STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0118	A. BUILDING: _____ B. WING _____	04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL VIRGINIA BEACH	5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462

(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) COMPLETE DATE
F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 04/09/18 through 04/12/18. Three complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 86 at the time of the survey. The survey sample consisted of 22 current Resident reviews and 3 closed record reviews.	F 000	**RECEIVED** MAY 11 2018 **VDH/OLC**	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. POLICIES AND PROCEDURES 12 VAC 5-371-140 (A) Cross reference to F tag 607 RESIDENT ASSESSMENT AND CARE PLANNING 12 VAC 5-371-250 (A) Cross reference to F tag 641 12 VAC 5-371-250 (C, F, I) Cross reference to F tag 657 DIRECTOR OF NURSING 12 VAC 5-371-200 (B.1.ii) Cross reference to F	F 001	**F 001** **POLICIES AND PROCEDURES** **12 VAC 5-371-140 (A)** Cross Reference to F tag 607 Cross Reference POC for F 607 **RESIDENT ASSESSMENT AND CARE PLANNING** **12 VAC 5-371-250 (A)** Cross Reference to F tag 641 Cross Reference POC for F 641 **12 VAC 5-371-250 (C, F, I)** Cross Reference to F tag 657 Cross Reference POC for F 657 **DIRECTOR OF NURSING** **12 VAC 5-371-200 (B.1.ii)** Cross Reference to F tag 658 Cross Reference POC for F 658	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashley B. Jackson, LNHA | TITLE: Administrator | (X6) DATE: 5/10/18

State of Virginia

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F 001	Continued From page 1 tag 658 NURSING SERVICES 12 VAC 5-371-220 (A, B) Cross reference to F tag 684 12 VAC 5-371-220 (D) Cross reference to F tag 695 12 VAC 5-371-220 (A) Cross reference to F tag 757 and 758 PHARMACEUTICAL SERVICES 12 VAC 5-371-300 (A) Cross reference to F tag 755 12 VAC 5-371-300 (H) Cross reference to F tag 756 CLINICAL RECORDS 12 VAC 5-371-360 (A) Cross reference to F tag 842 INFECTION CONTROL 12 VAC 5-371-180 (A) Cross reference to F tag 880	F 001	**NURSING SERVICES** **12 VAC 5-371-220 (A, B)** Cross Reference to F tag 684 Cross Reference POC for F 684 **12 VAC 371-220 (D)** Cross Reference to F tag 695 Cross Reference POC for F695 **12 VAC 5-371-220 (A)** Cross Reference to F tag 757 and 758 Cross Reference POC for F 757 and F 758 **PHARMACEUTICAL SERVICES** **12 VAC 5-371-300 (A)** Cross Reference to F tag 755 Cross Reference POC for F 755 **12 VAC 5-371-300 (H)** Cross Reference to F tag 756 Cross Reference to POC for F 756 **CLINICAL RECORDS** **12 VAC 5-371-360 (A)** Cross Reference to F tag 842 Cross Reference to POC for F 756 **INFECTION CONTROL** **12 VAC 5-371-180 (A)** Cross Reference to F tag 880 Cross Reference POC for F 880 **Completion Date: May 25, 2018**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL VIRGINIA BEACH	5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/09/18 through 04/12/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Three complaint(s) were investigated during the survey. The census in this 90 certified bed facility was 86 at the time of the survey. The final survey sample consisted of 22 current Resident reviews and 3 closed record reviews.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/09/18 through 04/12/18. Three complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 86 at the time of the survey. The final survey sample consisted of 22 current Resident reviews and 3 closed record reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures	F 607	F607 **Corrective Action(s):** Employee #25 a contract physical therapist has had a background check completed by the appropriate state agency. A facility Incident & Accident form has been completed for this incident.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashley B. Jacobson, LNHA — TITLE: Administrator — (X6) DATE: 5/10/18

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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F 607	Continued From page 1 to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to obtain a criminal record background check through the Virginia State Police for 1 of 25 employees (employee #25). The findings included: The facility staff failed to obtain a criminal record background check through the Virginia State Police for employee #25-a contracted physical therapist. The surveyor reviewed 25 newly hired employee personnel files on 4/11/18. Employee #25 was hired on 3/10/17 as a physical therapist (PT). Employee #25's personnel file did not contain a criminal record background check. The surveyor interviewed the human resources director on 4/11/18 at 9:55 a.m. and asked the human resources director to review the file for the completion of the criminal record background check. The HR director stated she didn't see one and then stated contracted staff are responsible for completing their records. The surveyor informed the administrator and the administrator stated the concern would be addressed with the contracted staff. The surveyor requested the facility policy on hiring /screening of new employees on 4/11/18.	F 607	**Identification of Deficient Practices & Corrective Action(s):** All other contract employees may have been potentially affected. The Therapy Company Human Resources department will audit 100% of all active contract therapy employee records to identify employees at risk. Any/all negative findings will be corrected at the time of discovery. A Facility Incident and Accident Report will be completed for any/all negative findings. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The Contract Therapy Program manager was inserviced and issued a copy of the policy & procedure regarding abuse prevention and pre-employment procedures by the Administrator. Perspective employees will not be allowed to work until all required documentation has been obtained and verified by the Contract Therapy Program manager. **Monitoring:** The Administrator is responsible for maintaining compliance. The Administrator and/or Human Resources Director will conduct monthly audits of all new hire contract therapy employee files each month to maintain compliance. The administrator will review all audits and report aggregate findings to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure and/or facility practice. **Completion Date: May 25, 2018**	

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F 607	Continued From page 2 The surveyor reviewed the facility policy titled "Background Screening Investigations" on 4/12/18. The policy read in part "1. The Personnel/Human Resources Director, or other designee, will conduct employment background checks, reference checks and criminal conviction checks (including fingerprinting as may be required by state law) on persons making application for employment with this facility. Such investigation will be initiated within two days of employment or offer of employment." The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above finding in the end of the day meeting on 4/11/18 at 5:15 p.m. No further information was provided prior to exit on 4/12/18.	F 607		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to maintain accurate MDS assessments for 11 of 25 Residents (Residents #8, #26, #46, #85, #76, #79, #30, #41, #48, #50, and #70). The findings included. 1. For Resident #8, the facility staff failed to maintain an accurate MDS (minimum data set) assessment in regards to alarms.	F 641	**F641** **Corrective Action(s):** Resident #8 has had their most recent MDS modified to accurately code section P to reflect the use of a Chair and/or Bed alarm. A facility Incident & Accident form was completed for this incident. Resident #26 has had their most recent MDS modified to accurately code sections J for falls, section N for current medications in use & section O to accurately reflect the Flu Vaccine was offered in facility. A facility Incident & Accident form was completed for this incident.	

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F 641	Continued From page 3 The record review revealed that Resident #8 had been admitted to the facility 10/02/17. Diagnoses included, but were not limited to, dementia without behavioral disturbances, diabetes, hyperlipidemia, and chronic kidney disease. Section C (cognitive patterns) of the Residents quarterly MDS assessment with an ARD (assessment reference date) of 01/08/18 was coded 1/1/1 to indicate the Resident had problems with long and short term memory and had modified independence in cognitive skills for daily decision making. Section P (restraints) was not coded to indicate the Resident used a chair and/or bed alarm. The most current POS (physician order summary) included an order for bed/chair alarms the date of this order was documented as 10/29/17. The comprehensive care plan included the problem area of falls. Interventions included, but were not limited to Bed/chair alarm as ordered. On 4/10/18 at approximately 3:45 p.m., the surveyor interviewed the MDS coordinator. After reviewing the MDS, the coordinator verbalized to the surveyor that the MDS had been inaccurately coded in regards alarms. On 04/10/18 at approximately 4:00 p.m., the surveyor and an employee from the activity department checked the Residents chair alarm. The chair alarm was observed to be in working order. The administrative staff were notified of the issue	F 641	Resident #46 has had their most recent MDS modified to accurately code section N- Medications to reflect the correct number of days insulin was administered in the last 7 days. A facility Incident & Accident form was completed for this incident. Resident #85 has had their most recent Discharge MDS assessment modified to accurately reflect the discharge location of resident #85 to the Hospital at time of discharge. A facility Incident & Accident form was completed for this incident. Resident #76 has had their most recent MDS modified to accurately code section O to reflect the use of a Chair and/or Bed alarm. A facility Incident & Accident form was completed for this incident. Resident #79 has had their most recent MDS modified to accurately code section K to reflect the current weight and section P to reflect the use of a Trunk Restraint. A facility Incident & Accident form was completed for this incident. Resident #30 has had their most recent MDS modified to accurately code section I to reflect the accurate diagnosis of dementia for resident 30. A facility Incident & Accident form was completed for this incident. Resident #41 has had their most recent MDS modified to accurately code section I to reflect the accurate diagnosis of CHF and Hypertension. A facility Incident & Accident form was completed for this incident.	

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F 641	Continued From page 4 regarding the MDS assessment during a meeting with the survey team on 04/12/18 at 3:12 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #26, the facility staff failed to accurately code the MDS (minimum data set) assessment in regards to the medications aspirin and plavix, falls, and in regards to the Residents flu vaccine. The record review revealed that Resident #26 had been admitted to the facility 02/01/17. Diagnoses included but were not limited to, cerebral infarction, adult failure to thrive, essential hypertension, constipation, chronic rhinitis, and aphasia. Section C (cognitive patterns) of the Residents quarterly MDS assessment with an ARD (assessment reference date) of 02/02/18 included a BIMS (brief interview for mental status) summary score of 15. Section J (health conditions) had been coded to indicate the Resident has one fall. Section N (medications) had been coded to indicate the Resident was receiving anticoagulant medications. Section O (special treatments, procedures, and programs) had been coded to indicate the Resident was not offered a flu vaccine at the facility. A review of the Residents current physician orders revealed that the Resident was receiving the medications aspirin and plavix. Per the RAI (resident assessment instrument) manual aspirin and clopidogrel (plavix) are antiplatelet medications and were not to be coded as	F 641	Resident #48 has had their most recent MDS modified to accurately code O to reflect the flu vaccine was given outside the facility and section P to reflect the use of a Chair and/or Bed alarm. A facility Incident & Accident form was completed for this incident. Resident #70 has had their most recent MDS modified to accurately code section O to reflect the influenza vaccine was given outside the facility. A facility Incident & Accident form was completed for this incident. Resident #50 has had their most recent MDS modified to accurately code section M to accurately reflect a stage II pressure injury and section O to reflect her refusal of the influenza vaccine. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of all residents current MDS assessments will be completed by the MDS Coordinator and/or designee to ensure that sections I, J, K, N, O, P of the MDS's are coded correctly. All negative findings will be reported to the MDS department for immediate correction. A Modification will be completed for each discrepancy identified on the most current MDS.	

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F 641	Continued From page 5 anticoagulant medications. When reviewing the nursing notes the surveyor was able to find evidence of two falls one on 12/02/17 and another on 01/11/18. On 04/11/18 at approximately 8:20 a.m., the surveyor spoke with DON (director of nursing) regarding the flu vaccine. The DON verbalized to the surveyor that the flu vaccine information was sent to the family and at the time the MDS was completed and it had not been returned to the facility. So, the MDS was coded incorrectly. The DON stated a correction had been completed. The administrative staff were notified of the issue regarding the MDS assessment during a meeting with the survey team on 04/12/18 at 3:12 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. For Resident #46, the facility inaccurately coded the Residents MDS (minimum data set) assessment in regards to insulin. The clinical record review revealed that Resident #46 had been admitted to the facility 12/06/10. Diagnoses included, but were not limited to, multiple sclerosis, Alzheimer's disease, depression, generalized anxiety disorder, and diabetes. Section C (cognitive patterns) of the Residents quarterly MDS assessment with an ARD (assessment reference date) of 03/02/18 included a BIMS (brief interview for mental status) summary score of 12 out of a possible 15 points.	F 641	**Systemic Change(s):** The Resident Interdisciplinary Care Team have been inserviced by the Regional Nurse consultant on the proper assessment and coding of all sections of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of resident data. **Monitoring:** The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 25, 2018**	

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F 641	Continued From page 6 Section N (medications) had been coded to indicate the Resident had received insulin injections for 3 out of the last 7 days. A review of the Residents eMARs (electronic medication administration records) revealed that the Resident had received insulin for 7 of 7 the days coded on the MDS assessment. On 4/10/18 at approximately 12:10 p.m., the surveyor and the MDS coordinator reviewed the Residents MDS assessment and eMARs. After this review the MDS coordinator verbalized to the surveyor that the MDS had been miscoded in regards to insulin injections. The administrative staff were notified of the issue regarding the MDS assessment during a meeting with the survey team on 04/12/18 at 3:12 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #85, the facility staff to accurately code the Residents MDS (minimum data set) assessment in regards to the Residents discharge from the facility. The record review revealed that Resident #85 had been admitted to the facility 02/16/18 and was discharged to an acute care hospital on 02/20/18. Diagnoses included, but were not limited to, atrial fibrillation, coronary artery disease, chronic obstructive pulmonary disease, and hypertension Section C (cognitive patterns) of the Residents	F 641		

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F 641	Continued From page 7 discharge MDS assessment with an ARD (assessment reference date) of 02/20/18 included a BIMS (brief interview for mental status) summary score of 0 out of a possible 15 points and had been coded to indicate the Resident had been discharged to the community. The discharge summary signed by the physician (02/22/18) revealed that Resident #85's discharge diagnosis was septic shock and he had been admitted to an ICU (intensive care unit). On 04/12/18 at 10:38 a.m., the surveyor reviewed this MDS with the MDS coordinator. After reviewing this MDS, the MDS coordinator verbalized to the surveyor that it had been coded inaccurately. The administrative staff were notified of the issue regarding the MDS assessment during a meeting with the survey team on 04/12/18 at 3:12 p.m. Prior to the exit conference the MDS coordinator provided the surveyor with a corrected copy of the MDS indicating the Resident had been discharged to an acute hospital. No further information regarding this issue was provided to the survey team prior to the exit conference. 5. The facility staff failed to maintain an accurate MDS (Minimum Data Set) assessment for Resident #76. Resident #76 was readmitted to the facility on 2/14/18 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia, seizure disorder and depression.	F 641		

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F 641	Continued From page 8 On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/26/18; the resident was coded as having short term and long-term memory loss and being moderately impaired in making daily decisions. Resident #76 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing. The surveyor performed a review of Resident #76's clinical record on 4/10/18. During this review, it was noted by the surveyor that Resident #76 had the following physician order: ..."Resident to wear clip alarm while in bed and in wc (wheelchair) ..." The resident's care plan was updated with a date of "12/26" which had the intervention of " ...alarms as ordered ..." for the problem of "At risk for falls with injury ..." The resident's MDS with ARD of 2/26/18 coded the resident under Section P, P0200, Alarms, as a "0" for bed and chair alarms being used. On 4/10/18 at approximately 2 pm, the surveyor asked MDS nurse #1 if bed and chair alarms should be coded on Resident #76 when the resident has an order as documented above. The MDS nurse #1 stated, "I will have to check and get back to you on this." The surveyor notified the administrative team of the above documented findings on 4/10/18 at 4:58 pm. On 4/11/18 at 7:45 am, the surveyor was provided a copy of the corrected MDS with bed and chair alarms being coded as "2" which means that the device was used daily. No further information was provided to the surveyor prior to the exit conference on 4/13/18.	F 641		

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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 641	Continued From page 9 6. The facility staff failed to maintain an accurate MDS (Minimum Data Set) assessment for Resident #79. Resident #79 was readmitted to the facility on 3/12/18 with the following diagnoses of, but not limited to high blood pressure, diabetes, stroke, depression and Chronic Obstructive Pulmonary Disease. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/24/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 5 out of a possible score of 15. Resident #79 was also coded as requiring extensive assistance of 1 staff member for dressing and personal care and being totally dependent on 1 staff member for bathing. The surveyor went into the resident's room on 4/11/18 at approximately 11:30 am. The surveyor observed the resident to be sitting up in his wheelchair with a lap belt tied around the resident's waist to the back of the wheelchair. The resident's representative was also in the room at the time this observation was made. The surveyor asked the representative if the resident could untie the lap belt. The representative stated in a whisper, "He can't get to it. It's done that way so that he can't wander off anymore." The surveyor asked the resident if he could undo the lap belt that was around his waist and he looked puzzled as to what the surveyor had asked him to do. The resident did not respond to the surveyor. The surveyor performed a review of Resident	F 641		

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#79's clinical record on 4/11/18. During this review, the surveyor noted on the MDS with ARD of 3/24/18, documented the resident's weight, under Section K, as 50 pounds. Also on the same MDS, the resident was not coded for the use of a restraint, under Section P, P0100. The surveyor reviewed the vital signs tab in the electronic clinical record and the weight documented on 3/12/18 was 150.2 pounds.

At 3:15 pm, the surveyor notified the MDS nurse #1 of the above documented findings.
On 4/11/18 at 5:15 pm, the surveyor notified the administrative team of the above documented findings of the incorrect weight on the MDS.

The surveyor was provided copies of the corrected MDS which had the resident's weight documented as 154 pounds in Section K and also had a trunk restraint coded in Section P as being used daily. These copies were left lying on the conference room table when the surveyor arrived to the facility on 4/12/18 at 7:45 am.

No further information was provided to the surveyor prior to the exit conference on 4/12/18.
7. For Resident #30 the facility staff failed to code diagnoses in Section I of the MDS.

Resident #30 was admitted to the facility on 08/08/16. Diagnoses included but not limited to anemia, thrombocytopenia, hyperlipidemia, dementia, depression, insomnia, tachycardia, chronic obstructive pulmonary disease, dysphagia, and osteoporosis.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/09/18 coded the Resident as 15 of 15 in section C,

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cognitive status. Section I of the MDS listed diagnoses as depression and asthma. This is a quarterly MDS.

Resident #30's clinical record was reviewed on 04/10/18 at approximately 1000. It contained a physician's order summary for the month of April, which read in part "Memantine HCl 10mg tablet- 1 tab by mouth 2 times a day dx (diagnosis) dementia" and "Aricept 10 mg tablet PO (by mouth) at bedtime Dx: dementia". The physician's order summary had diagnoses listed as dysphagia, chronic obstructive pulmonary disease, thrombocytopenia, hyperlipidemia, and mood disorder.

The surveyor requested and was provided with a diagnosis list for Resident #30. Diagnoses were listed as thrombocytopenia, hyperlipidemia, unspecified dementia without behavioral disturbance, major depressive disorder, recurrent, mild, insomnia, unspecified, chronic obstructive pulmonary disease w acute lower resp infc (respiratory infection), and dysphagia.

The surveyor spoke with MDS coordinator on 04/10/18 at approximately 1030 regarding Resident #30's diagnoses. Surveyor asked MDS coordinator specifically if the diagnosis of dementia should have been coded on the MDS, and MDS coordinator stated that it should have.

The concern of the inaccurate MDS was discussed with the administrative team during a meeting on 04/10/18 at approximately 1655.

No further information was provided prior to exit.

8. For Resident #41 the facility staff failed to code

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F 641	Continued From page 12 diagnoses in Section I of the MDS. Resident #41 was admitted to the facility on Diagnoses included but not limited to morbid obesity, spinal stenosis, chronic obstructive pulmonary disease, hypokalemia, congestive heart failure, sleep apnea, hypertension, and depression. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/16/18 coded the Resident as 15 of 15 in section C, cognitive status. Section I, active diagnoses, of this MDS listed diagnoses as depression and asthma with additional diagnoses listed as morbid obesity, spinal stenosis, spondylosis and muscle weakness. This is a quarterly MDS. The Resident's clinical record was reviewed on 04/11/18. It contained a physician's order summary for the month of April, which read in part "furosemide 40 mg tablet 1 tab PO (by mouth) daily -CHF (congestive heart failure)" and "Lisinopril 10 mg tablet-take one tab PO QD (every day), DX (diagnosis): HTN (hypertension)". Diagnoses on the physician's order summary were listed as spinal stenosis, morbid obesity, arthropathy, unspecified asthma, hypokalemia, acute on chronic systolic (congestive) heart failure, and major depressive disorder. Surveyor spoke with MDS coordinator on 04/12/18 at approximately 0935 regarding Resident #41's MDS. Surveyor asked MDS coordinator should the diagnoses listed on the physician's order summary be coded on the MDS and MDS coordinator stated "Let me investigate before I answer that".	F 641		

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F 641	Continued From page 13 On 04/12/18 at approximately 1015 the MDS coordinator provided the surveyor with a copy of section I of the Resident's MDS depression and asthma with additional diagnoses listed as morbid obesity, spinal stenosis, spondylosis and muscle weakness and stated that she had made a correction. The diagnoses listed on the corrected MDS were depression and asthma with additional diagnoses listed as morbid obesity, spinal stenosis, spondylosis and muscle weakness. This was the same as the original MDS. The concern of the incorrect MDS was discussed with the administrative team during a meeting on 04/12/18 at approximately 1510. No further information was provided prior to exit. 9. The facility staff failed to accurately code Section O (Special Treatment, Procedures, and Programs) and Section P (Restraints) on Resident #48's quarterly minimum data set (MDS) assessment. The clinical record of Resident #48 was reviewed 4/9/18 through 4/12/18. Resident #48 was admitted to the facility 11/28/17 with diagnoses, that included but not limited to Alzheimer's disease, dementia with behavioral disturbances, major depressive disorder, anxiety, adult failure to thrive, and history of falling. Resident #48's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/5/18 assessed the resident with long-term memory problems, short-term memory problems, and moderately impaired cognitive skills for daily decision-making. No identified indicators of psychosis, delirium, or	F 641		

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behaviors.

(a) The facility staff failed to accurately code Section O Special Treatment, Procedures, and Programs on Resident #48's quarterly MDS.

Section O Special Treatment, Procedures, and Programs was reviewed. Influenza Vaccine (O0250 A, B, and C) was reviewed. Section A read "Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season?" The question was answered "No" with instructions to skip to O0250C, If influenza vaccine not received, state reason. Section C was marked "5. Not offered." Information about the influenza vaccinations were kept with the director of nurses.
The surveyor requested information when Resident #48's influenza vaccination had been administered. The "Immunization List" for Resident #48 documented the resident had the influenza vaccination on 10/1/17 prior to admission to the facility.

Section C options also included: 1. Resident not in this facility during this year's influenza vaccination season. 2. Resident received outside of this facility. 3. Not eligible-medical contraindication 4. Offered and declined. 5. Not offered. 6. Inability to obtain influenza vaccine due to a declared shortage. 9. None of the above."

Resident #48 received the influenza vaccination outside of the facility; therefore, option 2 should have been marked/coded.
The surveyor interviewed minimum data set (MDS) assessment licensed practical nurse #1 on 4/11/18. MDS/LPN #1 stated the information in

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F 641	Continued From page 15 Section O about the influenza vaccination was incorrect and stated a correction would be done. (b). The facility staff failed to accurately code Section P Restraints on Resident #48's quarterly MDS with ARD of 3/5/18. Resident #48's December 2017 through April 2018 physician's order sheets had an order dated 12/5/17 that resident was to wear a clip alarm at all times for safety. A review of Section P Restraints and specifically P0200 Alarms did not have any type of alarm coded-bed, chair, floor mat, motion sensor, wander/elopement, and other alarm. The surveyor did observe Resident #48 on the morning of 4/10/18 at 8:53 a.m. sitting in a high back wheelchair in the TV area with a clip alarm attached from the back of the wheelchair to the resident's clothing. The unit manager licensed practical nurse #1 checked the alarm to ensure the alarm was working and the alarm sounded when activated. The surveyor interviewed the minimum data set (MDS) licensed practical nurse #1 on 4/10/18 at 3:53 p.m. regarding the coding of the clip alarm on the MDS. MDS/LPN #1 stated she had no documentation in the 7-day look back period to support the coding for the alarms. MDS/LPN #1 stated a correction of the quarterly MDS would be done. The surveyor informed the administrator and the director of nursing of the inaccurate coding on Resident #48's quarterly MDS in the end of the day meeting on 4/10/18 at 4:55 p.m., again on 4/11/18 at 5:15 p.m. and on 4/12/18 at 3:12 p.m.	F 641		

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F 641	Continued From page 16 No further information was provided prior to the exit conference on 4/12/18. 10. The facility staff failed to accurately code Section O Special Treatments, Procedures and Programs on Resident #70's admission minimum data set (MDS) assessment with assessment reference date (ARD) of 2/26/18 and the 14 day MDS with an ARD of 3/3/18. The clinical record of Resident #70 was reviewed 4/9/18 through 4/12/18. Resident #70 was admitted to the facility 2/19/18 with diagnoses that included but not limited to atrial fibrillation, bradycardia, hypokalemia, long QT syndrome, enterocolitis due to Clostridium difficile, anxiety disorder, chronic obstructive pulmonary disease, hyperlipidemia, pulmonary hypertension, Takotsubo syndrome, diverticulum of the esophagus, left ventricular failure, acute on chronic systolic heart failure, and anorexia. Both the 5 day and 14 day MDS coded the resident with a brief interview for mental status as a 15. The "Resident Immunization Record" for Resident #70 documented that the resident received the influenza vaccination on 12/17/17 per the daughter (dated 3/8/18). A review of Section O on the 5-day and 14 day MDS was coded with a 1. 1 read "Resident not in this facility during this year's influenza vaccination season." The surveyor interviewed the director of nursing on 4/10/18 at 11:22 a.m. regarding what the influenza season was for the facility. The DON stated the flu season was October 1st through	F 641		

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F 641	Continued From page 17 March 31st. The surveyor interviewed the minimum data set assessment licensed practical nurse #1 on 4/10/18 at 1:59 p.m. regarding the coding of Section O on the 5-day and 14 day MDS. MDS/LPN #1 stated, "I'll modify it. Flu season ends in December 2017. Daughter brought evidence of flu during a care plan meeting on 3/8/18. Will do modifications." The surveyor informed the administrator and the director of nursing of the above coding issue during the end of the day meeting on 4/10/18 at 4:55 p.m., 4/11/18 at 5:15 p.m. and again on 4/12/18 at 3:15 p.m. No further information was provided prior to the exit conference on 4/12/18. 11. The facility staff failed to accurately code Section M and Section O on Resident #50's 60 day minimum data set MDS) assessment with an assessment reference date (ARD) of 3/7/18. The clinical record of Resident #50 was reviewed 4/9/18 through 4/12/18. Resident #50 was admitted to the facility 5/6/09 and readmitted 1/10/18 with diagnoses that included but not limited to hemiplegia following cerebral vascular accident affecting unspecified side, adult failure to thrive, B12 nutritional deficiency, cognitive communication deficit, depressive disorder, adrenocortical insufficiency, aphasia, hypertension, nontoxic multinodal goiter, hypothyroidism, bilateral deep vein thrombosis, hypoxia, dementia, and anemia. Resident #50's 60 day minimum data set (MDS)	F 641		

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F 641	Continued From page 18 assessment with an assessment reference date (ARD) of 3/7/18 assessed the resident with short-term memory problems, long-term memory problems and moderately impaired cognitive skills for daily decision making. No indicators of delirium, behaviors or psychosis. (a). The facility failed to accurately code a stage 2 pressure ulcer in Section M Skin Conditions on the 60 day MDS with ARD of 3/7/18. The surveyor reviewed the wound care doctor's progress note dated 2/28/18. The note read "Pressure Wound of the Right Heel pressure stage 2 duration greater than 1 day, healing, manage pain and Pressure Ulcer sacrum pressure stage 2 duration greater than 1 day, healing manage pain." Section M Skin Conditions and specifically Section M0150 Risk of Pressure Ulcers was coded resident was at risk of developing pressure ulcers. M0210 Unhealed pressure ulcer(s) was coded with a "0"-does this resident have one or more unhealed pressure ulcer (s) at stage 1 or higher. The code was 0 with instructions to skip to M0900, Healed Pressure Ulcers. The surveyor interviewed the minimum data set (MDS) assessment licensed practical nurse #1 on 4/12/18. MDS/LPN #1 stated the area was coded as moisture associated skin damage. MDS/LPN #1 stated she would do a correction as Section M was not accurately coded. (b). The facility failed to accurately code the influenza vaccine in Section O Special Treatments, Procedures and Programs. Section O Special Treatments, Procedures and	F 641		

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F 641	Continued From page 19 Programs was reviewed. Section O0250 Influenza Vaccine was coded 0 and instructions to skip to O0250C, If influenza vaccine not received, state reason. Section C was coded "5"-not offered. The surveyor was unable to locate immunization record for Resident #50. The facility provided the discharge summary notes from Resident #50's discharge dated 12/5/17. The discharge summary read "Influenza Vaccine-Patient refused". Section C options also included: 1. Resident not in this facility during this year's influenza vaccination season. 2. Resident received outside of this facility. 3. Not eligible-medical contraindication 4. Offered and declined. 5. Not offered. 6. Inability to obtain influenza vaccine due to a declared shortage. 9. None of the above." The surveyor interviewed MDS/LPN on 4/11/18 at 4:56 p.m. regarding coding for the influenza vaccine. MDS/LPN #1 stated she would correct Section O. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse in the end of the day meeting on 4/11/18 at 5:15 p.m. and again on 4/12/18 at 3:15 p.m. No further information was provided prior to the exit conference on 4/12/18.	F 641		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655		

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F 655	Continued From page 20 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. (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	F 655	F655 **Corrective Action(s):** Resident #65, #67, #76, #184, #79, #50, #70, #134, #136, #45, #234 and #284's attending physicians and RP's were notified that the facility failed to provide a written summary of their base line care plan to the residents or their RP's at the time of admission. **Identification of Deficient Practices & Corrective Action(s):** All newly admitted residents may have potentially been affected. A 100% review of all new admissions in the last 30 days will be conducted by the DON, RCC and/or designee to identify residents who did not receive a written summary of their baseline comprehensive care plan All residents and RP's identified that did not received a written summary of their baseline comprehensive care plan will have their care plan reviewed and updated and a written summary of their resident centered care plan will be reviewed and given to the Residents and RP's identified. A Facility Incident & Accident Form will be completed for each incident identified.	

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F 655	Continued From page 21 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 and clinical record review, the facility staff failed to provide the resident and/or their representative with a summary of the baseline care plan for 12 of 25 Residents in the survey sample (Resident #65, #67, #76, #184, #79, #50, #70, #134, #136, #45, #234 and #284). The findings included: 1. The facility staff failed to provide the resident and representative with a summary of the baseline care plan for Resident #65. Resident #65 was readmitted to the facility on 12/22/17 with the following diagnoses of, but not limited to diabetes, Multiple Sclerosis, Manic Depression and Psychotic Disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/28/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #65 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing. The surveyor performed a clinical record review on 4/11and 4/12/18 on Resident #65. It was noted by the surveyor that no documentation was in the clinical record that stated the baseline care plan for Resident #65 was given to the resident and representative when the resident was	F 655	**Systemic Changes:** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise base line care plans within 48 hours of admission to the facility and a written summary will be given to the Resident and RP. The RCC and IDT will be inserviced by the regional nurse consultant on the development and review of the baseline as well as the process for reviewing the base line care plan with residents and RP's. **Monitoring:** The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits on all new admissions 48 hours after admission to ensure a base line care plan has been completed timely and that a written summary has been completed and reviewed with the resident and/or RP. Any/all negative findings will be reported to the RCC for immediate correction. Detailed findings of the Care Plan audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 25, 2018**	

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F 655	Continued From page 22 readmitted to the facility on 12/22/17. The surveyor notified MDS nurse #1 of the above documented findings on 4/12/18 at 2 pm. The MDS nurse #1 stated, ""I didn't know that I should had been doing them." The surveyor notified the administrative team of the above documented findings on 4/12/18 at 3:12 pm. No further information was provided to the surveyor prior to the exit conference on 4/12/18. 2. The facility failed to provide the resident and representative with a summary of the baseline care plan for Resident #67. Resident #67 was readmitted to the facility on 1/10/18 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, Alzheimer's disease, dementia, Parkinson's disease, anxiety disorder, depression, manic depression and Chronic Obstructive Pulmonary Disease. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/22/18 coded the resident with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #67 was also coded as requiring limited assistance of 1 staff member for dressing and extensive assistance of 1 staff member for personal hygiene. Resident #67 was also coded as being totally dependent on 1 staff member for bathing. The surveyor performed a clinical record review on Resident #67 on 4/10/18. It was noted by the surveyor that no documentation was in the clinical record that stated the baseline care plan for	F 655		

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F 655	Continued From page 23 Resident #67 was given to the resident and representative when the resident was readmitted to the facility on 1/10/18. During the resident interview conducted by the surveyor on 4/10/18 at 9:57 am, the resident stated when asked by the surveyor if she was given a copy of the baseline care plan when she was readmitted to the facility in January, "I don't remember." The surveyor notified MDS nurse #1 of the above documented findings on 4/10/18 at approximately 11:15 am in the conference room. The MDS nurse #1 stated, "I didn't know that I should had been doing them. I was notified of the change but I didn't thoroughly understand it at the time." The surveyor notified the administrative team on 4/10/18 at 4:58 pm and on 4/12/18 at 3:12 pm of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 4/12/18. 3. The facility failed to provide the resident and representative with a summary of the baseline care plan for Resident #76. Resident #76 was readmitted to the facility on 2/14/18 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia, seizure disorder and depression. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/26/18; the resident was coded as having short term and long-term memory loss and being moderately impaired in making daily decisions. Resident #76 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing.	F 655		

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F 655	Continued From page 24 The surveyor performed a review of Resident #76's clinical record on 4/10/18. During the clinical record review, the surveyor did not find any documentation that the baseline care plan was given to the resident and representative at the time of readmission to the facility on 2/14/18. The surveyor notified MDS nurse #1 of the above documented findings on 4/10/18 at approximately 11:15 am in the conference room. The MDS nurse #1 stated, "I didn't know that I should had been doing them. I was notified of the change but I didn't thoroughly understand it at the time." The surveyor notified the administrative team on 4/10/18 at 4:58 pm and on 4/12/18 at 3:12 pm of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 4/12/18. 4. The facility failed to provide the resident and representative with a summary of the baseline care plan for Resident #184. Resident #184 was admitted to the facility on 4/6/18 with the following diagnoses of, but not limited to sepsis, cerebral aneurysm, enterocolitis related to C-Diff, malignant neoplasm of lung, high blood pressure and malignant neoplasm of the brain. The admission MDS (Minimum Data Set) had not been completed at the time of this survey in the nursing facility. According to the admission nursing assessment dated for 4/6/18, it was documented that the resident is alert and oriented. It was also documented that Resident #184 requires extensive assistance of 1 staff member for transfers, walking, personal hygiene	F 655		

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F 655	Continued From page 25 and bathing. During the clinical record review performed by the surveyor on 4/11 and 4/12/18, it was noted that there was no documentation of the baseline care plan being given to the resident and representative when the resident was admitted to the facility on 4/6/18. The surveyor had previously notified MDS nurse #1 on 4/10/18 at approximately 11:15 am in the conference room of no documentation concerning baseline care plans being given to the resident and representative when a resident was admitted or readmitted to the facility. At that time the MDS nurse #1 stated, "I didn't know that I should had been doing them. I was notified of the change but I didn't thoroughly understand it at the time." The surveyor notified the administrative team on 4/12/18 at 3:12 pm of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 4/12/18. 5. The facility failed to provide the resident and representative with a summary of the baseline care plan for Resident #79. Resident #79 was readmitted to the facility on 3/12/18 with the following diagnoses of, but not limited to high blood pressure, diabetes, stroke, depression and Chronic Obstructive Pulmonary Disease. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/24/18 the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 5 out of a possible score of 15. The resident was also	F 655		

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coded as requiring extensive assistance of 1 staff member for dressing and personal care and being totally dependent on 1 staff member for bathing.

The surveyor performed a review of Resident #79's clinical record on 4/11/18. During this review, it was noted by the surveyor that there was no documentation of the baseline care plan being given to the resident and representative when the resident was readmitted to the facility on 3/12/18.

The surveyor had previously notified MDS nurse #1 on 4/10/18 at approximately 11:15 am in the conference room of no documentation concerning baseline care plans being given to the resident and representative when a resident was admitted or readmitted to the facility. At that time the MDS nurse #1 stated, "I didn't know that I should had been doing them. I was notified of the change but I didn't thoroughly understand it at the time."

The surveyor notified the administrative team on 4/12/18 at 3:12 pm of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 4/12/18.
6. The facility staff failed to provide Resident #70 or Resident #70's representative with a copy of the baseline care plan.

The clinical record of Resident #70 was reviewed 4/9/18 through 4/12/18. Resident #70 was admitted to the facility 2/19/18 with diagnoses that included but not limited to atrial fibrillation, bradycardia, hypokalemia, long QT syndrome, enterocolitis due to Clostridium difficle, anxiety

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disorder, chronic obstructive pulmonary disease, hyperlipidemia, pulmonary hypertension, Takotsubo syndrome, diverticulum of the esophagus, left ventricular failure, acute on chronic systolic heart failure, and anorexia.

Both the 5 day and 14 day MDS coded the resident with a brief interview for mental status as a 15.

The surveyor interviewed Resident #70 on 4/10/18 at 11:00 a.m. The surveyor asked the resident if the facility gave her a copy of her admission or baseline care plan. Resident #70 didn't recall getting one.

The surveyor interviewed the minimum data set (MDS) assessment licensed practical nurse #1 4/10/18. MDS/LPN #1 stated she had not done any baseline care plans on any residents and stated she had heard about doing them but had not read about it thoroughly.

The surveyor informed the administrator and the director of nursing of the above concern during the end of the day meeting on 4/11/18 at 5:15 p.m. and again on 4/12/18 at 3:15 p.m.

No further information was provided prior to the exit conference on 4/12/18.

7. The facility staff failed to provide Resident #134 or Resident #134's representative a copy of the baseline care plan.

The clinical record of Resident #134 was reviewed 4/9/18 through 4/12/18. Resident #134 was admitted to the facility 6/29/10 and readmitted 3/26/18 with diagnoses that included

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F 655	Continued From page 28 but not limited to status-post left above the knee amputation due to infected left knee hardware, chronic non-ambulation, osteoarthritis of knee, asthma, hypothyroidism, Alzheimer's disease, hyperlipidemia, glaucoma, chronic obstructive pulmonary disease, dementia without behavioral disturbances, hypertension, angina pectoris, cardiac pacemaker, blindness right eye, urine retention, and coronary artery disease. Resident #134's 5 day admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/2/18 assessed the resident with short-term memory problems, long-term memory problems, and moderately impaired cognitive skills for daily decision making. The surveyor reviewed the current comprehensive care plan dated 3/26/18 found in the clinical record; however, the baseline care plan was unable to be located. The surveyor interviewed Resident #134's daughter on 4/11/18 at 10:47 a.m. The daughter stated a baseline care plan was not given to her when her mom was readmitted 3/26/18. The surveyor interviewed the minimum data set (MDS) licensed practical nurse #1 on 4/11/18 at 4:56 p.m. MDS/LPN #1 stated she did not do any baseline care plans for any of the residents. The surveyor informed the administrator and the director of nursing of the above concern during the end of the day meeting on 4/11/18 at 5:15 p.m. and again on 4/12/18 at 3:15 p.m. No further information was provided prior to the exit conference on 4/12/18.	F 655		

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F 655	Continued From page 29 8. The facility staff failed to provide Resident #136 or Resident #136's representative a copy of the baseline care plan. The surveyor reviewed Resident #136's clinical record 4/9/18 through 4/12/18. Resident #136 was admitted to the facility 4/1/18 with diagnoses that included but not limited to hypertension, urinary tract infection, chronic obstructive pulmonary disease, radiculopathy, trochanteric bursitis, morbid obesity, right artificial hip joint, osteoarthritis, gastrointestinal hemorrhage, sleep apnea, depressive disorder, iron deficiency anemia, and venous thrombosis and embolus. Resident #136's admission minimum data set (MDS) had not yet been completed. The clinical record contained a baseline care plan dated 4/2/18. Instructions at the top of the baseline care plan read "The Baseline Care Plan must be developed within the first 48 hours of admission to the facility. The Baseline Care Plan must reflect the resident's stated goals and preferences and include interventions that address his/her current needs. Complete all sections. Signatures are required as designated." The baseline care plan did not have a signature of the resident or the resident representative. The only signature was that of the minimum data set licensed practical nurse #1 and dated 4/3/18. The surveyor interviewed Resident #136 on 4/10/18 at 4:00 p.m. Resident #136 stated she did not recall receiving a care plan when first admitted. The surveyor interviewed the minimum data set	F 655		

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(MDS) assessment licensed practical nurse #1 on 4/10/18 at 4:56 p.m. MDS/LPN #1 stated she did not complete a baseline care plan on any of the residents.

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 4/11/18 at 5:15 p.m. and again on 4/12/18 at 3:12 p.m.

No further information was provided prior to the exit conference on 4/12/18.

9. The facility staff failed to provide Resident #50 or Resident #50's representative a copy of the baseline care plan.

The clinical record of Resident #50 was reviewed 4/9/18 through 4/12/18. Resident #50 was admitted to the facility 5/6/09 and readmitted 1/10/18 with diagnoses that included but not limited to hemiplegia following cerebral vascular accident affecting unspecified side, adult failure to thrive, B12 nutritional deficiency, cognitive communication deficit, depressive disorder, adrenocortical insufficiency, aphasia, hypertension, nontoxic multinodal goiter, hypothyroidism, bilateral deep vein thrombosis, hypoxia, dementia, and anemia.

Resident #50's 60 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/7/18 assessed the resident with short-term memory problems, long-term memory problems and moderately impaired cognitive skills for daily decision making. No indicators of delirium, behaviors or psychosis.

The surveyor reviewed the current

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F 655	Continued From page 31 comprehensive care plan dated 1/10/18. However, the surveyor was unable to locate a copy of the baseline care plan in the clinical record. The surveyor interviewed the minimum data set (MDS) assessment licensed practical nurse #1 on 4/10/18 at 4:56 p.m. MDS/LPN #1 stated she did not complete a baseline care plan on any of the residents. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern on 4/11/18 at 5:15 p.m. and again on 4/12/18 at 3:15 p.m. No further information was provided prior to the exit conference on 4/12/18. 10. For Resident #45, the facility staff failed to provide the Resident and/or representative with a summary of the baseline care plan. The record review revealed that Resident #45 had been admitted to the facility 01/31/18. Diagnoses included, but were not limited to, diabetes, depression, hypertension, and chronic obstructive pulmonary disease. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/07/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. During an interview with the MDS coordinator on 04/12/18 at approximately 9:25 a.m., the MDS coordinator verbalized to the surveyor that she had not provided the Resident and/or	F 655		

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F 655	Continued From page 32 representative with a summary of the baseline care plan, as she was not aware that she needed to. The administrative staff was notified of the issues regarding the Residents baseline care plan on 04/12/18 at approximately 3:12 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 11. For Resident #234, the facility staff failed to provide the Resident and/or representative with a summary of the baseline care plan. The record review revealed that Resident #234 had been admitted to the facility 03/28/18. Diagnoses included, but were not limited to, atrial fibrillation, osteoarthritis, functional quadriplegia, and hypertension. There was no MDS (minimum data set) assessment information completed on this Resident. During an interview with the MDS coordinator on 04/11/18 at approximately 10:35 a.m., the MDS coordinator verbalized to the surveyor that she had not provided the Resident and/or representative with a summary of the baseline care plan, as she was not aware that she needed to. The administrative staff was notified of the issues regarding the Residents baseline care plan on 04/12/18 at approximately 3:12 p.m. No further information regarding his issue was	F 655		

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F 655	Continued From page 33 provided to the survey team prior to the exit conference. 12. For Resident #284, the facility staff failed to provide a written copy of the baseline care plan. Resident #284 was admitted to the facility 04/07/18. Diagnoses included but not limited to cerebral infarction, hypertension and aphasia. The Resident was a new admit and had not had a MDS (minimum data set) completed, but was assessed to be alert and oriented. The surveyor spoke with the MDS coordinator and requested a copy of the Resident's baseline care plan on 04/10/18 at approximately 0915. The surveyor could not locate any evidence that a written summary of the care plan had been provided to the Resident or the Resident's representative. Surveyor spoke with the MDS coordinator on 04/101/8 at approximately 0945 regarding providing a summary of the baseline care plan. MDS coordinator stated the Resident/representative had not been provided a summary of the care plan. Also stated that she had heard about this, but had not read about it thoroughly. The concern of not providing the Resident with a copy of the baseline care plan was discussed with the administrative team during a meeting on 04/101/8 at approximately 1655. No further information was provided prior to exit.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

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F 657	Continued From page 34 §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, the facility staff failed to review and revise the Comprehensive Resident Centered Care Plan for 2 of 25 residents in the survey sample (Resident #67 and #10). The findings included: 1. The facility staff failed to review and revise the	F 657	**F-657** **Corrective Action(s):** Resident #67's comprehensive cares plan has been reviewed and revised to reflect their current problems, goals and approaches/interventions to meet the residents specific medical and resident centered needs. A Facility Incident & Accident Form was completed for this incident. Resident #10's comprehensive cares plan has been reviewed and revised to reflect the use of a divided plate for all meals. A Risk Management Incident & Accident Form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** Any/all residents may have potentially been affected. A 100% review of all resident comprehensive care plans will be conducted by the RCC and/or designee to identify residents at risk. Residents identified at risk as having an inaccurate comprehensive care plan will be corrected at time of discovery and a Risk Management Incident & Accident Form will be completed for each incident identified.	

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F 657	Continued From page 35 Comprehensive Resident Centered Care Plan for Resident #67. Resident #67 was readmitted to the facility on 1/10/18 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, Alzheimer's disease, dementia, Parkinson's disease, anxiety disorder, depression, manic depression and Chronic Obstructive Pulmonary Disease. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/22/18 coded the resident with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #67 was also coded as requiring limited assistance of 1 staff member for dressing and extensive assistance of 1 staff member for personal hygiene. Resident #67 was as being totally dependent on 1 staff member for bathing. The surveyor performed a review of Resident #67's clinical record on 4/10 and 4/11/18. During this review, it was noted by the surveyor that on the comprehensive care plan the following areas of the care plan did not have a revise and review date. There were: " "Impaired Vision" with a "Problem Onset" date of 8/12/15 " "Allergic to Iodine, Iron salts, Toprol, has intolerance to Ultram, and Remeron, Codeine, Fish" with a 'Problem Onset" of 8/19/14 " "ADL (Activities of Daily Living) r/t (related to) inability to maintain ADLs at satisfactory level as evidenced by need of staff assist d/t (due to) dx. (disease) of Dementia, Pain, Depression, Parkinson's', Depression, Anxiety, ...Anemia, ...Poor Vision, and hx (history of) Pleural Effusion ...with a "Problem Onset" of 12/31/13 and has a	F 657	**Systemic Changes:** The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comprehensive assessment and/or revisions to the comprehensive care plan as indicated with any changes in resident condition. **Monitoring:** The RCC and DON are responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 25, 2018**	

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F 657	Continued From page 36 revision date of 3/17/17 " "At risk for Falls ..." with a "Problem Onset" of 8/19/14 " "High risk for increase bleeding and bruising r/t use of Blood thinning agent ..." with a "Problem Onset" of 8/19/14 The surveyor interviewed MDS nurse #1 and notified her of the above documented findings on 4/11/18 at 10:15 am. MDS nurse #1 stated, "I will have to go and see if there is another care plan that has been revised after this one." On 4/12/18 at 3:12 pm, the surveyor notified the administrative team of the above documented findings. The surveyor asked the director of nursing if there were any more updates or revisions to the care plan for Resident #67. The director of nursing stated she would look into this and get back to the surveyor. No further information was provided to the surveyor prior to the exit conference on 4/12/18. 2. The facility staff failed to review and revise Resident #10's current comprehensive care plan when a "scoop plate" was ordered. The clinical record of Resident #10 was reviewed 4/9/18 through 4/12/18. Resident #10 was admitted to the facility 1/12/17 and readmitted 7/5/17 with diagnoses that included but not limited to non-traumatic intracerebral hemorrhage, gastrostomy, gastro-esophageal reflux disease, hypertension, chronic rhinitis, Type 2 diabetes mellitus, long term use of insulin, hyperlipidemia, gastrointestinal hemorrhage, dysphagia, pain, and respiratory failure. Resident #10's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/10/18 assessed the	F 657		

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F 657	Continued From page 37	F 657		

resident with short-term memory problems, long-term memory problems, and modified independence for daily decision-making.

The clinical record of Resident #10 had a physician order dated 3/12/18 that read "Pt (patient) to have scoop plate @ (at) meals." The tray ticket dated 4/11/18 had scoop dish under feeding assistance devices.

The surveyor observed Resident #10 during lunch on 4/10/18 at 12:14 p.m. The plate was a divided plate. Resident #10 had a fork in the left hand eating potatoes.

The surveyor reviewed the current comprehensive care plan dated 1/12/17. One problem identified 7/5/17 read "At risk for unplanned wt. (weight) loss as evidenced by dx (diagnoses) dysphagia, diabetic, PEG tube, nausea/vomiting. Approaches included: Serve diet as ordered, RD (registered dietician) to review residents medical records and make recommendations-nursing to follow-up, supplements as ordered, accuchecks as ordered, meds as ordered-monitor for side effects and effectiveness, and PEG tube as ordered.

The care plan was not revised to include the order for the "scoop dish."

The surveyor interviewed the minimum data set licensed practical nurse #1 on 4/11/18 at 2:53 p.m. After reviewing the care plan, MDS/LPN #1 stated the scoop plate should be added as specialized equipment to the care plan.

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

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F 657	Continued From page 38 nurse of the above finding on 4/11/18 at 5:15 p.m. and again on 4/12/18 at 3:12 p.m. No further information was provided prior to the exit conference on 4/12/18.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review the facility staff failed to follow professional standards of practice for administering medications. The findings included: The facility staff failed to follow professional standards of nursing practice during a medication pass and pour observation, resulting in a medication error for Resident #30. Resident #30 was admitted to the facility on 08/08/16. Diagnoses included but not limited to anemia, thrombocytopenia, hyperlipidemia, dementia, depression, insomnia, tachycardia, chronic obstructive pulmonary disease, dysphagia, and osteoporosis. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/09/18 coded the Resident as 15 of 15 in section C, cognitive status. This is a quarterly MDS.	F 658	**F658** **Corrective Action(s):** Resident #30's attending physician has been notified that the facility staff failed to accurately administer Flonase Nasal Spray per physician orders. LPN #1 who performed the Med Pass observation has received one-on-one inservice training on the medication administration policy. A Facility Incident & Accident Form was completed for these incidents. **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving physician ordered Nasal Sprays may have been potentially affected. The DON, and/or designee will conduct medication pass observations on all resident's receiving physician ordered Nasal Spray medication to identify any residents at risk. All residents identified at risk will be corrected at time of discovery and One-on-one inservice training will be provided. an Incident & Accident form will be completed for each negative finding. The attending physicians will be notified of each incorrect medication order.	

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F 658	Continued From page 39 On 04/10/18 at approximately 0920, surveyor observed LPN #1 (licensed practical nurse) administering Resident #30's Flonase nasal spray. LPN #1 administered 1 spray of the Flonase into each of Resident #30's nostrils. Resident #30's medications were reconciled with the clinical record on 04/10/18 at approximately 0930. The clinical record contained a physician's order summary, which read in part "Flonase allergy RLF 50 mcg spr 2 sprays in both nares daily". The Resident's eMAR was reviewed and contained an entry, which read in part "Flonase allergy RLF 50 mcg spr 2 sprays in both nares daily". Surveyor spoke with LPN #1 on 04/10/18 at approximately 0935 regarding Resident #30's Flonase. Surveyor asked LPN #1 how many sprays of the Flonase she had administered and she stated 1 in each nostril. Surveyor asked LPN #1 to pull the order and look at it. LPN #1 did so, and then stated, "I guess I owe her one". The surveyor requested the facility standards of practice for administering medications from the DON (director of nursing) on 04/10/18 at approximately 1035 and was provided with a copy of a policy entitled "Administering Medications". This policy read in part "Policy Statement Medications shall be administered in a safe and timely manner, and as prescribed. 3. Medications must be administered in accordance with the orders, including any required time frame. 7. The individual administering the medication must check the label THREE (3) times to verify the right Resident, right medication, right dosage, right time and right method (route) of	F 658	**Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered medications and treatments per physician order. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for medication administration to include pre and post administration instructions. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or QA Nurse will perform 2 medication pass observations weekly in order to maintain compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 25, 2018**	

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F 658	Continued From page 40 administration before giving the medication." The concern of the incorrect dose of medication being administered was discussed with the administrative team during a meeting on 04/10/18 at approximately 1655. No further information was provided prior to exit.	F 658		
F 684 SS=D	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 staff interview, clinical record review and facility document review the facility staff failed to follow physician's orders for 1 of 25 Residents, #24. The findings included: For Resident #24 the facility staff failed to administer the medication Neurontin as ordered by the physician. Resident #24 was admitted to the facility on 09/10/11 and readmitted on 01/31/17. Diagnoses included but not limited to coronary artery disease, hypertension, diabetes mellitus, hyperlipidemia, cerebrovascular accident, dementia, hemiplegia, depression and psychotic	F 684	**F684** **Corrective Action(s):** Residents #24's attending physician was notified that the facility failed to ensure that physician ordered Neurontin was available for administration. A facility Incident and Accident form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving medications may have been potentially affected. The DON, QA nurse and Unit Managers will conduct a 100% audit of all residents MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.	

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F 684	Continued From page 41 disorder. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/01/18 coded the Resident as 3 out of 15 in section C, cognitive status. This is an annual MDS. Resident #24's clinical record was reviewed on 04/10/18. It contained a physician's order summary for the month of April which read in part "Neurontin 100mg capsule give one cap po (by mouth) BID (twice daily) for pain". The Resident's eMAR (electronic medication administration record) for April was reviewed and contained an entry which read in part "Neurontin 100mg capsule give one cap po (by mouth) BID (twice daily) for pain". This entry had been coded "N" on 04/02/18 for the 5pm dose. The surveyor spoke with RN (registered nurse) #1 on 04/10/18 at approximately 1515 regarding the coding on Resident #24's eMAR. RN #1 stated that she does not know what "N" stands for and does not remember why the medication was not administered, and that it might have been because it was not available in the medication cart. Surveyor asked RN #1 what she would do if medications were not available and she stated, "Wait for pharmacy to deliver, call the pharmacy to deliver, or check the stat box." The surveyor spoke with the QA nurse (quality assurance) on 04/10/18 at approximately 1530. Surveyor asked QA nurse what "N" on the eMAR stood for, and she stated "N" means the medication was not administered". The concern of the medications not being available was discussed with the administrative	F 684	**Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes following and administering medications per physician orders. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for following and administering medications per physician order to include the procedure for obtaining medications from pharmacy to ensure availability. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, QA nurse and/or Unit Managers will audit resident MAR's weekly to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 25, 2018**	

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F 684	Continued From page 42 team during a meeting on 04/10/18 at approximately 1655. On 04/11/18 at approximately 0945, the DON provided the surveyor with a copy of a medication error report, which read in part "5pm dose of medication was not given to Resident; nurse states medication was not found". DON also provided surveyor with a copy of an inservice training form, which read in part "1. Topics to be discussed: importance of checking stat box overflow, calling pharmacy when a medication is not available and if medication cannot be given calling MD + notify RP (responsible party) + document". DON and RN #1 signed this form. The surveyor requested and was provided with a policy entitled "Medication Shortage/Unavailable Medications", which read in part "Procedure 1. Upon discovery that facility has an inadequate supply of a medication to administer to a Resident, facility staff should immediately initiate action to obtain the medication from pharmacy. If the medication shortage is discovered at the time of medication administration, facility staff should immediately take the action specified in Sections 2 or 3 of the policy 7.0, as applicable. 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or a missed dose in the Resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility staff	F 684		

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F 684	Continued From page 43 should notify pharmacy and arrange for an emergency delivery". The surveyor requested and was provided with a copy of the emergency medication supply. The medication Neurontin 100 mg was listed as being available in the emergency medication supply. No further information was provided prior to exit.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, facility document review and clinical record review, the facility staff failed to ensure respiratory care equipment was maintained for 3 of 25 residents (Resident #50, Resident #136, and Resident #67) to include cleaning of the concentrator, following the physician order for amount of oxygen to be delivered and infection control for nebulizers. The findings included: 1. The facility staff failed to ensure Resident #50's oxygen concentrator was clean. The clinical record of Resident #50 was reviewed	F 695	**F695** **Corrective Action(s)** Resident #50 and #67 have had their oxygen concentrators thoroughly cleaned and all filters have been cleaned. A facility Incident and Accident form was completed for this incident. Resident #136's attending physician was notified that the facility failed to administer oxygen at the ordered flow rate. Resident #136's oxygen concentrator has been thoroughly cleaned, the Nebulizer mask and oxygen tubing has been replaced with a new one and were dated and stored in a clear plastic bag when not in use. A facility Incident & Accident form was completed for this incident.	

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F 695	Continued From page 44 4/9/18 through 4/12/18. Resident #50 was admitted to the facility 5/6/09 and readmitted 1/10/18 with diagnoses that included but not limited to hemiplegia following cerebral vascular accident affecting unspecified side, adult failure to thrive, B12 nutritional deficiency, cognitive communication deficit, depressive disorder, adrenocortical insufficiency, aphasia, hypertension, nontoxic multinodal goiter, hypothyroidism, bilateral deep vein thrombosis, hypoxia, dementia, and anemia. Resident #50's 60 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/7/18 assessed the resident with short-term memory problems, long-term memory problems and moderately impaired cognitive skills for daily decision making. No indicators of delirium, behaviors or psychosis. During the initial tour on 4/9/18, the surveyor observed Resident #50 in bed with an oxygen concentrator positioned at the bedside. The oxygen concentrator was set on 2 liters/nasal cannula. The surveyor noted an accumulation of dust on the concentrator. Resident #50's April 2018 physician's order were reviewed. Orders read "O2 at 2 LPM (liters per minute) to decrease work of breathing and keep SpO2> (oxygen saturation) (greater than) 93%, change oxygen tubing qweek (every week), and change nebulizer tubing and mask q week (every week)." The surveyor observed Resident #50 again on 4/10/18 at 8:42 a.m. Resident #50 was in bed with the oxygen concentrator set on 2 liters. Once again, the surveyor observed a fair amount of dust and debris on the concentrator, especially	F 695	**Identification of Deficient Practice & Corrective Action(s):** All other resident receiving physician ordered oxygen may have potentially been affected. A 100% review of all residents with physician ordered oxygen was conducted to identify any/all residents at risk. Any negative findings were corrected at time of discovery and new oxygen equipment was obtained and dated and stored correctly. As well as all concentrators were inspected for cleanliness. A facility Incident &Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Nursing staff will be inserviced by the DON on the proper procedure for cleaning, changing and storing of Oxygen equipment to include cleaning concentrators and storage of nasal cannulas and nebulizer tubing and masks when not in use. As well as administering oxygen per physician ordered rate. **Monitoring:** The DON and/or Unit Manager is responsible for maintaining compliance. The DON or Unit Manager will make weekly rounds to monitor for compliance. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. All negative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 25, 2018**	

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both air filters. A lint like substance greyish in color was observed on both filters. The oxygen tubing was dated 4/8/18. The surveyor interviewed the unit manager licensed practical nurse #1 on 4/10/18. The unit manager L.P.N. #1 stated the dated tubing indicated the date the tubing was changed. The surveyor and the unit manager L.P.N. #1 observed the oxygen concentrator together. The unit manager LPN #1 agreed with the surveyor that there was a large amount of accumulated dust on both filters. The unit manager L.P.N. #1 removed the air filters and stated she would take care of the issue. UM LPN #1 stated she would expect staff to clean the filters when the tubing was changed.

The surveyor informed the administrator and the director of nursing of the above concern on 4/10/18 at 4:55 p.m. and requested the facility policy on oxygen maintenance. The administrator stated the facility did not have a policy that specified cleaning of the oxygen equipment.

The surveyor reviewed the facility policy titled "Oxygen Administration" on 4/11/18. The policy read in part "Steps in the Procedure 6. Check the face mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. 10. Oxygen tubing, cannula/mask should be stored in a clean, clear plastic bag when not in use."

No further information was provided prior to the exit conference on 4/12/18.

2. The facility staff failed to failed to ensure the nebulizer facemask was clean, failed to ensure the oxygen concentrator was clean, failed to date the oxygen tubing when changed, and failed to

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follow the physician order for oxygen administration for Resident #136.

The surveyor reviewed Resident #136's clinical record 4/9/18 through 4/12/18. Resident #136 was admitted to the facility 4/1/18 with diagnoses that included but not limited to hypertension, urinary tract infection, chronic obstructive pulmonary disease, radiculopathy, trochanteric bursitis, morbid obesity, right artificial hip joint, osteoarthritis, gastrointestinal hemorrhage, sleep apnea, depressive disorder, iron deficiency anemia, and venous thrombosis and embolus.

Resident #136's admission minimum data set (MDS) had not yet been completed.

The surveyor observed Resident #136 during the initial tour on 4/9/18 at 6:15 p.m. The resident was observed in bed, watching television. On the nightstand, the surveyor observed a nebulizer machine with a facemask attached. The facemask was lying on top of the machine. The surveyor also observed the oxygen concentrator had dust and debris along the front of the machine and the air filters, located on each side of the machine, had a layer of dust that appeared "powdery." The oxygen tubing did not have a date when the tubing had been changed. The oxygen concentrator was turned off but the resident had the nasal cannula in both nostrils.

The surveyor informed the unit manager licensed practical nurse #1 that the resident's oxygen concentrator was not turned on. The resident stated she thought she felt air going through the tubing but when checked by the unit manager LPN #1 the machine was off. The unit manager LPN #1 was asked what liter the resident was

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F 695	Continued From page 47 ordered. The UM LPN #1 stated "2" and promptly turned the oxygen concentrator to 2 liter. Resident #136's April 2018 physician's order were reviewed. Orders read "O2 at 2 liters (liters) via NC (nasal cannula) continuous and change oxygen tubing weekly." The surveyor observed Resident #136 on 4/10/18 at 8:35 a.m. Resident #136 was observed in bed, oxygen on at 2 liters per nasal cannula. The oxygen concentrator was noted to have dust and debris on the front and the air filters had an accumulation of dust. The oxygen tubing did not have a date when the tubing was last changed. The surveyor informed the unit manager LPN #1 of the above concerns on 4/10/18 at 8:36 a.m. The unit manager LPN #1 removed the air filters, washed them with water, and placed the filters back in the concentrator. The UM LPN #1 also stated the oxygen tubing should be dated when changed weekly. The tubing should have been changed 4/8/18. The UM LPN #1 stated she would expect the nursing staff to clean the filters and date the tubing weekly. In addition, the surveyor did not observe a "No Smoking" sign on the door. The surveyor informed the administrator and the corporate registered nurse of the above concerns on 4/10/18 at 10:38 a.m. The surveyor informed the administrator and the director of nursing of the above concern on 4/10/18 at 4:55 p.m. and requested the facility policy on oxygen maintenance. The administrator stated the facility did not have a policy that specified cleaning of the oxygen equipment.	F 695		

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F 695	Continued From page 48 The surveyor reviewed the facility policy titled "Oxygen Administration" on 4/11/18. The policy read in part "Steps in the Procedure 6. Check the facemask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. 10. Oxygen tubing, cannula/mask should be stored in a clean, clear plastic bag when not in use." No further information was provided prior to the exit conference on 4/12/18. 3. The facility staff failed to maintain respiratory equipment for Resident #67. Resident #67 was readmitted to the facility on 1/10/18 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, Alzheimer's disease, dementia, Parkinson's disease, anxiety disorder, depression, manic depression and Chronic Obstructive Pulmonary Disease. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/22/18 coded the resident with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #67 was also coded as requiring limited assistance of 1 staff member for dressing and extensive assistance of 1 staff member for personal hygiene. Resident #67 was also coded as being totally dependent on 1 staff member for bathing. On 4/10/18 at 9:30 am, the surveyor went into the resident's room and noted that Resident #67 had O2 (oxygen) at 2 l/min (liters per minute) by nasal cannula. The oxygen tubing was dated with a date of 4/8/18. The O2 concentrator's filter was	F 695		

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F 695	Continued From page 49 observed to have dust and particles of debris on it that was visible to the surveyor's eye. LPN #1 was notified of the filter being dirty with dust and particles of debris visible to the eye. She stated she would have this taken care of right now. The surveyor asked LPN #! When she would expect staff to clean the oxygen concentrator's filter. LPN #1 stated she would expect staff to clean the filter when the oxygen tubing was changed on a weekly basis. The surveyor notified the administrative team of the above documented findings on 4/12/18 at 3:12 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 4/12/18.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755	**F755** **Corrective Action(s):** Resident 41's attending physician has been notified that the facility failed to ensure that the physician ordered Methocarbamol medication was available from pharmacy for administration to Resident #41. A facility Incident and Accident form has been completed for this incident. Resident 65's attending physician has been notified that the facility failed to ensure that the physician ordered MS Contin medication was available from pharmacy for administration to Resident #65. A facility Incident and Accident form has been completed for this incident.	

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F 755	Continued From page 50 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation the facility staff failed to ensure medications were available for administration for 2 of 25 Residents, #41 and #65. The findings included: 1. For Resident #41 the facility staff failed to ensure the medication methocarbamol was available for administration. Resident #41 was admitted to the facility on Diagnoses included but not limited to morbid obesity, spinal stenosis, chronic obstructive pulmonary disease, hypokalemia, congestive heart failure, sleep apnea, hypertension, and depression. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/16/18 coded the Resident as 15 of 15 in section C, cognitive status. This is a quarterly MDS.	F 755	**Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all resident's medication regimes has been conducted by the DON, QA nurse and/ or Unit managers to identify residents at risk. Residents found to be at risk due the medications being unavailable from the pharmacy will be corrected at time of discovery and their attending physicians will be notified. A facility Incident and Accident form has been completed for each. **Systemic Changes:** The Pharmacy Policy and Procedure has been reviewed and no changes are warranted. All licensed nursing staff have been inserviced on the Policy and Procedure for medication administration to included medications that are unavailable or do not arrive at the facility timely from the pharmacy for administration. The inservice will include the steps the nurses should take should a medication not be delivered timely from the pharmacy. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON or Unit manager will conduct weekly audits of resident MAR's each week to confirm the availability of all ordered drugs. All negative findings will be corrected at the time of discovery. Results of the reviews will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 25, 2018**	

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Resident #41's clinical record was reviewed on 04/11/18. It contained a physician's order summary for the month of March, which read in part "Methocarbamol 500mg tablet give two tabs (1,000 mg total) po (by mouth) QID (four times a day) DX (diagnosis): muscle spasms". The Resident's eMAR (electronic medication record) was reviewed and contained an entry, which read in part "Methocarbamol 500mg tablet give two tabs (1,000 mg total) po (by mouth) QID (four times a day) DX (diagnosis): muscle spasms". This entry was coded with "N" for 03/29/18 at 1 pm. The comments section of the eMAR had a note, which read in part "3:02 PM, 3/39/18 (Scheduled: 1:00PMm 3/28/18; Methocarbamol 500 mg tablet) Methocarbamol 500 mg give two ta ...scheduled for 03/29/2018 1:00 PM.mediciation in route //03/29/2018 3:02 PM".

The surveyor spoke with the QA nurse (quality assurance) on 04/10/18 at approximately 1530. Surveyor asked QA nurse what "N" on the eMAR stood for, and she stated "N" means the medication was not administered".

The surveyor requested and was provided with a policy entitled "Medication Shortage/Unavailable Medications", which read in part "Procedure 1. Upon discovery that facility has an inadequate supply of a medication to administer to a Resident, facility staff should immediately initiate action to obtain the medication from pharmacy. If the medication shortage is discovered at the time of medication administration, facility staff should immediately take the action specified in Sections 2 or 3 of the policy 7.0, as applicable. 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call

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pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or a missed dose in the Resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery".

The surveyor requested and was provided with a copy of the emergency medication supply. The medication Methocarbamol was not listed as being available.

The surveyor spoke with the administrator on 04/11/18 at approximately 1530 regarding Resident #41. The concern of the medication not being available for administration was brought to her attention at this time. Administrator stated that she might possibly have some information regarding this.

The concern of the medication not being available for administration was discussed with the administrative team during a meeting on 04/11/18 at approximately 1715.

No further information was provided prior to exit.

This is a complaint deficiency.
2. The facility failed to ensure that a physician ordered medication was available for administration to Resident #65.

Resident #65 was readmitted to the facility on

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F 755	Continued From page 53 12/22/17 with the following diagnoses of, but not limited to diabetes, Multiple Sclerosis, Manic Depression and Psychotic Disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/28/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #65 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing. The surveyor conducted a clinical record review on 4/11/18 for Resident #65. During this review, the surveyor noted in the nurses' notes dated and timed for 2/7/18 at 8:07 am that stated, "6 am Resident MS (MS Contin) was not in stock. RX (Pharmacy) was called & staff stated that the insurance would not allow it to be sent. Resident was given a oxycodone tab 1 & effective. 7 am On coming charge nurse made aware of the above to f/u (follow up) with supervisor." The surveyor reviewed the physician order sheet for February 2018 and noted the following order: "MS Contin 30 mg (milligram) Tablet take 1 tab po (by mouth) Q (every) 8 hrs (hours) ..." The surveyor also reviewed the MAR (Medication Administration Record) for Resident #65 for the month of February 2018. In the box for 2/6/18 at 10:00 pm for the medication of MS Contin an "N" with the nurses' initials were present. On 2/7/18 at 6 am, in the box for the medication MS Contin there was a "N" with the initials of the nurse documented on the resident's MAR. The surveyor reviewed the above documented findings with the director of nursing (DON) on	F 755		

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4/11/18 at approximately 10:45 am. The DON stated, "I will have to look into this a little deeper and find out why this medication was not available." The surveyor asked the DON what the "N" stood for in the documentation on the resident's MAR concerning the above documented date and times for the medication of MS Contin. The DON stated, "The N means that the medication was not given."
The DON returned to the surveyor at 1:30 pm and stated that she had looked over the manifest from the pharmacy and the facility had called the pharmacy on 2/5/18 and again on 2/6/18. The DON stated that she had spoken to _____ (Name of contact at pharmacy facility uses) and that the person there would be glad to speak to the surveyor. The DON gave the surveyor the phone number of this contact person at the pharmacy.

At 2 pm, the surveyor called Pharmacy contact #1 at the phone number supplied by the DON. According to the Pharmacy contact #1 that stated, "The facility had called the pharmacy on 2/5/18 and reported to the pharmacy that they were needing a refill on the resident's MS Contin. The pharmacy technician had contacted the insurance of the resident and it had been denied to have this refill. The facility called again on 2/6/18 and spoke to a pharmacy technician concerning the need for the refill on the resident's medication. Instead of the pharmacy technician going ahead and pushing thru the channels here at the pharmacy and asking for an emergency fill on this medication which would had changed the delivery date to 2/6/18 this was not done until later in the day on 2/6/18 and the delivery date was not changed and it was delivered to the facility on the run on 2/7/18. In my opinion, the

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F 755	Continued From page 55 ball was dropped within the pharmacy on this. On 4/12/18 at 3:12 pm, the surveyor notified the administrative team of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 4/12/18.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending	F 756	**F756** **Corrective Action(s):** Resident #34 has had their January pharmacy recommendations reviewed and signed by the DON. A facility Incident and Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. The DON has reviewed all consultant pharmacy recommendations for 2018 to identify residents in need of pharmacy recommendations, follow up, and review by the DON. **Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The DON has been inserviced on the revised Federal Regulations for drug regime review. The DON will review and sign all pharmacy recommendations monthly as required to ensure that any/all pharmacy recommendations have been addressed and proper notification to attending physicians has been completed.	

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HERITAGE HALL VIRGINIA BEACH	5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462

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F 756	Continued From page 56 physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the director of nursing signed the drug regimen review for one of 25 Residents in the survey sample (Resident #34). The findings included: Resident #34 was admitted to the facility on 12/4/14 with the following diagnoses of, but not limited to Peripheral Vascular Disease, diabetes, hyperlipidemia (high cholesterol), stroke, Alzheimer's disease, and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/23/18, the resident was coded as having short and long term memory problems with being moderately impaired in daily decision-making. Resident #34 was also coded as requiring extensive assistance of 1 staff member for dressing and personal care and being totally dependent on 1 staff member for bathing. The surveyor conducted a review of Resident #34's clinical record on 4/11/18. During this review, the surveyor noted a "Consultation Report	F 756	**Monitoring:** The DON is responsible for maintaining compliance. The DON will perform monthly audits of the pharmacy recommendations to ensure that the recommendations are being reviewed and signed by the DON and the attending physician. Any/all negative findings will be corrected at time of discovery. A Risk Management Tracking/Trending Report will be completed for each incident identified. Detail findings of this review will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 25, 2018**	

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F 756	Continued From page 57 ...January 1, 2018 through January 16, 2018" from the pharmacist. This recommendation was signed and acknowledged by the medical director and was dated "2 1 18". The surveyor also noted that the physician had marked a response with a check mark in the box that stated, "I have re-evaluated this therapy and DO NOT wish to implement any changes due to the reasons below. Rationale: Will f/u (follow up) @ (at) next recert (recertification)." It was noted by the surveyor that on this Consultation Report, there was no signature on this by the director of nursing. At approximately 3 pm, the surveyor showed this Consultation Report to the director of nursing and notified her of the missing signature on this by her. The director of nursing did not reply after looking at this with the surveyor. At 5:15 pm, the surveyor notified the administrative team of the above documented findings on Resident #34. No further information was provided to the surveyor prior to the exit conference on 4/12/18.	F 756		
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	F 757	**F757** **Corrective Action(s):** Resident #67's attending physician was notified that resident #67 received the pain medication Norco 5-325 without first attempting non-pharmacological interventions. A facility Incident & Accident form was completed for this incident.	

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F 757	Continued From page 58 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide non-pharmacological interventions prior to administering pain medications for 2 of 25 residents in the survey sample (Resident #67 and #184). The findings included: 1. The facility staff failed to provide non-pharmacological interventions prior to administrating pain medications to Resident #67. Resident #67 was readmitted to the facility on 1/10/18 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, Alzheimer's disease, dementia, Parkinson's disease, anxiety disorder, depression, manic depression and Chronic Obstructive Pulmonary Disease. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/22/18 coded the resident with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #67 was also coded as requiring limited	F 757	Resident #184's attending physician was notified that resident #184 received the pain medication Tramadol HCL 50mg without first attempting non-pharmacological interventions. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving PRN pain medications may have been potentially affected. The DON, QA Nurse and/or Unit Managers will review the Pain medication orders of all residents to ensure that non-pharmacological interventions are attempted prior to administering PRN Pain medications. Any/all negative findings will be addressed with nursing staff for corrective action. A Facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will be inserviced by the DON and/or regional nurse consultant and issued a copy of the facility policy and procedure for proper administration and monitoring of all medications. This includes attempting non-pharmacological interventions prior to administration of PRN pain medication.	

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F 757	Continued From page 59 assistance of 1 staff member for dressing and extensive assistance of 1 staff member for personal hygiene. Resident #67 was as being totally dependent on 1 staff member for bathing. The surveyor performed a review of Resident #67's clinical record on 4/10/18. During this review, it was noted by the surveyor that on the MAR (Medication Administration Record) for the month of April 2018, the resident received the following prn (as needed) pain medication: "Norco 5-325 Tablet Take one tablet every 4 hours as needed for pain." This medication was administrated to the resident on the following dates and times: 4/2 at 9:48 am and 4:02 pm, 4/3 at 9:15 am, 2:56 pm, 4/6 at 7:53 am, 4/7 at 5:37 am and 8:05 pm, and 4/8 at 5:39 am. The surveyor reviewed the Administration Record at the end of the MAR and the only non-pharmacological intervention documented for the above administration times of the prn pain medication was "Assessed for pain". The surveyor reviewed the resident's care plan and under the problem of "Alteration of comfort r/t (related to) pain" the interventions read in part: " "Monitor for worsening pain or pain not responding to current therapy, notify MD (medical doctor) for increase in strength or change in med. " Offer quiet environment and assist with positioning for comfort ... " Attempt non-pharmacologic pain relief measures such as repositioning, back rubs. Document effectiveness ... " Provide diversional activities, if applicable ..." On 4/10/18 at approximately 1:45 pm, the surveyor reviewed the above documented findings with the director of nursing (DON). The surveyor asked if assess for pain was considered a non-pharmacological intervention to be used	F 757	**Monitoring:** The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will complete weekly MAR audits coinciding with the Care plan calendar to monitor compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 25, 2018**	

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F 757	Continued From page 60	F 757		

prior to the administration of a prn pain medicine. The DON stated that assess for pain was a non-pharmacological intervention to be used by her staff. The surveyor asked the DON if that was the only non-pharmacological intervention that she would expect her nurses to use prior to them administrating a prn pain medication to a resident. The DON stated, "It is one that the staff can use." The surveyor asked the DON if there were any other interventions that the staff could use before administrating prn pain medicine to a resident and she stated, "Yes I see where you are coming from but assessing for pain is one of them."

The surveyor notified the administrative team of the above documented findings on 4/10/18 at 4:58 pm in the conference room.

The surveyor again notified the administrative team on 4/11/18 at 5:15 pm of the above documented findings on Resident #67 regarding no non-pharmacological interventions except for "assess for pain" used prior to the administration of a prn pain medication.

No further information was provided to the surveyor prior to the exit conference on 4/12/18.

2. The facility staff failed to provide non-pharmacological interventions prior to administering pain medication to Resident #184.

Resident #184 was admitted to the facility on 4/6/18 with the following diagnoses of, but not limited to sepsis, cerebral aneurysm, enterocolitis related to C-Diff, malignant neoplasm of lung, high blood pressure and malignant neoplasm of the brain. The admission MDS (Minimum Data

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F 757	Continued From page 61 Set) had not been completed at the time of this survey in the nursing facility. According to the admission nursing assessment dated for 4/6/18, it was documented that the resident is alert and oriented. It was also documented that Resident #184 requires extensive assistance of 1 staff member for transfers, walking, personal hygiene and bathing. During the clinical record review performed by the surveyor on 4/11 and 4/12/18. It was noted that the resident had a physician order for the following pain medication: "Tramadol HCL 50 mg (milligram) tablet - take 1 tab by mouth every 6 hours as needed DX (diagnosis) pain". The surveyor reviewed the MAR (Medication Administration Record) for April 2018 and noted that Resident #184 was given Tramadol for pain on the following dates and times: 4/8 at 9:04 am and 4/9 at 1:35 am. The non-pharmacological intervention that was documented on the Administration Record for each time the Tramadol was given for pain was "Assessed for pain". The surveyor notified the administrative team of the above documented findings on 4/12/18 at 3:15 pm. No further information was provided to the surveyor prior to the exit conference on 4/12/18.	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	F 758		

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F 758	Continued From page 62 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; §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.	F 758	**F 758** **Corrective Action(s):** Resident #70's attending physician was notified that resident #70 received PRN Xanax without an appropriate clinical indication to support its use and no non-pharmacological interventions were tried prior to medication administration. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving antipsychotic medications may have been potentially affected. The DON, ADON, and/or Pharmacy consultant will review the medication orders of all residents receiving psychotropic/antipsychotic medications to ensure that no unnecessary medications have been ordered and that all antipsychotic medications have an appropriate medical diagnosis and/or clinical indication for their use. Any/all negative findings will be communicated to the attending physicians for corrective action. A Facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will be inserviced by the DON and/or regional nurse consultant and issued a copy of the facility policy and procedure for proper administration and monitoring of psychotropic medication to include antipsychotic medications. This includes having an appropriate medical diagnosis or clinical indication for its use and the use of non-pharmacological interventions prior to using medication.	

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F 758	Continued From page 63 §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 and clinical record review, the facility staff failed to ensure 1of 25 residents was free of an unnecessary psychotropic medication (Resident #70). The findings included: The facility staff failed to ensure Resident #70 was free of an unnecessary medication. The facility staff failed to offer/provide non-pharmacologic interventions prior to the use of Xanax on five (5) different occasions. The clinical record of Resident #70 was reviewed 4/9/18 through 4/12/18. Resident #70 was admitted to the facility 2/19/18 with diagnoses that included but not limited to atrial fibrillation, bradycardia, hypokalemia, long QT syndrome, enterocolitis due to Clostridium difficile, anxiety disorder, chronic obstructive pulmonary disease, hyperlipidemia, pulmonary hypertension, Takotsubo syndrome, diverticulum of the esophagus, left ventricular failure, acute on chronic systolic heart failure, and anorexia. Both the 5 day and 14 day MDS coded the resident with a brief interview for mental status as a 15. Both anxiety and depression were coded in Section I Active Diagnoses. Resident #70's March 2018 physician order sheet included an order for Xanax 0.25 mg (milligrams)	F 758	**Monitoring:** The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will complete monthly chart audits coinciding with the Care plan calendar to monitor compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 25, 2018**	

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F 758	Continued From page 64 po (by mouth) q (every) 12 hours prn (as needed) for sleep/anxiety. The surveyor reviewed the March 2018 electronic medication administration record (eMAR) and the eMAR notes. Resident #70 was administered Xanax 0.25 mg on 3/10/18 at 9:19 p.m. per resident request. Xanax 0.25 mg was administered 3/21/18 at 5:50 p.m. No reason documented for the administration of the prn Xanax. Xanax 0.25 mg was administered 3/23/18 at 12:10 a.m. The 3/23/18 notes stated "per resident request." Resident #70 was administered Xanax 0.25 mg on 3/24/18 at 6:26 p.m. No reason for the administration of the medication was identified. Resident #70 received Xanax 0.25 mg on 3/26/18 at 8:21 p.m. No reason for the administration was documented. The surveyor reviewed the Departmental Notes for March 2018. The notes did not have evidence of non-pharmacologic interventions prior to the administration or a reason for the administration other than "resident request." Departmental Notes dated 3/10/18 (6:13 a.m. and 1:09 p.m.) did not have any reasons for the administration of the Xanax or any non-pharmacologic use prior to the administration of the medication. Departmental Note dated 3/21/18 (1:49 a.m.) did not reference any non-pharmacologic intervention prior to the use of Xanax. The note read in part "sleep habits are good." The departmental note dated 3/23/18 at 6:51 a.m. or the 3/24/18 note of 12:55 a.m. did not reference any non-pharmacologic intervention	F 758		

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F 758	Continued From page 65 prior to administration. There was not a departmental note written 3/24/18 after 12:55 a.m. The note written 3/25/18 at 12:22 a.m. did not reference any type of non-pharmacologic intervention or reason for the administration of Xanax. The surveyor informed the administrator and the director of nursing of the lack of non-pharmacologic interventions prior to the use of Xanax or the lack of documentation for the use of Xanax in the end of the day meeting on 4/11/18 at 5:15 p.m. The DON stated she wanted to review the information provided. No further information was provided prior to the exit conference on 4/12/18.	F 758		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842	**F842** **Corrective Action(s):** Resident #45's Pharmacy Consultation report has been filed in Resident 45's medical record. A facility Incident & Accident form has been completed for this incident. Resident #57's Pharmacy Consultation has been reviewed and signed by the DON and is now filed in Resident 95's medical record. A facility Incident & Accident form has been completed for this incident. Resident #234's attending physician has been notified that the facility staff failed to accurately document the administration of Resident 234's morning medications for one day. A facility Incident & Accident form has been completed for this incident.	

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F 842	Continued From page 66 (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 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	F 842	Resident #48's attending physician has been notified that the facility staff failed to accurately document that the physician ordered Clip Alarm was in place as ordered. A facility Incident & Accident form has been completed for this incident. Resident #87's attending physician has been notified that the facility staff failed to accurately document that the physician ordered treatments to the right inner thigh were completed as ordered for 2 days. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% review of all resident Medical Records will be conducted by the DON, QA Nurse and or designee to identify residents at risk. All negative findings will be clarified and/or correct as applicable at time of discovery. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff, Social Services director, Activity Director and dietary manager will be inserviced by the Regional Nurse Consultant or DON on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include Physician Orders, MAR's, TAR's and departmental notes according to the acceptable professional standards and practices.	

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F 842	Continued From page 67 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to maintain complete and accurate clinical records for five of 25 Residents. Residents #45, #57, #234, #48, and #87. The findings included. 1. For Resident #45, the facility staff failed to file a consultation report from the pharmacist for the month of February in the Residents clinical record. The record review revealed that Resident #45 had been admitted to the facility 01/31/18. Diagnoses included, but were not limited to, diabetes, depression, hypertension, and chronic obstructive pulmonary disease. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/07/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The clinical record included a progress note transcribed by the pharmacist on 02/14/18 at 1:05 p.m. "...See report for any noted irregularities	F 842	**Monitoring:** The Administrator and DON are responsible for maintaining compliance. The DON, QA Nurse and/or designee will conduct weekly chart audits coinciding with the Care Plan schedule to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 25, 2018**	

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and/or recommendation."

When reviewing the clinical record the surveyor was unable to find the results of this consult.

The facility provided the surveyor a copy of this consult on 04/12/18. No explanation was provided as to why it was not in the clinical record.

The administrative staff was notified of this issue on 04/12/18 at approximately 3:12 p.m.

Prior to the exit conference, the facility staff provided the surveyor with a copy of their policy/procedure titled "Charting and Documentation." This policy/procedure read in part, "All services provided to the resident...or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care..."

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #57, the DON (director of nursing) failed to sign the pharmacy consultation report for January 2018.

The record review revealed that Resident #57 was admitted to the facility 09/26/13. Diagnoses included but were not limited to, cerebral infarction, Alzheimer's disease, and dysphagia.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment

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with an ARD (assessment reference date) of 03/07/18 included a BIMS (brief interview for mental status) summary score of 9 of 15 points.

The clinical record included a pharmacy consultation report for January 2018. This report included recommendations from the consulting pharmacy. The physician had signed this report on 01/22/18. The line for the DON to sign had been left blank.

During an interview with the DON on 04/11/18 at approximately 10:05 a.m., the DON verbalized to the surveyor that she had reviewed the pharmacy consult but had not signed it.

The administrative staff was notified of this issue on 04/12/18 at approximately 3:12 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. For Resident #234, the facility staff failed to document for the administration of medications and supplements on 04/06/18.

The record review revealed that Resident #234 was admitted to the facility 03/28/18. Diagnoses included, but were not limited to, chest pain, atrial fibrillation, osteoarthritis, functional quadriplegia, and essential hypertension.

There was no completed MDS (minimum data set) assessment on this Resident. However, the Resident was alert and orientated.

A review of the Residents eMARs (electronic medication administration records) for the month

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of 04/2018 revealed that for 04/06/18 the nursing staff failed to document for the administration of miralax powder, colace, klor-con, furosemide, zyrtec, fluticasone, cardizem, protonix, lopressor, flovent, alum-mag hydroxide, pro-stat, and med pass.

On 04/11/18 at approximately 2:25 p.m., the surveyor and the unit manager reviewed the eMARs for 04/06/18. After this review, the unit manager stated she would review the clinical record further.

On 4/11/18 at approximately 3:10 p.m., LPN (licensed practical nurse) #1 verbalized to the surveyor that she had not felt well on 04/06/18 and had to leave work. LPN #1 stated she had not hit the final button but the medicines were administered and prepared.

During an interview with Resident #234 on 04/11/18 at approximately 3:45 p.m., the Resident stated she had received all her medications.

The administrative staff was notified of this issue on 04/12/18 at approximately 3:12 p.m.

Prior to the exit conference, the facility staff provided the surveyor with a copy of their policy/procedure titled "Charting and Documentation." This policy/procedure read in part, "All services provided to the resident...or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care...The following information is to be documented in the

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F 842	Continued From page 71 resident medical record...medication administered..." No further information regarding this issue was provided to the survey team prior to the exit conference. 4. The facility staff failed to document the clip alarm that was ordered to be worn at all times for safety on the December 2017 through April 2018 medication administration record/treatment administration record for Resident #48. The clinical record of Resident #48 was reviewed 4/9/18 through 4/12/18. Resident #48 was admitted to the facility 11/28/17 with diagnoses, that included but not limited to Alzheimer's disease, dementia with behavioral disturbances, major depressive disorder, anxiety, adult failure to thrive, and history of falling. Resident #48's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/5/18 assessed the resident with long-term memory problems, short-term memory problems, and moderately impaired cognitive skills for daily decision-making. No identified indicators of psychosis, delirium, or behaviors. The surveyor reviewed the December 2017 physician order sheet. The physician order dated 12/5/17 read "Resident to wear a clip alarm at all times for safety." The surveyor reviewed the December 2017 through April 2018 electronic treatment administration records (eTAR) but found no evidence the treatment had been documented as done. The entry on the December 2017 eTAR	F 842		

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F 842	Continued From page 72 read "Resident to wear a clip alarm at all times for safety." However, December 1 through December 4 had **** (asterisks) for documentation. After 12/4/17, each box was blank from 12/5/17 through 12/31/17. The same for January 2018 through April 2018. The surveyor informed the corporate registered nurse on 4/10/18 at 3:53 p.m. of the surveyor's inability to locate documentation of the order for the clip alarm. The corporate RN stated the "clip alarm" was ancillary and it would be charted in an alarm book. The surveyor informed the administrator and the director of nursing of the above concern on 4/10/18 at 4:55 p.m. On 4/11/18, the surveyor was provided a "Medication Error Report" dated 4/10/18 from the director of nursing. The DON stated the order was entered on the eTAR but a time interval or time code was not. The DON stated there was no negative outcome to the resident. The surveyor reviewed the facility policy on documentation titled "Charting and Documentation" on 4/12/18. The policy read in part "2. The following information is to be documented in the resident medical record: c. Treatments or services performed." No further information was provided prior to the exit conference on 4/12/18. 5. The facility staff failed to document physician ordered treatments to the right inner thigh of Resident #87 on 6/26/17 and 6/27/17.	F 842		

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The clinical record of Resident #87 was reviewed 4/11/18 through 4/12/18. Resident #87 was admitted to the facility 10/9/14, readmitted 5/20/16 and discharged 7/3/17. Resident #87's diagnoses included but not limited to morbid obesity, acute embolism and thrombosis of lower extremity, hypertension, dysphagia, hyperlipidemia, transient cerebral ischemic attacks, flaccid hemiplegia, pain, Type 2 diabetes mellitus, chronic kidney disease, vascular dementia, aphasia, vitamin D deficiency, urinary tract infection, cognitive communication deficit, expressive language disorder and severe stress.

Resident #87's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/22/17 assessed the resident with a BIMS score of 5/15 in Section C. There were no indicators of delirium, psychosis, or behaviors affecting others.

Resident #87 was totally dependent on 2 persons for bed mobility, transfers, dressing, toilet use, personal hygiene, locomotion on and off the unit. Resident #87 required extensive assistance of 1 person for eating. Functional limitation in range of motion was assessed in both upper and lower extremities on one side. Resident #87 was frequently incontinent of bladder and always incontinent of bowel. Resident #87 was identified to be at risk for the developing of pressure ulcers. No pressure ulcers were currently identified.

Resident #87's current comprehensive care plan dated 10/9/14 identified a problem with onset date of 10/9/14 that read "Potential for impaired skin integrity r/t (related to) dx (diagnosis) of CVA, rt (right) sided weakness, decrease in mobility, incontinence of B&B (bowel and bladder), obesity,

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F 842	Continued From page 74 and hx (history) of sheared area, fungal infections, moisture associated skin damage, refuses all showers. Approaches: Monitor for incont. (incontinence) q (every) 2 hrs (hours) and prn (as needed)-change promptly-provide cream care and barrier cream as ordered/needed, assist with repositioning q 2 hrs and prn, encourage po and fluid intake, monitor skin integrity daily and weekly, treatment as ordered, apply protective oint (ointment)/powder to skin as ordered/needed, apply specialty mattress as ordered, off load heels while in bed. The visual body map completed 6/23/17 shows "99" at right inner thigh front. Legend on the visual body map for 99=other. Wound Assessment Report Drainage=serous, small. No pain, no edema, measured 0.5 centimeters (length) x 2.50 cm (width) x 0.00 cm (depth). MD (medical doctor) and responsible party notified 6/23/17. Current weight 322 pounds. Orders dated 6/23/17 read "Cleanse R (right) inner thigh with DWC (dermal wound cleanser) pat dry, apply skin prep to surrounding area, apply wound gel to wound bed and cover with allevyn foam, change dressing qd (every day) and prn." The June 2017 and July 2017 treatment administration records were reviewed. The June 2017 entries from 6/23/17 through 6/30/17 were reviewed and 7/1/17 through 7/2/17. There were 2 days (6/26/17 and 6/27/17) where there is no documentation that care was provided. The Departmental Notes from 6/1/17 through 7/5/17 were reviewed. There was not a note for 6/26/17 or 6/27/17 for wound care provided. The surveyor requested the facility policy on pressure ulcer care from the administrator and	F 842		

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F 842	Continued From page 75 the director of nursing on 4/12/18. The policy titled "Pressure Ulcers/Skin Breakdown-Clinical Protocol" read in part "2. In addition, the nurse shall describe and document/report the following: d. Current treatments, including support surfaces." The surveyor reviewed the facility policy on documentation titled "Charting and Documentation" on 4/12/18. The policy read in part "2. The following information is to be documented in the resident medical record: c. Treatments or services performed." No further information was provided prior to the exit conference on 4/12/18.	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet	F 849	**F849** **Corrective Action(s):** Resident #48 & #86's attending physicians have been notified that the facility failed to coordinate a Hospice Services between the facility and Hospice agency for resident's #48 & #86. A Facility Incident/Accident form has been completed for each incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents with Hospice Services may have potentially been affected. A 100% audit of residents receiving Hospice Services will be completed to identify residents at risk. All negative findings will be corrected at the time of discovery. A Risk Management Incident & Accident form will be completed and proper notification made to the resident's attending physician.	

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F 849	Continued From page 76 professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice	F 849	**Systemic Changes:** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed staff will be inserviced by the Administrator and Hospice Director on the policy and procedure for coordinating care and services with the Hospice Agency for all residents receiving Hospice Services. **Monitoring:** The DON is responsible for maintaining compliance. The DON, Q Nurse and/or Unit Managers will review all physician Hospice orders to ensure that the facility has a coordinated Hospice Plan of Care for all residents receiving Hospice Services. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 25, 2018**	

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F 849	Continued From page 77 representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible	F 849		

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F 849	Continued From page 78 for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system.	F 849		

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F 849	Continued From page 79	F 849		

(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, the facility staff failed to coordinate hospice services for 2 of 25 residents (Resident #48 and Resident #86).

The findings included:

1. The facility staff failed to ensure hospice documentation was in the clinical record of Resident #48.

The clinical record of Resident #48 was reviewed 4/9/18 through 4/12/18. Resident #48 was admitted to the facility 11/28/17 with diagnoses, that included but not limited to Alzheimer's disease, dementia with behavioral disturbances, major depressive disorder, anxiety, adult failure to thrive, and history of falling.

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F 849	Continued From page 80 Resident #48's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/5/18 assessed the resident with long-term memory problems, short-term memory problems, and moderately impaired cognitive skills for daily decision-making. No identified indicators of psychosis, delirium, or behaviors. Section O Special Treatments, Procedures and Programs was coded for hospice care. The December 2017 through April 2018 had orders that read "Resident under hospice care upon admission-dated 12/28/17)." Resident #48's current comprehensive care plan had the problem of hospice but the entry did not have a date when implemented, goals or approaches. The surveyor reviewed the hospice contract on 4/11/18. The hospice contract read in part "1.6 Hospice Services means those services and items provided to a Hospice Patient , either directly or under arrangements that are reasonable and necessary for the palliation and management of the Hospice's patient's terminal illness and related conditions, as specified in the Plan of Care. 2. Duties and Obligations of Hospice-Coordination of Services- Hospice shall ensure the continuity of care for Hospice patients and their families in all care settings. Hospice will be responsible for coordinating patient care conferences, periodic patient and family assessments and evaluations, discharge planning and bereavement follow-up for all Hospice patients and their families. Hospice shall designate a member of each Interdisciplinary Group who is responsible for a hospice patient at	F 849		

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F 849	Continued From page 81 the facility. Hospice shall provide Facility with the following information specific to each Hospice Patient residing at facility: (i) The most recent Hospice Plan of Care; (ii) The Hospice election form and any advanced directives; (iii) The Physician Certification and recertification (s) of the terminal illness; (iv) The names and contact information for Hospice staff involved in the care of the Hospice Patient; (v) Instructions on how to access Hospice's 24 hour-on-call system; (vi) Hospice medication information; and (vii) Hospice Physician and attending physician orders. 4. Coordination of Services-4.4 Clinical records Facility and Hospice shall each prepare and maintain complete and detailed clinical records concerning each Hospice patient receiving Facility services and Hospice services under this agreement in accordance with prudent record-keeping procedures, their own policies and procedures, and applicable federal and state law and regulations and applicable Medicare and Medicaid program guidelines. Facility and Hospice will each maintain and subject to applicable laws and regulations regarding confidentiality of patient information, make available to each other for inspection and copying, detailed such clinical records concerning each Hospice Patient as necessary for the proper evaluation, screening, and provision of services to Hospice patient under this agreement. The clinical record contained a copy of the Recertification of Terminal Illness-60 -Day Benefit Period was dated 1/19/18 and ending 3/19/18. The surveyor found no current hospice orders for care-frequency of skilled nurse visits, frequency of certified nursing aides visits, social worker frequency and chaplain frequency visits. The	F 849		

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F 849	Continued From page 82 surveyor was unable to locate any certified nursing aide visits, chaplain visits and social worker visits in the clinical record. The surveyor interviewed the unit manager licensed practical nurse #1 on 4/10/18 at 2:58 p.m. about the aide visits. The unit manager LPN #1 stated the facility staff provided the resident baths/care. The unit manager LPN #1 stated she would call the hospice agency and get Resident #48's visit information. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern with lack of documentation from the hospice agency during the end of the day meeting on 4/10/18 at 4:55 p.m. No further information was provided prior to the exit conference on 4/12/18. 2. The facility staff failed to coordinate hospice services for Resident #86. Resident #86 was readmitted to the facility on 10/19/17 with the following diagnoses of, but not limited to anemia, high blood pressure, stroke, dementia, seizure disorder and anxiety disorder. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/26/17, the resident was coded as having short term and long term memory problems. The resident was also coded as being moderately impaired in making daily decisions. Resident #86 was totally dependent on 1 staff member for dressing, personal hygiene and bathing. During the clinical record review on 4/11 and	F 849		

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F 849	Continued From page 83 4/12/18 that was performed by the surveyor. It was noted by the surveyor a physician order dated for 10/24/17, which stated, "Hospice Care". The surveyor reviewed the clinical record and noted the only documentation in the record from Hospice was a Plan of Care dated for 10/21/17. According to the Plan of Care, the resident was to receive the following: Skilled Nursing visits 2 times a week for 14 weeks, Medical Social Worker visits 10/22/17 then 1 time a week for 1 week, then 1 time a week for 11 weeks, and Hospice aide visits 10/22/17 then 3 times a week for 12 weeks, then decrease to 2 times a week for 1 week. There was no documentation of these visits from each of the disciplines in the clinical record when reviewed by the surveyor. On 4/12/18 at 3:12 pm, the surveyor notified the administrative team of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 4/12/18.	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an 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	F 880	**F880** **Corrective Action(s):** Resident #136 has had his nebulizer mask and tubing changed and it is now stored properly per facility policy and procedure. An Incident & Accident form was completed for this incident. The Clean Linen cart on the Rose Garden Unit was removed from the unit and cleaned, the linen was removed, and clean linen was placed back on the clean linen cart and returned to unit.	

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F 880	Continued From page 84 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 (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.	F 880	**Identification of Deficient Practice(s) & Corrective Action(s):** All residents receiving nebulizer treatments may have potentially been affected. License staff will conduct daily rounds to monitor for proper infection control practices and storage of all nebulizer equipment. Any negative findings will be corrected at time of discovery. An incident & accident form will be completed for each negative finding. All Clean linen carts are now removed from the unit hallways after resident ADL care has been provided to prevent contamination from residents removing linen from the carts. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. Staff will be inserviced on the infection control policy and procedure and the proper cleaning and storage of all oxygen and nebulizer equipment. As well as, the proper storage and removal of the clean linen carts after ADL cart is performed on residents by the DON. **Monitoring:** The DON is responsible for maintaining compliance. The QA Program includes an audit tool for monitoring compliance. The DON, ADON and/or designee will perform weekly rounds to monitor for compliance. Findings of the audits will be reported to the QA Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 25, 2018**	

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F 880	Continued From page 85 §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, facility document review, and clinical record review, the facility staff failed to follow infection control guidelines for 2 of 25 residents (Resident #34 and Resident #136). The findings included: 1. The facility staff failed to ensure the nebulizer facemask was clean for Resident #136. The surveyor reviewed Resident #136's clinical record 4/9/18 through 4/12/18. Resident #136 was admitted to the facility 4/1/18 with diagnoses that included but not limited to hypertension, urinary tract infection, chronic obstructive pulmonary disease, radiculopathy, trochanteric bursitis, morbid obesity, right artificial hip joint, osteoarthritis, gastrointestinal hemorrhage, sleep apnea, depressive disorder, iron deficiency anemia, and venous thrombosis and embolus. Resident #136's admission minimum data set (MDS) had not yet been completed.	F 880		

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F 880	Continued From page 86 The surveyor observed Resident #136 during the initial tour on 4/9/18 at 6:15 p.m. The resident was observed in bed, watching television. On the nightstand, the surveyor observed a nebulizer machine with a facemask attached. The facemask was lying on top of the machine. The facemask was not secured in a clean plastic bag. The surveyor informed the unit manager LPN #1 of the above concerns on 4/10/18 at 8:36 a.m. The unit manager LPN #1 stated the nebulizer mask should be stored in a clean plastic bag. The surveyor informed the administrator and the corporate registered nurse of the above concerns on 4/10/18 at 10:38 a.m. The surveyor informed the administrator and the director of nursing of the above concern on 4/10/18 at 4:55 p.m. and requested the facility policy on equipment maintenance. The administrator stated the facility did not have a policy that specified cleaning of the equipment. The surveyor reviewed the facility policy titled "Oxygen Administration" on 4/11/18. The policy read in part "Steps in the Procedure 6. Check the facemask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. 10. Oxygen tubing, cannula/mask should be stored in a clean, clear plastic bag when not in use." No further information was provided prior to the exit conference on 4/12/18. 2. The facility staff failed to ensure infection control guidelines were maintained on the Rose Garden unit. Resident #34 was observed	F 880		

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F 880	Continued From page 87 removing clean linen from the linen cart. The surveyor observed Resident #34 at the linen cart on 4/11/18 at 4:29 p.m. Resident #34 was observed removing linen from the linen cart. The observation was seen by the unit manager licensed practical nurse #1 who intervened. The UM LPN #1 stated the resident never messes with the linen cart. The UM LPN #1 removed the resident from the linen cart. The UM LPN #1 informed the surveyor the linens from the cart had been removed and washed, the cart cleaned and the cart replaced with clean linens. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above infection control concerns during the end of the day meeting on 4/11/18 at 5:15 p.m. and again on 4/12/18 at 3:12 p.m. The surveyor reviewed the infection control program with the director of nursing on 4/12/18. Resident #34 was admitted to the facility 12/4/14 with diagnoses that included but not limited to Alzheimer's disease, peripheral vascular disease, hyperlipidemia, diabetes mellitus, depression, and cerebrovascular accident. Quarterly minimum data set (MDS) with an assessment reference date assessed the resident with short-term memory problem, long-term memory problem, and moderately impaired cognitive skills for daily decision-making. No further information was provided prior to the exit conference on 4/12/18.	F 880		
F 924 SS=D	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3)	F 924		

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F 924	Continued From page 88 §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure handrails were firmly affixed and in good repair on one of two units. The rose garden unit. The findings included. On 04/11/18, the surveyor observed that the handrails (two) between room 219 and the nurse's station were missing a brace. Thus allowing the handrails to be pushed in when resting or pushing on the handrail. The handrail between the laundry room and barber/beauty shop was cracked in two areas. On 04/11/18, the surveyor leaned against a handrail between room 219 and the nurse's station. This handrail bent in toward the wall. When looking at the handrail the surveyor observed that some of the braces between the handrail and the wall were missing. A second handrail in the same area was also missing braces and was able to be pushed in toward the wall. Maintenance employee #1 was shown the handrails. On 04/12/18 at 10:07 a.m., the surveyor checked the handrails to see if they had been fixed. No modifications had been made to either handrail. When checking other handrails the surveyor observed the handrail between the laundry room and the barber/beauty shop was cracked in two places.	F 924	**F924** **Corrective Action(s):** The handrails identified during the survey on the Rose Garden Unit have been repaired. **Identification of Deficient Practice(s) and Corrective Action(s):** All other unit handrails had the potential to be affected. The Maintenance director will inspect all handrails throughout the entire facility to identify areas at risk. Any/All negative findings will be corrected at time of discovery. **Systemic Change(s):** The facility policy & procedure for providing a safe, sanitary, and comfortable environment was reviewed and no changes are warranted at this time. All staff will be inserviced on reporting and recording maintenance request forms for items including handrails that need repair or replaced. The environmental services staff will inspect hand rails daily as part of their daily cleaning process throughout the building. Any/all negative findings will be reported to the maintenance director for repair. **Monitoring:** The Maintenance Director is responsible for maintaining compliance. The Maintenance Director and/or designee will complete the facility maintenance audit tool monthly to monitor compliance. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 25, 2018**	

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F 924	Continued From page 89 The surveyor was able to observe Residents in the hallway where the issues with the handrails were noted. The nurse consultant was notified of the issues with the handrails on 0412/18 at 10:10 a.m. The administrative staff was notified of the issues regarding the handrails on 04/12/18 at approximately 3:12 p.m. No further information regarding his issue was provided to the survey team prior to the exit conference.	F 924		