained of) pain to back, scale 4/10 (four of ten - ten being the worse pain ever) assisted and reposition while resident in chair." The nurse's note at 5:41 p.m. on 4/1/18 documented, "Effective follow up Pain scale was: 0."

The comprehensive care plan dated, 5/9/17 and revised 5/17/18, documented in part, "Focus: Needs pain management and monitoring related to contractures and muscle spasms, wounds, history of compression fractures." The "Interventions" documented in part, "Administer pain medications as ordered."

On 5/24/18 at 2:13 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked to read the physician order for Tylenol. When asked when the medication would be administered per the order, LPN #4 stated, "Every four hours for fever." When informed the medication was documented as being administered by a nurse for pain, LPN #4 stated, "There should be a separate order for pain and one for fever."

An interview was conducted with administrative staff member (ASM) #3, the nurse practitioner, on 5/24/18 at 3:20 p.m. When asked if an order for Tylenol documented to give the medication for fever, is the nurse allowed to give it for pain, ASM

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#3 stated, "If it's ordered for fever, it's not supposed to be given for pain."

The facility policy, "Medication orders" documented in part, "3. PRN (as-needed) orders shall specify the condition for which they are being administered, for example, 'as needed for pain.' The dose must also be specified, for example, '1 tablet for mild pain or 2 tablets for moderate pain."

The administrator was made aware of the above findings on 5/24/18 at 5:26 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=1622f694-4d63-4c56-8737-fae31f0ecfb7

(2) This information was obtained from the following webiste: https://medlineplus.gov/ency/article/002937.htm

2. a. The facility staff failed to clarify the order for notification of elevated blood sugars for Resident #15.

Resident #15 was admitted to the facility on 4/6/16 with a recent readmission on 4/27/17, with diagnoses that included but were not limited to: diabetes (a complex and chronic disorder of metabolism due either to partial or total lack of insulin secretion by the pancreas or to the inability of insulin to function normally in the body (1)), COPD (chronic obstructive pulmonary disease

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[general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis] (2)), high blood pressure, heart failure, pain, and difficulty walking.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 2/27/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she is capable of making cognitive daily decisions. Resident #15 was coded as requiring supervision with set up assistance for all of her activities of daily living.

The physician order dated, 11/10/17, documented, "Humalog Solution Insulin Lispro (HUMALOG is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. (3)) inject as per sliding scale if (blood sugar) 150 - 199 = 6 unit, less than 70 = 0 units, Follow hypoglycemic protocol and call MD (medical doctor); 200 - 249 = 8 units, greater than 500 call MD, 250 - 299 = 10 units, 300 - 349 = 12 units; 350 - 399 = 14 units, 400 - 450 = 16 units, 451 - 500 = 20 units., subcutaneously before meals and at bedtime related to diabetes mellitus due to underlying condition with unspecified complications. Call MD if less than 70 and greater than 400, patient may check her BS (blood sugar) and report number to staff for insulin coverage."

The April 2018 MAR (medication administration record) documented, "Humalog Solution Insulin Lispro, inject as per sliding scale if (blood sugar) 150 - 199 = 6 unit, less than 70 = 0 units, Follow

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hypoglycemic protocol and call MD; 200 - 249 = 8 units, greater than 500 call MD, 250 - 299 = 10 units, 300 - 349 = 12 units; 350 - 399 = 14 units, 400 - 450 = 16 units, 451 - 500 = 20 units., subcutaneously before meals and at bedtime related to diabetes mellitus due to underlying condition with unspecified complications. Call MD if less than 70 and greater than 400, patient may check her BS and report number to staff for insulin coverage." Resident #15's documented blood sugars were as follows:
4/2/18 at 9:00 p.m. = 419
4/4/18 at 6:30 a.m. = 412
4/8/18 at 9:00 p.m. = 423
4/11/18 at 11:30 a.m. = 422
4/13/18 at 9:00 p.m. = 423
4/18/18 at 9:00 p.m. = 410
4/21/18 at 9:00 p.m. = 425
4/22/18 at 11:30 a.m. = 432
4/22/18 at 9:00 p.m. = 431
4/25/18 at 9:00 p.m. = 445
4/29/18 at 4:30 p.m. = 406
4/29/18 at 9:00 p.m. = 408

The May 2018 MAR documented, "Humalog Solution Insulin Lispro, inject as per sliding scale if (blood sugar) 150 - 199 = 6 unit, less than 70 = 0 units, Follow hypoglycemic protocol and call MD; 200 - 249 = 8 units, greater than 500 call MD, 250 - 299 = 10 units, 300 - 349 = 12 units; 350 - 399 = 14 units, 400 - 450 = 16 units, 451 - 500 = 20 units., subcutaneously before meals and at bedtime related to diabetes mellitus due to underlying condition with unspecified complications. Call MD if less than 70 and greater than 400, patient may check her BS and report number to staff for insulin coverage." Resident #15's documented blood sugars were as follows:

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5/1/18 at 9:00 p.m. = 455
5/4/18 at 4:30 p.m. = 485
5/5/18 at 9:00 p.m. = 421
5/10/18 at 4:30 p.m. = 414
5/10/18 at 9:00 p.m. = 417
5/12/18 at 9:00 p.m. = 437
5/15/18 at 11:30 a.m. = 412
5/15/18 at 9:00 p.m. = 439
5/23/18 at 9:00 p.m. = 439

The comprehensive care plan dated, 4/22/16 and revised on 3/7/18, documented in part, "Focus: I am at Risk for Metabolic Complications due to: Diabetes Mellitus. I have episodes of hyperglycemia at times." The "Interventions" documented in part, "Labs (laboratory tests) and blood sugar check per physician order and PRN (as needed) for change in condition/manifestation of clinical signs or symptoms. Resident may assist or complete her own accuchecks (brand of glucometer machine used to obtain blood sugar reading) and show nursing the results. Observed for high blood sugar symptoms - increased thirst, increased hunger, increased urinary output."

An interview was conducted with LPN (licensed practical nurse) #4 on 5/24/18 at 2:21 p.m. LPN #4 was asked to review the above orders for insulin. Once reviewed, LPN #4 stated, "It needs to be clarified as to when we call the doctor for the blood sugar being over 400 or over 500."

On 5/24/18 at 3:22 p.m., an interview was conducted with administrative staff member (ASM) #3, the nurse practitioner. ASM #3 was asked to review the above orders for insulin. Once reviewed, ASM #3 stated, "This order needs clarification between notifying for greater than 400 or greater than 500."

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The facility policy, "Medication Orders" documented in part, 2. Any dose or order that appears inappropriate considering the resident's age, condition, allergies or diagnosis is verified by nursing with the prescriber."

"Always clarify with the prescriber any medication order that is unclear or seems in appropriate." (4)

The administrator was made aware of the above concern on 5/24/18 at 5:26 p.m.

On 5/25/18 at 10:37 a.m., ASM (administrative staff member) #1, the administrator, stated the professional standard of practice for the facility was Lippincott.

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 163.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(3) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c8ecbd7a-0e22-4fc7-a503-faa58c1b6f3f
.
(4) This information was obtained from: Fundamentals of Nursing, 5th edition, Lippincott, Williams & Wilkins, page 553.

2. b. The facility staff failed provide education and assess Resident #15's ability to do her own blood glucose (sugar) monitoring.

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On 5/23/18 at 5:00 p.m., medication administration observation was conducted with LPN (licensed practical nurse) # 1. At 5:29 p.m., LPN #1 stepped into Resident #15's room and had asked Resident #15 what her blood sugar level had read. LPN #1 stated that Resident #15 checked her own blood sugars and wrote them down on a notepad. LPN #1 stated that nursing staff check in with her to determine how much insulin to give. Resident #15 had stated that her blood sugar was 205. LPN #1 then administered 8 unit of Humalog (2) to Resident #15 per ordered sliding scale.

Review of Resident #15's clinical record, failed to evidence education or an assessment documenting that Resident #15 was safe and able to check her own blood sugars.

Review of Resident #15's diabetic care plan dated 4/22/16, documented the following information: "I am at risk for Metabolic Complications due to: Diabetes Mellitus. I have episodes of hyperglycemia at times. Goal: I will experience minimal signs and symptoms associated with hyperglycemia/hypoglycemia and long term complications associated with disease will be managed through next review date. Interventions...Resident may assist or complete her own accuchecks (brand of glucometer used to obtain blood glucose monitoring) and show nursing the results."

On 5/24/18 at 12:15 p.m., an interview was conducted with LPN #2. When asked the process if a resident wanted to self- administer their own medication, LPN #2 stated that nurses would have to do an assessment to determine if the resident is capable of administering their own

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medication. LPN #2 stated that they would have the resident do a return demonstration. When asked if this assessment was documented in the clinical record, LPN #2 stated that the facility used to have paper documentation but that there was no designated form since moving to the computer system. LPN #2 stated that she would document the assessment in a nursing note. When asked if the physician would have to be made aware that the resident is able to administer their own medication, LPN #2 stated that the resident would need an order to administer their own medication and that the physician would have to sign off on the order. When asked if the same process applied to a resident who wanted to do their own accuchecks, LPN #2 stated that the same process would apply. LPN #2 stated that nursing would want to make sure that the resident has the ability to check their own blood sugar, have the proper technique to take their own blood sugar and make sure infection control is maintain while the resident is taking their own blood sugar. LPN #2 could not recall if Resident #15 had an assessment for doing her own accuchecks.

On 5/24/18 at 12:58 p.m., an interview was conducted with LPN #4. When asked the process if a resident wanted to self-administer their own medications, LPN #4 stated that the DON (director of nursing) would do an assessment to determine that the resident was safe to administer their own medication. LPN #4 was not sure where the DON documented this assessment. LPN #4 stated that the floor nurses did not determine the resident's ability to self-administer medications. LPN #4 stated that if the resident can administer their own medications, it would be written on the care plan. LPN #4 stated that an order is not required for

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residents to self-administer their own medications.

On 5/24/18 at 1:30 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked the process if a resident wanted to self administer their own medication, ASM #2 stated that the staff would assess to see if the resident was alert and oriented enough to administer their own medication. ASM #2 then stated she would expect the nursing staff to give the resident the medication and watch the resident administer the medication each time it is due. ASM #2 stated that the physician would have to approve for the resident to have medications at their bedside to take. When asked if the same process would apply for a resident who wanted to do their own accuchecks, ASM #2 stated that she would expect her staff to assess to determine that the resident was alert, oriented, and capable enough to do their own accuchecks. ASM #2 stated that she would expect that the resident would be able to hold the glucometer appropriately. ASM #2 stated that she would expect her nursing staff to have the resident do a return demonstration. ASM #2 stated that she would expect to see the assessment in a nurse's note. ASM #2 stated that if the resident was safe to check their own blood sugars, she would expect to see that on the care plan. ASM #2 stated that a physician's order was not required for a resident to do their own accuchecks.

On 5/24/18 at 1:54 p.m., an interview was conducted with Resident #15. Resident #15 could not recall if she was provided education or assessed to do her own accuchecks Resident

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#15 stated that she has been doing her own accuchecks for twenty years.

On 5/24/18 at 3:01 p.m., ASM #2 stated that she could not find any education or any evidence that the resident was assessed to do her own accuchecks. ASM #2 stated that Lippincott was used as a professional reference.

According to Lippincott Manual of Nursing Practice Eighth Edition, page 921, "Standards of Care Guidelines: Caring for Patients With Diabetes Mellitus: When caring for patients with diabetes mellitus: Assess level of knowledge of disease and ability to care for self." "Gerontologic Alert: Assess elderly patients for sensory deficits, such as impaired vision, hearing, fine touch, and tremors that may have impact on learning...." (2)

According to Portable RN, The All- in One Nursing Reference Third Edition, page 216, Diabetes Mellitus: "Patient teaching: Be sure to cover: - Self monitoring of blood glucose level." (3)

On 5/24/18 at 3:19 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

No further information was presented prior to exit.

(1) Humalog is an insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. When given subcutaneously, HUMALOG has a more rapid onset of action and a shorter duration of action than regular human insulin. This information was

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obtained from The National Institutes of Health at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c5f75765-86b8-4926-b8c3-b42133ca7ac8.

(2) This information was obtained from: Lippincott Manual of Nursing Practice Eighth Edition, Lippincott, Williams & Wilkins, page 921.

(3) This information was obtained from: Portable RN, The All- in One Nursing Reference Third Edition, Lippincott, Williams & Wilkins, page 216.

3. The facility staff failed to clarify a physician's order to include the settings for Resident #95's CPAP (continuous positive airway pressure) machine.

Resident #95 was admitted to the facility on 7/12/17. Resident #95's diagnoses included but were not limited to diabetes, morbid obesity and difficulty swallowing. Resident #95's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/1/18, coded the resident's cognition as severely impaired. Section G coded Resident #95 as requiring extensive assistance of one staff with bed mobility, locomotion on the unit and dressing.

Review of Resident #95's clinical record revealed a physician's order that documented, "Apply Cpap machine each evening shift when resident is in bed and take off in the morning every evening and night shift." Resident #95's May 2018 eMAR (electronic medication administration record) documented, "Apply Cpap machine each evening shift when resident is in bed and take off in the morning every evening and night shift." The

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CPAP machine was documented as being on Resident #95 during the evening and night shifts on 5/23/18. Resident #95's comprehensive care plan dated 12/2/16 documented, "Alteration in Respiratory Status Due to Dx (diagnosis) OF Sleep apnea, CHF (congestive heart failure) and Allergic Rhinitis. Frequently removes and refuses own CPAP..."

On 5/24/18 at 3:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked what details a CPAP order should contain. LPN #4 stated, "It should have the settings on it because the CPAP is set up according to another company; they make the settings. I don't put it on. I'm strictly day shift. We have the settings set up by them (the other company). Whether they (the evening and night shift nurses) check, I don't know. If I were to come in, I would want to know what the settings should be. I would think the order would have it."

On 5/24/18 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #5 (a 3:00 p.m. to 11:00 p.m. shift nurse). LPN #5 confirmed the settings on Resident #95's CPAP machine were adjustable and were not locked in on the machine.

On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. ASM #2 was asked what details a CPAP order should contain. ASM #2 stated the order should contain the settings because they are specific to the patient.

The facility policy titled, "NON-CONTROLLED MEDICATION ORDERS" documented,

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"Medications are administered only upon receipt of a clear and complete, signed order by a person lawfully authorized to prescribe..."

No further information was presented prior to exit.

(1) "CPAP- Also known as Continuous Positive Airway Pressure
CPAP is a treatment that uses mild air pressure to keep your breathing airways open.
It involves using a CPAP machine that includes a mask or other device that fits over your nose or your nose and mouth, straps to position the mask, a tube that connects the mask to the machine ' s motor, and a motor that blows air into the tube. CPAP is used to treat sleep-related breathing disorders including sleep apnea. It also may be used to treat preterm infants who have underdeveloped lungs. If your doctor prescribes CPAP over other treatment options for your sleep apnea, your insurance will work with a medical device company to provide you with a CPAP machine and the disposable mask and tube. Your doctor will set up your machine with certain pressure settings. After using your machine for a while, your doctor and possibly your insurance company will want to check the data card from your machine to confirm that you are using your CPAP device and to see if the machine and its pressure settings are working to reduce or eliminate apnea events while you sleep." This information was obtained from the website: https://www.nhlbi.nih.gov/health-topics/cpap

4. The facility staff failed to document the amount of fluid consumed while Resident #70 was on a physician ordered fluid restriction.

Resident #70 was admitted to the facility on

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4/10/18 with diagnoses that included but were not limited to: muscle weakness, bipolar disorder (1), depression and high blood pressure.

The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 4/24/18 coded the resident as having scored a 15 out of 15 on the brief interview for mental status indicting the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the tray was set up.

Review of the resident's care plan initiated on 5/7/18 documented, "Focus. (Name of resident) is on a 1800 fluid restriction."

Review of the May 2018 physician's orders documented, "Fluid Restriction 1800cc (cubic centimeters)/day."

Review of the May 2018 medication administration record (MAR) documented, "Fluid Restriction 1800cc/day." There were check marks and nurses' initials on each shift. There was no documented evidence of the amount of fluid the resident consumed.

Review of the May 2018 nurse's notes did not documented evidence of the amount of fluid the resident consumed.

An interview was conducted on 5/25/18 at 9:36 a.m. with LPN (licensed practical nurse) #8. When asked about the process staff followed when a resident was on a fluid restriction, LPN #8 stated, "The fluid restriction should be on the

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MAR (medication administration record) for the nurses to indicate how much is given each shift per department." When asked if staff were to document the actual amount the resident consumed, LPN #8 stated, "Yeah." When asked why it was important to keep track of the intake, LPN #8 stated, "The doctor has them on a restriction for a purpose and we have to be able to monitor it." LPN #8 was asked to review Resident # 70's May 2018 MAR. When asked how staff or the physician know how much fluid the resident had consumed, LPN #8 stated, "You can't."

An interview was conducted on 5/25/18 at 9:45 a.m. with LPN #3. When asked how staff track the volume of fluid consumed if a resident was on a fluid restriction, LPN #3 stated, "It's calculated by the dietitian." When asked where this information was documented, LPN #3 stated, "It usually pops up on the MAR or the TAR (treatment administration record) and it asks for the input and we put it in." When asked if it is important to document the residents input, LPN #3 stated, "Yes, it's following the doctor's orders." LPN #3 was asked to review Resident #70's MAR/TAR. When asked how staff or the physician know if the resident was staying within the fluid restriction, LPN #3 stated, "I don't see it documented. It should it be documented."

On 5/25/18 at 1:20 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. When asked what professional standards they used, ASM #2 stated, "Lippincott.'"

Review of the facility's document titled, "DOCUMENTATION" documented,

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F 658	Continued From page 135 "Documentation is the process of preparing a complete record of a patient's care and is avital tool for communication among health care team members. Accurate, detailed charting shows the extent and quality of the care that nurses provide, the outcomes of that care and treatment and education that the patient still needs. Documentation is a valuable method for demonstrating that the nurse has applied nursing knowledge, skills, and judgment according to professional nursing standards." No further information was obtained prior to exit. 1. Bipolar disorder -- Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression. This information was obtained from: https://medlineplus.gov/bipolardisorder.html	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 684		

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interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure that five of 37 residents in the survey sample, (Residents #9, #11, #15, #19, and #95), received treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan.

1. a. The facility staff failed to administer Resident #9's medications per the route ordered by the physician.

1. b. The facility staff failed to administer Tylenol per the physician order for Resident #9.

2. The facility staff failed to apply a dressing per the physician order for Resident #11.

3. a. The facility staff failed to change a dressing per the physician order for Resident #15.

3. b. The facility staff failed to follow the physician orders for notification of elevated blood sugars for Resident #15.

4. The facility staff failed to obtain Resident #19's weekly weight from 4/24/18 through 5/9/18, per physician's order.

5. The facility staff failed to follow Resident #95's physician order for no shoe to the right foot.

The findings include:

1. a. The facility staff failed to administer Resident #9's medications per the route ordered by the physician.

F 684

1. Resident # 9 medication orders were clarified by physician on 5/25/18 to be administered by mouth. RP made aware. Resident # 9's Tylenol medication order was clarified by physician on 5/25/18. MD/RP notified of Resident #11's wound care interventions not followed as ordered on 6/14/18. MD notified of Resident # 15 wound care interventions not followed as ordered on 6/14/18. . MD/RP notified of Resident #19s weight not obtained as ordered on 6/14/18. MD/RP notified of Resident #95 interventions for no shoe to right foot not followed as ordered on 6/14/18.

2. Residents residing in facility are at risk for the same deficient practice.

3. DON/designee will re-educate nursing staff to ensure treatment and care is provided in accordance with professional standards of practice by 6/24/18. Education will include clarifying physician orders, provision of wound care, treatments, and interventions per orders, notification of physician of call parameters, and monitoring weights. DON/designee will review 24 hour report in morning meeting and afternoon stand down

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F 684	Continued From page 137 Resident #9 was admitted to the facility on 5/5/17 with diagnoses that included but were not limited to: dementia, contractures, feeding tube, anemia, Parkinson's disease (a slowly progressive disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and must weakness, sometimes with emotional instability (1)), insomnia, asthma, and adult failure to thrive (a geriatric syndrome termed "failure to thrive" has been described, consisting of weight loss, decreased appetite, poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low serum cholesterol. Failure to thrive occurs in both acute and chronic forms, leading to impaired functional status, morbidity from infection, pressure sores, and increased mortality (2)). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/2/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. The resident was coded as being totally dependent upon one or more staff members for all of her activities of daily living. In Section K - Nutrition/Swallowing, the resident was coded as having both a feeding tube and a mechanically altered diet. Under K0710, the resident was coded as receiving 25% or less of her nutrition via the artificial route (feeding tube). The physician orders dated, 5/5/17, documented: "Metoprolol Tartrate Tablet (used to treat high blood pressure (3)) 50 mg (milligrams); give 1 tablet via G-Tube (gastrostomy tube otherwise	F 684	meeting. In addition, a 24 hour chart check will be completed by 11-7 shift and any changes needed will be verified at that time. A random audit of medication and treatment orders will be completed 3 x week x 4 weeks by DON/designee to ensure orders are followed as indicated. DON/designee will residents on weekly and monthly weights to ensure care plan and/or physician order is being followed and/or documentation to support why weights were not obtained. Audits will be completed during weekly weight meetings. 4. Results of audits will be reviewed in monthly QAPI meeting. Trends identified will be addressed immediately and re-education provided as needed.	6/26/18

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known as a feeding tube (14)) two times a day related to hypertension (high blood pressure). Pravachol Tablet 20 mg (used to treat elevated cholesterol and triglycerides (4)); Give 20 mg via G-tube one time a day."

The physician orders dated, 5/25/17, documented, "Amlodipine Besylate Tablet (used to treat high blood pressure and heart disease (5)), Give 1 tablet via G-tube one time a day related to hypertensive."

The physician order dated, 5/26/17, documented, "Carbidopa-Levodopa Tablet (used to treat Parkinson's disease (6)) 25-100 mg; give 1 tablet via G-tube three times a day."

The physician order dated, 6/16/17, documented, "Baclofen Tablet (used to relax certain muscles in the body (7)) 10 mg, Give 5 mg via G-tube every 8 hours for spasms."

The physician order dated, 9/27/17, documented, "Thera-M Tablet (multiple vitamins and minerals); give 1 tablet by mouth one time a day for supplement. Do not give in PEG (Percutaneous endoscopic gastrostomy feeding (14)) tube."

The physician order dated, 10/2/17, documented, "Pepcid tablet (used to treat gastroesophageal reflux disease (8)) via PEG-tube at bedtime related to gastroesophageal reflux disease."

The physician order dated, 10/9/17, documented, "Potassium Chloride Packet 20 mEq (milli-equivalent) (used to replace potassium in the bloodstream (9)) Give 1 packet via Peg-tube one time a day."

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The physician order dated, 12/14/18, documented, "Vitamin C (Vitamin C is an antioxidant. It is important for your skin, bones, and connective tissue. It promotes healing and helps the body absorb iron (10)), tablet 500 mg; give 1 tablet by mouth two times a day for supplement."

The physician order dated, 1/31/18, documented, "Remeron Tablet (Mirtazapine) (used to treat depression (11)) Give 7.5 mg by mouth at bedtime related to adult failure to thrive."

The physician order dated, 2/28/18, documented, "Ferrous Sulfate Liquid 220 mg/ml (milligrams per milliliter); (used to treat iron deficiency anemia (12)), Give 220 mg via PEG-tube in the morning related to anemia."

The comprehensive care plan dated, 10/18/17, and revised on 5/17/18, documented in part, "Focus: (Resident #90 has potential for imbalanced nutrition...presence of PEG with flushes only."

An interview was conducted with LPN (licensed practical nurse) #4 on 5/24/18 at 2:08 p.m. LPN #4 was asked how Resident #9 takes her medications. LPN #4 stated, "She takes her pills by mouth but we still flush her peg." The orders above were reviewed with LPN #4. LPN #4 stated, "They all don't say the same thing." LPN #4 was asked how long the resident had been receiving all of her medications by mouth. LPN #4 stated, "One to two months." LPN #4 was asked if the physician orders for medications should coincide with how the medications are being administered. LPN #4 stated, "Yes." When asked if these orders need to be clarified, LPN #4

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stated, "Yes."

On 5/24/18 at 3:19 p.m. An interview was conducted with administrative staff member (ASM) #3, the nurse practitioner. ASM #3 was asked how Resident #9 receives her medications. ASM #3 stated, "Through her PEG tube." The orders above were reviewed with ASM #3, and ASM #3 confirmed that half the medication orders instructed for medications to be given via the feeding tube and half the medication orders documented by mouth. ASM #3 was informed the nurse LPN #4 stated she gives all of Resident #9's medications by mouth, ASM #3 stated, "We need to clarify those orders."

The facility policy, "Medication Orders" documented in part, 2. Any dose or order that appears inappropriate considering the resident's age, condition, allergies or diagnosis is verified by nursing with the prescriber."

"Always clarify with the prescriber any medication order that is unclear or seems inappropriate." (13)

The administrator was made aware of the above concerns on 5/24/18 at 5:26 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.
(2) This information was obtained from the following website: https://grants.nih.gov/grants/guide/pa-files/PA-93-022.html.
(3) This information was obtained from the

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F 684	Continued From page 141 following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011186/?report=details. (4) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=897AD8B7-921D-EB02-A61C-3419E662A2DA. (5) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008948/?report=details. (6) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=abff005f-23fc-4d1e-b469-88aa07589a43. (7) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009200/?report=details. (8) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010262/?report=details (9) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=af7ef02a-1a51-4747-b4a0-7e270136f161. (10) This information was obtained from the following website: https://medlineplus.gov/vitaminc.html. (11) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?id=62223. (12) This information was obtained from the following website:	F 684		

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https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a017eb78-8c70-4b59-b7c0-22ec6945c1a1
(13) This information was obtained from Fundamentals of Nursing, 5th edition, Lippincott, Williams & Wilkins, page 553.
(14) This information was obtained from the website:
https://medlineplus.gov/ency/article/002937.htm

1. b. The facility staff failed to administer Tylenol per the physician order for Resident #9.

The physician order dated, 5/25/17, documented, "Acetaminophen Tablet (Tylenol - used to treat fever and mild pain (1)) 325 mg; give 2 tablets via PEG-tube (Percutaneous endoscopic gastrostomy or feeding tube (2)) every 4 hours as needed for fever over 100 degrees F (Fahrenheit). Take two tablets to equal 650 mg via peg tube for fever over 100 degrees."

The April 2018 medication administration record (MAR) documented, "Acetaminophen Tablet 325 mg; give 2 tablets via PEG-tube every 4 hours as needed for fever over 100 degrees F. Take two tablets to equal 650 mg via peg tube for fever over 100 degrees F." It was documented on 4/1/18 as having been administered at 2:22 p.m.

The nurse's note dated, 4/1/18 at 2:22 p.m. documented, "Resident c/o (complained of) pain to back, scale 4/10 (four of ten - ten being the worse pain ever) assisted and reposition while resident in chair." The nurse's note at 5:41 p.m. on 4/1/18 documented, "Effective follow up Pain scale was: 0."

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The comprehensive care plan dated, 5/9/17 and revised 5/17/18, documented in part, "Focus: Needs pain management and monitoring related to contractures and muscle spasms, wounds, history of compression fractures." The "Interventions" documented in part, "Administer pain medications as ordered."

On 5/24/18 at 2:13 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked to read the physician order for Tylenol. When asked when the medication would be administered per the order, LPN #4 stated, "Every four hours for fever." When informed the medication was documented as being administered by a nurse for pain, LPN #4 stated, "There should be a separate order for pain and one for fever."

An interview was conducted with administrative staff member (ASM) #3, the nurse practitioner, on 5/24/18 at 3:20 p.m. When asked if an order for Tylenol documented to give the medication for fever, is the nurse allowed to give it for pain, ASM #3 stated, "If it's ordered for fever, it's not supposed to be given for pain."

The facility policy, "Medication orders" documented in part, "3. PRN (as-needed) orders shall specify the condition for which they are being administered, for example, 'as needed for pain.' The dose must also be specified, for example, '1 tablet for mild pain or 2 tablets for moderate pain."

The administrator was made aware of the above findings on 5/24/18 at 5:26 p.m.

No further information was provided prior to exit.

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(1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=1622f694-4d63-4c56-8737-fae31f0ecfb7

(2) This information was obtained from the following webiste: https://medlineplus.gov/ency/article/002937.htm

2. The facility staff failed to apply a dressing per the physician order for Resident #11.

Resident #11 was admitted to the facility on 2/5/15 with a readmission on 12/21/17 with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in which wastes and impurities are removed from the blood by a special machine) (1), depression, dementia, high blood pressure, and asthma.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 2/27/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. Resident #11 was coded are requiring extensive assistance of one staff member for most of her activities of daily living.

The comprehensive care plan dated, 4/2/18, documented in part, "Focus: I am at risk for alteration in skin integrity/pressure ulcers related to occasional bowel and bladder incontinence and requires assistance with bed mobility, history of

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pressure ulcers. I have shear wounds at this time." The "Interventions" documented in part, "Treatments as ordered."

On 5/23/18 at 4:21 p.m., Administrative staff member (ASM) #4, the wound care doctor, accompanied this writer and an observation of the wound on Resident #11's right upper buttock was conducted. The wound was described as a "shear" wound and not a pressure ulcer. The area was .9 cm (centimeters) by .5 cm. The dressing removed from the wound by ASM #4 was a hydrocolloid dressing. The hydrocolloid dressing was in the shape of a butterfly and covered both sides of the buttocks. ASM #4 stated he didn't think he had ordered that kind of dressing. There was no date on the dressing. After the wound care, ASM #4 reviewed his orders for the wound, and stated he had not ordered the hydrocolloid dressing but had ordered medi-honey and a protective dressing.

The physician order dated, 5/18/18, documented, "Right Upper Buttock; cleanse with NS (normal saline), apply medi-honey (a certified medical honey used to treat wounds and inhibit infections) (2), cover with dry protective dressing, three days per week, every evening shift every Mon, Wed, Fri."

An interview was conducted with ASM #3, the nurse practitioner, on 5/25/18 at 9:43 a.m. When asked if applying a dressing to a wound that is not ordered could cause any problems, ASM #3 stated, "It would affect the healing of the wound."

An interview was conducted with ASM #4 on 5/25/18 at 10:15 a.m. When asked if having the wrong dressing on the wound could affect the

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wound, ASM #4 stated, "If any other case, I would say yes, but in this case it was okay. It was just as good as the medi-honey that I had prescribed."

The facility policy, "Skin Program" documented in part, "Resident(s) with wounds will have appropriate treatment. If there is deterioration or no change in a wound within 2 weeks, the treatment will be changed."

A policy on dressing changes was requested from ASM #2, the director of nursing on 5/25/18 at approximately 1:15 p.m.

The administrator, ASM #1 and the director of nursing, ASM #2 were made aware of the above concern on 5/25/18 at 1:10 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 266.
(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2686636/

3. a. The facility staff failed to change a dressing per the physician order for Resident #15.

Resident #15 was admitted to the facility on 4/6/16 with a recent readmission on 4/27/17, with diagnoses that included but were not limited to: diabetes (a complex and chronic disorder of metabolism due either to partial or total lack of insulin secretion by the pancreas or to the inability

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of insulin to function normally in the body) (1), COPD (chronic obstructive pulmonary disease [general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis]) (2), high blood pressure, heart failure, pain, and difficulty walking.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 2/27/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she is capable of making cognitive daily decisions. Resident #15 was coded as requiring supervision with set up assistance for all of her activities of daily living.

Observation was made of Resident #15's left foot on 5/23/18 at 10:41 a.m. The dressing on the resident's foot was dated 5/21/18. Resident #15 was interviewed at this time. The resident stated the dressing is supposed to be changed every day but it's not done every day. The nurse told her she would return to do the dressing last night but never came back. Resident #15 stated that she has had the toe wound for over four years and the callus on the heel has split open.

The physician orders dated, 3/20/18 documented, "Left heel cleanse with NS (normal saline). Pat dry, apply silver hydrogel (Hydrogel Dressing is intended for the management of wounds and to provide an antimicrobial barrier (3)) and dry dsg (dressing) daily every evening shift. Left plantar Second toe - cleanse with NS, pat dry, apply medi-honey (a certified medical honey used to treat wounds and inhibit infections (4)) and dry dsg daily every evening shift."

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The May 2018 TAR (treatment administration record) documented the dressing had been completed as ordered on 5/22/18.

The comprehensive care plan dated, 6/21/17 and revised on 3/7/18, documented in part, "Focus: I have the potential for impaired skin integrity due to: diabetes, obesity, recurring edema to bilateral lower extremities. I have altered skin integrity with areas noted on toes and heels." The "Interventions" documented in part, "Treatments as ordered."

An interview was conducted with LPN (licensed practical nurse) #1, the nurse who documented the wound as completed on 5/22/18, on 5/24/18 at 4:55 p.m. When asked if she completed the dressing on 5/22/18, LPN #1 stated, "If I signed it off I did it." The observation of the dressing on 5/23/18 with the date of 5/21/18 was shared with LPN #1. LPN #1 stated, "I got distracted. I was calling the nurse who was supposed to relieve me. I told the resident I would be back to do the dressing. I guess I never went back." When asked why she would document that she did the treatment when she did not do it, LPN #1 stated, "I don't know."

An interview was conducted with LPN #5 on 5/24/18 at 5:11 p.m. LPN #5 was asked if a dressing is ordered every evening, when it should the wound treatment be done. LPN #5 stated, "You have between 3:00 p.m. and 11:00 p.m. to get it done." When asked what staff do if they cannot complete the dressing change, LPN #1 stated, "You pass it on to the next shift and don't sign that you did it."

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The administrator, ASM (administrative staff member) #1 and the director of nursing, ASM #2 were made aware of the above concern on 5/25/18 at 1:10 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 163.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(3) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=91244d66-ed63-4a70-a1ce-e2b77a6b09e1.
(4) This information was obtained from the following website: (2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2686636/

3. b. The facility staff failed to follow the physician orders for notification of elevated blood sugars for Resident #15.

Resident #15 was admitted to the facility on 4/6/16 with a recent readmission on 4/27/17, with diagnoses that included but were not limited to: diabetes (a complex and chronic disorder of metabolism due either to partial or total lack of insulin secretion by the pancreas or to the inability of insulin to function normally in the body) (1) , COPD (chronic obstructive pulmonary disease

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[general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis]) (2), high blood pressure, heart failure, pain, and difficulty walking.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 2/27/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she is capable of making cognitive daily decisions. Resident #15 was coded as requiring supervision with set up assistance for all of her activities of daily living.

The physician order dated, 11/10/17, documented, "Humalog Solution Insulin Lispro (HUMALOG is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. (3)) inject as per sliding scale if (blood sugar) 150 - 199 = 6 unit, less than 70 = 0 units, Follow hypoglycemic protocol and call MD (medical doctor); 200 - 249 = 8 units, greater than 500 call MD, 250 - 299 = 10 units, 300 - 349 = 12 units; 350 - 399 = 14 units, 400 - 450 = 16 units, 451 - 500 = 20 units., subcutaneously before meals and at bedtime related to diabetes mellitus due to underlying condition with unspecified complications. Call MD if less than 70 and greater than 400, patient may check her BS (blood sugar) and report number to staff for insulin coverage."

The April 2018 MAR (medication administration record) documented, "Humalog Solution Insulin Lispro, inject as per sliding scale if (blood sugar) 150 - 199 = 6 unit, less than 70 = 0 units, Follow

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hypoglycemic protocol and call MD; 200 - 249 = 8 units, greater than 500 call MD, 250 - 299 = 10 units, 300 - 349 = 12 units; 350 - 399 = 14 units, 400 - 450 = 16 units, 451 - 500 = 20 units., subcutaneously before meals and at bedtime related to diabetes mellitus due to underlying condition with unspecified complications. Call MD if less than 70 and greater than 400, patient may check her BS and report number to staff for insulin coverage." Resident #15's documented blood sugars were as follows:
4/2/18 at 9:00 p.m. = 419
4/4/18 at 6:30 a.m. = 412
4/8/18 at 9:00 p.m. = 423
4/11/18 at 11:30 a.m. = 422
4/13/18 at 9:00 p.m. = 423
4/18/18 at 9:00 p.m. = 410
4/21/18 at 9:00 p.m. = 425
4/22/18 at 11:30 a.m. = 432
4/22/18 at 9:00 p.m. = 431
4/25/18 at 9:00 p.m. = 445
4/29/18 at 4:30 p.m. = 406
4/29/18 at 9:00 p.m. = 408

Review of the nurse's notes for April 2018 failed to evidence any documented notification to the physician for the recorded blood sugars documented above.

The May 2018 MAR documented, "Humalog Solution Insulin Lispro, inject as per sliding scale if (blood sugar) 150 - 199 = 6 unit, less than 70 = 0 units, Follow hypoglycemic protocol and call MD; 200 - 249 = 8 units, greater than 500 call MD, 250 - 299 = 10 units, 300 - 349 = 12 units; 350 - 399 = 14 units, 400 - 450 = 16 units, 451 - 500 = 20 units., subcutaneously before meals and at bedtime related to diabetes mellitus due to underlying condition with unspecified

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complications. Call MD if less than 70 and greater than 400, patient may check her BS and report number to staff for insulin coverage."
Resident #15's documented blood sugars were as follows:
5/1/18 at 9:00 p.m. = 455
5/4/18 at 4:30 p.m. = 485
5/5/18 at 9:00 p.m. = 421
5/10/18 at 4:30 p.m. = 414
5/10/18 at 9:00 p.m. = 417
5/12/18 at 9:00 p.m. = 437
5/15/18 at 11:30 a.m. = 412
5/15/18 at 9:00 p.m. = 439
5/23/18 at 9:00 p.m. = 439

Review of the nurse's notes for May 2018 failed to evidence any documented notification to the physician for the recorded blood sugars documented above.

The comprehensive care plan dated, 4/22/16 and revised on 3/7/18, documented in part, "Focus: I am at Risk for Metabolic Complications due to: Diabetes Mellitus. I have episodes of hyperglycemia at times." The "Interventions" documented in part, "Labs (laboratory tests) and blood sugar check per physician order and PRN (as needed) for change in condition/manifestation of clinical signs or symptoms. Resident may assist or complete her own accuchecks (glucometer machine used for obtaining blood sugar readings to monitor blood sugars) and show nursing the results. Observed for high blood sugar symptoms - increased thirst, increased hunger, increased urinary output."

An interview was conducted with LPN (licensed practical nurse) #4 on 5/24/18 at 2:21 p.m. LPN #4 reviewed the above order for Humalog insulin.

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When asked what staff should do, per the order, if the resident's blood sugar is greater than 400, LPN #4 stated, "We should notify the doctor/nurse practitioner." When asked where staff document that notification, LPN #4 stated, "It should be in the nurse's notes."

An interview was conducted with ASM (administrative staff member) #3, the nurse practitioner; on 5/24/18 at 3:22 p.m. ASM #3 reviewed the physician order above for the Humalog insulin sliding scale. ASM #3 was then asked what is the nurses should do when the resident's blood sugar is greater than 400, ASM #3 stated, "I would expect them to notify me or the doctor." When asked why it is important to notify the doctor of elevated blood sugars, ASM #3 stated, "I would need to adjust her insulin and elevated blood sugars can cause medical complications."

The administrator, ASM #1 was made aware of the above concern on 5/24/18 at 5:26 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 163.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(3) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c8ecbd7a-0e22-4fc7-a503-faa58c1b6f3f

4. The facility staff failed to obtain Resident #19's weekly weight from 4/24/18 through 5/9/18, per

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physician's order.

Resident #19 was admitted to the facility on 3/17/17. Resident #19's diagnoses included but were not limited to Huntington's disease (1), major depressive disorder and high cholesterol. Resident #19's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/6/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section K coded Resident #19 as having a weight gain of five percent or more in the last month or ten percent or more in the last six months.

Review of Resident #19's clinical record revealed a physician's order dated 2/22/18 for weekly weights. Resident #19's comprehensive care plan dated 3/24/17 documented, "(Name of Resident #19) is at risk for imbalanced nutrition r/t (related to) dx (diagnosis) dependence on PEG (2) for nutrition & hydration, hx (history) sig (significant) wt (weight) change, dx huntingtons dx...Weigh per protocol..."

Review of Resident #19's weights revealed a weight obtained on 4/24/18 was 130.2 pounds. The next weight was not obtained until 5/9/18 (15 days later) and was 133.8 pounds.

On 5/24/18 at 3:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked when physician ordered weekly weights should be obtained. LPN #4 stated the unit manager's hand out weekly weights when they are due and it is within a week. When asked to clarify, LPN #4 stated the weight should be obtained within seven days or sooner. LPN #4 was shown Resident #19's physician

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order for weekly weights and shown the resident's weights documented above. LPN #4 confirmed another weight should have been obtained between 4/24/18 and 5/9/18.

On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "Weighing the Resident" documented, "At a minimum, all residents of the facility shall be weighed upon admission and monthly unless ordered otherwise by the physician or as directed by the weight committee."

No further information was presented prior to exit.

(1) "Huntington's disease (HD) is an inherited disease that causes certain nerve cells in the brain to waste away. People are born with the defective gene, but symptoms usually don't appear until middle age. Early symptoms of HD may include uncontrolled movements, clumsiness, and balance problems. Later, HD can take away the ability to walk, talk, and swallow. Some people stop recognizing family members. Others are aware of their environment and are able to express emotions." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=huntington%27s+disease&_ga=2.232040607.1046050702.1527592979-139120270.1477942321

(2) "PEG stands for percutaneous endoscopic gastrostomy, a procedure in which a flexible

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feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and esophagus." This information was obtained from the website: https://www.asge.org/home/for-patients/patient-information/understanding-peg

5. The facility staff failed to follow Resident #95's physician order for no shoe to the right foot.

Resident #95 was admitted to the facility on 7/12/17. Resident #95's diagnoses included but were not limited to diabetes, morbid obesity and difficulty swallowing. Resident #95's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/1/18, coded the resident's cognition as severely impaired. Section G coded Resident #95 as requiring extensive assistance of one staff with bed mobility, locomotion on the unit and dressing.

Review of Resident #95's clinical record revealed a physician's order dated 7/26/17 that documented, "No shoe to Right Foot every shift." Resident #95's May 2018 eTAR (electronic treatment administration record) documented, "No shoe to Right Foot every shift."

A note signed by the wound care physician on 5/9/18 documented a wound on the right second toe that was 0.5 centimeters (length) by 0.6 centimeters (width). The note documented a treatment order and a recommendation to off-load the wound.

Resident #95's comprehensive care plan dated

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2/14/18 documented, "(Name of Resident #95) is at risk for ALTERATION IN SKIN INTEGRITY/PRESSURE ULCERS due to: Assistance required in bed mobility, Bowel incontinence, Obesity. (Name of Resident #95) has open areas to lower extremities r/t (related to) trauma...Interventions: No shoe to right foot..."

On 5/23/18 at approximately 8:15 a.m., 5/23/18 at approximately 11:00 a.m. and 5/24/18 at approximately 8:45 a.m., Resident #95 was observed in a wheelchair in the bedroom. A shoe was observed on the resident's right foot. A sign on Resident #95's closet documented, "(Name of Resident #95). NO Shoe to Right Foot."

On 5/24/18 at 3:09 p.m., an interview was conducted with CNA (certified nursing assistant) #1 (the CNA caring for Resident #95). CNA #1 was asked if Resident #95 had any footwear restrictions. CNA #1 stated, "He's not supposed to have a shoe on his right foot." When asked why, CNA #1 stated, "I believe he has a sore on his toe." CNA #1 was made aware this surveyor observed a shoe on Resident #95's right foot this morning. CNA #1 stated she put a shoe on the resident's foot as a safety precaution while transferring the resident with a sit to stand lift and forgot to remove the shoe. CNA #1 was made aware this surveyor observed a shoe on Resident #95's right foot during the previous morning. CNA #1 stated she thought the restorative staff also puts a shoe on the resident's foot to complete exercises.

On 5/24/18 at 3:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked why Resident #95 had a physician's order for no shoe to the right foot.

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F 684	Continued From page 158 LPN #4 stated Resident #95 had scrapes on his toes and the thought was that his shoes were irritating his toes. When asked if Resident #95 was supposed to have a shoe on the right foot when sitting in the wheelchair, LPN #4 stated the resident should have a slipper sock or soft slipper as opposed to a hard shoe. On 5/24/18 at 4:20 p.m., this surveyor showed LPN #4 the shoe that had been on Resident #95's right foot. LPN #4 stated she would have preferred a slipper to be on the resident's right foot. On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure an environment free from accidents and hazards for four of 37 residents in the survey	F 689	1. Resident #37 is discharged from facility. Resident #46 was re-assessed for hot liquids and plan of care updated with appropriate interventions. Maintenance director removed the commercial power strip from Resident # 51 room on 5/25/18. Resident # 35 was no longer resides at facility. Maintenance director repaired West 1 shower room door on 5/25/18. 2. Residents residing in facility are at risk for the same deficient practice.	

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F 689	Continued From page 159 sample, (Residents #37, 46, 51 and 35); and in one of six shower rooms, (the shower room on West 1). 1. The facility staff failed to serve coffee with a lid and to supervise the resident while drinking hot liquids per the hot liquid safety evaluation for Resident #37. 2. The facility staff failed to serve coffee with a lid and to supervise the resident while drinking hot liquids per the hot liquid safety evaluation for Resident #46. 3. The facility staff failed to ensure that commercial power strips were not in use in Resident #51's patient vicinity. 4a. The facility failed to ensure two fall mats were in place when Resident # 35 was in bed. Resident #35 was observed in bed on two occasions with only one fall mat on the right side of the bed. 4b. The facility staff failed to ensure Resident # 35's bed was in the lowest position while the resident was lying in bed. 5. The facility staff failed to maintain a shower room door in a manner to prevent hazards in one of six shower rooms, shower room on West 1. The findings include: 1. Resident #37 was admitted to the facility on 1/24/13 and readmitted on 10/25/17 with diagnoses that included but were not limited to: lung disease, depression, high cholesterol, psychosis and muscle weakness.	F 689	3. Administrator/designee will re-educate staff on safety standards to ensure residents receive supervision as needed and the environment is free of accident hazards. Re-education will include ensuring residents receive supervision with hot liquids and/or coffee lids per care plan, reporting hazards and/or areas needing repair by 6/24/18. Administrator/designee will re-educate residents on safety, including to not use extension cords or power strips in their room during next resident council meeting. Department Heads and Maintenance director will conduct rounds daily, Mon – Fri to ensure resident rooms and resident care areas are free of hazards. Department heads will observe 5 meals per week for 4 weeks to ensure residents receive supervision and/or devices per plan of care. Issues identified will be addressed immediately. 4. Results of audits and rounds will be reviewed in the monthly QAPI meeting. Trends identified will be addressed and corrective measures put in place.	6/26/18

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The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 3/20/18 coded the resident as having scored a seven out of 15 on the brief interview for mental status indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance for bed mobility, dressing and toileting. The resident was coded as requiring set up assistance with the meal tray.

An observation was made on 5/24/18 at 8:35 a.m. of Resident #37. The resident was lying in bed. The breakfast tray was on the over bed table next to the bed. The coffee cup was on the tray without a lid.

Review of the hot liquid safety evaluation dated 10/15/17 documented, "A. Safety Evaluation. This assessment identifies if the resident is at risk for injury while handling and drinking hot liquids. Place a check mark if the following apply to the resident being assessed: 1.(box checked) Has a cognitive impairment or drowsiness that impacts the resident's perception and awareness to hot liquids and safety measures including but not limited to: altered comprehension and/or memory impairment. 4. Altered muscle strength (hands was checked). 8. Episodes of behavior which could cause injury if occurring while the resident is handling hot liquids.(box checked) 11. (Boxes checked) 1. Cup with lid or other adaptive cup. (Box checked) 2. Staff assistance. 4. To drink hot liquids at table only."

Review of the resident's care plan initiated on 10/7/17 did not evidence documentation regarding a hot liquid safety plan of care.

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When asked if a care plan would be developed for a resident who had been assessed as a safety risk from hot liquids, RN #2 stated, "Yes because they are at high risk for burns if not supervised."

An interview was conducted on 5/25/18 at 8:11 a.m. with LPN (licensed practical nurse) #8, the unit manager. When asked if a care plan would be developed if a resident were assessed to be a safety risk from hot liquids, LPN #8 stated, "Yes." When asked why LPN #8 stated to help keep the resident safe.

An interview was conducted on 5/25/18 at 8:20 a.m. with CNA (certified nursing assistant) #3, the resident's aide. When asked how she knew what care a resident needed, CNA stated, "We look at the care plan or the kardex at the nurse's station. It'll tell us how they eat, how they ambulate." When asked if a care plan or kardex would have information if a resident was a safety risk from hot liquids, CNA #3 stated, "It should be." When asked if she had any residents who were a safety risk for hot liquids, CNA #3 stated, "No."

Review of the resident's CNA kardex did not evidence documentation regarding hot liquids precautions.

On 5/25/18 at 1:20 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 provided prior to exit.

2. The facility staff failed to serve coffee with a lid and to supervise the resident while drinking hot

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liquids per the hot liquid safety evaluation for Resident #46.

Resident #46 was admitted to the facility on 1/24/13 and readmitted on 10/25/17 with diagnoses that included but were not limited to: lung disease, anxiety, insomnia, heart failure and muscle weakness.

The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 5/15/18 coded the resident as having a 14 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance for all activities of daily living. The resident was coded as requiring assistance with meals.

An observation was made on 5/24/18 at 8:30 a.m., of Resident #46. The resident was sitting up in bed eating breakfast. The coffee cup did not have a lid on it. There was no staff in the room.

On 5/25/18 at 7:50 a.m., the food cart arrived on the unit where the resident resided. The coffee was in an insulated pitcher on top of the cart. When asked if this was the coffee for all of the residents on the unit, OSM (other staff member) #8, the dietary manager stated it was. OSM #8 then took the temperature of the coffee using a facility thermometer and the temperature reading was 124 degrees Fahrenheit.

An observation was made on 5/25/18 at 8:01 a.m. of Resident #46. The resident was sitting up in bed eating breakfast. The resident was observed drinking from a coffee cup. The cup did not have a lid on it. There was no staff in the room.

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Review of the hot liquid safety evaluation dated 5/20/17 documented, "A. Safety Evaluation. This assessment identifies if the resident is at risk for injury while handling and drinking hot liquids. Place a check mark if the following apply to the resident being assessed: 4. Altered muscle strength (hands was checked). 11. 1. Cup with lid or other adaptive cup. (Box checked) 2. Staff assistance (box checked)."

Review of the resident's care plan initiated on 5/22/17 did not evidence documentation regarding a hot liquid safety plan of care.

An interview was conducted on 5/24/18 at 12:57 p.m. with RN (registered nurse) #2, the MDS coordinator. When asked if a care plan would be developed for a resident who had been assessed as a safety risk from hot liquids, RN #2 stated, "Yes because they are at high risk for burns if not supervised."

An interview was conducted on 5/25/18 at 8:11 a.m. with LPN (licensed practical nurse) #8, the unit manager. When asked why residents had care plans, LPN #8 stated, "In order to communicate to the other disciplines." When asked if a care plan would be developed if a resident was assessed to be a safety risk from hot liquids, LPN #8 stated, "Yes." When asked why the resident would have a care plan for hot liquids, LPN #8 stated it was to keep the residents safe. LPN #8 was made aware that Resident #46 had a hot liquid assessment that documented the resident should have a lid on hot liquids and staff supervision. LPN #8 stated she was not aware of the hot liquid assessment.

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An interview was conducted on 5/25/18 at 8:20 a.m. with CNA (certified nursing assistant) #3, the resident's aide. When asked how she knew what care a resident needed, CNA stated, "We look at the care plan or the kardex at the nurse's station. It'll tell us how they eat, how they ambulate." When asked if a care plan or kardex would have information if a resident was a safety risk from hot liquids, CNA #3 stated, "It should be." When asked if she had any residents who were a safety risk for hot liquids, CNA #3 stated, "No."

Review of the resident's CNA kardex did not evidence documentation regarding hot liquids precautions.

On 5/25/18 at 1:20 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 provided prior to exit.

3. The facility staff failed to ensure that a commercial power strip was not in use in Resident #51's patient vicinity (1).

Resident #51 was admitted to the facility on 2/1/13 with diagnoses that included but were not limited to: cognitive deficit, diabetes, arthritis, muscle weakness and high blood pressure.

The most recent MDS, quarterly assessment with an ARD of 4/10/18 coded the resident as having a 15 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the

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resident could perform after the tray was prepared.

An observation was made on 5/24/18 at 1:53 p.m. of Resident #51's room. The resident had a commercial power strip lying on the floor next to the bed. The resident's refrigerator, television and telephone charger were plugged into the power strip.

An interview was conducted on 5/24/18 at 2:34 p.m. with OSM (other staff member) #1, the director of maintenance. When asked which residents could have power strips, OSM #1 stated, "None." When asked the process staff followed if electronic equipment or a power strip were brought into the facility, OSM #1 stated, "If someone brings in anything electronic into the building we are supposed to check it." When asked to observe the power strip in Resident #51's room, OSM #1 stated, "Some things they are not supposed to have like that in there (indicating the power strip)." OSM #1 stated, "What we've been doing is taking all of the outlets and we are upgrading them, that's a room that we haven't done a makeover on yet. I'm going to upgrade the plug."

An interview was conducted on 5/24/18 at 2:40 p.m. with OSM #9, a housekeeper. When asked if the residents can have a power strip, OSM #9 stated, "No. Because it's not safe".

An interview was conducted on 5/24/18 at 2:42 p.m. with CNA (certified nursing assistant) #1. When asked if a resident could have a power strip, CNA #1 stated, "No." When asked why, CNA #1 stated, "I guess it could cause fires." When asked what staff did if they found a power

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strip in a resident's room, CNA #1 stated, "Remove it and let maintenance know."

On 5/25/18 at 1:20 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 provided prior to exit.

1 Patient care vicinity -- In its Standard for Health Care Facilities (NFPA 99), (1) NFPA defines a patient care area as "any portion of a health care facility wherein patients are intended to be examined or treated." For equipment intended to be used within these areas-which include patient, examining, and treatment rooms, as well as any similar areas in which the patient is likely to come into contact with electrical devices-NFPA specifies that chassis leakage currents should not exceed 300 microamperes. (Note that this limit was increased from the pre-1993 limit of 100 microamperes.) However, NFPA does permit exceptions under certain conditions; for example, leakage currents up to 500 microamperes are permitted if the leakage current does not represent a hazard to the patient and if the grounding connection remains intact. Also, when chassis leakage from equipment that will be used in the area exceeds 500 microamperes, NFPA permits the use of leakage current reduction methods, such as adding an isolation transformer or redundant ground.

Within the patient care area, NFPA further requires that any equipment intended for placement near the patient meet additional requirements. NFPA refers to the area near the patient as the patient care vicinity, which it

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F 689	Continued From page 167 defines as "a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, . . . or other device that supports the patient . . . [and] vertically to 7 ft 6 in (2.3 m) above the floor." For equipment to be used in this space, NFPA requires that the resistance between conductive chassis surfaces and a reference grounding point not exceed 0.50 W. (NFPA established the concept of a patient care vicinity so that the entire room would not need to meet the stricter requirement.) This information was obtained from: http://www.mdsr.ecri.org/summary/detail.aspx?doc_id=8286 4a. The facility failed to ensure two fall mats were in place when Resident # 35 was in bed. Resident #35 was observed in bed on two occasions with only one fall mat on the right side of the bed. Resident # 35 was admitted to the facility on 11/01/06 with a readmission of 06/04/07 with diagnoses that included but were not limited to Alzheimer's disease (1), dysphagia (2), osteoporosis (3) heart failure, and hypertension (4). Resident # 35's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/20/18, coded Resident # 35 as scoring a 2 (two) on the brief interview for mental status (BIMS) of a score of 0 - 15, 2 (two) - being severely impaired of cognition for making daily decisions. Resident # 35 was coded as requiring extensive assistance of one staff member for activities of daily living.	F 689		

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On 05/23/18 at 9:10 a.m., an observation of Resident # 35 revealed she was lying in her bed. Further observation revealed a fall mat on the floor next to right side of the bed.

On 05/23/18 at 10:24 a.m., an observation of Resident # 35 revealed she was lying in her bed. Further observation revealed a fall mat on the floor next to right side of the bed.

On 05/23/18 at approximately 10:28 a.m., a CNA (certified nursing assistant) and a staff member from the maintenance department arrived at Resident # 35's room. The maintenance staff member was observed carrying a fall mat. The CNA and maintenance staff entered Resident # 35's room and placed the fall mat down on the floor to the left side of Resident #35's bed.

The care plan for Resident # 35 dated 03/28/18 documented, "Focus: (Resident # 35) is at risk for falls related to use of antidepressant medication, Dx (diagnoses) of Alzheimer's Dementia and Psychosis. Demonstrates cognitive loss and poor safety awareness. Has history of falls." Under "Interventions" it documented, "Fall mats at bedside while in bed. Date initiated: 05/23/18."

On 05/23/18 at approximately 10:32 a.m., an interview was conducted with CNA # 10. When asked about the placement of the second fall mat and the facility's procedure regarding fall mats, CNA # 10 stated, "When a resident has had a fall or is a fall risk there should be two fall mats placed on either side of the resident's bed." When asked why a second fall mat was placed for Resident #35, CNA # 10 stated, "I was asked why there isn't two fall mats in Resident # 35's room. I told them there never has been. I was

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then told to go get one."

On 05/23/18 at 1:42 p.m., an interview was conducted with LPN (licensed practical nurse) # 3. When asked to describe the procedure for the use of a fall mat, LPN # 3 stated, "If the resident has a history of falls or is a fall risk they have a fall mat." When asked how it is determined if a resident receives one or two fall mats, LPN # 3 stated, "I don't know how they determine that. I'll get back to you." On 05/23/18 at 4:12 p.m., LPN # 3 stated, "The number of fall mats is resident specific.'"

On 05/23/18 at 1:47 p.m., an interview with RN registered nurse) # 1. When asked to describe the procedure for the use of a fall mat, RN # 1 stated, "If the resident is a high fall risk and if they don't get out of bed independently. If they are independent the mat may cause a high risk for falls." When asked how it is determined if a resident receives one or two fall mats, RN # 1 stated, "Most of the time we use two to cover both the right and left side of the bed." When asked what the facility's policy states regarding the use of fall mats, RN # 1 stated, "I'll find out." On 05/23/18 at 2:06 p.m., RN # 1 stated, "The number of fall mats is patient specific, it should care planned upon arrival and discussed with management." When asked if a physician order is required, RN # 1 stated, "No it is a nursing intervention but it is on the care plan." RN #1 was asked to review the care plan for Resident # 35 dated 03/28/18 and the intervention "Fall mats at bedside while in bed." After reading the preceding information, RN # 1 was asked to interpret the statement. RN # 1 stated that the word "mats" was plural and that there should have been two fall mats for Resident # 35.

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On 05/24/18 at 1:35 p.m., an interview was conducted with LPN # 9, unit manager. When asked why Resident # 35 was given a second fall mat on 05/23/18, LPN # 9 stated, "She required it. It was suppose to be in place."

On 05/24/18 at approximately 5:55 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 brain disorder that seriously affects a person's ability to carry out daily activities) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

(2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(3) Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.

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

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4b. The facility staff failed to ensure Resident # 35's bed was in the lowest position while the resident was lying in bed.

On 05/23/18 at 5:15 p.m. an observation and measurement was made of Resident # 35's bed. Resident # 35 was lying in bed. Using a standard carpenter's ruler Resident # 35's bed height was measured. Measuring from the floor to the surface of the mattress the height of the bed measured 29 and a half inches.

On 05/24/18 at 1:15 p.m., an observation and measurement was made of Resident # 35's bed. Resident # 35 was lying in bed. Using a standard carpenter's ruler Resident # 35's bed height was measured. Measuring from the floor to the surface of the mattress the height of the bed measured 19 inches.

The care plan for Resident # 35 dated 03/28/18 documented, "Focus: (Resident # 35) is at risk for falls related to use of antidepressant medication, Dx (diagnoses) of Alzheimer's Dementia and Psychosis. Demonstrates cognitive loss and poor safety awareness. Has history of falls." Under "Interventions" it documented, "Bed in lowest position while in bed related to history of falls. Date initiated: 10/18/2016."

On 05/23/18 at 1:30 p.m., interview and observation of resident # 35's bed was conducted with CNA (certified nursing assistant) # 3. Upon entering the resident's room and observing the height of the bed CNA # 3 was asked if the bed was in the lowest position. CNA # 3 stated, "I think it can go lower." Upon measuring the height of the bed CNA # 3 agreed it measured 19 inches from the floor. CNA # 3 then picked up the

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remote control for the bed and lowered the bed. Upon measuring the height of the bed from the floor to the surface of the mattress it measured 15 inches. CNA # 3 looked at the ruler and confirmed the measurement., When asked who was responsible for ensuring the bed was in the lowest position CNA # 3 stated, "The nurse and myself." When asked how often the height of the bed is checked CNA # 3 stated, "Everytime someone goes into the room." When asked when the last time she was in Resident # 35's room CNA # 3 # stated, "About 15 minutes ago. I repositioned (Resident # 35)." When asked if she checked the height of the bed CNA # 3 stated, "No, I picked up her tray and repositioned her. It was overlooked."

On 05/24/18 at 1:35 p.m., an interview was conducted with LPN # 9, unit manager regarding the bed height for resident # 35. LPN # 9 stated, "It should be in the lowest position. When asked how often the height of the bed is checked LPN # 9 stated, "Whenever the nurse or CNA goes into the room and when they conduct rounds." LPN # 9 was then informed of the observations and measurements of Resident # 35's bed. LPN # 9 had no comment.

On 05/24/18 at approximately 5:55 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.

5. The facility staff failed to maintain a shower room door in a manner to prevent hazards in one of six shower rooms, shower room on West 1.

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F 689	Continued From page 173 Observation was made of the shower room on West 1 on 5/22/18 at approximately 9:15 a.m. The bottom of the shower door was missing a part of the plastic protective cover on the lower half of the door and had many scratches. The bottom left lower corner was broken off approximately two to three inches wide and four to five inches high. The edges of the plastic cover were sharp. Throughout the survey process, residents were observed going into the shower room with the assistance of the staff. An interview was conducted with other staff member (OSM) # 1, the director of maintenance; on 5/24/18 at 2:42 p.m., OSM #1 was shown the door to the shower room opposite room 78. OSM #1 stated he was aware of the need for painting but he was unaware of the sharp edges and the piece of the plastic cover that was missing. OSM #1 stated that the edges of the door could be a hazard to the residents using this shower room. An interview was conducted with CNA (certified nursing assistant) #1, on 5/24/18 at 2:47 p.m. When asked what she does if she finds something broken, CNA #1 stated, "We put it in the book." A red book with West 1 written on the front was shown to this surveyor. When asked about the process staff follows if they find something broken that is a danger or hazard to the resident, CNA #1 stated, "We page or call maintenance." A "Maintenance Request Form" was presented as the facility did not have a policy on reporting maintenance concerns. The form documented in	F 689		

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F 689	Continued From page 174 part, ""Please fill out with as much detail as possible. Maintenance personnel should be contacted ASAP (as soon as possible) if the issue if a Life Safety concern. All request for major and minor issues not involving life safety (such as painting or wall scratches/marks) can just be listed in the maintenance request log and maintenance with (sic) address the issues as soon as they can. Thank you." Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 5/25/18 at 1:10 p.m. No further information was provided prior to exit.	F 689		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757	1. Resident # 82 physician was notified of blood pressure medication was not held per parameter on 5/9/18. Nursing staff notified physician on 6/14/18. 2. Residents residing in facility are at risk for same deficient practice. 3. DON/designee will re-educate nursing staff on unnecessary drugs, following physician orders and notification of physician by 6/24/18. A random audit of medication administration records will be completed 3 x week x 4 weeks by DON/designee to ensure orders are followed and physician is notified as indicated. Issues identified will be addressed immediately.	

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F 757	Continued From page 175 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure one of 37 residents in the survey sample, Resident #82, was free from unnecessary medications. The facility staff failed to hold Resident #82's blood pressure medication per the physician's ordered parameters on 5/9/18. The findings include: Resident #82 was admitted to the facility on 10/31/17. Resident #82's diagnoses included but were not limited to diabetes, high blood pressure and anxiety disorder. Resident #82's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/24/18, coded the resident as being cognitively intact. Review of Resident #82' clinical record revealed a physician's order dated 12/5/17 that documented to give clonidine (1) 0.1 mg (milligrams) by mouth every morning and at bedtime and to hold the medication if the resident's blood pressure is less than 120/70. Review of Resident #82's May 2018 eMAR (electronic medication administration record) revealed on 5/9/18 at 6:00 a.m., the resident's blood pressure was 113/68 and clonidine was administered (as evidenced by a check mark and a nurse's initials). Further review	F 757	4. Results of audits and rounds will be reviewed in the monthly QAPI meeting. Trends identified will be addressed and re-education provided as needed.	6/26/18

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F 757	Continued From page 176	F 757		

of the eMAR and review of nurses' notes dated 5/9/18 failed to reveal documentation that the 5/9/18 6:00 a.m. dose of clonidine was held.

Resident #82's comprehensive care plan dated 10/18/16 documented, "Impaired Cardiovascular status related to: dx (diagnosis) of anemia and Hypertension (high blood pressure) and hx (history) of chest pain and hypokalemia (low potassium), PVD (peripheral vascular disease)...Interventions: Medications as ordered by physician and Observe use and effectiveness..."

On 5/24/18 at 3:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked how nurses document an administered medication. LPN #4 stated she checks and initials the MAR (medication administration record). LPN #4 was asked how nurses document a held medication. LPN #4 stated she checks the number "3" on the MAR, which indicates, "Hold/See nurses note" and by coding a "3", a page comes up on the computer for her to document a progress note. LPN #4 was shown Resident #82's physician order for clonidine and asked what should be done if the resident's blood pressure is below 120/70. LPN #4 stated she would not give the medication and she would let the nurse practitioner or doctor know. When asked why, LPN #4 stated, "Because they need to know if we are not giving a medication so they can adjust whatever they need to adjust." At this time, Resident #82's May 2018 eMAR was reviewed with LPN #4. LPN #4 confirmed it looked like clonidine was administered to Resident #82 when it should have been held on 5/9/18.

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On 5/24/18 at 4:31 p.m., an interview was conducted with LPN #6 (the nurse who checked and initialed clonidine administration to Resident #82 on 5/9/18 at 6:00 a.m.) LPN #6 was asked how she documents that a medication is administered and how she documents that a medication is held. LPN #6 stated she signs the medication off when she administers it and there is an option in the computer system to document when a medication is held. LPN #6 was asked if she ever had to hold any of Resident #82's medications in May 2018. LPN #6 stated there were times where she documented the resident's blood pressure medication was given but she actually held the medication. When asked if she administered or held Resident #82's blood pressure medication on 5/9/18, LPN #6 stated she could not remember.

On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "Medication Administration General Guidelines" documented, "Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber...Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given...2. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (for example, the resident is not in the nursing care center at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An

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F 757	Continued From page 178 explanatory note is entered on the reverse side of the record provided for PRN (as needed) documentation..." No further information was presented prior to exit. (1) Clonidine is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682243.html	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758	1. Residents # 70 physician was notified to reassess the need for PRN [as needed] anti-anxiety medication on 6/14/18. Resident # 9's medications were reviewed by NP on 5/24/18 and provided appropriate diagnosis for use of antidepressant. 2. Residents residing in facility are at risk for same deficient practice. 3. DON/designee will re-educate nursing staff on unnecessary drugs, including psychotropic drug use, ensuring appropriate diagnoses are in place for medications, and process to re-assess residents after 14 days of PRN psychotropic medications. Pharmacy consultant will review residents receiving psychotropic medications monthly and provide recommendations as indicated to	

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F 758	Continued From page 179 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to ensure two of 37 residents in the survey sample, Resident #70 and Resident #9, were free from psychoactive medications. 1. The facility staff failed to reassess the need for an anti-anxiety medications after 14 days as required for Resident #70. 2. The facility staff failed to have an appropriate diagnosis for the use of an antidepressant for Resident #9. The findings include:	F 758	facility and physician. DON/designee review residents receiving psychotropic medications weekly during the restraint (reduction) meeting to ensure residents are re-assessed after 14 days of psychotropic med use. DON/designee review residents receiving psychotropic medications during the weekly chemical restraint reduction meeting to ensure residents receiving psychotropic medications have appropriate diagnosis for use, are re-assessed and/or gradual dose reduction if indicated. Issues identified are addressed as indicated. 4. Results of audits will be reviewed in monthly QAPI meeting. Trends identified will be addressed immediately and re-education provided as needed.	6/26/18

F 758 Continued From page 180 F 758

1. Resident #70 was admitted to the facility on 4/10/18 with diagnoses that included but were not limited to: muscle weakness, bipolar disorder (1), depression and high blood pressure.

The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 4/24/18 coded the resident as having scored 15 out of 15 on the brief interview for mental status indicting the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the tray was set up.

Review of the resident's care plan initiated on 4/11/18 documented, "Focus. (name of resident) has a potential for drug related complications associated with use of PSYCHOTROPIC medications related to: Anti-anxiety medication, Anti-psychotic medication. Interventions. Provide Medications as ordered by physician and evaluate for effectiveness."

Review of the May 2018 physician orders documented, "Clorazepate Dipotassium (2) tablet 3.75 MG (milligram) Give 2 tablet (sic) by mouth every 8 hours as needed for anxiety. Order Date. 04/10/2018."

Review of the May 2018 medication administration record documented, "Clorazepate Dipotassium tablet 3.75 MG (milligram) Give 2 tablet (sic) by mouth every 8 hours as needed for anxiety. Order Date. 04/10/2018." The medication was documented as given on four occasions during the month of May 2018.

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Review of the physician's notes did not evidence documentation regarding the effectiveness of the medication.

An interview was conducted on 5/24/18 at 2:20 p.m. with ASM (administrative staff member) #5, physician. When asked if he cared for Resident #70, ASM #5 stated he did. When asked the process he followed for as needed anti-anxiety medications, ASM #3 stated, "I usually let psych (psychiatry) take care of those. They were here this morning."

An interview was conducted on 5/24/18 at 2:25 p.m. with LPN #8, When asked how long an as needed anti-anxiety medication order was good for, "I think it's two weeks. We usually consult psych."

Review of the psychiatric note dated 5/17/18 did not evidence documentation about the anti-anxiety medication. Further review of the clinical record did not evidence documentation regarding a psychiatric note for 5/24/18.

An interview was conducted on 5/25/18 at 11:35 a.m. with ASM #3, the nurse practitioner. when asked about the process she followed for a resident prescribed an as needed anti-anxiety medication, ASM #3 stated, "If it's a benzo (benzodiazepine) it needs to be re-evaluated in 14 days. The policy would be you're only to have them on any kind of antipsychotic for 14 days." When asked to review Resident #70's clorazepate dipotassium order, ASM #3 stated it should have been re-evaluated in 14 days. ASM #3 stated the psychiatric nurse practitioner was not available that day.

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On 5/25/18 at 1:20 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, "Medication Monitoring" did not specifically address re-assessing an anti-anxiety as needed medication every 14 days.

No further information was obtained prior to exit.

1. Bipolar disorder -- Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression. This information was obtained from: https://medlineplus.gov/bipolardisorder.html

2. Clorazepate dipotassium -- A benzodiazepine with anxiolytic, sedative, hypnotic, and anticonvulsant properties. Clorazepate dipotassium exerts its effect by de-activating the nervous system through potentiation of the inhibitory effect of gamma-aminobutyric acid (GABA) on the GABA-A receptors by binding to a site that is distinct from the GABA binding site. Its inhibitory effect is caused by an increase in GABA-mediated chloride channel opening events, leading to hyperpolarization and synaptic inhibition. This informationw as obtained from: https://www.ncbi.nlm.nih.gov/medgen/3122

2. The facility staff failed to have an appropriate diagnosis for the use of an antidepressant for Resident #9.

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F 758	Continued From page 183 Resident #9 was admitted to the facility on 5/5/17 with diagnoses that included but were not limited to: dementia, contractures, feeding tube, anemia, Parkinson's disease (a slowly progressive disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and must weakness, sometimes with emotional instability (1)), insomnia, asthma, and adult failure to thrive (a geriatric syndrome termed "failure to thrive" has been described, consisting of weight loss, decreased appetite, poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low serum cholesterol. Failure to thrive occurs in both acute and chronic forms, leading to impaired functional status, morbidity from infection, pressure sores, and increased mortality (2)). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/2/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. The resident was coded as being totally dependent upon one or more staff members for all of her activities of daily living. In Section I - Active Diagnoses, the resident was not coded for any Psychiatric/Mood disorders including depression. The physician order dated, 1/31/18 documented, "Remeron Tablet (REMERON® (mirtazapine) Tablets are indicated for the treatment of major depressive disorder (3)); give 7.5 mg (milligrams) by mouth at bedtime related to ADULT FAILURE TO THRIVE."	F 758		

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The April and May 2018 Medication administration record (MAR) documented, "Remeron Tablet; give 7.5 mg by mouth at bedtime related to ADULT FAILURE TO THRIVE." The medication was documented as administered every day during April and May 2018.

The "Psychiatric Evaluation" dated, 4/18/18, documented in part, "Diagnosis, Assessment and Plan: Dementia, Failure to thrive."

The Comprehensive Care Plan dated, 3/13/18, documented in part, "Focus: Potential for drug related complications associated with use of psychotropic medications related to Anti-depressants; I am at risk of having s/s (signs and symptoms) of depressed mood such as: being tearful, feeling hopeless, feeling down and sad."

An interview was conducted with LPN (licensed practical nurse) #4 on 5/24/18 at 2:16 p.m. LPN #4 was asked what Remeron is prescribed and used for. LPN #4 stated, "For appetite and sleep. It's an antidepressant and given at night for appetite." When asked if failure to thrive is an appropriate diagnoses for Remeron, LPN #4 stated, "No, it's an anti-depressant."

An interview was conducted with administrative staff member (ASM) #3, the nurse practitioner, on 5/24/18 at 3:16 p.m. When asked what Remeron is used for, ASM #3 stated, "Depression." When asked if failure to thrive is an acceptable diagnosis for the use of Remeron, ASM #3 stated, "No. I've been trying to clean up the physician orders when I do the monthly reviews."

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F 758	Continued From page 185 The administrator was made aware of the above concern on 5/24/18 at 5:26 p.m. The following in part are documented side effects of Remeron: "REMERON and other antidepressant medicines may cause serious side effects, including: 7. Sleepiness. It is best to take REMERON® close to bedtime. 10. Increases in appetite or weight." (3) 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 437. (2) This information was obtained from the following website: https://grants.nih.gov/grants/guide/pa-files/PA-93-022.html. (3) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?id=62223	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		

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F 761	Continued From page 186 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, it was determined facility staff failed to store medications in a safe manner for two of five facility medication carts, the West 2 cart and West 1 cart. 1. The facility staff failed to lock an unattended medication cart on the West 2 unit. 2. The facility staff failed to ensure discontinued medications were not stored in the medication cart on the West 1 unit. The findings include: 1. An observation was made on 5/25/18 at 10:17 a.m. of the West 2 unit medication cart. The cart was against the wall opposite the nurses' station there were no staff within line of sight of the cart. At 10:20 a.m. a CNA (certified nursing assistant) walked past the cart while pushing a resident in a wheelchair. At 10:21 another staff member	F 761	1. LPN #2 was re-educated on ensuring medication carts are locked when unattended by the Unit Manager on 5/25/18. Unit manager discarded the box of Budesonide Inhalation Solution on 5/25/18. 2. Residents residing in facility are at risk for the same deficient practice. 3. DON/designee will re-educate nursing staff on medication storage, including ensuring medication carts are locked when unattended and expired medications are discarded as indicated. DON/designee will conduct daily rounds, ensuring medication carts are locked and medications are securely stored. DON/designee will audit 2 medications carts per week x 4 weeks to ensure expired medications are discarded as indicated. Issues identified will be addressed immediately. 4. Results of audits will be reviewed in monthly QAPI meeting. Trends identified will be addressed immediately and re-education provided as needed.	6/26/18

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walked past the cart. At 10:24 a.m. LPN (licensed practical nurse) #2 walked past the cart and then returned and locked it.

An interview was conducted on 5/25/18 at 10:25 a.m. with LPN #2. When asked why medication carts were to be locked when left when unattended, LPN #2 stated, "Well safety. Anyone could get in it if it's not locked and you're not there."

On 5/25/18 at 1:20 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Medication Administration. General Guidelines" documented, "POLICY. Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Medication Administration. 17. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. The cart must be clearly visible to the personnel administering medications when unlocked."

No further information was obtained prior to exit.

2. The facility staff failed to ensure discontinued medications were not stored in the medication cart on the West 1 unit.

On 5/23/18 at 11:00 a.m., observation of a medication cart on the West 1 unit was conducted. A box was found with six unopened pouches of the following medication: Budesonide

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 761	Continued From page 188	F 761		

(Pulmicort (1)) inhalation Suspension 0.25 mg (milligrams)/2 ml (milliliters). The medication had the following expiration date on the bottom of the box: 6/2018. The medication also had a label that documented the following: "Discard after: 2/15/18."

On 5/23/18 at 11:52 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked if the Pulmicort was expired, LPN #4 stated that the facility had recently switched pharmacies and that the label that stated "discard after: 2/15/18" was from the old pharmacy. LPN #4 stated nursing staff go by the expiration date "6/2018" for the new pharmacy. LPN #4 stated the Pulmicort had been discontinued anyway. When asked when the Pulmicort was discontinued, LPN #4 stated she was not sure. When asked who was responsible for checking the medication carts for expired or discontinued medications, LPN #4 stated that all nurses could check the carts. LPN #4 stated that nurses should be checking the carts once a week. LPN #4 also stated that pharmacy also checks the medication carts. LPN #4 stated that the Pulmicort was missed. When asked if discontinued medications should be on the medications cart, LPN #4 stated that they should not. When asked about the process staff follows for getting rid of discontinued medications, LPN #4 stated she could not send medications back to pharmacy that are opened or have been in the facility for greater than 30 days. LPN #4 stated she would discard the medication. A copy of the order to discontinue the Pulmicort was requested.

On 5/24/18 at 12:30 p.m., a copy of the Pulmicort order was presented. The Pulmicort was discontinued on 5/4/17.

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F 761	Continued From page 189 On 5/24/18 at 3:19 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, "Medication Storage," documents in part, the following: "Outdated, contaminated, discontinued or deteriorated medications and those that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal." No further information was presented prior to exit. (1) Budesonide inhalation suspension is indicated for the maintenance treatment of asthma. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=4f339e84-33be-44d1-bbae-e0579da12c7f	F 761		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (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. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review	F 770		

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F 770	Continued From page 190 and clinical record review, it was determined that the facility staff failed to obtain laboratory services per physician's orders for two of 37 residents in the survey sample, Residents #38 and #70. 1. The facility staff failed to obtain a CMP (comprehensive metabolic panel (1)) for Resident #38 per a physician's order dated 4/9/18. Instead, a BMP (basic metabolic panel (1)) was obtained. 2. The facility staff failed to obtain a physician ordered laboratory specimen for Resident #70. The findings include: 1. Resident #38 was admitted to the facility on 6/28/16. Resident #38's diagnoses included but were not limited to difficulty swallowing, major depressive disorder and muscle weakness. Resident #38's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/20/18, coded the resident's cognition as moderately impaired. Section G coded Resident #38 as requiring extensive assistance of one staff with bed mobility, dressing toilet use and personal hygiene. Review of Resident #38's clinical record revealed a nurse's note dated 4/9/18 that documented, "Resident need (sic) more assistance with ADL (activities of daily living), feeling weak, N/O (New order) NP (nurse practitioner) blood CBXC (sic), BMP, pt (patient) ate 75% lunch, denies any pain/distress." Another nurse's note dated 4/9/18 documented, "Writer spoke with resident's daughter and concerns voiced regarding 'noticing dad is having more difficulty standing and has	F 770	1. Resident #38 physician was notified of BMP (basic metabolic panel) obtained by facility on 4/9/18. Physician was notified by nursing staff on 6/14/18. Resident #70 physician was notified of laboratory specimen not obtained as ordered on 5/7/18 as ordered. Physician was notified by facility staff on 6/14/18. 2. Residents residing in facility are at risk for same deficient practice. 3. DON/designee will re-educate nursing staff on facility process for laboratory services, including obtaining specimens as ordered. DON/designee will review 24 hour report in morning meeting and afternoon stand down meeting to ensure physician orders with labs are obtained as ordered. In addition, a 24 hour chart check will be completed by 11-7 shift to verify orders are obtained as indicated. DON/designee will audit labs daily, Monday – Friday for 2 weeks, then weekly x 4 weeks; to ensure lab orders are followed as orders. 4. Results of audits will be reviewed in monthly QAPI meeting. Trends identified will be addressed immediately and re-education provided as needed.	6/26/18

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more weakness.' CNA (Certified nursing assistant) stated the same observations during care. Spoke with NP and plans to order labs [laboratory tests] and consult PT (physical therapy) for eval (evaluation). Will continue to monitor resident's weakness and intake."

A physician's order dated 4/9/18 documented, "Blood CBC (2), CMP on 4/10/18 one time a day related to MUSCLE WEAKNESS..." Resident #38's April 2018 eTAR (electronic treatment administration record) documented, "Blood CBC, CMP on 4/10/18 one time a day related to MUSCLE WEAKNESS..."

Further review of Resident #38's clinical record revealed lab results dated 4/10/18 for a CBC and a BMP.

On 5/24/18 at 3:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked to explain the difference between a CMP and a BMP. LPN #4 stated, "One is a complete metabolic panel and the other is a basic metabolic panel. They have different tests in them." LPN #4 was asked about the process staff follows for ensuring a CMP is obtained as ordered. LPN #4 stated, "We do the lab papers. We are not here when they (the lab technicians who draw the blood) come but if it comes back and we see the wrong one was done of course we are going to notify them and draw the right tests." On 5/24/18 at 4:20 p.m., Resident #38's clinical record was reviewed with LPN #4 and LPN #4 confirmed a BMP and not a CMP was obtained on 4/10/18.

On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2

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F 770 Continued From page 192 F 770

(the director of nursing) were made aware of the above concern.

The facility/lab document titled, "Laboratory Services for Skilled Nursing Facilities" documented, "(Name of Lab Company) will provide diagnostic services for patients in the skilled nursing facility (SNF) as ordered by a Medical Practitioner. Orders received by the SNF will be communicated to (name of Lab Company). The orders for a human specimen will be analyzed with results reported to the SNF. Result reports will be communicated by the preferred communication media of the SNF. Laboratory diagnostic services are provided to meet the needs of all patients at the skilled nursing facility and to assist the nursing team to meet the highest practicable level of well being for each patient."

No further information was presented prior to exit.

(1) "A metabolic panel is a group of tests that measures different chemicals in the blood. These tests are usually done on the fluid (plasma) part of blood. The tests provide information about your body's chemical balance and metabolism. They can give doctors information about your muscles (including the heart), bones, and organs, such as the kidneys and liver.
There are two types: basic metabolic panel (BMP) and comprehensive metabolic panel (CMP). The BMP checks your blood sugar, calcium, and electrolytes. The BMP also has tests such as creatinine to check your kidney function. The CMP includes all of those tests, as well as tests of your cholesterol, protein levels, and liver function." This information was obtained

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from the website:
https://medlineplus.gov/metabolicpanel.html

(2) A CBC (complete blood count) is a test that measures different components in the blood. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=cbc&_ga=2.265218191.1046050702.1527592979-139120270.1477942321

2. The facility staff failed to obtain a physician ordered laboratory specimen for Resident #70.

Resident #70 was admitted to the facility on 4/10/18 with diagnoses that included but were not limited to: muscle weakness, bipolar disorder (1), depression and high blood pressure.

The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 4/24/18 coded the resident as having scored 15 out of 15 on the brief interview for mental status indicting the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the tray was set up.

Review of the resident's care plan initiated on 4/11/18 documented, "Focus. (Name of resident) has impaired Cardiovascular status related to: Hypertension...Interventions. Lab (laboratory) work or X-rays as ordered by physician."

Review of the 5/5/18 physician orders documented, "BMP (2) on Monday 5/7/18.

Review of the 5/5/18 laboratory log did not

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evidence documentation indicating the laboratory specimen was to be obtained.

Review of the clinical record did not evidence documentation regarding the BMP laboratory results.

A request was made on 5/24/18 at 8:15 a.m., from ASM (administrative staff member) #2, the director of nursing for evidence of the laboratory results.

A repeated request was made on 5/24/18 at 2:15 p.m., from ASM #2 for evidence of the laboratory results.

On 5/25/18 at 1:20 p.m., a third request was made from ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing for the laboratory results.

On 5/25/18 at 2:30 p.m. ASM #2 stated, "I don't have those." When asked about the process staff were to follow to obtain laboratory specimens, ASM #2 stated, "We put it into our lab log for the day it was ordered. Our lab comes on Tuesday and Thursday. The results are faxed back and then we expect them notify the physician."

Review of the facility's policy titled, "Laboratory Services for Skilled Nursing Facilities" documented, "PROCEDURE. C. A requisition will be completed by the SNF (skilled nursing facility) to include the necessary details and orders as indicated by the Medical Practitioner."

No further information was provided prior to exit.

1. Bipolar disorder -- Bipolar disorder is a serious

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mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression. This information was obtained from: https://medlineplus.gov/bipolardisorder.html

2. "A metabolic panel is a group of tests that measures different chemicals in the blood. These tests are usually done on the fluid (plasma) part of blood. The tests provide information about your body's chemical balance and metabolism. They can give doctors information about your muscles (including the heart), bones, and organs, such as the kidneys and liver.
There are two types: basic metabolic panel (BMP) and comprehensive metabolic panel (CMP). The BMP checks your blood sugar, calcium, and electrolytes. The BMP also has tests such as creatinine to check your kidney function. The CMP includes all of those tests, as well as tests of your cholesterol, protein levels, and liver function." This information was obtained from the website:
https://medlineplus.gov/metabolicpanel.html

F 773 SS=D Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) F 773

§483.50(a)(2) The facility must-
(i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.
(ii) Promptly notify the ordering physician,

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F 773	Continued From page 196 physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff obtained a laboratory test not ordered by the physician for one of 37 residents in the survey sample, Residents #38. The facility staff obtained a BMP (basic metabolic panel (2)) without a physician's order. The physician ordered CMP (comprehensive metabolic panel (1)) for Resident #38, and not a BMP. The findings include: Resident #38 was admitted to the facility on 6/28/16. Resident #38's diagnoses included but were not limited to difficulty swallowing, major depressive disorder and muscle weakness. Resident #38's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/20/18, coded the resident's cognition as moderately impaired. Section G coded Resident #38 as requiring extensive assistance of one staff with bed mobility, dressing toilet use and personal hygiene. Review of Resident #38's clinical record revealed a nurse's note dated 4/9/18 that documented, "Resident need (sic) more assistance with ADL	F 773	1. Resident #38 physician was notified of BMP (basic metabolic panel) obtained by facility on 4/9/18. Physician was notified by nursing staff on 6/14/18. 2. Residents residing in facility are at risk for same deficient practice. 3. DON/Designee will re-educate nursing staff on physician notification regarding labs and residents plan of care. DON/designee will review 24 hour report in morning meeting and afternoon stand down meeting to ensure physician orders with labs are obtained as ordered. In addition, a 24 hour chart check will be completed by 11-7 shift to verify orders are obtained as indicated. DON/designee will audit labs daily, Monday – Friday for 2 weeks, then weekly x 4 weeks; to ensure lab orders are followed as orders and physician is notified. 4. Results of audits will be reviewed in monthly QAPI meeting. Trends identified will be addressed immediately and re-education provided as needed.	6/26/18

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(activities of daily living), feeling weak, N/O (New order) NP (nurse practitioner) blood CBXC (sic), BMP, pt (patient) ate 75% lunch, denies any pain/distress." Another nurse's note dated 4/9/18 documented, "Writer spoke with resident's daughter and concerns voiced regarding 'noticing dad is having more difficulty standing and has more weakness.' CNA (Certified nursing assistant) stated the same observations during care. Spoke with NP and plans to order labs [laboratory tests] and consult PT (physical therapy) for eval (evaluation). Will continue to monitor resident's weakness and intake."

A physician's order dated 4/9/18 documented, "Blood CBC (2), CMP on 4/10/18 one time a day related to MUSCLE WEAKNESS..." Resident #38's April 2018 eTAR (electronic treatment administration record) documented, "Blood CBC, CMP on 4/10/18 one time a day related to MUSCLE WEAKNESS..."

Further review of Resident #38's clinical record revealed lab results dated 4/10/18 for a CBC and a BMP.

On 5/24/18 at 3:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked to explain the difference between a CMP and a BMP. LPN #4 stated, "One is a complete metabolic panel and the other is a basic metabolic panel. They have different tests in them." LPN #4 was asked about the process staff follows for ensuring a laboratory test is obtained only when ordered. LPN #4 stated, "We do the lab papers. We are not here when they (the lab technicians who draw the blood) come but if it comes back and we see the wrong one was done of course we are going to notify

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them and draw the right tests." On 5/24/18 at 4:20 p.m., Resident #38's clinical record was reviewed with LPN #4. LPN #4 confirmed a BMP was obtained on 4/10/18, without a physician's order.

On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility/lab document titled, "Laboratory Services for Skilled Nursing Facilities" documented, "(Name of Lab Company) will provide diagnostic services for patients in the skilled nursing facility (SNF) as ordered by a Medical Practitioner. Orders received by the SNF will be communicated to (name of Lab Company). The orders for a human specimen will be analyzed with results reported to the SNF. Result reports will be communicated by the preferred communication media of the SNF. Laboratory diagnostic services are provided to meet the needs of all patients at the skilled nursing facility and to assist the nursing team to meet the highest practicable level of well being for each patient."

No further information was presented prior to exit.

(1) "A metabolic panel is a group of tests that measures different chemicals in the blood. These tests are usually done on the fluid (plasma) part of blood. The tests provide information about your body's chemical balance and metabolism. They can give doctors information about your muscles (including the heart), bones, and organs, such as the kidneys and liver.

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F 773	Continued From page 199 There are two types: basic metabolic panel (BMP) and comprehensive metabolic panel (CMP). The BMP checks your blood sugar, calcium, and electrolytes. The BMP also has tests such as creatinine to check your kidney function. The CMP includes all of those tests, as well as tests of your cholesterol, protein levels, and liver function." This information was obtained from the website: https://medlineplus.gov/metabolicpanel.html (2) A CBC (complete blood count) is a test that measures different components in the blood. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=cbc&_ga=2.265218191.1046050702.1527592979-139120270.1477942321	F 773		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly 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.	F 812	1. Dietary manager cleaned the area beneath the ice machine on 5/24/18. CNA #2 was re-educated on safe food handling by the Administrator on 5/23/18. 2. Residents residing in facility are at risk for same deficient practice.	

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F 812	Continued From page 200 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined the facility staff failed to serve food in a sanitary manner in the kitchen and for one of 37 residents in the survey sample, Resident #14, and during dining observation in one of two dining rooms, the Bistro. 1. The facility staff failed to keep the floor, under the ice machine, free from clutter and trash. 2. The facility staff failed to serve food to Resident #14 in a sanitary manner. CNA (certified nursing assistant) #2 touched the food cart with a bare hand then touched a roll with the same bare hand and served the roll to Resident #14. 3. The facility staff failed to serve food in a sanitary manner in the Bistro dining room. The findings include: 1. The facility staff failed to keep the floor, under the ice machine, free from clutter and trash. Observation was made of the kitchen on 5/23/18 at 8:29 a.m. accompanied by other staff member (OSM) #8, the dietary manager. Observation was made of the ice machine near the entrance to the dining room. Under the ice machine was a plastic mug, a pod of half-and-half creamer, tinfoil, and napkins. When asked if those items should be under the ice machine, OSM #8 stated, "No,	F 812	3. Administrator/designee will re-educate staff on ensuring food is served in a sanitary manner, ensuring food is not touched with bare hands and proper hand hygiene is performed. Dietary manager re-educated dietary on cleaning standards and schedules on 5/31/18. Department heads will observe 5 meals a week for 4 weeks to ensure residents are served meals in a sanitary manner. Dietary manager/designee will complete an audit of the kitchen areas 5 times a weeks for 4 weeks to ensure cleanliness throughout the kitchen. 4. Results of audits will be reviewed in monthly QAPI meeting. Trends identified will be addressed immediately and re-education provided as needed.	6/26/18

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Ma'am." OSM #8 stated, "The staff is to sweep and mop the kitchen after every meal."

The facility policy, "Environment" documented in part, "All food preparation areas, food service areas and dining areas will be maintained in a clean and sanitary condition. Procedures: 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting and ventilation...4. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas and surfaces."

The administrator (administrative staff member) ASM #1 was made aware of the above concern on 5/24/18 at 5:26 p.m.

2. The facility staff failed to serve food to Resident #14 in a sanitary manner. CNA (certified nursing assistant) #2 touched the food cart with a bare hand then touched a roll with the same bare hand and served the roll to Resident #14.

Resident #14 was admitted to the facility on 12/20/12. Resident #14's diagnoses included but were not limited to chronic kidney disease, pain and anxiety disorder. Resident #14's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 2/27/18, coded the resident as being cognitively intact.

On 5/23/18 at 12:47 p.m., CNA #2 was observed serving meal trays. CNA #2 applied hand sanitizer, opened the food cart with her right bare hand, removed a meal tray from the cart and

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closed the meal cart. CNA #2 then entered Resident #14's room, removed a roll from plastic wrap, and placed the roll on the resident's meal tray with her bare right hand. On 5/23/18 at 12:51 p.m., the roll was no longer observed on Resident #14's meal tray. The resident stated he ate the roll. On 5/23/18 at 2:40 p.m., an interview was conducted with CNA #2. CNA #2 was asked how food should be handled in a sanitary manner. CNA #2 stated, "You shouldn't touch with your bare hands. It's not your food. I wouldn't want someone touching my food." When asked why, CNA #2 stated, "Sanitary issues. Nails are unclean. Even with the bread, you work around the Saran wrap and don't touch." CNA #2 was made aware this surveyor observed her touch Resident #14's roll with her bare hand after touching the food cart. CNA #2 stated she was rushing during meal service and it was possible she touched the roll with her bare hand.

On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "Meal Distribution" documented, "6. Proper food handling techniques to prevent contamination and temperature maintenance controls will be used for point-of-service dining..."

No further information was presented prior to exit.

3. The facility staff failed to serve food in a sanitary manner in the Bistro dining room.

A dining observation was made on 5/23/18 at

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F 812	Continued From page 203 12:30 p.m. in the Bistro dining room. CNA #5 served a resident their meal and cut up their food. CNA (certified nursing assistant) #5 then went to another resident, picked up the resident's bread with her bare hands, and buttered it. CNA #5 then moved on to assist other residents. An interview was conducted on 5/23/18 at 2:42 p.m. with CNA #5. When asked when staff wash their hands, CNA #5 stated, "After the third time after you use a hand sanitizer. I wash my hands for 20 seconds." When asked if was acceptable to handle resident's food with bare hands, CNA #5 stated, "No." When asked why, CNA #5 stated, "It's not good. We have germs." CNA #5 was then informed of the above observation. On 5/25/18 at 1:20 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 provided prior to exit.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842	1. LPN # 6 was re-educated by the Unit Manager regarding inaccurate documentation of resident #82 blood pressure medication. Resident # 34 physician was notified of blood pressure medication being withheld due to hold parameters in May 2018. Physician was notified by facility staff on 6/14/18.	

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F 842	Continued From page 204 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches	F 842	2. Residents residing in facility are at risk for same deficient practice. 3. DON/designee will re-educate nursing staff on documentation standards, to ensure documentation is accurately reflects services provided. Nursing staff will be re-educated on physician notification, to include documentation is present when physician is notified. A random audit of medication and treatment orders will be completed 3 x week x 4 weeks by DON/designee to documentation supports care provided and physician notified is documented in the medical record. 4. Results of audits will be reviewed in monthly QAPI meeting. Trends identified will be addressed immediately and re-education provided as needed.	6/26/18

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legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(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 the facility staff failed to maintain an accurate clinical record for two of 37 residents in the survey sample, Resident #82 and Resident #34.

1. LPN (Licensed practical nurse) #6 inaccurately documented Resident #82's blood pressure medication was administered although she held the medication on 5/19/18.

2. The facility staff failed to document that the physician was notified that the blood pressure medication was held seven out of 24 opportunities for Resident #34.

The findings include:

1. Resident #82 was admitted to the facility on 10/31/17. Resident #82's diagnoses included but were not limited to diabetes, high blood pressure and anxiety disorder. Resident #82's most recent MDS (minimum data set), a quarterly assessment

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with an ARD (assessment reference date) of 4/24/18, coded the resident as being cognitively intact.

Review of Resident #82' clinical record revealed a physician's order dated 12/5/17 that documented to give clonidine (1) 0.1 mg (milligrams) by mouth every morning and at bedtime and to hold the medication if the resident's blood pressure is less than 120/70. Review of Resident #82's May 2018 eMAR (electronic medication administration record) revealed on 5/19/18 at 6:00 a.m., the resident's blood pressure was 110/68 and clonidine was administered (as evidenced by a check mark and a nurse's initials). Further review of the eMAR and review of nurses' notes dated 5/19/18 failed to reveal documentation that the 5/9/18 6:00 a.m. dose of clonidine was held.

Resident #82's comprehensive care plan dated 10/18/16 failed to document information regarding accurate medication administration documentation.

On 5/24/18 at 3:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked how nurses document an administered medication. LPN #4 stated she checks and initials the MAR (medication administration record). LPN #4 was asked how nurses document a held medication. LPN #4 stated she checks the number "3" on the MAR, which indicates, "Hold/See nurses note" and by coding a "3", a page comes up on the computer for her to document a progress note. At this time, Resident #82's May 2018 eMAR was reviewed with LPN #4. LPN #4 confirmed it looked like clonidine was administered to Resident #82 when it should have been held on 5/9/18.

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On 5/24/18 at 4:31 p.m., an interview was conducted with LPN #6 (the nurse who checked and initialed clonidine administration to Resident #82 on 5/19/18 at 6:00 a.m.) LPN #6 was asked how she documents that a medication is administered and how she documents that a medication is held. LPN #6 stated she signs the medication off when she administers it and there is an option in the computer system to document when a medication is held. LPN #6 was asked if she ever had to hold any of Resident #82's medications in May 2018. LPN #6 stated there were times where she documented the resident's blood pressure medication was given but she actually held the medication. When asked if she administered or held Resident #82's blood pressure medication on 5/19/18, LPN #6 stated she held the medication although she documented she gave it.

On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "Medication Administration General Guidelines" documented, "Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given...2. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (for example, the resident is not in the nursing care center at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An

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explanatory note is entered on the reverse side of the record provided for PRN (as needed) documentation..."

No further information was presented prior to exit.

(1) Clonidine is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682243.html

2. The facility staff failed to document that the physician was notified that the blood pressure medication was held seven out of 24 opportunities for Resident #34.

Resident #34 was admitted to the facility on 6/2//17 with diagnoses that included but were not limited to: dementia, pneumonia, heart failure and high blood pressure.

The most recent MDS, a significant change assessment, with an ARD of 3/20/18 coded the resident as having scored 12 out of 15 on the brief interview for mental status indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the resident's care plan initiated on 6/6/17 documented, "Focus. I have impaired Cardiovascular status. Interventions. Observe for abnormal vital signs (blood pressure, pulse, respirations and temperature) and report."

Review of the May 2018 physician's orders documented, "Coreg (1) 3.125 MG (milligram) Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION Hold

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for SBP (systolic blood pressure, the upper number) <110 or HR (heart rate) <55."

Review of the May 2018 MAR (medication administration record) documented, "Coreg Tablet 3/125 MG Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION Hold for SBP <110 or HR<55." On seven out of 24 opportunities a "3" was documented in the box. Review of the chart codes at the bottom of the page documented, "3=Hold/See Nurse Notes."

Review of the May 2018 nurse's notes did not evidence documentation that the physician had been notified that the medication had been held.

An interview was conducted on 5/24/18 at 2:06 p.m. with RN (registered nurse) #1, the resident's nurse. When asked about the process staff follows if a medication is held, RN #1 stated, If we hold the medication we notify the doctor and make sure they're aware of it, let the RP (responsible party) know." When asked if staff were expected to document that the physician was notified, RN #1 stated, "Yes."

5/25/18 at 9:43 a.m. with ASM (administrative staff member) #3, the nurse practitioner. When asked if staff were expected to notify her if a resident's medication was held, ASM #3 stated, "Yes." When asked if she was aware that Resident #34's Coreg had been held on several occasions, ASM #3 stated, "Yes I was aware of the low blood pressure, the staff let me know. You can see in my notes that I'm decreasing the medications because of her blood pressure."

On 5/25/18 at 1:20 p.m. ASM #1, the

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administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Medication Administration" documented, "POLICY. Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by person legally authorized to do so. PROCEDURES. Documentation. 2. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time....the spacer provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reversed side of the record provided for PRN (as needed) documentation. If two consecutive doses of a vital medication are withheld or refused, the physician is notified."

No further information was obtained prior to exit.

1. Coreg -- COREG is indicated for the treatment of mild-to-severe chronic heart failure of ischemic or cardiomyopathic origin, usually in addition to diuretics, ACE inhibitors, and digitalis, to increase survival and, also, to reduce the risk of hospitalization [see Drug Interactions (7.4) and Clinical Studies (14.1)]. This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=fdb12700-116b-4203-8d74-9a94b9401fe6

F 880 SS=D Infection Prevention & Control
CFR(s): 483.80(a)(1)(2)(4)(e)(f) F 880

§483.80 Infection Control
The facility must establish and maintain an

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infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(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:

§483.80(a)(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;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(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

1. Resident #108's catheter collection properly anchored to prevent touching the floor on 5/24/18. Resident #11, #99, and #15 were assessed without remark by nursing staff on 6/15/18.

2. Residents residing in facility are at risk for same deficient practice.

3. DON/Designee will re-educate nursing staff on Infection Prevention and Control standards, including hand hygiene when providing incontinence care, preventing items from touching the floor, and infection control practices during medication administration.
DON/designee will conduct 3 resident care observations/audits per week for 4 weeks. Observations will include medication administration and provision of incontinence care to ensure infection control standards are being followed.

4. Results of audits will be reviewed in monthly QAPI meeting. Trends identified will be addressed immediately and re-education provided as needed.

Completion date: 6/26/18

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(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.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain infection control practices for one of 37 residents in the survey sample, Resident #108 and for three of 7 residents in the Medication Administration task, Residents #11, #99, and #15.

1. The facility staff failed to use proper hand hygiene during Resident # 108's incontinence care and failed to keep Resident # 108's catheter collection bag off the floor.

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2. The facility staff failed to wash or sanitize their hands in between administering medications to Resident #11, #99 and #15.

3. The facility staff failed to sanitize the rubber top of a vial of insulin prior to the insertion of the syringe needle for Resident #15.

The findings include:

1. The facility staff failed to use proper hand hygiene during Resident # 108's incontinence care and failed to keep Resident # 108's catheter collection bag off the floor.

Resident # 108 was admitted to the facility on 10/22/16 with a readmission of 08/05/17 with diagnoses that included but were not limited to Parkinson's disease (1), dysphagia (2), benign prostatic hyperplasia (3), depressive disorder (4), peripheral vascular disease (5) and heart disease (6).

Resident #108's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 05/07/18, coded Resident # 108 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 108 was coded as being totally dependent of one staff member for activities of daily living. In "Section H Bladder and Bowel" under "H0100 Appliances" coded Resident # 108 as "A. Indwelling Catheter (including suprapubic catheter and nephrostromy)."

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On 05/23/18 at 4:49 p.m., an observation of Resident # 108's incontinence care was conducted. Resident # 108 was lying in bed. CNA (certified nursing assistant) # 8 put on a pair of plastic disposable gloves, she then opened the cabinet in resident's room gathering supplies, opened the room door and asked staff in the hall for wipes and trash bags. CNA # 8 while wearing the same gloves used the bed remote to adjust Resident # 108 to the appropriate height, removed gloves, retrieved a box of wipes brought into room by another staff member, put on another pair of gloves, removed the resident's shorts and brief. Resident # 108 was observed to have had a bowel movement. Wearing the same gloves CNA #8 used wipes to clean Resident #108. CNA #8 then placed the soiled wipes into the plastic trash bag, rolled the resident onto his right side, cleaned Resident #108's bottom, and placed the soiled wipes and brief into the plastic bag. CAN #8 then rolled Resident #108 onto right side and placed a clean brief under resident, and fitted the brief to Resident # 108. While still wearing the same gloves CNA # 8 adjusted Resident # 108's pillows, used the bed remote to adjust the height of the bed by lowering it to the lowest position, then removed her gloves, gathered up the trash bag and dirty linen bag, opened the privacy curtain and then washed her hands. Resident #108's catheter collection bag was observed attached to the side of bed resting directly on the floor.

On 05/24/18 at 8:30 a.m., an interview was conducted with CNA # 8 regarding the incontinence care she provided to Resident # 108 on 05/23/18. When asked to describe the infection control procedures that should be followed during incontinence care, CNA # 8

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stated, "I wash my hands, put on gloves, gather items for care. When I'm finished take off the gloves put them in trash bag tie up the bags linen and trash and take them to the shower room, there are linen and trash bins in the shower room, then wash my hands." When asked to describe the procedure for washing hands when using gloves, CNA # 8 stated, "Before you put them on and after you take them off each time." After being informed of the observation conducted on 05/23/18, CNA # 8 recalled and agreed that she should have changed her gloves several times throughout the process of providing incontinence care.

When asked to describe the positioning of a catheter collection bag, CNA # 8 stated, "The collection bag should not be on the floor, he (Resident #108) is a fall risk and I lowered the bed and didn't realize the bag was on the floor.

On 05/24/18 at approximately 5:55 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 type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

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(3) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(5) 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.

(6) There are many different forms of heart disease. The most common cause of heart disease is narrowing or blockage of the coronary arteries, the blood vessels that supply blood to the heart itself. This is called coronary artery disease and happens slowly over time. It's the major reason people have heart attacks. Other kinds of heart problems may happen to the valves in the heart, or the heart may not pump well and cause heart failure. Some people are born with heart disease. This information was obtained from the website:

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F 880	Continued From page 217 https://medlineplus.gov/heartdiseases.html. 2. The facility staff failed to wash or sanitize their hands in between administering medications to Resident #11, #99 and #15. Resident #11 was admitted to the facility on 2/5/15 and readmitted on 12/21/17 with diagnoses that included but were not limited to end stage renal disease, hypothyroidism, high blood pressure, and delusional disorders. Resident #11's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 2/27/18. Resident #11 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #99 was admitted to the facility on 3/1/18 with diagnoses that included but were not limited to muscle weakness, atrial fibrillation, high blood pressure and diabetes mellitus. Resident #99's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 5/3/18. Resident #99 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS. Resident #15 was admitted to the facility on 4/6/16 and readmitted on 4/27/17 with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), pain in the left shoulder, low back pain, diabetes mellitus, heart failure, and hypothyroidism. Resident #15's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 2/27/18.	F 880		

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Resident #15 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS.

On 5/23/18 at 5:00 p.m., medication administration observation was conducted with LPN (licensed practical nurse) # 1. At 5:05 p.m., LPN #1 applied gloves and started preparing medications for Resident #11. The following medications were prepared:

1) Renegal Tablet 800 mg
2) Vitamin C 500 mg

LPN #1 placed the medication in applesauce and then administered the medicine to Resident #11. LPN #1 then walked out of Resident #11's room, took off her gloves, and signed off that the medications were given on the eMAR (electronic medication administration record).

At 5:20 p.m., LPN #1 applied gloves and started preparing the following medication for Resident #99:

3) Metformin 500 mg tablet

LPN #1 did not sanitize or wash her hands prior to the administration of Metformin to Resident #99. LPN #1 removed her gloves after the administration of the Metformin and began to prepare medication for the next resident, Resident #15.

At 5:29 p.m., LPN #1 applied gloves and prepared the following medication for Resident #15:

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4) Humalog 8 units sliding scale insulin.

LPN #1 opened the container to the insulin and took out the insulin vial. LPN #1 drew up 8 units of Humalog and administered the medication to Resident #15. LPN #1 then removed her gloves. LPN #1 did not wash or sanitize her hands before and after the administration of Humalog.

On 5/24/18 12:15 p.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked how to maintain infection control during medication pass, LPN #2 stated that she would wash or sanitize her hands in-between giving medication to each resident. LPN #2 stated that gloves should also be worn for injections such as insulin. When asked if she would still wash her hands if she were wearing gloves during medication pass, LPN #2 stated that hands should always be washed or sanitized after gloves are removed.

On 5/24/18 at 12:58 p.m., an interview was conducted with LPN #4. When asked how to maintain infection control during medication pass, LPN #4 stated that she would wash or sanitizer her hands before and after medications were given. LPN #4 stated that she would do this even if she were wearing gloves when administering the medication.

On 5/24/18, LPN #1 could not be reached for an interview.

On 5/24/18 at 3:19 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

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The facility policy titled, "Medication Administration General guidelines," documents in part, the following: "Hands are washed with soap and water and gloves are applied before administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications. Hands are washed with soap and water again after administration and with any resident contact. Antimicrobial sanitizer may be used in place of soap and water as allowed per state nursing regulations and facility policy."

No further information was presented prior to exit.

(1) Renegal- is indicated for the control of serum phosphorus in patients with chronic kidney disease (CKD) on dialysis. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=5e30120b-f2bf-43a0-86b2-44ae996dc681

(2) Vitamin C, also known as L-ascorbic acid, is a water-soluble vitamin that is naturally present in some 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/VitaminC-HealthProfessional/

(3) Metformin is used to treat high blood sugar that are caused by a type of diabetes mellitus such as type two diabetes. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011121/?report=details

(4) Humalog is an insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. When given

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subcutaneously, HUMALOG has a more rapid onset of action and a shorter duration of action than regular human insulin. This information was obtained from The National Institutes of Health at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c5f75765-86b8-4926-b8c3-b42133ca7ac8.

3. The facility staff failed to sanitize the rubber top of a vial of insulin prior to the insertion of the syringe needle for Resident #15.

Resident #15 was admitted to the facility on 4/6/16 and readmitted on 4/27/17 with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), pain in the left shoulder, low back pain, diabetes mellitus, heart failure, and hypothyroidism. Resident #15's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 2/27/18. Resident #15 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS.

On 5/23/18 at 5:00 p.m., medication administration observation was conducted with LPN (licensed practical nurse) # 1. At 5:29 p.m., LPN #1 applied gloves and prepared the following medication for Resident #15:

1) Humalog 8 units sliding scale insulin.

LPN #1 opened the container to the insulin and took out the insulin vial. The insulin vial was not a new vial. LPN #1 did not sanitize the top of the vial prior to inserting the insulin needle. LPN #1

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drew up 8 units of Humalog and administered the medication to Resident #15.

On 5/24/18 at 12:58 p.m., an interview was conducted with LPN #4. When asked how she would maintain infection control while drawing up insulin, LPN #4 stated that if the resident did not have a new bottle of insulin, she would wipe the top with an alcohol swap before inserting the needle. LPN #4 stated that this was done to maintain infection control.

On 5/24/18, LPN #1 could not be reached for an interview.

On 5/24/18 at 3:19 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, "Medication Administration: Injectable Vials and Ampules," did not address the above concerns.

No further information was presented prior to exit.

(1) Humalog is an insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. When given subcutaneously, HUMALOG has a more rapid onset of action and a shorter duration of action than regular human insulin. This information was obtained from The National Institutes of Health at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c5f75765-86b8-4926-b8c3-b42133ca7ac8.

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