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
	495283	A. BUILDING ______ B. WING ______	C 06/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-IMPERIAL	1719 BELLEVUE AVENUE RICHMOND, VA 23227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 05/30/18 through 06/01/18 and 06/04/18 through 06/05/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.	E 024	**E-024** Criteria 1 The role or other volunteers and staffing are identified in the facility assessment. Volunteers and facility staff are to be re-educated on emergency preparedness and roles within the plan. Criteria 2 Current residents have the potential to be affected. Criteria 3 Facility staff and volunteers are to be educated on emergency preparedness. Criteria 4 Administrator or designee will audit emergency preparedness training/documentation weekly x2 weeks, and monthly x2 months. Criteria 5 The facility's alleged date of compliance is 7/10/18.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE NHA (X6) DATE 7-6-2018

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

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E 024	Continued From page 1 The facility staff failed to develop policies and procedures for the use of volunteers and other staffing strategies in the emergency plan. The findings include: On 05/31/18, at 2:00 p.m., a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator and OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence policies and procedures for the use of volunteers and other staffing strategies in the emergency plan. ASM # 1 stated that the facility did not have it. On 06/01/18 at approximately 1:55 p.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was obtained prior to exit.	E 024		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including	E 039	**E-039** Criteria 1 Facility has contacted the local emergency officials in an effort to identify a community based exercise.	

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E 039	Continued From page 2 unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set	E 039	Criteria 2 Current residents have the potential to be affected. Criteria 3 Facility staff and volunteers are to be educated on emergency preparedness. Criteria 4 Administrator or designee will audit emergency preparedness training/documentation weekly x2 weeks, and monthly x2 months. Criteria 5 The facility's alleged date of compliance is 7/10/18.	

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E 039	Continued From page 3	E 039		

of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.

The facility staff failed to provide documented evidence of the facility's efforts to identify a full-scale community based exercise, and the facility's exercise analysis and response and how the facility updated its emergency program based on the exercise analysis.

The findings include:

On 05/31/18 at 2:00 p.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, administrator and OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to provide documented evidence of the facility's efforts to identify a full-scale community based exercise and the facility's exercise analysis, response, and how the facility updated its emergency program, based on the exercise analysis. ASM # 1 stated that the facility did not have it.

On 06/01/18 at approximately 1:55 p.m. ASM

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(administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was obtained prior to exit.

F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey was conducted 5/30/18 through 6/1/18 and 6/4/18 through 6/5/18. 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 128 bed certified bed facility was 103 at the time of the survey. The survey sample consisted of 46 current Resident record reviews (Residents #39, 68, 1, 24, 5, 96, 30, 32, 80, 63, 15, 28, 57, 43, 7, 85, 23, 47, 351, 48, 21, 20, 27, 46, 18, 35, 99, 100, 87, 12, 22, 355, 8, 65, 90, 51, 56, 13, 36, 75, 356, 98, 42, 14, 3, and 83) and four closed record reviews (Residents #301, 102, 101 A and 101 B).

F 550 SS=E Resident Rights/Exercise of Rights
CFR(s): 483.10(a)(1)(2)(b)(1)(2)

§483.10(a) Resident Rights.
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or

F 550 — Provider's plan of correction:

F-550

It is the intended practice of this facility to honor a residents right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility as defined by 483.10(a)(1)(2)(b)(1)(2).

Criteria 1

Resident #'s 355, and #27 are discharged.
Resident #5, #15, 18, and #98 are receiving feeding assistance and tray service in a dignified manner.

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F 550	Continued From page 5 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care in a manner to promote dignity for six of 50 residents in the survey sample, Residents #18, #355, #27, #98, #5 and #15. 1. a. The facility staff failed to immediately feed Resident #18 after placing a meal tray in front of	F 550	Criteria 2 Residents who receive meal service in the dining room, require feeding assistance and those residents who are deemed safe smokers have the potential to be affected. Observations of like residents have been completed to ensure staff are following facility policies. Criteria 3 Nursing staff were re-educated by DON/Designee on the facility dining policy, providing assistance for residents in a dignified manner and policy on appropriate use of smoking aprons Criteria 4 The DON or designee will complete audits/observations for safe smokers, dining room service and staff assisting residents with meals, daily x5 days, once weekly x2 weeks and monthly x2 months.	

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F 550	Continued From page 6 the resident. On 5/30/18, CNA (certified nursing assistant) #3 placed a meal tray on the table in front of Resident #18 and did not return to feed the resident for ten minutes. 1. b. The facility staff failed to provide a dignified dining experience for Resident #18. While feeding Resident #18, CNA (certified nursing assistant) #3 scraped food from the resident's chin and fed the food to the resident. 2. The facility staff failed to maintain the dignity of Resident #355 by requiring him to wear a protective smoking apron even though facility staff had assessed the resident to be an independent smoker. 3. The facility staff failed to maintain the dignity of Resident #27 by requiring her to wear a protective smoking vest/apron even though facility staff had assessed Resident #27 as an independent smoker. 4. The facility staff left Resident #98 sitting at the lunch table for 16 minutes without a tray while four other residents at the table were eating. 5. The facility staff stood over Resident #5 while providing feeding assistance. 6. The facility staff fed Resident #15 in an undignified manner. While being fed by staff, food dropped off the spoon onto the clothing protector. The facility staff scooped up the food with the spoon and fed it to the resident. The findings include: 1. a. The facility staff failed to feed Resident #18	F 550	Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed. Criteria 5 The facility's alleged date of compliance is 7/10/2018.	

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immediately after placing a meal tray in front of the resident. On 5/30/18, CNA (certified nursing assistant) #3 placed a meal tray on the table in front of Resident #18 and did not return to feed the resident for ten minutes.

Resident #18 was admitted to the facility on 4/25/11. Resident #18's diagnoses included but were not limited to legal blindness, high cholesterol and paralysis. Resident #18's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/23/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G documented Resident #18 was totally dependent on one staff for eating.

On 5/30/18 at 12:24 p.m., a dining observation was conducted in the dining room. CNA #3 placed Resident #18's covered meal tray on the table in front of the resident then continued to serve other residents their meal trays. CNA #3 did not return to feed Resident #18 until 12:34 p.m.

On 6/1/18 at 12:56 p.m., an interview was conducted with CNA #2. CNA #2 was asked if meal trays are left in front of residents for periods of time before the residents are fed. CNA #2 stated, "Normally we will pass them out in the order that's on the cart. We put the ones that are feeders in front of them so they have a tray and are not at the table without a tray, while seated with other people at the table who have trays, but when done passing trays, we come back to feed them." When asked how long the trays are left in front of the people who have to be fed, CNA #2 stated, "Not long. Like two or three minutes. It doesn't take long to pass out the trays." When

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asked how she would feel if her meal tray was placed in front of her and she was not fed for ten minutes, CNA #2 stated, "I would feel some type of way. We try to staff more people in the dining room so they won't have to wait long to be fed. The nurses or the dietician will come in to help us." When again asked how she would feel, CNA #2 stated, "Horrible and starving."

On 6/4/18 at 10:04 a.m., an interview was conducted with CNA #3. CNA #3 was asked if residents are fed immediately after being served their meal tray. CNA #3 stated, "Sometimes no. We serve everyone their trays first. Everyone has to have a tray. We have a seating arrangement and trays come in that order." When asked how she would feel if her meal tray was placed in front of her and she was not fed for ten minutes, CNA #3 stated, "That don't sound right. As long as you keep the top on and say you are coming back." When asked to clarify if she thought it was ok to leave the meal tray in front of a resident for ten minutes before feeding him/her as long as the lid is left on the food and she tells the resident she is coming back, CNA #3 stated, "Yes." CNA #3 could not recall any details regarding the lunch meal service on 5/30/18.

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "Your Resident Rights" documented, "The resident has a right to a dignified existence, self-determination, and communication with access to persons and services inside and outside the facility...4. Respect and dignity- The resident has a right to

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be treated with respect and dignity..."

No further information was presented prior to exit.

1. b. The facility staff failed to provide a dignified dining experience for Resident #18. While feeding Resident #18, CNA (certified nursing assistant) #3 scraped food from the resident's chin and fed the food to the resident.

On 5/30/18 at 12:34 p.m., CNA #3 was observed feeding Resident #18 a pureed meal in the dining room. While feeding the resident, food was observed on the resident's chin. CNA #3 scraped the food in an upward motion from the resident's chin and placed the food into Resident #18's mouth twice.

On 6/4/18 at 10:04 a.m., an interview was conducted with CNA #3. CNA #3 was asked what should be done if while feeding a resident, food falls onto the resident's chin. CNA #3 stated, "Take a napkin and wipe it off and use a food clothing protector." When asked if it was dignified to scrape food from a resident's chin and place the scraped food into the resident's mouth, CNA #3 stated, "That's nasty. That's a dignity issue. That's like a baby. You don't do a grown person like that." CNA #3 could not recall any details regarding the lunch meal service on 5/30/18.

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

2. The facility staff failed to maintain the dignity of

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F 550	Continued From page 10 Resident #355 by requiring him to wear a protective smoking apron even though facility staff had assessed the resident to be an independent smoker. Resident #355 was admitted to the facility on 5/26/18. Resident #355's diagnoses included but were not limited to heart failure, high blood pressure and difficulty in walking. Resident #355's admission MDS (minimum data set) assessment was not complete. An admission assessment dated 5/26/18 documented the resident was able to communicate needs and was oriented to time, person and situation. The admission assessment documented Resident #355 was a current smoker in a non-smoking facility. Resident #355's care plan dated 5/27/18 documented, "History of smoking in community...Educate/review non smoking status of the center. Complete Smoking Evaluation per facility guidelines." Review of Resident #355's clinical record revealed a smoking assessment dated 5/30/18. The form titled, "Smoking Facility-Smoking Evaluation" documented the following: "1. Cognitive Function: 1a. Short term memory is ok; recall after 5 minutes- Yes 1b. Long term memory is OK: recall of long past events- Yes 1c. Adequate memory/recall ability: recall of activities over last 7 days- Yes 1d. Able to make decisions regarding tasks of daily life (e.g., decisions are consistent and reasonable) - Yes 2. Visual Function:	F 550		

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F 550	Continued From page 11 2a. Patient sees adequately, e.g., sees regular newsprint without difficulty- Yes 3. Communication Function 3a. Patient is able to make needs known verbally- Yes 4. Physical Function: 4a. Patient is free of physical limitations interfering with the ability to perform safe smoking techniques, e.g., able to grasp and handle cigarette, lighter or matches without assistance- Yes 5. Patient Interview 5a. Patient understands that smoking may only take place at designated times in designated smoking areas- Yes 5b. Patient understands that smoking accessories (cigarettes, lighter, matches, etc.) must be returned to and kept under the control of the center staff when not in use- Yes 5c. Patient is able to communicate the safety risks associated with smoking- Yes 6. Patient Observation: 6a. Patient demonstrates safe smoking techniques: holding cigarette, lighting cigarette, extinguishing matches, lighter & cigarette after use and disposal of ashes- Yes 6b. Patient remains alert during the course of smoking- Yes 6c. Patient is free from evidence of burn injuries or holes noted on clothing or wheelchair- Yes 7. Determination: 7a. Independent Smoker: Capable and independent, requires no supervision to smoke- Yes 7a1. Proceed to care plan Focus: History of smoking in community/Inappropriate smoking related to: Focus: History of smoking in community/Inappropriate smoking related to:	F 550		

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Goal: Will remain compliant with center smoking procedure and individual smoking restrictions
Intervention: Complete Smoking Evaluation per facility guidelines.
7b. At risk smoker- No.
8. Additional Information
8a. Comments: (blank)."

On 5/30/18 at 3:00 p.m., Resident #355 was observed smoking a pipe outside in the courtyard with staff supervision. The resident was wearing a silver gray smoking apron (used to protect the resident's clothing and body if the resident dropped the pipe). Resident #355 voiced concern about wearing the smoking apron, in the presence of the staff member. The resident stated the apron was very demeaning to him and made him feel like a child.

On 6/1/18 at 9:46 a.m., an interview was conducted with ASM (administrative staff member) #4 (the assistant director of nursing) and ASM #2 (the director of nursing). ASM #4 was asked the facility process for determining which residents who smoke have to wear smoking aprons. ASM #4 stated, "They are certainly available for everybody." When asked if all residents who smoke have to wear smoking aprons, ASM #2 stated she would have to read the complete smoking policy because she had been employed at the facility for about a month.

On 6/1/18 at 10:22 a.m., ASM #4 stated the decision regarding which residents must wear smoking aprons is dependent on each resident's smoking assessment.

On 6/1/18 at 10:47 a.m., an interview was conducted with Resident #355. Resident #355

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stated the smoking apron made him feel like he was part of a barbecue due to the color of the apron. When asked if he had reported his dislike of the apron to facility staff, Resident #355 stated he had told staff in passing that the apron was ridiculous.

On 6/1/18 at 11:02 a.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 was asked if all residents who smoke have to wear a smoking apron. CNA #1 stated, "They are supposed to for safety precautions."

On 6/1/18 at 11:09 a.m., another interview was conducted with ASM #2. ASM #2 was asked to review the facility smoking policy and Resident #355's smoking assessment. ASM #2 was asked if Resident #355 should have to wear a smoking apron. ASM #2 stated, "No he doesn't have to because he's been designated a safe smoker."

On 6/4/18 at 5:44 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern.

The facility document titled, "SMOKING GUIDELINES" documented, "PURPOSE: To determine if a patient is an Independent Smoker or an At Risk Smoker before the patient exercises the privilege to smoke while residing within the center and to establish guidelines for all patients that desire to smoke, as well as non-smokers...Evaluate patients that smoke utilizing the Smoking Evaluation tool either: (a) upon admission; (b) when a previous non-smoking patient takes up smoking; (c) if unsafe smoking practices are observed in a current smoker; or, (d) when a patient that

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smokes has a significant change in medical condition...Upon completion of the evaluation, the interdisciplinary team, including the attending physician, will make a decision whether the patient is an Independent Smoker or an At Risk Smoker
-if the patient is determined to be an Independent Smoker, the patient may smoke without assistance at center designated times. Independent Smokers must still follow smoking guidelines including but not limited to, keeping smoking accessories in control of center staff when not in use and smoking only in designated areas at designated times
-if the patient is determined to be an At Risk Smoker, the patient is required to wear a protective smoking vest or apron if needed and is supervised while smoking..."

No further information was presented prior to exit.

3. The facility staff failed to maintain the dignity of Resident #27 by requiring her to wear a protective smoking vest/apron even though facility staff had assessed Resident #27 as an independent smoker.

Resident #27 was admitted to the facility on 3/9/18, with diagnoses that included but were not limited to: low back pain, diabetes, difficulty in walking, and muscle weakness.

The most recent MDS (minimum data set) assessment, a 30 day Medicare assessment, with an ARD (assessment reference date) of 4/4/18, coded the resident as scoring 15 on the BIMS (brief interview for mental status) score, indicating that she had no cognitive impairment. She was coded as always understanding others

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and always making herself understood. Resident #27 was coded as requiring one-person physical assistance for bed mobility and transfers, and staff supervision/set up for toileting, personal hygiene, bathing and dressing.

On 5/30/18 at 3:00 p.m., Resident #27 was observed smoking a cigarette outside in the courtyard with staff supervision. The resident was wearing a silver gray smoking apron (used to protect the resident's clothing and body if the resident dropped the pipe). Resident #27 voiced concern about wearing the smoking apron, in the presence of the staff member. The resident stated the apron made her feel like a baby.

The group interview was conducted on 5/31/18 at 11:30 a.m. with seven residents participating. The residents were asked if the staff treated them with dignity. At that time, Resident #27 stated the staff "treated her like a baby" when she went on her smoking breaks. Resident #27 stated they have made her wear the vest/apron ever since she was admitted on 3/9/18. She stated the staff required that she be supervised and wear a smoking vest/apron even though she had told the staff that she has never burned her clothes by dropping ashes.

During a record review on 05/31/18 at 1:48 p.m., it was noted that a "Smoking Assessment" had been performed on Resident #27 on 4/13/18. Based on the "Smoking Assessment", Resident #27 was documented as being an "Independent Smoker: Capable and independent, requires no supervision to smoke".

Resident #27's comprehensive care plan, dated 4/13/18, documented in part, "Focus: History of

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smoking in community". The "Interventions" documented in part, "Secure the smoking materials at nurses' station ...Discuss smoking habits with patient/family and develop an agreed upon smoking plan". The interventions did not document the use of a smoking vest/apron for this Resident.

On 5/31/18 at 2:52 p.m., Resident #27 was observed outside smoking, apron on, talking to staff member.

During an interview with ASM, (administrative staff member), #4, the assistant director of nursing, on 6/1/18 at 9:45 a.m., ASM #4 confirmed that the smoking assessment was performed on 04/13/18. ASM #4 stated that the smoking assessment should be done at admission; however, if they don't say they smoke on admission, the assessment will be done prior to the resident being allowed to go out to smoke. When asked if a resident can smoke without an assessment, she stated, "The smoking assessment must be done". When asked who is required to wear the protective vests/aprons, ASM #4 stated, "They are available for everyone". When asked if everyone has to wear the vests/aprons, ASM #4 and ASM #2, the director of nursing, stated they needed to review the smoking policy prior to answering.

An interview was conducted with Resident #27 on 6/1/18 at 10:09 a.m. Resident #27 stated that she has smoked from the day she got to the center. She stated she has been smoking since she was eighteen years old. She further stated she has no problem following the smoking rules but does not understand why she has had to wear apron since her admission on 3/9/18. Resident

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#27 stated, "As long as I have my faculties, I should not be treated like a child; I always hold my cigarette away from myself and not over self as I do not want to burn my clothes or get ash on me". When asked if she has ever asked staff about the aprons, she stated that she was told by the staff, "It's the rule".

An interview was conducted with LPN (licensed practical nurse) #4 on 6/1/18 at 10:43 a.m. When asked about the procedure for smokers, she stated, "Smokers are assessed and given the rules". When asked who is required to wear the protective aprons, she stated, "Everyone has to wear the apron".

An interview was conducted with CNA (certified nursing assistant) #1 on 6/1/18 at 11:00 a.m. regarding the smoking breaks. CNA #1 stated she puts the vests on the smokers and then sits with them. She lights all of their cigarettes. She stated residents have complained in the past about the vests but none have complained to her recently. When asked if all residents who smoke have to wear the vest, she stated, "Yes, for safety precautions". She stated if someone refuses to wear the vest she will get a supervisor to explain why the vests are required.

An interview was conducted with ASM #2 on 6/1/18 at 11:10 a.m. She stated she had reviewed the "Smoking Guidelines" and she confirmed that based on the guidelines, an Independent Smoker should not be required to wear a protective vest/apron. She acknowledged that this practice would make the Independent Smoker feel as though they were being treated as a child.

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F 550	Continued From page 18 A review of the facility's "Smoking Guidelines" was performed. The guidelines state that "If the patient is determined [by the IDT (interdisciplinary team)] to be an Independent Smoker, the patient may smoke without assistance at center designated times...if the patient is determined [by the IDT] to be an At Risk Smoker, the patient is required to wear a protective smoking vest or apron if needed and is supervised while smoking". ASM #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing, and ASM #5, the quality assurance consultant, were made aware of the above concerns on 6/4/18 at 5:30 p.m. No further information was provided prior to exit. 4. The facility staff left Resident #98 sitting at the lunch table for 16 minutes without a tray while four other residents at the table were eating. Resident #98 was admitted to the facility on 5/7/18 with the diagnoses of but not limited to gout, right above knee amputation, high blood pressure, benign prostatic hyperplasia, dementia, stroke, and seizures. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 5/14/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident required extensive care for all areas of activities of daily living; and was incontinent of bowel and had an indwelling catheter for bladder. On 5/30/18 at 12:42 p.m., there were 8 residents in the Laurel dining room, already eating. At 12:50 p.m., OSM #5 (Other Staff Member)	F 550		

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F 550	Continued From page 19 brought Resident #98 into the room, and placed Resident #98 at the table with 4 other residents already eating. At 1:06 p.m., OSM #5 returned to the dining room with the lunch tray for Resident #98. Resident #98 sat at the table for 16 minutes where four other residents were already eating, before being provided his lunch tray and staff assisted him to eat. On 5/31/18 at 9:18 a.m., in an interview with CNA #5 (Certified Nursing Assistant), who was in the dining room at the time of the observation and who ultimately assisted Resident #98 with feeding, CNA #5 stated that therapy had the resident and was feeding him in his room, and then brought him into the dining room. She stated they had to get him another tray to eat. When asked about him sitting at the table for 16 minutes without a try while watching others eat, CNA #5 stated, "In my mind, he could mingle with peers, but he doesn't really talk." On 6/5/18 at 11:22 a.m., in an interview with OSM #5, she stated that there was some miscommunication with the kitchen about the resident's lunch. She stated she had requested a plate in order to do an evaluation with the resident regarding his eating and swallowing. OSM #5 stated she had requested that in addition, his usual lunch also be sent up on the meal cart, but it was not. She stated that when she brought the resident into the dining room, she did not know his lunch tray was not on the cart that was on the unit, and had to go to the kitchen to get him one. OSM #5 stated that it took some time to rectify the situation and she didn't think it would take that long, but that in hindsight, Resident #98 should not have been left at a table where others were already eating if his tray was not available.	F 550		

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A review of the facility policy, "Your Resident Rights" failed to reveal any criteria for a home-like dining experience. However, the policy did document, "The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident...."

On 6/5/18 at approximately 12:30 p.m., the administrator and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

5. The facility staff stood over Resident #5 while providing feeding assistance.

Resident #5 was admitted on 9/8/11 with the diagnoses of but not limited to colon cancer, peripheral vascular disease, high blood pressure, and a colostomy. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/2818. The resident was coded as extensively cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, toileting, and hygiene; extensive assistance for transfers, dressing, and eating; and as incontinent of bladder and had an

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F 550	Continued From page 21 ostomy for bowel. On 5/30/18 12:42 p.m., eight residents were observed in the Laurel dining room. CNA #6 (Certified Nursing Assistant) was observed standing over Resident #5 while feeding Resident #5. On 6/5/18 10:42 a.m., in an interview with CNA #4, she stated that staff are to sit next to the resident when feeding them, and not stand over them. On 6/5/18 at approximately 12:30 PM, the administrator and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey. 6. The facility staff fed Resident #15 in an undignified manner. While being fed by staff, food dropped off the spoon onto the clothing protector. The facility staff scooped up the food with the spoon and fed it to the resident. Resident #15 was admitted to the facility on 10/4/11 with the diagnoses of but not limited to dementia, obstructive uropathy, stroke, benign prostatic hyperplasia, and arthritis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/16/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, dressing, and transfers; extensive assistance for bed mobility and eating; and as incontinent of	F 550		

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F 550	Continued From page 22 bowel and had an indwelling catheter for bladder. On 5/30/18 12:42 p.m., 8 residents were observed in the Laurel dining room. At 12:47 p.m., CNA #5 (Certified Nursing Assistant), while feeding Resident #15 spilled some mashed potatoes off the spoon onto the resident's clothing protector. CNA #5 then scooped it up the spilled mashed potatoes on the clothing protector with the spoon and fed it to the resident. On 5/31/18 at 9:18 a.m., in an interview with CNA #5, she stated it was not dignified to scoop the spilled food off the clothing protector and then feed it to the resident. CNA #5 stated, "That is a mom thing to do." On 6/5/18 at approximately 12:30 p.m., the administrator and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.	F 550		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580	**F-580** *It is the intent of this facility to notify of changes specified in 483.10(g)(14)(i)-(iv)(15).* Criteria 1 Physicians/NP will be notified of resident's #'96, and #87 regarding change in condition and residents #42, 23, 18 and 56 regarding medication unavailability.	

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F 580	Continued From page 23 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review	F 580	Criteria 2 Residents with changes in condition with blood sugar and residents whose medications are unavailable have the potential to be affected. Criteria 3 Licensed nursing staff were re-educated by DON/Designee on physician notification for changes in condition with blood sugar and unavailability of medication. Criteria 4 The DON or designee will audit medication administration records x5 daily, weekly x2 weeks and monthly x2 months to ensure compliance with physician notification. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed. Criteria 5 The facility's alleged date of compliance is 7/10/2018.	

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and clinical record review, it was determined the facility staff failed to notify the physician and/or the responsible representative for a change in condition for six of 50 residents in the survey sample, Residents #96, 87, 42, 23, 18, and 56.

1. The facility staff failed to notify the physician of elevated blood sugar for Resident #96 per the physician orders.

2. The facility staff failed to notify the physician of holding a long acting insulin for Resident #87.

3. The facility staff failed to notify the physician when Resident #42's medications were not available for administration.

4. The facility staff failed to notify Resident #23's physician (or nurse practitioner) when medications were unavailable for administration on multiple dates in February 2018.

5. The facility staff failed to notify Resident #18's physician (or nurse practitioner) when medications were unavailable for administration on multiple dates in January 2018 and April 2018.

6. The facility staff failed to notify Resident #56's physician (or nurse practitioner) when medications were unavailable for administration on multiple dates from February 2018 through May 2018.

The findings include:

1. The facility staff failed to notify the physician of elevated blood sugar for Resident #96 per the physician orders.

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Resident #96 was admitted to the facility on 3/28/18 with a recent readmission on 6/2/18 with diagnoses that included but were not limited to: heart failure, end stage renal disease requiring hemodialysis (A procedure used in toxic conditions and renal [kidney] failure in which wastes and impurities are removed from the blood by a special machine (1)), asthma, and diabetes.

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 5/22/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions.

The physician order dated, 3/28/18, documented, "Novolog Solution (a fast acting insulin used to treat diabetes (3)) 100unit/ML (milliliters) inject as per sliding scale: if 150 - 200 (blood sugar) = 4 units, 201 - 250 = 6 units, 251 - 300 = 8 units, 301 - 350 = 10 units, 351 - 400 = 12 units subcutaneously before meals and at bedtime for DM (diabetes mellitus). Blood sugar greater than 400 give 15 units and notify MD (medical doctor)."

The MAR (medication administration record) for April 2018 documented, "Novolog Solution 100unit/ML inject as per sliding scale: if 150 - 200 = 4 units, 201 - 250 = 6 units, 251 - 300 = 8 units, 301 - 350 = 10 units, 351 - 400 = 12 units subcutaneously before meals and at bedtime for DM. Blood sugar greater than 400 give 15 units and notify MD." The MAR documented on 4/4/18 at 4:30 p.m., the resident's blood sugar was 498.

Review of the nurse's note dated, 4/4/18 at 4:45

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p.m. documented, "BS (blood sugar) 498." There was no note or documentation evidencing the doctor was notified of the blood sugar being over 400 as per the physician order.

The comprehensive care plan dated, 3/29/18, documented in part, "Focus: The resident is on insulin r/t (related to) diabetes." The "Interventions" documented in part, "Monitor blood sugar, lab (laboratory) results as ordered by physician."

An interview was conducted with LPN (licensed practical nurse) #9 on 6/4/18 at 11:07 a.m. LPN #9 was asked to review the Novolog insulin order above. When asked what the nurse should do if the resident's blood sugar is 498, LPN #9 stated, "Give 15 units and call the doctor." When asked where this is documented, LPN #9 stated, "It should be in the progress notes."

An interview was conducted with RN (registered nurse) #4, the unit manager; on 6/4/18 at 11:21 a.m., RN #4 was asked to review the above Novolog order. Once the order was reviewed, RN #4 was asked what the staff should do if the resident's blood sugar is 498, RN #4 stated, "You give the 15 units and call the doctor." When asked where this notification is documented, RN #4 stated, "It should be in the progress note." The eMAR (electronic medication administration record) notes were shown to RN #4. RN #4 stated if it's not documented it was not done.

The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/4/18 at

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5:40 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010726/?report=details.

2. The facility staff failed to notify the physician of holding a long acting insulin for Resident #87.

Resident #87 was admitted to the facility on 5/22/15 with a recent readmission on 3/23/18 with diagnoses that included but were not limited to: dementia, high blood pressure, depression, diabetes, and muscle weakness.

The most recent MDS (minimum data set) assessment, a Medicare 60 day assessment, with an assessment reference date of 5/18/18, coded the resident as scoring an "11" on the BIMS (brief interview for mental status) score, indicating he is moderately impaired to make daily cognitive decisions. Resident #87 was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of his activities of daily living.

The physician order dated, 2/28/18, documented, "Lantus Solution (a long acting insulin used to treat diabetes (1)) 100Units/ML (milliliters); inject 20 units subcutaneously at bedtime for DM

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(diabetes mellitus)."

The March 2018 MAR (medication administration record) documented, Lantus Solution 100Units/ML (milliliters); inject 20 units subcutaneously at bedtime for DM (diabetes mellitus). The dose for 3/4/18 was documented as not given.

The nurse's note for 3/4/18 documented, "Accucheck (brand of glucometer used to obtain blood sugar check) 98. There was no further documentation regarding why the medication was not administered and no documentation evidencing the physician was notified the insulin was held.

The physician order dated, 3/23/18, documented, "Insulin Glargine Solution (Lantus insulin) 100Unit/ML; inject 20 units subcutaneously at bedtime for DM."

The May 2018 MAR documented, "Insulin Glargine Solution (Lantus insulin) 100Unit/ML; inject 20 units subcutaneously at bedtime for DM." The dose for 5/29/18 was documented as not having been administered. The eMAR (electronic medication administration record) dated 5/29/18, documented, "Held for low glucose." The medication is scheduled for 9:00 p.m. The blood sugar at 9:00 p.m. was documented as 118.

The comprehensive care plan dated, 1/30/17 documented in part, "Endocrine System related to: dm (diabetes mellitus)," The "Interventions" documented in part, "Administer medications per the physician order."

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On 6/4/18 at 1:42 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to review the Lantus insulin order, and was then asked if there was any reason staff would hold or not administer the medication. RN #1 stated, "I would be dependent upon the blood sugar. If it was way below the normal range, you would hold the Lantus and call the doctor." RN #1 reviewed the May 2018 MAR for Resident # 87 documenting that the Lantus was held for a blood sugar of 118. RN #1 stated, "That (the Lantus insulin) shouldn't have been held. It's a long acting insulin."

The nurses that held the insulin on the two days documented above were unavailable for interview.

An interview was conducted with LPN (licensed practical nurse) #8 on 6/4/18 at 2:08 p.m., regarding when she would hold Lantus insulin, LPN #8 stated, "I would hold it if the blood sugar is low." When asked to describe low, LPN #8 stated, "Below 60 and call the doctor." When asked if she would hold Lantus insulin for a blood sugar of 118, LPN #8 stated, "No, Lantus peaks later. It's not a short acting insulin."

The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/4/18 at 5:40 p.m.

No further information was provided prior to exit.
(1) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf

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06DD3.

3. The facility staff failed to notify the physician when Resident #42's medications were not available for administration.

Resident # 42 was admitted to the facility on 1/9/18 with a recent readmission on 3/12/18 with diagnoses that included but were not limited to: high blood pressure, heart disease, dementia, stroke, and atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output (1)).

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 4/18/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of his activities of daily living.

The nurse's note dated, 4/9/18 at 2:47 p.m. documented in part, "Lab (laboratory) result in and reading (+) (positive) for C-Diff (clostridium difficile)."

Clostridium difficile is a gram-positive anaerobic bacterium most often associated with antibiotic-associated diarrhea. Symptoms may range from asymptomatic carrier states to severe pseudomembranous colitis and are caused by toxins produced by the organism. Although

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c-difficile infection can be caused by almost any antibiotic that disrupts the intestinal flora, it's classically associated with clindamycin use. Patients at high risk for this disorder include those that are taking many kinds of antibiotics immunosuppressed individuals, and those in nursing homes. C-difficile may be transmitted directly from patient to patient via contaminated hands of facility personnel (most common) or indirectly through contaminated equipment such as bedpans, urinals, call bells, ...and surfaces such as bedrails, floors, and toilet seats ...because spores of c-difficile are resistant to most commonly used facility disinfectants the patients room may be contaminated even after the patient has been discharged. (2)

The physician order dated, 4/8/18 documented, "Vancomycin solution (an antibiotic when taken orally is used to treat C-Diff (3)) 50MG/ML (milligrams per milliliter); Give 5 ML via PEG-tube (Percutaneous endoscopic gastrostomy (4)) four times a day for C-Diff for 10 days."

The nurse's eMAR (electronic medication administration record) note dated, 4/12/18 at 6:41 p.m. documented in part, "Unavailable to administer." The nurse's eMAR note dated, 4/12/18 at 9:02 p.m. documented, "Unavailable to administer."

The physician order dated, 3/12/18, documented, "Floranex Tablet (is a probiotic used to treat various forms of diarrhea (5)) Give 1 tablet via PEG - Tube in the morning for diarrhea."

The nurse's eMAR note dated, 4/13/18 at 5:10 a.m. documented, "On order."
The nurse's eMAR note dated, 4/14/18 at 5:41

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a.m. documented, "waiting for pharmacy delivery."

The physician order dated, 3/12/18 documented, "Atorvastatin Calcium Tablet 40 MG; give 40 mg via PEG-Tube at bedtime for hyperlipidemia (elevated lipids in the blood, such as cholesterol and triglycerides (6)).

The nurse's eMAR note dated, 4/28/18 at 8:08 p.m. documented, "Medication not present in facility. Medication reordered. Awaiting delivery."

The physician order dated, 5/23/18, documented, "Vasolex Ointment (VASOLEX (Trademark) OINTMENT is used to promote wound healing and the treatment of decubitus ulcers, varicose ulcers and dehiscent wounds (7)); apply to groin and scrotum topically every shift for itching."

The nurse's eMAR note dated, 5/24/18 at 5:52 a.m. documented, "Awaiting pharmacy delivery." The nurse's eMAR note dated, 5/24/18 at 1:50 p.n. documented, "Awaiting delivery."

An interview was conducted with RN (registered nurse) #2 on 6/5/18 at 11:09 a.m. When asked about the process staff follows when medications are not available at the scheduled time of administration, RN #2 stated, "I double-check my cart. Then I call the pharmacy. Oh, I have to check the emergency box. Then I call the pharmacy and ask them to deliver them stat (Immediately)." When asked what steps take if the medication is not delivered and not available in the STAT box, RN #2 stated, "I let the resident know what is going on. I call the doctor that the medication is not available for this dose." When asked where is the notification is documented,

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RN #2 stated it would be documented in a nursing note or under the eMAR notes that you spoke with the doctor or nurse practitioner. I would have to call the resident representative also."

An interview was conducted with RN # 4, the unit manager, on 6/5/18 at 11:15 a.m. When asked about the process staff follow if a scheduled medication is not available on the medication cart, RN #4 stated, "I expect them to search their cart. Talk to the other nurses to make sure it didn't get on another cart by accident. Go to the med (medication) room and search there. Let the patient know you don't have the medication. Call the doctor and the pharmacy. Let the pharmacy know it's (medication) not here and get the ETA (estimated time of arrival) of when it will be here. I still call the doctor and inform them the medication is not available and await their instructions." When asked if the facility had an emergency drug box, RN #4 stated, "Yes, I would check that before calling the pharmacy." When asked where all this is documented, RN #4 stated it should be in a nurse's note or in the medication record notes.

The administrator, administrative staff member (ASM) #1, ASM #5, the quality assurance consultant and AM #7, the administrator from another corporate facility, were made aware of the above concern on 6/5/18 at 12:36 p.m.

No further information was obtained prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.

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(2) Springhouse Handbook of Diseases- Causes, Signs and Symptoms, Patient Care- 2007 Springhouse Corporation pages 217-219.
(3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012602/?report=details.
(4) This information was obtained from the following website: https://medlineplus.gov/ency/article/002937.htm
(5) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2838518/
(6) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009143/?report=details.
(7) This information was obtained from the following website: https://www.drugs.com/pro/vasolex-ointment.html
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4. The facility staff failed to notify Resident #23's physician (or nurse practitioner) when medications were unavailable for administration on multiple dates in February 2018.

Resident #23 was admitted to the facility on 10/11/17. Resident #23's diagnoses included but were not limited to GERD (gastro-esophageal reflux disease), dementia (1) and a pressure injury (2). Resident #23's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/28/18, coded the resident's cognitive skills for daily decision-making as severely impaired.

Review of Resident #23's clinical record revealed the following physician's orders:

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F 580	Continued From page 35 -10/11/17- Protonix (3) 40 mg (milligrams) one time a day for GERD. -10/18/17- Nystatin (4) 100,000 unit per milliliter-5 milliliters three times a day for oral care. Review of Resident #23's February 2018 MAR (medication administration record) revealed the following: -The code "9- Other/See Nurse Notes" was documented in regards to the administration of Protonix for all three doses of Nystatin on 2/11/18. -The code "9" was documented in regards to the administration of all three doses of Nystatin on 2/24/18. -The code "9" was documented in regards to the administration of all three doses of Nystatin on 2/25/18. Further review of Resident #23's clinical record revealed the following nurses' notes: -Nurses' notes dated 2/11/18 that documented Nystatin was on order and Protonix was unavailable to administer. -Nurses' notes dated 2/24/18 and 2/25/18 that documented Nystatin was on order. The above notes failed to document Resident #23's physician (or nurse practitioner) were notified regarding the unavailable medications. Resident #23's care plan dated 10/12/17 documented, "GI (Gastrointestinal) distress r/t (related to) GERD. Administer medications per physician orders..." On 6/4/18 at 2:43 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked if the physician should be notified if a medication is not available for administration. LPN #3 stated, "Yes. You are	F 580		

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supposed to notify the physician and get a hold order." LPN #3 stated nurses are supposed to document the physician notification.

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility/pharmacy policy titled, "7.0 Medication Shortages/Unavailable Medications" documented, "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 the pharmacy...4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions."

No further information was presented prior to exit.

(1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.240726468.691240467.1528283828-139120270.1477942321

(2) "A pressure sore (injury) is any redness or

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break in the skin caused by too much pressure on your skin for too long a period of time." This information was obtained from the website: http://sci.washington.edu/info/pamphlets/pressure_sores.asp

(3) "Pantoprazole (Protonix) is used to treat gastroesophageal reflux disease (GERD), a condition in which backward flow of acid from the stomach causes heartburn and possible injury of the esophagus (the tube between the throat and stomach)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601246.html

(4) Nystatin is used to treat fungal infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682758.html

5. The facility staff failed to notify Resident #18's physician (or nurse practitioner) when medications were unavailable for administration on multiple dates in January 2018 and April 2018.

Resident #18 was admitted to the facility on 4/25/11. Resident #18's diagnoses included but were not limited to legal blindness, high cholesterol and paralysis. Resident #18's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/23/18, coded the resident's cognitive skills for daily decision-making as severely impaired.

Review of Resident #18's clinical record revealed the following physician's orders:

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-8/27/14- Baclofen (1) 5 mg (milligrams) by mouth two times a day for pain.
-1/22/18- Erythromycin (2) ointment 5mg/gm (gram) - instill 0.5 strip in left eye two times a day for three months for legal blindness.

Review of Resident #18's January 2018 MAR (medication administration record) revealed the following:
-The code "9- Other/See Nurse Notes" was documented in regards to Baclofen administration at 9:00 a.m. on 1/12/18 and 1/14/18
-The code "9" was documented in regards to Erythromycin ointment administration on 1/22/18 at 5:00 p.m.
-The code "5- Hold/See Nurse Notes" was documented in regards to Erythromycin ointment administration on 1/29/18 at 9:00 a.m.

Further review of Resident #18's clinical record revealed the following nurses' notes:
-1/12/18 "Baclofen Tablet- Give 5 mg by mouth two times a day for pain- not on hand will re order from pharmacy."
-1/14/18 "Baclofen Tablet. Medication unavailable."
-1/22/18 "Erythromycin Ointment 5 MG/GM. Instill 0.5 strip in left eye two times a day related to LEGAL BLINDNESS, AS DEFINED IN USA for 3 Months 1/2 ribbon to OD (right eye). Medication on order from pharmacy."
-1/29/18 "Erythromycin Ointment 5 MG/GM. Instill 0.5 strip in left eye two times a day related to LEGAL BLINDNESS, AS DEFINED IN USA for 3 Months 1/2 ribbon to OD (right eye)- awaiting medication from pharmacy, MD (medical doctor) and RP (responsible party) nnotified (sic)."

The above notes failed to document Resident

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#18's physician (or nurse practitioner) was notified regarding the unavailable medications, except for the note dated 1/29/18.

Review of Resident #18's April 2018 MAR revealed the following:
-The code "9- Other/See Nurse Notes" was documented in regards to Erythromycin administration at 5:00 p.m. on 4/9/18 and 4/14/18.

Further review of Resident #18's clinical record revealed the following nurses' notes:
-4/9/18 "Erythromycin Ointment 5 MG/GM. Instill 0.5 strip in left eye two times a day related to LEGAL BLINDNESS, AS DEFINED IN USA for 3 Months 1/2 ribbon to OD (right eye) - Medication not located in med cart or at bedside. Medication reordered. Awaiting delivery from pharmacy."
-4/14/18 "Erythromycin Ointment 5 MG/GM. Instill 0.5 strip in left eye two times a day related to LEGAL BLINDNESS, AS DEFINED IN USA for 3 Months 1/2 ribbon to OD (right eye)- Medication not present in facility. Medication ordered from pharmacy. Awaiting delivery."

The above notes failed to document Resident #18's physician (or nurse practitioner) was notified regarding the unavailable medications.

Resident #18's care plan dated 6/18/09 and 3/26/18 documented, "Erythromycin Ointment related to LEGAL BLINDNESS, for 3 months. Administer as ordered by MD (medical doctor)...potential for Pain due to osteo, general hx (history) spasams (sic). Administer pain medication as per MD orders..."

On 6/4/18 at 2:43 p.m., an interview was conducted with LPN (licensed practical nurse) #3.

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LPN #3 was asked if the physician should be notified if a medication is not available for administration. LPN #3 stated, "Yes. You are supposed to notify the physician and get a hold order." LPN #3 stated nurses are supposed to document the physician notification.

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) Baclofen is used to treat muscle spasms. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682530.html

(2) Erythromycin is used to treat infections. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=erythromycin&_ga=2.141112693.691240467.1528283828-139120270.1477942321

6. The facility staff failed to notify Resident #56's physician (or nurse practitioner) when medications were unavailable for administration on multiple dates from February 2018 through May 2018.

Resident #56 was admitted to the facility on 6/5/15 and readmitted on 4/10/18. Resident #56's diagnoses included but were not limited to high cholesterol, diabetes and paralysis. Resident #56's most recent MDS (minimum data

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set), a quarterly assessment with an ARD (assessment reference date) of 5/1/18, coded the resident's cognition as moderately impaired.

Review of Resident #56's clinical record revealed the following physician's orders:
-12/28/17- Pred Forte (1) eye drops (no strength) - four drops in the left eye four times a day for infection.
-12/28/17 and 4/10/18- Systane (2) 0.4/0.3% eye drops- one drop in both eyes four times a day for dry eyes.
-12/28/17- Latanoprost (3) eye drops- one drop in both eyes at bedtime for glaucoma.
-12/28/17- Lidocaine (4) 2% gel- apply topically to knees two times a day for pain.
-12/28/17- Plavix (5) - 75 mg by mouth one time a day for stroke.
-1/5/18- Hydralazine (6) - 50 mg by mouth three times a day for high blood pressure.
-4/10/18- Dorzolamide (7) 22.3/6.8 mg/ml (milliliters) eye drops- one drop in both eyes two times a day for glaucoma.
-12/28/17- Amlodipine Besylate (8) - 10 mg (milligrams) by mouth one time a day for high blood pressure.

Review of Resident #56's February 2018 MAR (medication administration record) revealed the following:
-The code "9- Other/See Nurse Notes" was documented in regards to administration of Latanoprost, the 5:00 p.m. and 9:00 p.m. dose of Pred Forte, the 5:00 p.m. and 9:00 p.m. dose of Systane and the 5:00 p.m. dose of Lidocaine on 2/3/18.
-The code "9" was documented in regards to administration of Latanoprost, the 5:00 p.m. and 9:00 p.m. dose of Pred Forte, the 5:00 p.m. and

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9:00 p.m. dose of Systane and the 5:00 p.m. dose of Lidocaine on 2/4/18.
- The code "9" was documented in regards to the administration of the 1:00 p.m. dose of Pred Forte and the 1:00 p.m. dose of Systane on 2/10/18.
-The code "9" was documented in regards to the administration of Plavix, Amlodipine, the 9:00 a.m., 1:00 p.m. and 9:00 p.m. dose of Pred Forte, all four doses of Systane and both doses of Lidocaine on 2/11/18.
-The code "9" was documented in regards to the administration of Plavix and all four doses of Systane on 2/24/18.
-The code "9" was documented in regards to the administration of Plavix and all four doses of Systane on 2/25/18.

Further review of Resident #56's clinical record revealed the following nurses' notes:
-Nurses' notes dated 2/3/18 that documented Pred Forte, Latanoprost, Systane and Lidocaine was unavailable to administer.
-Nurses' notes dated 2/4/18 that documented Lidocaine, Systane, Latanoprost and Pred Forte was unavailable to administer.
-Nurses' notes dated 2/10/18 that documented Pred Forte and Systane was unavailable.
-Nurses' notes dated 2/11/18 that documented Systane, Lidocaine, Pred Forte, Amlodipine and Plavix were unavailable to administer.
- Nurses' notes dated 2/24/18 that documented Systane and Plavix were unavailable to administer.
-Nurses' notes dated 2/25/18 that documented Systane and Plavix were unavailable to administer.
The above notes failed to document Resident #56's physician (or nurse practitioner) was notified regarding the unavailable medications.

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Review of Resident #56's March 2018 MAR revealed the following:
-The code "9- Other/See Nurse Notes" was documented in regards to administration of all four doses of Systane on 3/10/18 and 3/11/18.
-The code "9" was documented in regards to administration of the 5:00 p.m. and 9:00 p.m. doses of Systane on 3/24/18 and 3/25/18.

Further review of Resident #56's clinical record revealed nurses' notes dated 3/10/18, 3/11/18, 3/24/18 and 3/25/18 that documented Systane was unavailable to administer.
The above notes failed to document Resident #56's physician (or nurse practitioner) was notified regarding the unavailable medications.

Review of Resident #56's April 2018 MAR revealed the following:
-The code "9-Other/See Nurse Notes" was documented in regards to administration of the 5:00 p.m. dose of Hydralazine and the 5:00 p.m. dose of Systane on 4/10/18. Nurses' notes dated 4/10/18 documented the Hydralazine and Systane was pending pharmacy delivery.

The above notes failed to document Resident #56's physician (or nurse practitioner) was notified regarding the unavailable medications.

Review of Resident #56's May 2018 MAR revealed the following:
-The code "9-Other/See Nurse Notes" was documented in regards to the administration of the 9:00 a.m. dose of Dorzolamide on 5/19/18. A nurse's note dated 5/19/18 documented, "Medication not in building, on order."

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The above note failed to document Resident #56's physician (or nurse practitioner) was notified regarding the unavailable medication.

Resident #56's comprehensive care plan dated 6/5/15, 6/15/15 and 6/1/17 documented, "Cardiac disease related to Hypertension (high blood pressure), hyperlipidemia (high cholesterol). Administer medication per physician orders...eye prophalactic (sic). Administer medication per physician orders...ASA (Aspirin) and Plavix At (sic.) risk for adverse effects. Administer per physician orders...potential for pain due to decreased mobility, dm (diabetes mellitus). Administer pain medication per physician orders...impaired vision as related to glaucoma. Eye meds as on mars..."

On 6/4/18 at 2:43 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked if the physician should be notified if a medication is not available for administration. LPN #3 stated, "Yes. You are supposed to notify the physician and get a hold order." LPN #3 stated nurses are supposed to document the physician notification.

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) Pred Forte is used to treat eye inflammation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682794.html

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F 580	Continued From page 45 (2) Systane is used to treat dry eyes. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3130915/ (3) Latanoprost is used to treat glaucoma. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010869/?report=details (4) Lidocaine gel is used to treat pain. This information was obtained from the website: https://medlineplus.gov/ency/article/003059.htm (5) Plavix is used to prevent life-threatening problems with the heart and blood vessels in people who have had a heart attack or stroke. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601040.html (6) Hydralazine is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682246.html (7) Dorzolamide is used to treat glaucoma. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697049.html (8) Amlodipine Besylate is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a692044.html	F 580		
F 582	Medicaid/Medicare Coverage/Liability Notice	F 582		

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CFR(s): 483.10(g)(17)(18)(i)-(v)

§483.10(g)(17) The facility must--
(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident

F 582

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It is the intended practice of this facility to inform each resident of their Medicaid/Medicare coverage/liability notice.

Criteria 1
Resident # 301 is discharged.

Criteria 2
Residents who are receiving skilled services with Medicare coverage have the potential to be affected. An audit was completed of residents with Medicare coverage whose skilled services were discontinued, looking back to 6/5/18.

Criteria 3
Facility Social workers were re-educated by Administrator/ designee on the policy for issuing Advance beneficiary notices.

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F 582	Continued From page 47 representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to provide an advanced beneficiary notice for one of 50 residents in the survey sample, Resident # 301. The facility staff failed to issue an advanced beneficiary notice to Resident # 301 or Resident # 301's responsible party prior to the last day of coverage on 01/03/2018. The findings include: Resident # 301 was admitted to the facility on 12/04/17 with diagnoses that included but were not limited to: insomnia (1), hypothyroidism (2), hypertension (3), bilateral (right and left) osteoarthritis of the knee (4) and right knee replacement. Further review of the clinical record revealed Resident # 301 was admitted for skilled services on 12/04/18 and discharged from skilled services on 01/03/2018.	F 582	Criteria 4 The Administrator or designee will audit residents discharged from skilled services daily x5 days, weekly x2 weeks and monthly x2 months to ensure compliance with issuing an advanced beneficiary notice. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed. Criteria 5 The facility's alleged date of compliance is 7/10/18.	

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Resident # 301's most recent MDS (minimum data set), a 30-day assessment with an ARD (assessment reference date) of 12/30/17, coded Resident # 301 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively for making daily decisions. Resident # 301 was coded as requiring supervision to limited assistance of one staff member for activities of daily living.

On 05/30/18 at approximately 10:00 a.m., during the entrance conference with ASM (administrative staff member) # 1, the administrator, a request was made for the "Completion of the "SNF (Skilled Nursing Facility) Beneficiary Protection Notice Review" form for Resident # 301.

On 05/31/18 at approximately 4:50 p.m., ASM # 1, the administrator, provided this surveyor with the "SNF (Skilled Nursing Facility) Beneficiary Protection Notice Review" form for Resident # 301. Review of the "SNF Beneficiary Protection Notice Review" form revealed blanks under "Medicare Part A Skilled Services Episode Start Date" and "Last covered day of Part A Service." Under "1. Was an SNF ABN (Advance Beneficiary Notice), Form CMS (Centers for Medicare/Medicaid Services) - 1055 provided to the resident?" it documented, "No- If no, explain why the form was not provided." Further review of this section failed to evidence further documentation. Under "2. Was a NOMNC (Notice of Medicare Non-Coverage) (CMS-10123) provide to the resident?" it documented, "No - if no explain why the form was not provided." Further review of this section failed to evidence further documentation. When asked why the form was blank and why an ABN was not issued ASM # 1 stated, "We were in a transition of a

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social worker."

On 06/01/18 at approximately 9:15 a.m., an interview was conducted with OSM (other staff member) # 1, social services director. When asked to describe the process for issuing an ABN (advanced beneficiary notice) OSM # 1 stated, "Once we have a discharge date we issue a notice of non-coverage no later than 48 hours prior to the last day of coverage." When asked why an ABN was not issued to Resident # 301, OSM # 1 stated, "I don't know. It was when the previous social worker was here and she is no longer here."

On 06/04/18 at approximately 5:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A common sleep disorder. If you have it, you may have trouble falling asleep, staying asleep, or both. As a result, you may get too little sleep or have poor-quality sleep. You may not feel refreshed when you wake up. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/insomnia.html.

(2) Not enough thyroid hormone to meet your body's needs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html.

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F 582	Continued From page 50 (3) Low blood pressure. This information was taken from the website: https://medlineplus.gov/lowbloodpressure.html. (4) The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html.	F 582		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584	**F-584** *It is the intended practice of this facility to honor a resident's right to a safe, clean, comfortable and homelike environment, including but not limited to providing a homelike dining experience.* Criteria 1 Observations have been completed to ensure staff are providing a homelike dining experience for resident #'s 24, 5, 32, 15, 57, 7, 35, 8, and 98. Criteria 2 Residents who eat meals in the Laurel dining room have the potential to be affected. Dining observations have been completed to ensure plates are removed from the trays for a homelike dining experience.	

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§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide a homelike dining experience for nine of 9 residents in the Laurel dining room; Residents #24, #5, #32, #15, #57, #7, #35, #8, and #98.

On 5/30/18 at 12:42 p.m., there were eight residents observed in the Laurel dining room, already eating (Residents #24, #5, #32, #15, #57, #7, #35, and #8.) At 12:50 p.m., staff were observed brining a ninth resident (Resident #98) into the dining room. All nine residents were observed being served their meal on trays, cafeteria/institutional style. The plates were not removed from the trays for a restaurant/home-like dining experience.

The findings include:

Resident #24 was admitted to the facility on 10/5/16 with the diagnoses of but not limited to

Criteria 3
Nursing staff were re-educated by DON/Designee on removing plates from trays when serving meals to residents, and providing a homelike dining experience.

Criteria 4
The administrator or designee will monitor the Laurel dining room for meals daily x5 days, weekly x2 weeks and monthly x2 months to ensure compliance. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed.

Criteria 5
The facility's alleged date of compliance is 7/10/18.

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heart disease and dementia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/29/18. The resident was coded as being moderately impaired in ability to make daily life decisions.

Resident #5 was admitted on 9/8/11 with the diagnoses of but not limited to colon cancer, peripheral vascular disease, high blood pressure, and a colostomy. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/2818. The resident was coded as extensively cognitively impaired in ability to make daily life decisions.

Resident #32 was admitted to the facility on 6/12/15 with the diagnoses of but not limited to fractured right femur, chronic embolism and thrombosis of lower extremity, and dementia. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 4/6/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions.

Resident #15 was admitted to the facility on 10/4/11 with the diagnoses of but not limited to dementia, obstructive uropathy, stroke, benign prostatic hyperplasia, and arthritis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/16/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions.

Resident #57 was admitted on 11/26/11 with the diagnoses of but not limited to stroke, blindness,

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F 584	Continued From page 53 diabetes, heart failure, high blood pressure, and dementia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/2/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. Resident #7 was admitted on 6/19/14 with the diagnoses of but not limited to multiple sclerosis, dysphagia, left above knee amputation, dementia, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/3/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. Resident #35 was admitted to the facility on 11/29/17 with the diagnoses of but not limited to osteoarthritis, high blood pressure, diabetes, gout, and dementia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/1/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. Resident #8 was admitted to the facility on 4/5/17 with the diagnoses of but not limited to atrial fibrillation, depression, hearing loss, post traumatic stress disorder, and artificial eye. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 3/7/18. The resident was coded as mildly impaired in ability to make daily life decisions. Resident #98 was admitted to the facility on 5/7/18 with the diagnoses of but not limited to	F 584		

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gout, right above knee amputation, high blood pressure, benign prostatic hyperplasia, dementia, stroke, and seizures. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 514/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions.

On 5/30/18 at 12:42 p.m., there were eight residents observed in the Laurel dining room, already eating (Residents #24, #5, #32, #15, #57, #7, #35, and #8.) At 12:50 p.m., staff were observed brining a ninth resident (Resident #98) into the dining room. All nine residents were observed being served their meal on trays, cafeteria/institutional style. The plates were not removed from the trays for a restaurant/home-like dining experience.

On 6/5/18 at approximately 11:00 a.m., in an interview with CNA (certified nursing assistant) #4, CNA #4 stated, "We leave them (plates) on the tray. That's how we have always done it. We remove them (plates) in the main dining room, but not the Laurel dining room." When asked if this was cafeteria or institutional style dining or if it was restaurant or home-like dining style, CNA #4 stated, "I would say it is like a cafeteria experience. They should have a restaurant experience. This is their home."

A review of the facility policy, "Your Resident Rights" failed to reveal any criteria for a home-like dining experience. However, the policy did document, "The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must treat each

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resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident...."

On 6/5/18 at approximately 12:30 p.m., the administrator and director of nursing (Administrative Staff Members, ASM #1 and #2 respectively) were made aware of the findings. Both, ASM #1 and ASM #2 stated the staff have been educated multiple times on removing the trays and providing a home-like dining experience. No further information was provided by the end of the survey.

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

§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid

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It is the intended practice of this facility to honor transfer and discharge requirements, including but not limited to ensuring physician documentation in clinical record upon transfer to hospital and providing required documents to receiving hospital upon transfer.

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under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident

Criteria 1
Residents #75 and 101A are discharged.
Should residents # 32, 20, 99, 96, 87, 90, 42, 75, 23 and 36 require a facility initiated hospital transfer, physicians/NP's will document the need for the transfer to the hospital, and the facility will provide the residents comprehensive care plan goals to the hospital.

Criteria 2
Residents in the facility who require a facility initiated transfer to the hospital have the potential to be affected. Physicians/NP's will document in the resident medical record, the need for facility initiated transfer to the hospital, and the facility will provide the comprehensive care plan goals to the hospital.

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F 622	Continued From page 57 needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to meet the appropriate transfer requirements for 12 of 50 residents in the survey sample, Residents #'s 100, 75, 20, 32, 99, 101 A, 23, 36, 96, 87, 90 , and 42. 1. The facility staff failed to ensure the physician (and/or nurse practitioner) documented why a facility-initiated transfer was necessary for Resident #100, and failed to provide evidence that the resident's comprehensive care plan goals	F 622	Criteria 3 Licensed nurses were re-educated by DON/Designee on providing comprehensive care plan goals to hospital staff with a facility initiated transfer to the hospital and Physicians/NPs were re-educated on documenting why the facility initiated discharge to the hospital was necessary. Criteria 4 DON or designee will audit facility initiated transfers to the hospital, daily x5 days, weekly x2 weeks, and monthly x2 months. . Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed. Criteria 5 The facility's alleged date of compliance is 7/10/2018.	

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were provided to the hospital staff for facility initiated transfers to the hospital on 04/01/18 and on 05/25/18 for Resident # 100.

2. The facility staff failed to ensure the physician (and/or nurse practitioner) documented why a facility-initiated transfer was necessary for Resident #75, and failed to provide evidence that the resident's comprehensive care plan goals were provided to the hospital staff for facility initiated transfers to the hospital on 05/25/18 for Resident # 75.

3. Resident #20 was hospitalized on 4/27/18-5/1/18. The facility staff failed to provide evidence that the comprehensive care plan goals were sent to the receiving hospital.

4. Resident #32 was hospitalized on 3/27/18 to 3/29/18. The facility failed to evidence that the resident's comprehensive care plan goals were provided to the receiving hospital.

5. Resident #99 was hospitalized on 2/2/18 to 2/10/18, 3/22/18 to 3/28/18, and 4/3/18 to 4/27/18. The facility failed to evidence that the resident's comprehensive care plan goals were provided to the receiving hospital.

6. Resident #101A transferred to the hospital on 1/1/18. The facility staff failed to evidence that the comprehensive care plan goals were sent to the receiving hospital.

7. The facility staff failed to ensure the physician (and/or nurse practitioner) documented why a facility-initiated transfer was necessary for Resident #23 and failed to provide evidence that

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the resident's comprehensive care plan goals were provided to the hospital staff when Resident #23 was transferred to the hospital on multiple dates from March 2018 through May 2018.

8. The facility staff failed to ensure the physician (and/or nurse practitioner) documented why a facility-initiated transfer was necessary for Resident #36 and failed to provide evidence that the resident's care plan goals were provided to the hospital staff when Resident #36 was transferred to the hospital on multiple dates from December 2017 through March 2018.

9. Resident #96 was sent to the hospital on 4/9/18. The facility failed to evidence that the care plan goals were provided to the receiving hospital.

10. Resident #87 was sent to the hospital on 3/8/18. The facility failed to evidence that the care plan goals were provided to the receiving hospital.

11. Resident #90 was transferred to the hospital on 4/18/18. The facility failed to evidence the care plan or care plan goals were sent to the receiving hospital.

12. Resident #42 was transferred to the hospital on 2/5/18 and 2/25/18. The facility failed to evidence the care plan or care plan goals were sent to the receiving hospital.

The findings include:

1. The facility staff failed to ensure the physician (and/or nurse practitioner) documented why a facility-initiated transfer was necessary for

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Resident #100, and failed to provide evidence that the resident's comprehensive care plan goals were provided to the hospital staff for facility initiated transfers to the hospital on 04/01/18 and on 05/25/18 for Resident # 100.

Resident # 100 was admitted to the facility on 03/02/18 with a readmission of 05/30/18 with diagnoses that included but were not limited to heart failure, hypertension (1), gastroesophageal reflux disease (2), diabetes mellitus (3), dementia (4) and seizure disorder (5).

Resident # 100's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 100 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions.

The nurse's "Progress Notes," dated 4/1/2018 22:38 (10:38 p.m.) for Resident # 100 documented, "Resident was found in distress with breathing and foaming at the mouth, resident very guarding of chest. Resident 90% (percent) incoherent. Resident very pale. Resident had involuntary movements in her abdomen. O2 (oxygen) sats (saturation) were ranging from 89 to 93. Primary doctor called and I was told to send her out to (Name of Hospital). Resident daughter aware."

The nurse's "Progress Notes," dated 04/05/2018 17:27 (5:27 p.m.) for Resident # 100 documented, "Resident readmitted back to facility @ (at) 1:50 p.m. Was transported from (Name of Hospital). Alert and responsive. Resident will be on IV (intravenous) ABT (antibiotic) until 4/10, she

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has a double lumen (6) in her right arm Resident has scatter scabs on back of neck and abdomen. Left lateral ankle has some discoloration."

The nurse's "Progress Notes," dated 5/25/2018 21:36 (9:36 p.m.) for Resident # 100 documented, "Resident sending out to (Name of Hospital) this morning on the 7-3 (7:00 a.m. to 3:00 p.m.) shift under the approval of MD (medical doctor) and daughter for elevated BUN (blood urea nitrogen). No other info (information) from Hospital this evening."

The nurse's "Progress Notes," dated 5/30/2018 20:34 (8:34 p.m.) for Resident # 100 documented, "Resident arrived at 3p.m. this afternoon under the care of (Name of Physician) and with orders for hospice care. Alert and oriented x 1 (times one). No [sic] able to make needs known. Incontinent of bowel and bladder. No distress noted upon arrival. Family arrived at bedside. Will continue to monitor."

Review of the physician's most recent progress notes dated April 2018 through May 2018 failed to evidence documentation of the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 100.

Review of resident # 100's clinical record failed to evidence the receiving facility received a copy of Resident # 100's care plan goals.

On 06/05/18 at 8:33 a.m., an interview was conducted with nursing RN (registered nurse) # 2 from unit one regarding information provided to the receiving facility for a facility initiated transfer.

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When asked describe what documentation is provided to the receiving facility when a resident is transferred RN # 2 stated, "The nurse manager usually puts together the paper work for the transfer if she is not here we follow the list on the folder. We call the family and physician. We make a copy of the list and keep it in the resident's chart." A review of the folder provided by RN # 2 revealed an envelope with a list of documents printed on the face of the envelope. It documented, "Post Acute Care Transfer Document Checklist. Copies Sent with Patient (check all that apply). These documents should ALWAYS accompany patient: Patient Transition Care Form; Face sheet; H&P (History and Physical) or Admission Note; Last Two Days of Progress Notes; Medication Reconciliation Form; Current Medication List or Current MAR (medication administration record); Prescriptions; Advance Directives or POLST (Provider Orders for Life-Sustaining Treatment); Recent MD/NP/PA (medical doctor/nurse practitioner/physician assistant) orders related to Acute Condition (last 48 hours); Relevant Lab (laboratory) Results; Relevant X-Rays and Personal Belongings Sent with Patient." When asked if a copy of the resident's comprehensive care plan goals are included in the list of documents to be sent with a resident for a facility initiated transfer, RN # 2 stated, "No."

On 06/05/18 at 8:57 a.m., an interview was conducted with RN # 1 unit manager of unit two regarding information provided to the receiving facility for a facility-initiated transfer. RN # 2 stated, "We do the acute transfer form in the assessment tab of PCC (point click care- electronic health record) and that goes with them to the hospital. If that is not done a

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re-hospitalization form, under the assessment tab is completed and it stays in the facility. We send the items on the "Post Acute Care Transfer Document Checklist" We were never told to send a copy of the care plan goals."

On 06/05/18 at 10:10 a.m., a telephone interview was attempted with ASM (administrative staff member) # 6, the nurse practitioner; ASM # 6 was unavailable for interview.

On 06/05/18 at 10:13 a.m., an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked to describe what is documented when a resident is transferred to the hospital ASM # 2 stated, "They complete a progress note weather they are in the building or not because they (physician's) are called by the nurse." When asked if the physician documents the specific needs the facility could not meet, the facility's efforts to meet those needs and the specific needs the receiving facility could provide to meet the needs of Resident, ASM # 2 stated, "No."

On 06/04/18 at approximately 5:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

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

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

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

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

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

(6) The space in the interior of a hollow tubular structure (artery or intestine). This information was obtained from the website: http://www.medilexicon.com/dictionary/51452.

2. The facility staff failed to ensure the physician (and/or nurse practitioner) documented why a facility-initiated transfer was necessary for Resident #75, and failed to provide evidence that the resident's comprehensive care plan goals were provided to the hospital staff for facility initiated transfers to the hospital on 05/25/18 for Resident # 75.

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Resident # 75 was admitted to the facility on 02/15/17 with a readmission of 06/01/18 with diagnoses that included but were not limited to hypertension (1), gastroesophageal reflux disease (2), diabetes mellitus (3), anxiety (4) and peripheral vascular disease (5).

Resident # 75's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/14/18, coded Resident # 75 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

The nurse's "Progress Notes," dated 05/25/18 for Resident # 75 documented, "12:29 p.m. Resident alert and orientated x4 (times four) c/o (complaint of) nausea, "I felt like I was going to throw up this morning." Multiple bowel movements today. Reports SOB (short of breath), scheduled neb (nebulizer) treatments given MD (medical doctor) and family informed, per (Name of Physician) resident sent to (Name of Hospital) ER (emergency room). Discharged instructions reviewed with niece."

Review of the physician's most recent progress notes dated May 2018 failed to evidence documentation of the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 75.

Review of resident # 75's clinical record failed to evidence the receiving facility received a copy of Resident # 75's care plan goals.

On 06/05/18 at 8:57 a.m., an interview was

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conducted with RN # 1 unit manager of unit two regarding information provided to the receiving facility for a facility-initiated transfer. When asked describe what documentation is provided to the receiving facility when a resident is transferred RN # 2 stated, " We do the acute transfer form in the assessment tab of PCC (point click care-electronic health record) and that goes with them to the hospital. If that is not done a re-hospitalization, form under the assessment tab is completed and it stays in the facility. We send the items on the 'Post Acute Care Transfer Document Checklist'. We were never told to send a copy of the care plan goals."

On 06/05/18 at 10:10 a.m., a telephone interview was attempted with ASM (administrative staff member) # 6, the nurse practitioner; ASM # 6 was unavailable for interview.

On 06/05/18 at 10:13 a.m., an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked to describe what is documented when a resident is transferred to the hospital ASM # 2 stated, "They complete a progress note weather they are in the building or not because they (physician's) are called by the nurse." When asked if the physician documents the specific needs the facility could not meet, the facility's efforts to meet those needs and the specific needs the receiving facility could provide to meet the needs of Resident, ASM # 2 stated, "No."

On 06/04/18 at approximately 5:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

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No further information was provided prior to exit.

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

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

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

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

(5) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.No further information was provided prior to exit.
3. Resident #20 was hospitalized on 4/27/18-5/1/18. The facility staff failed to provide evidence that the comprehensive care plan goals

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were sent to the receiving hospital.

Resident #20 was admitted to the facility on 8/8/17, with a most recent readmission date of 5/1/18. Diagnoses included but were not limited to: diabetes, high blood pressure, right total hip replacement, and atrial fibrillation (irregular heartbeat) (1).

The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 3/23/18, coded the resident as scoring a 3 on the BIMS (brief interview for mental status) score, indicating that she has severe cognitive impairment.

The nurse's progress note dated 4/27/18 at 18:08 p.m. documented in part, "Resident was refusing all care today, day [sic] reported that she refused pain medication [sic] stated that she wanted to go home [sic]. Resident lab (laboratory result) showed UTI (urinary tract infection) an order to start on ABT (antibiotic therapy) was written. Family member came in and demanded that resident sent out to [name of hospital]. MD (medical doctor) was notified and resident was transferred to the hospital".

A "Rehospitalization Dashboard Data" form completed on 4/30/18, documented in part, "The decision to transfer the patient was made by: Nurse Practitioner ...Additional comments: Resident lab showed UTI. Family member came in and demanded that resident sent out to [name of hospital]. MD was notified".

Review of the clinical record failed to evidence that the comprehensive care plan with goals were

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included in the resident's transfer documentation sent to the receiving hospital.

An interview was conducted with RN, registered nurse, #2 on 6/5/18 at 8:33 a.m. RN #2 provided the facility's "Post Acute Care Transfer Document Checklist" envelope that documents the paper work that is to be sent in the envelope when a resident is transferred to another facility. The checklist failed to document that the comprehensive care plan is to be sent as well. When asked if the facility staff sends the comprehensive care plan with goals when a resident is transferred to the hospital, RN #2 stated, she did not know but the unit manager might know the answer to that question.

An interview was conducted with RN #1, unit manager, on 6/5/18 at 8:57 a.m. When asked to describe the paperwork that is sent with a Resident when transferred to the hospital, RN #1 stated, they fill out the "Acute Transfer Form" and add all of the information into that envelope and the envelope goes with the resident to the hospital. RN #1 stated, "If the "Acute Transfer Form" is not done when the resident is transferred, they fill out the "Rehospitalization" form. RN #1 was asked if they send comprehensive care plans or any documentation regarding Resident goals. RN #1 stated they do not send care plans or anything regarding goals when transferring Residents to the hospital.

ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 6/5/18 at 10:13 a.m.

No further information was provided prior to exit.

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1) This information was obtained from the following website:
https://medlineplus.gov/atrialfibrillation.html

4. Resident #32 was hospitalized on 3/27/18 to 3/29/18. The facility failed to evidence that the resident's comprehensive care plan goals were provided to the receiving hospital.

Resident #32 was admitted to the facility on 6/12/15 with the diagnoses of but not limited to fractured right femur, chronic embolism and thrombosis of lower extremity, and dementia. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 4/6/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. .

A review of the clinical record revealed Resident #32 was sent to the hospital on 3/27/18. Further review failed to reveal evidence of what documentation was sent to the hospital with the resident.

On 6/5/18 at 8:34 a.m., in an interview with RN #2 (Registered Nurse), she stated that items such as the face sheet, medications, labs, etc., are provided to the hospital. She then stated there is a folder with a checklist on it that staff follows. RN #2 provided the folder and the checklist on the folder did not include resident comprehensive care plan goals. When asked about sending comprehensive care plan goals, RN #2 stated that they do not since it isn't on the checklist.

On 6/5/18 at 8:57 a.m., in an interview with RN

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#1, she stated, "We were never trained that we are required to send care plan goals."

On 6/5/18 at 10:13 a.m., the administrator and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

5. Resident #99 was hospitalized on 2/2/18 to 2/10/18, 3/22/18 to 3/28/18, and 4/3/18 to 4/27/18. The facility failed to evidence that the resident's comprehensive care plan goals were provided to the receiving hospital.

Resident #99 was admitted to the facility on 2/7/14 with the diagnoses of but not limited to Parkinson's disease, chronic kidney disease, pressure ulcer, obstructive uropathy, anxiety disorder, dysphagia, adrenocortical insufficiency, atrial fibrillation, hypothyroidism, dementia, and prostate cancer. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/4/18. The resident was coded as being moderately impaired in ability to make daily life decisions.

A review of the clinical record revealed that Resident #99 was hospitalized on 2/2/18 to 2/10/18, 3/22/18 to 3/28/18, and 4/3/18 to 4/27/18. Further review failed to reveal evidence of what documentation was sent to the hospital with the resident.

On 6/5/18 at 8:34 a.m., in an interview with RN #2

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(Registered Nurse), she stated that items such as the face sheet, medications, labs, etc., are provided to the hospital. She then stated there is a folder with a checklist on it that staff follows. RN #2 provided the folder and the checklist on the folder did not include resident comprehensive care plan goals. When asked about sending comprehensive care plan goals, RN #2 stated that they do not since it isn't on the checklist.

On 6/5/18 at 8:57 a.m., in an interview with RN #1, she stated, "We were never trained that we are required to send care plan goals."

On 6/5/18 at 10:13 a.m., the administrator and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

6. Resident #101A transferred to the hospital on 1/1/18. The facility staff failed to evidence that the comprehensive care plan goals were sent to the receiving hospital.

Resident #101A was admitted to the facility on 12/15/17 and discharged to the hospital on 1/1/18. The resident had the diagnoses of but not limited to diabetes, seizures, heart disease, depression, glaucoma, dysphagia, and stroke, benign prostatic hyperplasia. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 12/22/17. The resident was coded as being moderately impaired in the ability to make daily life decisions.

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A review of the clinical record revealed that Resident #101A was sent to the hospital on 1/1/18. Further review failed to reveal evidence of what documentation was sent to the hospital with the resident.

On 6/5/18 at 8:34 a.m., in an interview with RN #2 (Registered Nurse), she stated that items such as the face sheet, medications, labs, etc., are provided to the hospital. She then stated there is a folder with a checklist on it that staff follows. RN #2 provided the folder and the checklist on the folder did not include resident comprehensive care plan goals. When asked about sending comprehensive care plan goals, RN #2 stated that they do not since it isn't on the checklist.

On 6/5/18 at 8:57 a.m., in an interview with RN #1, she stated, "We were never trained that we are required to send care plan goals."

On 6/5/18 at 10:13 a.m., the administrator and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.
7. The facility staff failed to ensure the physician (and/or nurse practitioner) documented why a facility-initiated transfer was necessary for Resident #23 and failed to provide evidence that the resident's comprehensive care plan goals were provided to the hospital staff when Resident #23 was transferred to the hospital on multiple dates from March 2018 through May 2018.

Resident #23 was admitted to the facility on 10/11/17. Resident #23's diagnoses included but were not limited to GERD (gastro-esophageal reflux disease), dementia (1) and a pressure

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checklist.

On 6/5/18 at 8:55 a.m., an interview was conducted with RN #1 (unit manager). RN #1 was asked what documentation is provided to hospital staff when a resident is transferred to the hospital. RN #1 stated she normally completes the acute transfer form and that is sent to the hospital. When asked if she provides any other documents, RN #1 stated she provides the applicable items listed on the post acute care transfer checklist. When asked if she provides comprehensive care plan goals, RN #1 stated that was never required and she was never trained to do that.

Review of Resident #23's acute transfer forms failed to reveal documentation regarding Resident #23's care plan goals.

On 6/5/18 at 10:10 a.m., a telephone interview was attempted with the nurse practitioner. She was unavailable for interview.

On 6/5/18 at 10:13 a.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing). ASM #2 was asked if the physician and/or nurse practitioner completes documentation, each time a resident is transferred to the hospital. ASM #2 stated the physician and/or nurse practitioner should be completing a progress note each time a resident is transferred to the hospital, even if the physician/nurse practitioner is not present at the time of transfer. ASM #1 and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.

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(1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.240726468.691240467.1528283828-139120270.1477942321

(2) "A pressure sore (injury) is any redness or break in the skin caused by too much pressure on your skin for too long a period of time." This information was obtained from the website: http://sci.washington.edu/info/pamphlets/pressure_sores.asp

8. The facility staff failed to ensure the physician (and/or nurse practitioner) documented why a facility-initiated transfer was necessary for Resident #36 and failed to provide evidence that the resident's comprehensive care plan goals were provided to the hospital staff when Resident #36 was transferred to the hospital on multiple dates from December 2017 through March 2018.

Resident #36 was admitted to the facility on 12/22/17. Resident #36's diagnoses included but were not limited to stroke, diabetes and seizures. Resident #36's most recent MDS (minimum data set), a 60 day Medicare assessment with an ARD

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(assessment reference date) of 5/9/18, coded the resident's cognitive skills for daily decision-making as severely impaired.

Review of Resident #36's clinical record revealed the resident was transferred to the hospital on 12/29/17, 2/17/18 and 3/5/18. Further review of Resident #26's clinical record failed to reveal physician (or nurse practitioner) documentation that documented why the facility-initiated transfer was necessary for each transfer.

Further review of Resident #36's clinical record failed to reveal the facility staff provided Resident #36's care plan goals to the hospital staff during each of the above transfers.

On 6/5/18 at 8:35 a.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked what documentation is provided to hospital staff when a resident is transferred to the hospital. RN #2 stated there is an envelope with a check off list and she sends everything that is documented on the check off list. When asked if the care plan goals are provided to hospital staff, RN #2 stated she prints the physician orders and the nurse manager usually gathers the paperwork. When asked what documentation she sends if the nurse manager is not present, RN #2 stated she goes by the check off list on the envelope. Review of the "envelope" titled, "POST ACUTE CARE TRANSFER DOCUMENT CHECKLIST" failed to reveal care plan goals on the checklist. RN #2 confirmed the comprehensive care plan goals probably are not sent since they are not listed on the envelope checklist.

On 6/5/18 at 8:55 a.m., an interview was

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conducted with RN #1 (unit manager). RN #1 was asked what documentation is provided to hospital staff when a resident is transferred to the hospital. RN #1 stated she normally completes the acute transfer form and that is sent to the hospital. When asked if she provides any other documents, RN #1 stated she provides the applicable items listed on the post acute care transfer checklist. When asked if she provides comprehensive care plan goals, RN #1 stated that was never required and she was never trained to do that.

Review of Resident #36's acute transfer forms failed to reveal documentation regarding Resident #36's care plan goals.

On 6/5/18 at 10:10 a.m., a telephone interview was attempted with the nurse practitioner. She was unavailable for interview.

On 6/5/18 at 10:13 a.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing). ASM #2 was asked if the physician and/or nurse practitioner completes documentation, each time a resident is transferred to the hospital. ASM #2 stated the physician and/or nurse practitioner should be completing a progress note each time a resident is transferred to the hospital, even if the physician/nurse practitioner is not present at the time of transfer. ASM #1 and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.
9. Resident #96 was sent to the hospital on 4/9/18. The facility failed to evidence that the care plan goals were provided to the receiving

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F 622	Continued From page 79 hospital. Resident #96 was admitted to the facility on 3/28/18, with a recent readmission on 6/2/18 with diagnoses that included but were not limited to: heart failure, end stage renal disease requiring hemodialysis (A procedure used in toxic conditions and renal [kidney] failure in which wastes and impurities are removed from the blood by a special machine.)(1), asthma, chronic pain, sleep apnea, diabetes, and COPD (chronic obstructive pulmonary disease - a general term for chronic, nonreversible lung disease that is usually a combination of chronic bronchitis and emphysema) (2). The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 5/22/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions. The following paragraph has been typed exactly as it appeared in the nurse's notes. The nurse's note dated, 4/9/18 at 7:30 a.m. documented, "residents vitals (vital signs) were as follows 99.4 (temperature), 105 (heart rate), 24 (respirations), 185/71 (blood pressure), 72% (oxygen saturation), residents b/s (blood sugar) 90 resident presented with respiratory distress residents presenting with labored breathing, residents O2 sats (saturation) 68 on O2 (continuous) via nasal cannula at 3lpm (liters per minute) resident received neb (nebulizer) tx (treatment) however resident O2 sats did not reach above 72%. resident has a hx (history) of COPD and CHF (congestive heart failure)	F 622		

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residents has been presenting with poor appetite however resident displayed no s/s (signs and symptoms) of hypo/hyperglycemia (too high or too low blood sugar) resident lung sounds were as follows resident presented with rhonchi in the upper right and left lobe wheezing in the lower right lobe and completely diminished in the lower left MD (medical doctor) called and findings reported resident is a full code and was transferred to the ER (emergency room) for further evaluation via ambulance no further concerns resident her own RP (responsible party)."

An interview was conducted with RN #2 on 6/5/18 at 8:33 a.m. RN #2 was asked to explain what documents are sent with the resident when they are transferred to the hospital. RN #2 stated the facility has an envelope with a check off list. The nurse completes the check off list after placing the items in the envelope. When asked if the comprehensive care plan or care plan goals are sent with the resident, RN #2 went to get the envelop that is sent with the resident. Upon return, the envelope was reviewed and the comprehensive care plan goals or comprehensive care plan were not listed on the envelope as part of the transfer package.

An interview was conducted with RN #1, the unit manager, on 6/5/18 at 8:55 a.m. When asked if the comprehensive care plan or comprehensive care plan goals are sent with the resident when they go to the hospital, RN #1 stated, "No, I have not been trained that we are required to do that. If it's a new process then we will have to start doing that."

The administrator (administrative staff member

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[ASM#1]) and director of nursing, ASM #2 were made aware of the above concern on 6/5/18 at 10:13 a.m. ASM #1 and ASM#2 were asked to provide any documentation related to the care plan goals being sent to the hospital with the residents.

No further information was provided.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

10. Resident #87 was sent to the hospital on 3/8/18. The facility failed to evidence that the care plan goals were provided to the receiving hospital.

Resident #87 was admitted to the facility on 5/22/15, with a recent readmission on 3/23/18 with diagnoses that included but were not limited to: dementia, high blood pressure, depression, diabetes, and muscle weakness.

The most recent MDS (minimum data set) assessment, a Medicare 60 day assessment, with an assessment reference date of 5/18/18, coded the resident as scoring an "11" on the BIMS (brief interview for mental status) score, indicating he is moderately impaired to make daily cognitive decisions.

The nurse's note dated 3/8/18 documented, "At 1930 (7:30 p.m.) resident was found in bed shaking, with whitish foam secretion coming out of his mouth. Resident was verbal, eyes open

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unfocused. Skin cool and clammy, diaphoretic. Vital signs 93.7 (temperature) 78 (heart rate), 22 (respirations) 102/56 (blood pressure). Blood glucose was 178 at this time. MD (Medical doctor) notified order to send out was received after the EMS (emergency medical service) was here. Wife was notified. Resident was transported to (name of hospital) for treatment."

An interview was conducted with RN #2 on 6/5/18 at 8:33 a.m. RN #2 was asked to explain what documents are sent with the resident when they are transferred to the hospital. RN #2 stated the facility has an envelope with a check off list. The nurse completes the check off list after placing the items in the envelope. When asked if the comprehensive care plan or care plan goals are sent with the resident, RN #2 went to get the envelop that is sent with the resident. Upon return, the envelope was reviewed and the comprehensive care plan goals or comprehensive care plan were not listed on the envelope as part of the transfer package.

An interview was conducted with RN #1, the unit manager, on 6/5/18 at 8:55 a.m. When asked if the comprehensive care plan or comprehensive care plan goals are sent with the resident when they go to the hospital, RN #1 stated, "No, I have not been trained that we are required to do that. If it's a new process then we will have to start doing that."

The administrator (administrative staff member [ASM#1]) and director of nursing, ASM #2 were made aware of the above concern on 6/5/18 at 10:13 a.m. ASM #1 and ASM#2 were asked to provide any documentation related to the care plan goals being sent to the hospital with the

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residents.

No further information was provided.

11. Resident #90 was transferred to the hospital on 4/18/18. The facility failed to evidence the care plan or care plan goals were sent to the receiving hospital.

Resident #90 was admitted to the facility 4/5/18 with a recent readmission on 4/20/18 with diagnoses that included but were not limited to: Subdural hematoma (a collection of blood beneath the dura mater and above the arachnoid membrane of the brain) (1), history of colon cancer, fractures of the ribs, depression, anxiety, and legally blind.

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 5/18/18, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating he is severely impaired to make daily cognitive decisions.

The nurse's note dated, 4/18/18 at 12:05 a.m. documented, "Patient was sent out to (Name of hospital) ED (emergency department); patient's GT (gastrostomy tube) came out with the valve still inflated. Notified NP (nurse practitioner) on call. Made several attempts to call RP (responsible party)/emergency contact but none answered and voicemail was not set up to leave any message."

An interview was conducted with RN #2 on 6/5/18 at 8:33 a.m. RN #2 was asked to explain what documents are sent with the resident when they

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are transferred to the hospital. RN #2 stated the facility has an envelope with a check off list. The nurse completes the check off list after placing the items in the envelope. When asked if the comprehensive care plan or care plan goals are sent with the resident, RN #2 went to get the envelop that is sent with the resident. Upon return, the envelope was reviewed and the comprehensive care plan goals or comprehensive care plan were not listed on the envelope as part of the transfer package.

An interview was conducted with RN #1, the unit manager, on 6/5/18 at 8:55 a.m. When asked if the comprehensive care plan or comprehensive care plan goals are sent with the resident when they go to the hospital, RN #1 stated, "No, I have not been trained that we are required to do that. If it's a new process then we will have to start doing that."

The administrator (administrative staff member [ASM#1]) and director of nursing, ASM #2 were made aware of the above concern on 6/5/18 at 10:13 a.m. ASM #1 and ASM#2 were asked to provide any documentation related to the care plan goals being sent to the hospital with the residents.

No further information was provided.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 549 and 265.

12. Resident #42 was transferred to the hospital on 2/5/18 and 2/25/18. The facility failed to evidence the care plan or care plan goals were sent to the receiving hospital.

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Resident # 42 was admitted to the facility on 1/9/18 with a recent readmission on 3/12/18 with diagnoses that included but were not limited to: high blood pressure, heart disease, dementia, stroke, and atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output) (1).

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 4/18/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make cognitive daily decisions.

The nurse's note dated 2/5/18 at 3:59 p.m. documented, "Resident sent to (name of hospital) per (name of NP) d/t (due to) having SOB (shortness of breath) and increased pulse. Pt. (patient) son was notified of transfer. Skin assessment completed upon exiting the building."

This note is typed exactly as it appears in the clinical record. The nurse's note dated 2/25/18 at 6:54 a.m. documented, "Upon doing rounds and administering medication resident was assessed by nurse to be lethargic and diaphoretic residents vitals were as follows 102.2 (temperature) 110 (heart rate), 22 (respirations) 84/52 (Blood pressure) 86% on O2 (oxygen) via nasal cannula resident also had large amount of blood in his Foley bag residents lung sound wet with rhonchi noted in the upper and lower lobes MD [medical doctor] called and made aware and order was to have resident transferred to the ER for further

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evaluation at 11:45 p.m. resident was transferred to (name of hospital) and report called in RP [responsible part] called and voicemail left to return call to the facility resident was admitted to the hospital for sepsis."

An interview was conducted with RN #2 on 6/5/18 at 8:33 a.m. RN #2 was asked to explain what documents are sent with the resident when they are transferred to the hospital. RN #2 stated the facility has an envelope with a check off list. The nurse completes the check off list after placing the items in the envelope. When asked if the comprehensive care plan or care plan goals are sent with the resident, RN #2 went to get the envelop that is sent with the resident. Upon return, the envelope was reviewed and the comprehensive care plan goals or comprehensive care plan were not listed on the envelope as part of the transfer package.

An interview was conducted with RN #1, the unit manager, on 6/5/18 at 8:55 a.m. When asked if the comprehensive care plan or comprehensive care plan goals are sent with the resident when they go to the hospital, RN #1 stated, "No, I have not been trained that we are required to do that. If it's a new process then we will have to start doing that."

The administrator (administrative staff member [ASM#1]) and director of nursing, ASM #2 were made aware of the above concern on 6/5/18 at 10:13 a.m. ASM #1 and ASM#2 were asked to provide any documentation related to the care plan goals being sent to the hospital with the residents.

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F 622	Continued From page 87 No further information was provided. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of	F 623	**F-623** *It is the intended practice of this facility to uphold the requirements before transfer/discharge including but not limited to, written notification of the resident's responsible party and the ombudsman regarding reasons for transfer/discharge to hospital.* Criteria 1 Resident #75 and 101A are discharged. Should a facility initiated hospital transfer be necessary, a written notification for reasons of hospital transfer will be provided to the responsible party for residents #100, 75, 32, 99, 101A, 23, 36, 96, 87, 90, and 42 Should a facility initiated hospital transfer be necessary, a written notification for reasons of hospital transfer will be provided to Ombudsman, for residents 23, 36, and 87.	

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this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and

Criteria 2
Residents in the facility who require a facility initiated transfer to the hospital have the potential to be affected. The ombudsman and responsible party will be notified in writing regarding the reason for transfer to the hospital.

Criteria 3
Licensed nurses and administrative staff were re-educated by the DON/Designee on providing written notification to the responsible party and ombudsman for the reasons of the facility initiated hospital transfer.

Criteria 4
Don/designee will audit facility initiated hospital transfers daily x5 days, weekly x2 weeks and monthly x2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed.

Criteria 5
The facility's alleged date of compliance is 7/10/18.

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email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide written documentation of the transfer to the responsible party for eleven of 50 residents in the survey sample, Residents #'s 100, 75, 32, 99, 101A, 23, 36, 96, 87, 90 , and 42.

1. The facility staff failed to provide written notification to the resident and responsible party (RP), for a facility initiated transfer to the hospital on 04/01/18 and on 05/25/18 for Resident # 100.

2. The facility staff failed to provide written

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notification to the resident, the responsible party (RP) and the ombudsman for a facility initiated transfer on 05/25/18 for Resident # 75.

3. Resident #32 was sent to the hospital on 3/27/18 to 3/29/18. The facility failed to evidence that the resident representative was provided written notification of the transfer.

4. Resident #99 was hospitalized on 2/2/18 to 2/10/18, 3/22/18 to 3/28/18, and 4/3/18 to 4/27/18. The facility failed to evidence that the resident representative was provided written notification of the transfer.

5. Resident #101A was sent to the hospital on 1/1/18. The facility staff failed to evidence that the resident representative and Ombudsman were provided written notification of the transfer.

6. Resident #23 was transferred to the hospital on multiple dates from March 2018 through May 2018. The facility staff failed to provide written notification of the facility initiated transfer to the resident's representative, and failed to send a copy of such notice to the ombudsman.

7. Resident #36 was transferred to the hospital on multiple dates from December 2017 through March 2018. The facility staff failed to provide written notification of the facility initiated transfer to the resident's representative, and failed to send a copy of such notice to the ombudsman..

8. Resident #96 was sent to the hospital on 4/9/18. The facility failed to evidence written notification was provided to the resident and/or responsible representative upon transfer to the hospital.

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9. Resident #87 was sent to the hospital on 3/8/18. The facility failed to evidence written notification to the resident and/or resident representative upon transfer to the hospital and failed to notify the ombudsman of the acute transfer to the hospital.

10. Resident #90 was transferred to the hospital on 4/18/18. The facility failed to evidence the written notification was provided to the resident and/or responsible representative upon transfer to the hospital.

11. Resident #42 was transferred to the hospital on 2/5/18 and 2/25/18. The facility failed to evidence the written notification was provided to the resident and/or responsible representative upon transfer to the hospital.

The findings include:

1. The facility staff failed to provide written notification to the resident and responsible party (RP), for a facility initiated transfer to the hospital on 04/01/18 and on 05/25/18 for Resident # 100.

Resident # 100 was admitted to the facility on 03/02/18 with a readmission of 05/30/18 with diagnoses that included but were not limited to heart failure, hypertension (1), gastroesophageal reflux disease (2), diabetes mellitus (3), dementia (4) and seizure disorder (5).

Resident # 100's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 100 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0

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- 15, 3 (three) - being severely impaired of cognition for making daily decisions.

Review of resident # 100's clinical record failed revealed Resident #100 was transferred to the hospital on 4/1/18 and 5/25/18. Further review of Resident #100's clinical record failed to evidence written notification to the resident and responsible party (RP) for the facility initiated transfer to the hospital on 04/01/18 and on 05/25/18.

On 06/05/18 at 8:33 a.m., an interview with nursing RN (registered nurse) # 2 from unit one regarding written notification to the resident, responsible party (RP). RN # 2 stated, "No we don't provide them anything in writing. If they asked I'm sure we could provide something."

On 06/05/18 at 8:57 a.m., an interview was conducted with RN # 1 unit manager of unit two regarding written notification to the resident, responsible party (RP). RN # 1 stated, "No we call them and document in the record."

On 06/04/18 at approximately 5:30 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

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

(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information

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was obtained from the website:
https://www.nlm.nih.gov/medlineplus/gerd.html.

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

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

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

(6) The space in the interior of a hollow tubular structure (artery or intestine). This information was obtained from the website: http://www.medilexicon.com/dictionary/51452.

2. The facility staff failed to provide written notification to the resident, the responsible party (RP) and the ombudsman for a facility initiated transfer on 05/25/18 for Resident # 75.

Resident # 75 was admitted to the facility on 02/15/17 with a readmission of 06/01/18 with diagnoses that included but were not limited to hypertension (1), gastroesophageal reflux disease (2), diabetes mellitus (3), anxiety (4) and peripheral vascular disease (5).

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Resident # 75's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/14/18, coded Resident # 75 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

Review of Resident # 75's clinical record revealed the resident was transferred to the hospital on 5/25/18. Further review of Resident #75's clinical record failed to evidence written notification to the resident, responsible party (RP) and the ombudsman of a facility initiated transfer to the hospital on 05/25/18.

On 06/05/18 at 8:33 a.m., an interview with nursing RN (registered nurse) # 2 from unit one regarding written notification to the resident, responsible party (RP). RN # 2 stated, "No we don't provide them anything in writing. If they asked I'm sure we could provide something."

On 06/05/18 at 8:57 a.m., an interview was conducted with RN # 1 unit manager of unit two regarding written notification to the resident, responsible party (RP). RN # 1 stated, "No we call them and document in the record."

On 06/05/18 at 9:22 a.m., an interview was conducted with OSM (other staff member) # 1, social services director. When asked about notification to the ombudsman for a facility-initiated transfer, OSM # 1 stated, "I keep a record of it." When asked if the ombudsman was notified of Resident # 75's transfer to the hospital on 05/25/18, OSM # 1 stated she would check. At 9:59 a.m., OSM # 1 stated, "I don't

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have a notification for (Resident # 75) because the social worker at hospital stated she (Resident # 75) was going home from the hospital."

On 06/04/18 at approximately 5:30 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

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

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

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

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

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

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F 623	Continued From page 96 vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html. 3. Resident #32 was sent to the hospital on 3/27/18 to 3/29/18. The facility failed to evidence that the resident representative was provided written notification of the transfer. Resident #32 was admitted to the facility on 6/12/15 with the diagnoses of but not limited to fractured right femur, chronic embolism and thrombosis of lower extremity, and dementia. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 4/6/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. A review of the clinical record revealed that Resident #32 was sent to the hospital on 3/27/18. Further review failed to reveal that written notification of the transfer was provided to the resident's representative. On 6/5/18 at 8:34 a.m., in an interview with RN #2 (Registered Nurse), when asked if the facility provided anything in writing to the resident representative regarding the transfer, RN #2 stated, "No." On 6/5/18 at 8:57 a.m., in an interview with RN #1, when asked if the facility provided anything in writing to the resident representative regarding the transfer, RN #1 stated, "No, we call."	F 623		

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The facility provided the policy, "Discharge: Other Institution or Non-Emergency Acute Setting." A review of this policy failed to reveal any criteria for providing the resident representative with written documentation of the resident's hospitalization.

On 6/5/18 at 10:13 a.m., the Administrator and Director of Nursing (ASM #1 and ASM #2, respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

4. Resident #99 was hospitalized on 2/2/18 to 2/10/18, 3/22/18 to 3/28/18, and 4/3/18 to 4/27/18. The facility failed to evidence that the resident representative was provided written notification of the transfer.

Resident #99 was admitted to the facility on 2/7/14 with the diagnoses of but not limited to Parkinson's disease, chronic kidney disease, pressure ulcer, obstructive uropathy, anxiety disorder, dysphagia, adrenocortical insufficiency, atrial fibrillation, hypothyroidism, dementia, and prostate cancer. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/4/18. The resident was coded as being moderately impaired in ability to make daily life decisions.

A review of the clinical record revealed that Resident #99 was hospitalized on 2/2/18 to 2/10/18, 3/22/18 to 3/28/18, and 4/3/18 to 4/27/18. Further review failed to reveal that written notification of the transfer was provided to the resident's representative.

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On 6/5/18 at 8:34 a.m., in an interview with RN #2 (Registered Nurse), when asked if the facility provided anything in writing to the resident representative regarding the transfer, she stated, "No."

On 6/5/18 at 8:57 a.m., in an interview with RN #1, when asked if the facility provided anything in writing to the resident representative regarding the transfer, she stated, "No, we call."

On 6/5/18 at 10:13 a.m., the Administrator and Director of Nursing (ASM #1 and ASM #2, respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

5. Resident #101A was sent to the hospital on 1/1/18. The facility staff failed to evidence that the resident representative and Ombudsman were provided written notification of the transfer.

Resident #101A was admitted to the facility on 12/15/17 and discharged to the hospital on 1/1/18. The resident had the diagnoses of but not limited to diabetes, seizures, heart disease, depression, glaucoma, dysphagia, and stroke, benign prostatic hyperplasia. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 12/22/17. The resident was coded as being moderately impaired in the ability to make daily life decisions.

A review of the clinical record revealed that Resident #101A was sent to the hospital on

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1/1/18.
Further review failed to reveal that written notification of the transfer was provided to the resident's representative.

On 6/5/18 at 8:34 a.m., in an interview with RN #2 (Registered Nurse), when asked if the facility provided anything in writing to the resident representative regarding the transfer, she stated, "No."

On 6/5/18 at 8:57 a.m., in an interview with RN #1, when asked if the facility provided anything in writing to the resident representative regarding the transfer, she stated, "No, we call."

On 6/5/18 at 9:22 a.m., in an interview with OSM #1 (Other Staff Member, the Social Worker), when asked about notifying the Ombudsman when a resident is sent to the hospital, OSM #1 stated she keeps a book of email, and read/confirm receipts; and that she sends a monthly list to the Ombudsman. OSM #1 was not able to provide evidence that the Ombudsman was notified of the hospital transfer for Resident #101. The monthly list for January 2018 did not contain Resident #101 on it even though he was discharged on 1/1/18.

On 6/5/18 at 10:13 a.m., the Administrator and Director of Nursing (ASM #1 and ASM #2, respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.
6. Resident #23 was transferred to the hospital on multiple dates from March 2018 through May 2018. The facility staff failed to provide written notification of the facility initiated transfer to the

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resident's representative, and failed to send a copy of such notice to the ombudsman.

Resident #23 was admitted to the facility on 10/11/17. Resident #23's diagnoses included but were not limited to GERD (gastro-esophageal reflux disease), dementia (1) and a pressure injury (2). Resident #23's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/28/18, coded the resident's cognitive skills for daily decision-making as severely impaired.

Review of Resident #23's clinical record revealed the resident was transferred to the hospital on 3/14/18, 4/7/18, 5/5/18 and 5/21/18. Further review of Resident #23's clinical record failed to reveal written notification of the transfer was provided to the resident's representative, or the ombudsman.

On 6/5/18 at 8:35 a.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked if she notifies the ombudsman when a resident is transferred to the hospital. RN #2 stated she notifies the manager who notifies "everyone." RN #2 stated she does call the family and physician. When asked if she provides any written documentation to the residents' representative, RN #2 stated she does not but she could print out the note regarding the transfer if requested by the representative.

On 6/5/18 at 8:55 a.m., an interview was conducted with RN #1 (unit manager). RN #1 was asked if she provides written notice to residents' representatives when residents are transferred to the hospital. RN #1 stated she only calls the representatives and documents the

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family was notified. RN #1 was asked if she notifies the ombudsman when a resident is transferred to the hospital. RN #1 stated she has never had to.

On 6/5/18 at 9:22 a.m., an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 was asked if she notifies the ombudsman when residents are transferred to the hospital. OSM #1 stated she does and keeps a record. When asked how long she has been doing this, OSM #1 stated she would have to look in her book. OSM #1 was asked to provide evidence that the ombudsman was notified regarding Resident #23's transfers to the hospital.

On 6/5/18 at 9:59 a.m., OSM #1 provided evidence that the ombudsman was notified when Resident #23 was transferred to the hospital on 5/21/18. OSM #1 stated she did not have evidence to show the ombudsman was notified when Resident #23 was transferred to the hospital on 3/14/18, 4/7/18 and 5/5/18. When asked if she provides any notification to residents' representatives when residents are transferred to the hospital, OSM #1 stated she does not.

On 6/5/18 at 10:13 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to

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do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.240726468.691240467.1528283828-139120270.1477942321

(2) "A pressure sore (injury) is any redness or break in the skin caused by too much pressure on your skin for too long a period of time." This information was obtained from the website: http://sci.washington.edu/info/pamphlets/pressure_sores.asp

7. Resident #36 was transferred to the hospital on multiple dates from December 2017 through March 2018. The facility staff failed to provide written notification of the facility initiated transfer to the resident's representative, and failed to send a copy of such notice to the ombudsman.

Resident #36 was admitted to the facility on 12/22/17. Resident #36's diagnoses included but were not limited to stroke, diabetes and seizures. Resident #36's most recent MDS (minimum data set), a 60 day Medicare assessment with an ARD (assessment reference date) of 5/9/18, coded the resident's cognitive skills for daily decision-making as severely impaired.

Review of Resident #36's clinical record revealed the resident was transferred to the hospital on 12/29/17, 2/17/18 and 3/5/18. Further review of

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Resident #36's clinical record failed to reveal written notification of the transfer was provided to the resident's representative, or the ombudsman.

On 6/5/18 at 8:35 a.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked if she notifies the ombudsman when a resident is transferred to the hospital. RN #2 stated she notifies the manager who notifies "everyone." RN #2 stated she does call the family and physician. When asked if she provides any written documentation to the residents' representative, RN #2 stated she does not but she could print out the note regarding the transfer if requested by the representative.

On 6/5/18 at 8:55 a.m., an interview was conducted with RN #1 (unit manager). RN #1 was asked if she provides written notice to residents' representatives when residents are transferred to the hospital. RN #1 stated she only calls the representatives and documents the family was notified. RN #1 was asked if she notifies the ombudsman when a resident is transferred to the hospital. RN #1 stated she has never had to.

On 6/5/18 at 9:22 a.m., an interview was conducted with OSM (other staff member) #1 (the social services director). OSM #1 was asked if she notifies the ombudsman when residents are transferred to the hospital. OSM #1 stated she does and keeps a record. When asked how long she has been doing this, OSM #1 stated she would have to look in her book. OSM #1 was asked to provide evidence that the ombudsman was notified regarding Resident #36's transfers to the hospital.

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On 6/5/18 at 9:59 a.m., OSM #1 provided evidence that the ombudsman was notified when Resident #36 was transferred to the hospital on 2/17/18 and 3/5/18. OSM #1 stated she did not have evidence to show the ombudsman was notified when Resident #36 was transferred to the hospital on 12/29/17. When asked if she provides any notification to residents' representatives when residents are transferred to the hospital, OSM #1 stated she does not.

On 6/5/18 at 10:13 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.
8. Resident #96 was sent to the hospital on 4/9/18. The facility failed to evidence written notification was provided to the resident and/or responsible representative upon transfer to the hospital.

Resident #96 was admitted to the facility on 3/28/18, with a recent readmission on 6/2/18 with diagnoses that included but were not limited to: heart failure, end stage renal disease requiring hemodialysis (A procedure used in toxic conditions and renal [kidney] failure in which wastes and impurities are removed from the blood by a special machine.)(1), asthma, chronic pain, sleep apnea, diabetes, and COPD (chronic obstructive pulmonary disease - a general term for chronic, nonreversible lung disease that is usually a combination of chronic bronchitis and emphysema) (2).

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment,

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with an assessment reference date of 5/22/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions.

Review of the clinical record revealed Resident #96 was transferred to the hospital on 4/9/18. Further review of Resident #96's clinical record failed to reveal written notification of the facility-initiated transfer was provided to the resident or the resident's representative.

An interview was conducted with RN (registered nurse) #2 on 6/5/18 at 8:33 a.m. When asked if the nurses provide anything in writing to the resident and/or the resident representative when a resident is transferred to the hospital, RN #1 stated, "No, but we've never had a family ask for anything."

An interview was conducted with RN #1 on 6/5/18 at 8:55 a.m. When asked if the facility provides any written notification to the resident and/or resident representative when a resident is transferred to the hospital, RN #1 stated, "No, we call the family and document it in the chart."

The administrator (administrative staff member [ASM#1]) and director of nursing, ASM #2 were made aware of the above concern on 6/5/18 at 10:13 a.m. ASM #1 and ASM #2 were asked to provide any documentation provided to the resident and/or resident representative.

No further information was provided.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and

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Chapman, page 266.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

9. Resident #87 was sent to the hospital on 3/8/18. The facility failed to evidence written notification to the resident and/or resident representative upon transfer to the hospital and failed to notify the ombudsman of the acute transfer to the hospital.

Resident #87 was admitted to the facility on 5/22/15, with a recent readmission on 3/23/18 with diagnoses that included but were not limited to: dementia, high blood pressure, depression, diabetes, and muscle weakness.

The most recent MDS (minimum data set) assessment, a Medicare 60 day assessment, with an assessment reference date of 5/18/18, coded the resident as scoring an "11" on the BIMS (brief interview for mental status) score, indicating he is moderately impaired to make daily cognitive decisions.

Review of the clinical record revealed Resident #87 was transferred to the hospital on 3/23/18. Further review of Resident #87's clinical record failed to reveal written notification of the facility-initiated transfer was provided to the resident, the resident's representative and the ombudsman.

An interview was conducted with RN (registered nurse) #2 on 6/5/18 at 8:33 a.m. When asked if the nurses provide anything in writing to the resident and/or the resident representative when a resident is transferred to the hospital, RN #2

F 623 Continued From page 107 F 623

stated, "No, but we've never had a family ask for anything." RN #2 was asked if the nurse's notify the ombudsman. RN #2 stated she did not know who the ombudsman was.

An interview was conducted with RN #1 on 6/5/18 at 8:55 a.m. When asked if the facility provides any written notification to the resident and/or resident representative when a resident is transferred to the hospital, RN #1 stated, "No, we call the family and document it in the chart." When asked if the nurses notify the ombudsman, RN #1 stated, I've never done that. "

The administrator (administrative staff member [ASM#1]) and director of nursing, ASM #2 were made aware of the above concern on 6/5/18 at 10:13 a.m. ASM #1 and ASM #2 were asked to provide any documentation related to the written notification to the resident and/or resident representative, and notification to the ombudsman of the transfer to the hospital. .

No further information was provided.

10. Resident #90 was transferred to the hospital on 4/18/18. The facility failed to evidence the written notification was provided to the resident and/or responsible representative upon transfer to the hospital.

Resident #90 was admitted to the facility 4/5/18 with a recent readmission on 4/20/18 with diagnoses that included but were not limited to: Subdural hematoma (a collection of blood beneath the dura mater and above the arachnoid membrane of the brain) (1), history of colon cancer, fractures of the ribs, depression, anxiety,

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and legally blind.

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 5/18/18, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating he is severely impaired to make daily cognitive decisions.

Review of the clinical record revealed Resident #90 was transferred to the hospital on 4/18/18. Further review of Resident #90's clinical record failed to reveal written notification of the facility-initiated transfer was provided to the resident, the resident's representative and the ombudsman.

An interview was conducted with RN (registered nurse) #2 on 6/5/18 at 8:33 a.m. When asked if the nurses provide anything in writing to the resident and/or the resident representative when a resident is transferred to the hospital, RN #1 stated, "No, but we've never had a family ask for anything."

An interview was conducted with RN #1 on 6/5/18 at 8:55 a.m. When asked if the facility provides any written notification to the resident and/or resident representative when a resident is transferred to the hospital, RN #1 stated, "No, we call the family and document it in the chart."

The administrator (administrative staff member [ASM#1]) and director of nursing, ASM #2 were made aware of the above concern on 6/5/18 at 10:13 a.m. ASM #1 and ASM #2 were asked to provide any documentation provided to the

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F 623	Continued From page 109 resident and/or resident representative. No further information was provided. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 549 and 265. 11. Resident #42 was transferred to the hospital on 2/5/18 and 2/25/18. The facility failed to evidence the written notification was provided to the resident and/or responsible representative upon transfer to the hospital. Resident # 42 was admitted to the facility on 1/9/18 with a recent readmission on 3/12/18 with diagnoses that included but were not limited to: high blood pressure, heart disease, dementia, stroke, and atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output) (1). The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 4/18/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make cognitive daily decisions. Review of the clinical record revealed Resident #42 was transferred to the hospital on 2/5/18 and 2/25/18. Further review of Resident #42's clinical record failed to reveal written notification of the facility-initiated transfer was provided to the resident, and the resident's representative.	F 623		

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An interview was conducted with RN (registered nurse) #2 on 6/5/18 at 8:33 a.m. When asked if the nurses provide anything in writing to the resident and/or the resident representative when a resident is transferred to the hospital, RN #1 stated, "No, but we've never had a family ask for anything."

An interview was conducted with RN #1 on 6/5/18 at 8:55 a.m. When asked if the facility provides any written notification to the resident and/or resident representative when a resident is transferred to the hospital, RN #1 stated, "No, we call the family and document it in the chart."

The administrator (administrative staff member [ASM#1]) and director of nursing, ASM #2 were made aware of the above concern on 6/5/18 at 10:13 a.m. ASM #1 and ASM #2 were asked to provide any documentation provided to the resident and/or resident representative.

No further information was provided.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.

F 624 SS=E Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) F 624

§483.15(c)(7) Orientation for transfer or discharge.
A facility must provide and document sufficient preparation and orientation to residents to ensure

F-624
It is the intended practice of this facility to ensure resident preparation for safe/orderly transfer/discharge, including documentation related to resident orientation for facility-initiated transfer/discharge.

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F 624	Continued From page 111 safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence that two of 50 residents in the survey sample were prepared and oriented for a transfer to the hospital; Residents #99, and #101. 1. Resident #99 was hospitalized on 2/2/18 to 2/10/18, 3/22/18 to 3/28/18, and 4/3/18 to 4/27/18. The facility failed to evidence that the resident was prepared and oriented for the transfers. 2. Resident #101A was sent to the hospital on 1/1/18. The facility staff failed to evidence that the resident was prepared and oriented for the transfer. The findings include: 1. Resident #99 was hospitalized on 2/2/18 to 2/10/18, 3/22/18 to 3/28/18, and 4/3/18 to 4/27/18. The facility failed to evidence that the resident was prepared and oriented for the transfers. Resident #99 was admitted to the facility on 2/7/14 with the diagnoses of but not limited to Parkinson's disease, chronic kidney disease, pressure ulcer, obstructive uropathy, anxiety disorder, dysphagia, adrenocortical insufficiency,	F 624	Criteria 1 Resident 101A was discharged. Should resident # 99 require a facility initiated transfer to the hospital, resident preparation and orientation of transfer will be documented in the medical record. Criteria 2 Residents transferred to the hospital have the potential to be affected. Documentation will be completed in the medical record of resident orientation and preparation for facility initiated hospital transfer. Criteria 3 Licensed nursing staff training were re-educated by DON/Designee on documentation related to facility initiated hospital transfers to include preparation and orientation of the resident.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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atrial fibrillation, hypothyroidism, dementia, and prostate cancer. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/4/18. The resident was coded as being moderately impaired in ability to make daily life decisions.

A review of the clinical record revealed that Resident #99 was hospitalized on 2/2/18 to 2/10/18, 3/22/18 to 3/28/18, and 4/3/18 to 4/27/18. Further review failed to reveal evidence that the resident was prepared and oriented for the transfer.

On 6/5/18 at 8:34 a.m., an interview was conducted with RN #2 (Registered Nurse). RN #3 was asked how a resident is prepared and oriented for a facility-initiated transfer. RN #2 stated "Tell them what is going on, that we notified your doctor, that we are sending you to hospital and which one, we let their family know, we put together their paperwork, let them know they are going in ambulance." When asked if any of this is documented, RN #2 stated, "We should write it in nurse's note, that patient is aware."

On 6/5/18 at 8:57 a.m., an interview was conducted with RN #1. When asked how is the resident prepared and oriented for a facility initiated transfer, RN #1 stated, "Tell them this is what is happening and what we are going to be doing.:" When asked if this is documented, RN #1 stated, "We are supposed to document that it was explained to resident. I'm not gonna say that everyone documents it."

The facility provided the policy, "Discharge: Other Institution or Non-Emergency Acute Setting." A

Criteria 4

DON or designee will audit facility-initiated transfers to the hospital, daily x5 days, weekly x2 weeks and monthly x2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed.

Criteria 5

The facility's alleged date of compliance is 7/10/18.

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F 624	Continued From page 113 review of this policy revealed, "....7. Introduce self, explain procedure and provide privacy....Document the discharge in (facility electronic medical record program)." On 6/5/18 at 10:13 a.m., the Administrator and Director of Nursing (ASM #1 and ASM #2, respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey. 2. Resident #101A was sent to the hospital on 1/1/18. The facility staff failed to evidence that the resident was prepared and oriented for the transfer. Resident #101A was admitted to the facility on 12/15/17 and discharged to the hospital on 1/1/18. The resident had the diagnoses of but not limited to diabetes, seizures, heart disease, depression, glaucoma, dysphagia, and stroke, benign prostatic hyperplasia. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 12/22/17. The resident was coded as being moderately impaired in the ability to make daily life decisions. A review of the clinical record revealed that Resident #101A was sent to the hospital on 1/1/18. Further review failed to reveal evidence that the resident was prepared and oriented for the transfer. On 6/5/18 at 8:34 a.m., an interview was conducted with RN #2 (Registered Nurse). RN	F 624		

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#3 was asked how a resident is prepared and oriented for a facility-initiated transfer. RN #2 stated "Tell them what is going on, that we notified your doctor, that we are sending you to hospital and which one, we let their family know, we put together their paperwork, let them know they are going in ambulance." When asked if any of this is documented, RN #2 stated, "We should write it in nurse's note, that patient is aware."

On 6/5/18 at 8:57 a.m., an interview was conducted with RN #1. When asked how is the resident prepared and oriented for a facility initiated transfer, RN #1 stated, "Tell them this is what is happening and what we are going to be doing.:" When asked if this is documented, RN #1 stated, "We are supposed to document that it was explained to resident. I'm not gonna say that everyone documents it."

The facility provided the policy, "Discharge: Other Institution or Non-Emergency Acute Setting." A review of this policy revealed, "....7. Introduce self, explain procedure and provide privacy....Document the discharge in (facility electronic medical record program)."

On 6/5/18 at 10:13 a.m., the Administrator and Director of Nursing (ASM #1 and ASM #2, respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

F 625 SS=E Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) F 625

§483.15(d) Notice of bed-hold policy and return-

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§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide the bed hold policy to the resident and or resident representative (RR), prior to and or at the time of transfer, for eight of 50 residents in the survey sample, Residents #'s 100, 75, 99, 101, 36, 96, 90 , and 42.

1. The facility staff failed to provide Resident # 100's representative written notification of the bed

F 625

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It is the intended practice of this facility to provide written notice of the facility bedhold policy, to the resident and or resident representative within 24 hours of a facility-initiated transfer to the hospital.

Criteria 1

Resident # 75 is discharged.
Should Residents #100, 99, 101, 36, 96, 90 and 42, require a facility initiated transfer to the hospital, the facility will provide resident/representative written notification within 24 hours of the bedhold policy.

Criteria 2

Residents transferred to the hospital have the potential to be affected. Those residents/representatives will be provided written notification of the bedhold policy within 24 hours of a facility initiated hospital transfer.

Criteria 3

Nurses were re-educated by DON/Designee on providing written notification of bedhold policy to resident/responsible party within 24

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hold policy when the resident was transfer to the hospital on 04/01/18 and on 05/25/18.

2. The facility staff failed to provide Resident # 75's representative written notification of the bed hold policy when the resident was transfer to the hospital on 05/25/18.

3. Resident #99 was hospitalized on 2/2/18 to 2/10/18, 3/22/18 to 3/28/18, and 4/3/18 to 4/27/18. The facility staff failed to evidence that the resident / resident representative was provided with a written bed hold notification for each transfer.

4. Resident #101A was sent to the hospital on 1/1/18. The facility staff failed to evidence that the resident / resident representative was provided with a written bed hold notification at the time of transfer.

5. The facility staff failed to provide Resident #36 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on multiple dates from December 2018 through March 2018.

6. Resident #96 was sent to the hospital on 4/9/18. The facility staff failed to provide the bed hold policy at the time of the facility initiated transfer.

7. Resident #90 was transferred to the hospital on 4/18/18. The facility failed to provide the bed hold policy at the time of the facility initiated transfer.

8. Resident #42 was transferred to the hospital on 2/5/18 and 2/25/18. The facility failed to provide

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hours of facility-initiated transfer to the hospital.

Criteria 4

DON or designee will audit facility initiated hospital transfers for compliance with bedhold policy, daily x5 days, weekly x2 weeks and monthly x2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed.

Criteria 5

The facility's alleged date of compliance is 7/10/2018.

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the bed hold policy at the time of the facility initiated transfer.

The findings include:

1. The facility staff failed to provide Resident # 100's representative written notification of the bed hold policy when the resident was transfer to the hospital on 04/01/18 and on 05/25/18.

Resident # 100 was admitted to the facility on 03/02/18 with a readmission of 05/30/18 with diagnoses that included but were not limited to heart failure, hypertension (1), gastroesophageal reflux disease (2), diabetes mellitus (3), dementia (4) and seizure disorder (5).

Resident # 100's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 100 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions.

Review of Resident #100's clinical record revealed the resident was transferred to the hospital on 04/01/18 and on 05/25/18. Further review of Resident # 100's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident #100"s representative.

On 06/05/18 at 9:12 a.m., an interview was conducted with OSM (other staff member) # 2, admissions coordinator. When asked to describe the procedure for the issuing of bed hold, OSM # 2 stated, "Upon admission I go over the bed hold policy and they are given a copy. I tell them

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should you go to the hospital, manage care or Medicare is paying for the hospital and to hold the bed you must call us. If they are private pay, they will always call and ask to have the bed held. If they are transferred, I don't do anything in regard to the bed hold, but do make a courtesy call to see how the resident is doing. We don't give them any paper work at the time of the transfer."

On 06/04/18 at approximately 5:30 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

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

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

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

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

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

2. The facility staff failed to provide Resident # 75's representative written notification of the bed hold policy when the resident was transfer to the hospital on 05/25/18.

Resident # 75 was admitted to the facility on 02/15/17 with a readmission of 06/01/18 with diagnoses that included but were not limited to hypertension (1), gastroesophageal reflux disease (2), diabetes mellitus (3), anxiety (4) and peripheral vascular disease (5).

Resident # 75's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/14/18, coded Resident # 75 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

Review of Resident # 75's clinical record revealed the resident was transferred to the hospital on 5/25/18. Further review of Resident # 75's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident # 75's representative.

On 06/05/18 at 9:12 a.m., an interview was conducted with OSM (other staff member) # 2, admissions coordinator. When asked to describe the procedure for the issuing of bed hold, OSM #

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2 stated, "Upon admission I go over the bed hold policy and they are given a copy. I tell them should you go to the hospital, manage care or Medicare is paying for the hospital and to hold the bed you must call us. If they are private pay, they will always call and ask to have the bed held. If they are transferred, I don't do anything in regard to the bed hold, but do make a courtesy call to see how the resident is doing. We don't give them any paper work at the time of the transfer."

On 06/04/18 at approximately 5:30 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

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

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

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

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

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(5) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.
3. Resident #99 was hospitalized on 2/2/18 to 2/10/18, 3/22/18 to 3/28/18, and 4/3/18 to 4/27/18. The facility staff failed to evidence that the resident / resident representative was provided with a written bed hold notification for each transfer.

Resident #99 was admitted to the facility on 2/7/14 with the diagnoses of but not limited to Parkinson's disease, chronic kidney disease, pressure ulcer, obstructive uropathy, anxiety disorder, dysphagia, adrenocortical insufficiency, atrial fibrillation, hypothyroidism, dementia, and prostate cancer. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/4/18. The resident was coded as being moderately impaired in ability to make daily life decisions.

A review of the clinical record revealed that Resident #99 was hospitalized on 2/2/18 to 2/10/18, 3/22/18 to 3/28/18, and 4/3/18 to 4/27/18. Further review failed to reveal evidence that a written bed hold notification was provided to the resident / resident representative.

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On 6/5/18 at 8:34 a.m., in an interview with RN #2 (Registered Nurse), when asked when asked about providing a bed hold, RN #2 stated, "We don't have anything to do with bed holds." When asked who is responsible, RN #2 sated, "Admissions."

On 6/5/18 at 8:57 a.m., in an interview with RN #1, when asked about providing a bed hold, RN #1 stated, "Admissions does bed holds."

On 6/5/18 at 9:12 a.m., in an interview with OSM #2 (Other Staff Member), the Admissions Coordinator, OSM #2 stated, "For each hospitalization, I don't do anything. We do a courtesy call to see how resident is doing. No written bed holds are provided except on admission. If they have a question, will go over it again....The only time they get a written copy for hospitalization is if they want the bed hold and come in and pay for it and sign the form."

The facility provided the policy, "Discharge: Other Institution or Non-Emergency Acute Setting." A review of this policy revealed, "....10. Provide bed hold policy as required by state or county regulations (available from admissions office.)"

A review of the facility policy, "Bedhold Agreement" documented, "1. If I am away from the Center for more than 24 hours, I will be offered the option to pay for a bedhold (sic) to hold my bed and retain my belongings in the Center. If I do not pay for a bedhold (sic), the Center may assign the bed to another patient. 2. Medicare does not pay for a bedhold (sic). If I wish to hold my bed, I am responsible to pay for it. 3. Virginia Medicaid does not pay for a bedhold (sic) if discharged to the hospital. If I

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F 625	Continued From page 123 wish to hold my bed, I am responsible to pay for it. Virginia Medicaid will pay for a bedhold (sic) only as described in Attachment A. 4. The cost for a bedhold (sic) is equal to the Center's daily room and board rate. 5. If I have a bedhold (sic), I will be readmitted to the Center according to the Center's policies and procedures unless the Center can no longer appropriately care for me. I will return to the room I previously occupied unless my condition requires that I be moved to a different room to receive necessary care. 6. If I decline the bedhold (sic), but choose to return to the Center after my absence, I understand that I will be readmitted and assigned to the next available and appropriate bed unless the Center can no longer appropriately care for me. 7. I acknowledge that I received the Center's bedhold information at the time of admission and I have had the opportunity to ask questions. Check one: { } I decline the bedhold (sic). { } I consent to the bedhold (sic) and agree to pay for the bed at the private pay rate of $_____ per day until I return to the Center or until the day that I notify the Center that I no longer want the bedhold (sic)." On 6/5/18 at 10:13 a.m., the Administrator and Director of Nursing (ASM #1 and ASM #2, respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey. 4. Resident #101A was sent to the hospital on 1/1/18. The facility staff failed to evidence that the resident / resident representative was provided with a written bed hold notification at the time of transfer.	F 625		

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Resident #101A was admitted to the facility on 12/15/17 and discharged to the hospital on 1/1/18. The resident had the diagnoses of but not limited to diabetes, seizures, heart disease, depression, glaucoma, dysphagia, and stroke, benign prostatic hyperplasia. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 12/22/17. The resident was coded as being moderately impaired in the ability to make daily life decisions.

A review of the clinical record revealed that Resident #101A was sent to the hospital on 1/1/18. Further review failed to reveal evidence that a written bed hold notification was provided to
the resident / resident representative.

On 6/5/18 at 8:34 a.m., in an interview with RN #2 (Registered Nurse), when asked when asked about providing a bed hold, RN #2 stated, "We don't have anything to do with bed holds." When asked who is responsible, RN #2 sated, "Admissions."

On 6/5/18 at 8:57 a.m., in an interview with RN #1, when asked about providing a bed hold, RN #1 stated, "Admissions does bed holds."

On 6/5/18 at 9:12 a.m., in an interview with OSM #2 (Other Staff Member), the Admissions Coordinator, OSM #2 stated, "For each hospitalization, I don't do anything. We do a courtesy call to see how resident is doing. No written bed holds are provided except on admission. If they have a question, will go over it

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again....The only time they get a written copy for hospitalization is if they want the bed hold and come in and pay for it and sign the form."

On 6/5/18 at 10:13 a.m., the Administrator and Director of Nursing (ASM #1 and ASM #2, respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

5. The facility staff failed to provide Resident #36 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on multiple dates from December 2018 through March 2018.

Resident #36 was admitted to the facility on 12/22/17. Resident #36's diagnoses included but were not limited to stroke, diabetes and seizures. Resident #36's most recent MDS (minimum data set), a 60 day Medicare assessment with an ARD (assessment reference date) of 5/9/18, coded the resident's cognitive skills for daily decision-making as severely impaired.

Review of Resident #36's clinical record revealed the resident was transferred to the hospital on 12/29/17, 2/17/18 and 3/5/18. Further review of Resident #36's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident #36 or the resident's representative when the resident was discharged to the hospital on the above dates.

On 6/5/18 at 8:35 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the admissions department provides bed hold information to residents and families.

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F 625	Continued From page 126 On 6/5/18 at 9:12 a.m., an interview was conducted with OSM (other staff member) #2 (the admissions coordinator). OSM #2 stated she reviews the bed hold agreement with residents and representatives upon admission to the facility. OSM #2 stated the agreement documents, "If you go to the hospital and you want to hold the bed please call and we will implement a bed hold and you will have to pay." When asked if she provides information regarding the bed hold policy when residents are discharged to the hospital, OSM #2 stated, "I do not do anything. A lot of times we call the family to see how they are doing and the family asks if we are going to hold the bed and we say we will do our best because they aren't willing to pay." OSM #2 stated she does not provide any written documentation and does not review the bed hold agreement over the phone but would explain if the family asked. On 6/5/18 at 10:13 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 6. Resident #96 was sent to the hospital on 4/9/18. The facility staff failed to provide the bed hold policy at the time of the facility initiated transfer. Resident #96 was admitted to the facility on 3/28/18, with a recent readmission on 6/2/18 with diagnoses that included but were not limited to: heart failure, end stage renal disease requiring hemodialysis (A procedure used in toxic conditions and renal [kidney] failure in which wastes and impurities are removed from the	F 625		

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blood by a special machine.)(1), asthma, chronic pain, sleep apnea, diabetes, and COPD (chronic obstructive pulmonary disease - a general term for chronic, nonreversible lung disease that is usually a combination of chronic bronchitis and emphysema) (2).

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 5/22/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions.

Review of the clinical record revealed Resident #96 was transferred to the hospital on 4/9/18. Further review of Resident #96's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident #96 or the resident's representative when the resident was discharged to the hospital on 4/9/18.

An interview was conducted with RN #2 (registered nurse) on 6/5/18 at 8:33 a.m. When asked if the nurses provide a bed hold policy to the resident and/or resident representative at the time of transfer, RN #2 stated, "No, I believe admissions takes care of that."

An interview was conducted with RN #1 on 6/5/18 at 8:55 a.m. When asked if the nurses provide a bed hold policy to the resident and/or representative at the time of the transfer, RN #1 stated, "Admissions does the bed holds."

An interview was conducted with other staff

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member (OSM) #2, the admissions coordinator, on 6/5/18 at 9:12 a.m., regarding the provision of the bed hold policy upon transfer to the hospital. When asked if anything is given to the resident and/or resident representative when they are transferred, OSM #2 stated, "No."

The administrator (administrative staff member [ASM #1]) and director of nursing, ASM #2 were made aware of the above concern on 6/5/18 at 10:13 a.m. ASM #1 and ASM #2 were asked to provide any documentation provided to the resident and/or resident representative regarding the bed hold policy when they were transferred to the hospital.

No further information was provided.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

7. Resident #90 was transferred to the hospital on 4/18/18. The facility failed to provide the bed hold policy at the time of the facility initiated transfer.

Resident #90 was admitted to the facility 4/5/18 with a recent readmission on 4/20/18 with diagnoses that included but were not limited to: Subdural hematoma (a collection of blood beneath the dura mater and above the arachnoid membrane of the brain) (1), history of colon cancer, fractures of the ribs, depression, anxiety, and legally blind.

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The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 5/18/18, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating he is severely impaired to make daily cognitive decisions. The resident was coded as requiring limited to extensive assistance of one staff member for most of his activities of daily living. He was dependent upon the staff for his nutritional needs.

The nurse's note dated, 4/18/18 at 12:05 a.m. documented, "Patient was sent out to (Name of hospital) ED (emergency department); patient's GT (gastrostomy tube) came out with the valve still inflated. Notified NP (nurse practitioner) on call. Made several attempts to call RP (responsible party)/emergency contact but none answered and voicemail was not set up to leave any message."

Further review of Resident #90's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident #90 or the resident's representative when the resident was discharged to the hospital on 4/18/18.

An interview was conducted with RN (registered nurse) #2 on 6/5/18 at 8:33 a.m. When asked if the nurses provide a bed hold policy to the resident and/or resident representative at the time of transfer, RN #2 stated, "No, I believe admissions takes care of that."

An interview was conducted with RN #1 on 6/5/18 at 8:55 a.m. When asked if the nurses provide a

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bed hold policy to the resident and/or representative at the time of the transfer, RN #1 stated, "Admissions does the bed holds."

An interview was conducted with other staff member (OSM) #2, the admissions coordinator, on 6/5/18 at 9:12 a.m., regarding the provision of the bed hold policy upon transfer to the hospital. When asked if anything is given to the resident and/or resident representative when they are transferred, OSM #2 stated, "No."

The administrator (administrative staff member [ASM #1]) and director of nursing, ASM #2 were made aware of the above concern on 6/5/18 at 10:13 a.m. ASM #1 and ASM #2 were asked to provide any documentation provided to the resident and/or resident representative regarding the bed hold policy when they were transferred to the hospital.

No further information was provided.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 549 and 265.

8. Resident #42 was transferred to the hospital on 2/5/18 and 2/25/18. The facility failed to provide the bed hold policy at the time of the facility initiated transfer.

Resident # 42 was admitted to the facility on 1/9/18 with a recent readmission on 3/12/18 with diagnoses that included but were not limited to: high blood pressure, heart disease, dementia, stroke, and atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of

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the ventricles and resulting in decreased heart output) (1).

Resident # 42 was admitted to the facility on 1/9/18 with a recent readmission on 3/12/18 with diagnoses that included but were not limited to: high blood pressure, heart disease, dementia, stroke, and atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output) (1).

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 4/18/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make cognitive daily decisions.

Review of the clinical record revealed Resident #42 was transferred to the hospital on 2/5/18 and 2/25/18. Further review of Resident #42's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident #42 or the resident's representative when the resident was discharged to the hospital on 2/5/18 and 2/25/18.

An interview was conducted with RN (registered nurse) #2 on 6/5/18 at 8:33 a.m. When asked if the nurses provide a bed hold policy to the resident and/or resident representative at the time of transfer, RN #2 stated, "No, I believe admissions takes care of that."

An interview was conducted with RN #1 on 6/5/18

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F 625	Continued From page 132 at 8:55 a.m. When asked if the nurses provide a bed hold policy to the resident and/or representative at the time of the transfer, RN #1 stated, "Admissions does the bed holds." An interview was conducted with other staff member (OSM) #2, the admissions coordinator, on 6/5/18 at 9:12 a.m., regarding the provision of the bed hold policy upon transfer to the hospital. When asked if anything is given to the resident and/or resident representative when they are transferred, OSM #2 stated, "No." The administrator (administrative staff member [ASM #1]) and director of nursing, ASM #2 were made aware of the above concern on 6/5/18 at 10:13 a.m. ASM #1 and ASM #2 were asked to provide any documentation provided to the resident and/or resident representative regarding the bed hold policy when they were transferred to the hospital. No further information was provided. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.	F 655	**F-655** *It is the intended practice of this facility to 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.*	

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F 655	Continued From page 133 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 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide	F 655	Criteria 1 The facility reviewed the baseline care plan with resident #98 and responsible party. Criteria 2 Residents who admit to the facility have the potential to be affected. Criteria 3 Licensed nurses were re-educated by DON/Designee on providing a summary of the baseline care plan to residents and or resident representative. Criteria 4 DON or designee will audit residents who admit to the facility to ensure they were provided a review of the baseline care plan, daily x5, weekly x2 weeks and monthly x2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed. Criteria 5 The facility's alleged date of compliance is 7/10/2018.	

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the resident and/or the resident representative with the baseline care plan for 1 of 50 residents in the survey sample; Resident #98.

The facility staff failed to evidence that the baseline care plan was provided to Resident #98 and or the resident representative.

The findings include:

Resident #98 was admitted to the facility on 5/7/18 with the diagnoses of but not limited to gout, right above knee amputation, high blood pressure, benign prostatic hyperplasia, dementia, stroke, and seizures. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 5/14/18. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for all areas of activities of daily living; and was coded as incontinent of bowel and as having an indwelling catheter for bladder.

A review of the clinical record revealed that Resident #98 was admitted on 5/7/18. Further review failed to reveal any evidence that the baseline care plan was provided to the resident representative. A review of the care plan revealed the following areas that were care planned within the first 14 days of admission: pain (dated 5/8/18), activities (dated 5/14/18), self-care deficit (dated 5/8/18), assistance for eating (dated 5/9/18), assistance for transfers (dated 5/15/18), non-compliance with care (dated 5/17/18), cognitive loss (dated 5/10/18), difficulty communicating (dated 5/17/18), indwelling

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catheter (dated 5/8/18), potential for discharge (dated 5/8/18), falls (dated 5/8/18), cardiac disease (5/16/18), GI distress (gastrointestinal) (dated 5/16/18), neurological deficiencies (dated 5/16/18), anticoagulant therapy (dated 5/16/18), nutritional risk (dated 5/16/18), skin integrity (5/8/18), pain related to leg amputation (dated 5/8/18), adjustment to disability (dated 5/17/18) and impaired vision (dated 5/17/18).

On 6/5/18 at 10:50 a.m., in an interview with LPN #1 (Licensed Practical Nurse) when asked about providing the baseline care plan to the resident or resident representative,, LPN #1 stated that she does not, and to check with MDS.

On 6/5/18 at 10:56 a.m., in an interview with RN #1 (Registered Nurse), when asked about providing the resident representative with a copy of the baseline care plan, RN #1 stated, "We've never done that."

On 6/5/18 at 11:00 a.m., in an interview with RN #5, the MDS nurse. RN #5 stated the interdisciplinary team would provide the baseline care plan at a family meeting conducted about 72 hours after the resident's admission. RN #5 stated to check with social services, as MDS was not part of that meeting.

On 6/5/18 at 11:05 a.m., in an interview with OSM #1 (Other Staff Member), the social worker, OSM #1 stated she would look into it.

On 6/5/18 at approximately 2:30 p.m., the DON (Director of Nursing, - Administrative Staff Member - ASM #2) stated that it had not been the practice to provide the baseline care plan and that the facility is addressing this through a

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F 655	Continued From page 136 Performance Improvement Plan (PIP). A review of the facility policy, "Creating & (and) Maintaining Care Plans" documented, "The patient's care plan is a communication tool that guides members of the interdisciplinary team (IDT) in how to meet each individual patient's needs. It also identifies the types & methods of care that the patient should receive...." the policy did not specify that the resident representative should be provided with a copy of the care plan. No further information was provided by the end of the survey.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656	**F- 656** *It is the intended practice of this facility to ensure the development and implementation of a comprehensive care plan.* Criteria 1 Resident #83 is discharged. Physician for R96 was notified of the 498 blood sugar and the care plan is currently being followed for monitoring of blood sugars. Physician for R21 was notified of skin prep order not followed, and care plan intervention for skin care is implemented.	

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F 656	Continued From page 137 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to develop and/or implement the comprehensive care plan for eleven of 50 residents in the survey sample, Resident #96, 21, 87, 51, 30, 99, 23, 56, 18, 83 and 351. 1. The facility staff failed to implement Resident #96's comprehensive care plan for monitoring blood sugars per the physician order. 2. The facility staff failed to implement Resident #21's comprehensive care plan for preventing pressure ulcers. 3. The facility staff failed to implement Resident # 87's comprehensive care plan for the	F 656	Physician for R87 was notified of insulin order not followed, and care plan intervention for following physician orders is implemented. Pain care plan for R51 was reviewed for non-pharmacological interventions. Non-pharm care plan interventions offered to resident prior to administration of prn pain med are being documented. Oxygen orders for R30, and R83 were verified and are being administered per physician order. The care plan intervention is implemented. Physician was notified of medications not administered for R23, R56 and R18. Medications are being administered as ordered by the physician and the care plan intervention is implemented. Pain care plan for R351 was reviewed for non-pharmacological interventions. Non-pharm care plan interventions offered to resident prior to administration of prn pain med are being documented.	

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F 656	Continued From page 138 administration of insulin. 4. The facility staff failed to follow Resident # 51's comprehensive care plan for the implementation of non- pharmacological interventions prior to the use of prn (as needed) pain medication. 5. The facility staff failed to implement /follow Resident #30's comprehensive care plan for the administration of oxygen. 6. The facility staff failed to implement/ follow Resident #99's comprehensive care plan for the administration of oxygen. 7. The facility staff failed to implement Resident #23's comprehensive care plan for wound care and medication administration. 8. The facility staff failed to implement Resident #56's comprehensive care plan for medication administration. 9. The facility staff failed to implement Resident #18's comprehensive care plan for medication administration. 10. The facility staff failed to implement Resident #83's comprehensive care plan for oxygen administration. 11. The facility staff failed to implement Resident #351's comprehensive care plan for tube feeding/flush administration. The findings include: 1. Resident #96 was admitted to the facility on 3/28/18, with a recent readmission on 6/2/18 with	F 656	Criteria 2 Residents that have care plan interventions related to following physician orders and or monitoring for blood sugars, skin care, insulin, pain and non-pharmacologicals, oxygen, medications and tube feed flushes have the potential to be affected and were reviewed to ensure interventions are implemented. Criteria 3 Licensed nurses and IDT members will be re-educated on implementing care plan interventions and following physician orders. Criteria 4 DON or designee will audit MARS/TARS and progress notes to ensure care plan interventions are implemented and Physician orders are followed, daily x5 days, weekly x2 weeks and monthly x2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed. Criteria 5 The facility's alleged date of compliance is 7/10/2018.	

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F 656	Continued From page 139 diagnoses that included but were not limited to: heart failure, end stage renal disease requiring hemodialysis (A procedure used in toxic conditions and renal [kidney] failure in which wastes and impurities are removed from the blood by a special machine.) (1), asthma, chronic pain, sleep apnea, diabetes, and COPD (chronic obstructive pulmonary disease - a general term for chronic, nonreversible lung disease that is usually a combination of chronic bronchitis and emphysema) (2). The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 5/22/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions. The resident was coded as requiring supervision with set up assistance for all of her activities of daily living. The comprehensive care plan dated, 3/29/18, documented in part, "Focus: The resident is on insulin r/t (related to) diabetes." The "Interventions" documented in part, "Monitor blood sugar, lab (laboratory) results as ordered by physician." The physician order dated, 3/28/18, documented, "Novolog Solution (a fast acting insulin used to treat diabetes (3)) 100unit/ML (milliliters) inject as per sliding scale: if 150 - 200 (blood sugar) = 4 units, 201 - 250 = 6 units, 251 - 300 = 8 units, 301 - 350 = 10 units, 351 - 400 = 12 units subcutaneously before meals and at bedtime for DM (diabetes mellitus). Blood sugar greater than 400 give 15 units and notify MD (medical doctor)."	F 656		

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The MAR (medication administration record) for April 2018 documented, "Novolog Solution 100unit/ML inject as per sliding scale: if 150 - 200 = 4 units, 201 - 250 = 6 units, 251 - 300 = 8 units, 301 - 350 = 10 units, 351 - 400 = 12 units subcutaneously before meals and at bedtime for DM. Blood sugar greater than 400 give 15 units and notify MD." The MAR documented on 4/4/18 at 4:30 p.m., the resident's blood sugar was 498.

Review of the nurse's note dated, 4/4/18 at 4:45 p.m. documented, "BS (blood sugar) 498." There was no note or documentation evidencing the doctor was notified of the blood sugar being over 400 as per the physician order.

An interview was conducted on 6/4/18 at 1:42 with RN (registered nurse) #1, the unit manager. When asked the purpose of the care plan, RN #1 stated, "The care plan is the action of what we are going to do. What goals and expectations of the patient." When asked who has access to the care plans, RN #1 stated, "The nurses and recently the CNAs (certified nursing assistants)."

An interview was conducted with LPN (Licensed practical nurse) #8 on 6/4/18 at 2:08 p.m., regarding the purpose of the care plan. LPN #8 stated, "It's to ensure the patient's needs are being met and protected and they are getting the services they need or want." When asked if the care plan should be followed, LPN #8 stated, "Absolutely."

The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/4/18 at

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F 656	Continued From page 141 5:40 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. 2. The facility staff failed to implement Resident #21's comprehensive care plan for preventing pressure ulcers. Resident #21 was admitted to the facility on 12/21/15 with diagnoses that included but were not limited to: heart failure, diabetes, high blood pressure, dementia, and gout (a disease in which a defect in uric acid metabolism cause the acid and its salts to accumulate in the blood and joints, causing pain and swelling of the joints, sometimes accompanied by fever and chills). (1) The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/27/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. Section M - Skin Conditions, coded the resident as being at risk for developing pressure ulcers. The comprehensive care plan dated, 12/21/15 and revised on 3/8/16 documented in part, "Focus: At risk for alteration in skin integrity	F 656		

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related to: h/o (history of) pressure ulcers, impaired mobility, incontinence, decreased activity, nutritional impairment, friction and shear, DM (diabetes), HTN (high blood pressure), dementia, and dry skin." The "Interventions" documented in part, "Provide preventative skin care routinely and prn (as needed)."

The physician order dated, 5/24/17, documented, "Skin Prep* to left heel every day and evening shift for preventive." *SKIN-PREP is a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films. SKIN-PREP can also be used to prepare skin attachment sites for drainage tubes, external catheters, surrounding ostomy sites and adhesive dressings."(2)

The Treatment Administration Record (TAR) for March 2018 documented, "Skin Prep to left heel every day and evening shift for preventive." The TAR failed to evidence administration of the treatment on 8 out of 62 opportunities. The treatment was not administered on 3/6/18, 3/10/18, 3/13/18, 3/16/18, 3/26/18, 3/29/18 and 3/31/18 at the scheduled time of 3:15 p.m. The treatment was not documented as administered on 3/16/18 at 7:15 a.m.

The Treatment Administration Record (TAR) for April 2018 documented, "Skin Prep to left heel every day and evening shift for preventive." The TAR failed to evidence administration of the treatment on three out of 60 opportunities. The treatment was not administered on 4/5/18, 4/8/18 and 4/12/18 all at the 3:15 p.m. scheduled time.

The Treatment Administration Record (TAR) for

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May 2018 documented, "Skin Prep to left heel every day and evening shift for preventive." The TAR failed to evidence administration of the treatment on two out of the 61 opportunities. The treatment was not administered on 5/13/18 at 7:15 a.m. and 5/19/18 at 3:15 p.m. scheduled time.

Observation was made of Resident #21's left heel on 6/1/18 at 10:18 a.m. with LPN (licensed practical nurse) #3. The left heel blanched without difficulty.

An interview was conducted with LPN #4 on 6/1/18 at 10:21 a.m. LPN #4 was asked to review the TARs for March, April and May 2018 for Resident #21's skin prep treatment. When asked what the blanks on the TAR indicated, LPN #4 stated, "If it's not documented, it's not done."

An interview was conducted on 6/4/18 at 1:42 with RN (registered nurse) #1, the unit manager. When asked the purpose of the care plan, RN #1 stated, "The care plan is the action of what we are going to do. What goals and expectations of the patient." When asked who has access to the care plans, RN #1 stated, "The nurses and recently the CNAs (certified nursing assistants)."

An interview was conducted with LPN (Licensed practical nurse) #8 on 6/4/18 at 2:08 p.m. When asked if the care plan should be followed, LPN #8 stated, "Absolutely."

The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/4/18 at

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5:40 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 252.
(2) This information was obtained from the following website:
http://www.smith-nephew.com/professional/products/advanced-wound-management/skin-prep/

3. The facility staff failed to implement Resident # 87's comprehensive care plan for the administration of insulin.

Resident #87 was admitted to the facility on 5/22/15 with a recent readmission on 3/23/18 with diagnoses that included but were not limited to: dementia, high blood pressure, depression, diabetes, and muscle weakness.

The most recent MDS 9minimum data set) assessment, a Medicare 60 day assessment, with an assessment reference date of 5/18/18, coded the resident as scoring an "11" on the BIMS (brief interview for mental status) score, indicating he is moderately impaired to make daily cognitive decisions. Resident #87 was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of his activities of daily living.

The comprehensive care plan dated, 1/30/17 documented in part, "Endocrine System related to: dm (diabetes mellitus)," The "Interventions" documented in part, "Administer medications per the physician order."

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The physician order dated, 2/28/18, documented, "Lantus Solution (a long acting insulin used to treat diabetes (1)) 100Units/ML (milliliters); inject 20 units subcutaneously at bedtime for DM (diabetes mellitus)."

The March 2018 MAR (medication administration record) documented, Lantus Solution 100Units/ML (milliliters); inject 20 units subcutaneously at bedtime for DM (diabetes mellitus). The dose for 3/4/18 was documented as not given.

The nurse's note for 3/4/18 documented, "Accucheck (brand of glucometer used to obtain blood sugar check) 98. There was no further documentation regarding why the medication was not administered and no documentation evidencing the physician was notified the insulin was held.

The physician order dated, 3/23/18, documented, "Insulin Glargine Solution (Lantus insulin) 100Unit/ML; inject 20 units subcutaneously at bedtime for DM."

The May 2018 MAR documented, "Insulin Glargine Solution (Lantus insulin) 100Unit/ML; inject 20 units subcutaneously at bedtime for DM." The dose for 5/29/18 was documented as not having been administered. The eMAR (electronic medication administration record) dated 5/29/18, documented, "Held for low glucose." The medication is scheduled for 9:00 p.m. The blood sugar at 9:00 p.m. was documented as 118.

An interview was conducted with LPN (Licensed

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practical nurse) #8 on 6/4/18 at 2:08 p.m., regarding the purpose of the care plan. LPN #8 stated, "It's to ensure the patient's needs are being met and protected and they are getting the services they need or want." When asked if the care plan should be followed, LPN #8 stated, "Absolutely."

The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/4/18 at 5:40 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=B861FDD9-E134-436E-8C0C-A60DD0006DD3.

5. The facility staff failed to follow Resident # 51's comprehensive care plan for the implementation of non- pharmacological interventions prior to the use of prn (as needed) pain medication.

Resident # 51 was admitted to the facility on 08/25/17 with a readmission of 10/16/18 with diagnoses that included but were not limited to hypertension (1), Barrett's esophagus (2), diabetes mellitus (3), cirrhosis of the liver (4) and depression (5).

Resident # 51's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/24/18, coded Resident # 51 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily

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F 656	Continued From page 147 decisions. Resident # 51 was coded as being independent with setup or limited assistance of one staff member for activities of daily living. Section "J0300 Pain Presence" coded Resident # 51's pain as frequently at a level eight. The POS (physician's order sheet) dated June 2018 for resident # 51 documented, "Oxycodone (6) Tablet 5 MG (milligram). Give 5 mg by mouth every 6 (six) hours as needed for abdominal cramps/pain. Order date: 10/16/2017. Start Date: 10/16/2017." The eMAR (electronic medication administration record) dated March 2018 documented, "Oxycodone Tablet 5 MG. Give 5 mg by mouth every 6 (six) hours as needed for abdominal cramps/pain. Review of the eMAR revealed oxycodone 5 mg was administered to Resident # 51: On 03/01/18 at 1804 (6:04 p.m.) with a pain level of 5 (five). On 03/02/18 at 0818 (8:18 a.m.) with a pain level of 8 (eight) and at 2009 (8:09 p.m.) with a pain level of 4 (four). On 03/04/18 at 1048 (10:48 a.m.) with a pain level of 9 (nine) and at 2100 (9:00 p.m.) with a pain level of 8 (eight). On 03/05/18 at 1907 (7:09 p.m.) with a pain level of 5 (five). On 03/07/18 at 1616 (4:16 p.m.) with a pain level of 5 (five). On 03/08/18 at 0100 (1:00 a.m.) with a pain level of 3 (three) and at 1326 (1:26 p.m.) with a pain level of 7 (seven). On 03/09/18 at 1550 (3:50 p.m.) with a pain level of 4 (four). On 03/11/18 at 2017 (8:17 p.m.) with a pain level of 6 (six).	F 656		

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On 03/16/18 at 1204 (12:04 p.m.) with a pain level of 8 (eight) and at 2204 (10:24 p.m.) with a pain level of 7 (seven).
On 03/17/18 at 0826 (8:26 a.m.) with a pain level of 6 (six) and at 2309 (11:09 p.m.) with a pain level of 3 (three).
On 03/18/18 at 0537 (5:37 a.m.) with a pain level of 5 (five) and at 1311 (1:11 p.m.) with a pain level of 7 (seven).
On 03/19/18 at 0901 (9:01 a.m.) with a pain level of 6 (six).
On 03/21/18 at 1345 (1:45 p.m.) with a pain level of 7 (seven).
On 03/23/18 at 0804 (8:04 a.m.) with a pain level of 7 (seven).
On 03/29/18 at 0808 (8:08 a.m.) with a pain level of 8 (eight).
On 03/30/18 at 1828 (6:28 p.m.) with a pain level of 3 (three).
On 03/31/18 at 1018 (10:18 a.m.) with a pain level of 8 (eight).
Further review of the eMAR dated March 2018 failed to evidence documentation of non-pharmacological interventions prior to the administration of Norco.

Review of the Nurse's "Progress Notes" dated 03/01/18 through 03/30/18 failed to evidence documentation of non- pharmacological interventions prior to the administration of oxycodone.

The comprehensive care plan for Resident # 51 with an initiation date of 10/19/2017 documented, "Focus. Potential for pain. Date initiated 10/19/2017." Under "Interventions" it documented, "Encourage/Assist to reposition frequently to position of comfort. Date initiated 10/19/2017."

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On 06/05/18 at 10:40 a.m. an interview was conducted with RN (registered nurse) # 3, nurse supervisor. When asked to describe the purpose of the care plan RN # 3 stated, "Use the interventions that are in place to address the resident's needs and to see if the care is effective." After reviewing Resident # 51's comprehensive care plan for pain and the intervention "Encourage/Assist to reposition frequently to position of comfort" RN # 3 was asked to interpret the intervention. RN # 3 stated, "It's the use of non-pharmacological interventions." RN # 3 further stated, "The care plan is not being followed."

On 06/04/18 at approximately 5:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

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

(2) A disorder in which the lining of the esophagus is damaged by stomach acid. The esophagus is also called the food pipe or swallowing tube. This information was obtained from the website: https://medlineplus.gov/ency/article/001143.htm.

(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:

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https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(4) A scarring of the liver and poor liver function. It is the last stage of chronic liver disease. Cirrhosis is the end result of chronic liver damage caused by chronic (long-term) liver disease. Common causes of chronic liver disease in the United States are: Hepatitis B or hepatitis C infection or alcohol abuse. This information was obtained from the website: https://medlineplus.gov/ency/article/000255.htm.

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

(6) Oxycodone is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

5. The facility staff failed to implement /follow Resident #30's comprehensive care plan for the administration of oxygen.

Resident #30 was admitted to the facility on 9/27/17 with the diagnoses of but not limited to stroke, high cholesterol, atrial fibrillation, chronic obstructive pulmonary disease, dementia, gastrostomy feeding tube, neurogenic bladder,

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depression, high blood pressure, cataracts, and benign prostatic hyperplasia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 4/5/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living; as incontinent of bowel and as having an indwelling catheter for bladder.

A review of the clinical record revealed a physician's order dated 1/16/18 for "O2 (oxygen) on @ (at) 2 lit (liters) via nasal cannula every shift for COPD (Chronic Obstructive Pulmonary Disease)."

A review of the comprehensive care plan revealed one dated 4/11/18 for "Cardiac disease related to hyperlipidemia, Hypertension, A FIB (atrial fibrillation)." The interventions included one dated 4/11/18 for "Administer oxygen as ordered." In addition, the care plan included one dated 4/11/18 for "At risk for respiratory impairment related to COPD." This care plan included an intervention dated 4/11/18 for "Administer oxygen as per physician order."

Observations made of Resident #30 on 5/30/18 at 1:47 p.m., 5/30/18 at 3:48 p.m., 5/31/18 at 9:37 a.m., 5/31/18 at 11:02 a.m., and 5/31/18 at 11:50 p.m., revealed the resident in bed with the nasal cannula in place and the oxygen concentrator set at 3.5 liters per minute. Another surveyor verified this observation.

On 6/5/18 at approximately 10:50 a.m., in an interview with LPN (Licensed Practical Nurse) #6, she stated that nurses should be checking the

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oxygen rates.

On 6/5/18 at 10:56 a.m., in an interview with RN (Registered Nurse) #1, RN #1 stated that the nurses should be checking the oxygen.

On 6/5/18 at 12:03 p.m., in an interview with LPN #1, when asked if the care plan was being followed regarding the administration of oxygen to Resident #30, LPN #1 stated no, it was not.

A review of the facility policy, "Oxygen Administration" documented, "Procedure: 1. Verify Physician's order."

A review of the facility policy, "Creating & (and) Maintaining Care Plans" documented, "The patient's care plan is a communication tool that guides members of the interdisciplinary team (IDT) in how to meet each individual patient's needs. It also identifies the types & methods of care that the patient should receive....Once the care plan is developed, the staff must implement the interventions identified in the care plan."

On 6/5/18 at approximately 12:30 p.m., the administrator and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

6. The facility staff failed to implement/ follow Resident #99's comprehensive care plan for the administration of oxygen.

Resident #99 was admitted to the facility on

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F 656	Continued From page 153 2/7/14 with the diagnoses of but not limited to Parkinson's disease, chronic kidney disease, pressure ulcer, obstructive uropathy, anxiety disorder, dysphagia, adrenocortical insufficiency, atrial fibrillation, hypothyroidism, dementia, and prostate cancer. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/4/18. The resident was coded as being moderately impaired in ability to make daily life decisions. A review of the clinical record revealed a physician's order dated 4/28/18 for "2L (2 liters) O2 (Oxygen) Nasal Cannula PRN (as needed) for SOB (shortness of breath)/wheezing." A review of the comprehensive care plan revealed one dated 3/28/15 for "Cardiac disease related to hypotension, atrial fib (atrial fibrillation)." The interventions included one dated 3/28/15 for "Administer oxygen as ordered." Observations made of Resident #90 on 5/31/18 at 9:30 a.m., 5/31/18 at 12:40 p.m., and 5/31/18 at 12:45 p.m., revealed the resident's nasal cannula was in place and the oxygen concentrator rate was set at 1.75 liters per minute. Another surveyor verified this observation. On 6/5/18 at approximately 10:50 a.m., in an interview with LPN (Licensed Practical Nurse) #6, she stated that nurses should be checking the oxygen rates. On 6/5/18 at 10:56 a.m., in an interview with RN (Registered Nurse) #1, RN #1 stated that the nurses should be checking the oxygen.	F 656		

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On 6/5/18 at 12:03 p.m., in an interview with LPN #1, when asked if the care plan was being followed regarding the administration of oxygen to Resident #90, LPN #1 stated no, it was not.

On 6/5/18 at approximately 12:30 PM, the administrator and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

7. The facility staff failed to implement Resident #23's care plan for medication administration.

Resident #23 was admitted to the facility on 10/11/17. Resident #23's diagnoses included but were not limited to GERD (gastro-esophageal reflux disease), dementia (1) and a pressure injury (2). Resident #23's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/28/18, coded the resident's cognitive skills for daily decision-making as severely impaired.

Resident #23's comprehensive care plan dated 10/12/17 documented, "GI (Gastrointestinal) distress r/t (related to) GERD. Administer medications per physician orders..."

Review of Resident #23's clinical record revealed the following physician's orders:
-10/11/17- Protonix (1) 40 mg (milligrams) one time a day for GERD.
-10/18/17- Nystatin (2) 100,000 unit per milliliter- 5 milliliters three times a day for oral care.

Review of Resident #23's February 2018 MAR (medication administration record) revealed the

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following:
-The code "9- Other/See Nurse Notes" was documented in regards to the administration of Protonix and all three doses of Nystatin on 2/11/18.
-The code "9" was documented in regards to the administration of all three doses of Nystatin on 2/24/18.
-The code "9" was documented in regards to the administration of all three doses of Nystatin on 2/25/18.

Further review of Resident #23's clinical record revealed the following nurses' notes:
-Nurses' notes dated 2/11/18 that documented Nystatin was on order and Protonix was unavailable to administer.
-Nurses' notes dated 2/24/18 and 2/25/18 that documented Nystatin was on order.

On 6/4/18 at 10:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to explain the purpose of the care plan. LPN #1 stated, "To inform the nursing personnel and health care (staff) and to make sure that they (the residents) are being monitored in a way to achieve the goals they are set for." When asked how staff ensures residents' care plans are implemented and followed, LPN #1 stated, "It depends on what it is." LPN #1 stated the care plan is constantly being updated. LPN #1 stated she is familiar with the residents she cares for but she also glances at their care plans.

On 6/4/18 at 2:43 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked about the process followed to ensure medications are available for administration. LPN #3 stated medication refills

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are supposed to be ordered when there is a three-day supply of the medication left. LPN #3 was asked what should be done if a medication is not available for administration. LPN #3 stated she always documents that the medication is not available and she contacts the pharmacy. LPN #3 stated she calls the pharmacy and reads off a list of needed medications after she completes her medication pass. LPN #3 stated the pharmacy is located in town so medications can be delivered within an hour if she tells the pharmacy to "STAT it over (send immediately)."

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) "Pantoprazole (Protonix) is used to treat gastroesophageal reflux disease (GERD), a condition in which backward flow of acid from the stomach causes heartburn and possible injury of the esophagus (the tube between the throat and stomach)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601246.html

(2) Nystatin is used to treat fungal infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682758.html

8. The facility staff failed to implement Resident #56's care plan for medication administration.

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Resident #56 was admitted to the facility on 6/5/15 and readmitted on 4/10/18. Resident #56's diagnoses included but were not limited to high cholesterol, diabetes and paralysis. Resident #56's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/1/18, coded the resident's cognition as moderately impaired.

Resident #56's comprehensive care plan dated 6/5/15, 6/15/15 and 6/1/17 documented, "Cardiac disease related to Hypertension (high blood pressure), hyperlipidemia (high cholesterol). Administer medication per physician orders...eye prophalactic (sic). Administer medication per physician orders...ASA (Aspirin) and Plavix At risk for adverse effects. Administer per physician orders...potential for pain due to decreased mobility, dm (diabetes mellitus). Administer pain medication per physician orders...impaired vision as related to glaucoma. Eye meds as on mars [medications administration record]..."

Review of Resident #56's clinical record revealed the following physician's orders:
-12/28/17- Pred Forte (1) eye drops (no strength) - four drops in the left eye four times a day for infection.
-12/28/17 and 4/10/18- Systane (2) 0.4/0.3% eye drops- one drop in both eyes four times a day for dry eyes.
-12/28/17- Latanoprost (3) eye drops- one drop in both eyes at bedtime for glaucoma.
-12/28/17- Lidocaine (4) 2% gel- apply topically to knees two times a day for pain.
-12/28/17- Plavix (5) - 75 mg by mouth one time a day for stroke.
-1/5/18- Hydralazine (6) - 50 mg by mouth three times a day for high blood pressure.

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-4/10/18- Dorzolamide (7) 22.3/6.8 mg/ml (milliliters) eye drops- one drop in both eyes two times a day for glaucoma.
-12/28/17- Amlodipine Besylate (8) - 10 mg (milligrams) by mouth one time a day for high blood pressure.

Review of Resident #56's February 2018 MAR (medication administration record) revealed the following:
-The code "9- Other/See Nurse Notes" was documented in regards to administration of Latanoprost, the 5:00 p.m. and 9:00 p.m. dose of Pred Forte, the 5:00 p.m. and 9:00 p.m. dose of Systane and the 5:00 p.m. dose of Lidocaine on 2/3/18.
-The code "9" was documented in regards to administration of Latanoprost, the 5:00 p.m. and 9:00 p.m. dose of Pred Forte, the 5:00 p.m. and 9:00 p.m. dose of Systane and the 5:00 p.m. dose of Lidocaine on 2/4/18.
- The code "9" was documented in regards to the administration of the 1:00 p.m. dose of Pred Forte and the 1:00 p.m. dose of Systane on 2/10/18.
-The code "9" was documented in regards to the administration of Plavix, Amlodipine, the 9:00 a.m., 1:00 p.m. and 9:00 p.m. dose of Pred Forte, all four doses of Systane and both doses of Lidocaine on 2/11/18.
-The code "9" was documented in regards to the administration of Plavix and all four doses of Systane on 2/24/18.
-The code "9" was documented in regards to the administration of Plavix and all four doses of Systane on 2/25/18.
Further review of Resident #56's clinical record revealed the following nurses' notes:
-Nurses' notes dated 2/3/18 that documented Pred Forte, Latanoprost, Systane and Lidocaine

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was unavailable to administer.
-Nurses' notes dated 2/4/18 that documented Lidocaine, Systane, Latanoprost and Pred Forte was unavailable to administer.
-Nurses' notes dated 2/10/18 that documented Pred Forte and Systane was unavailable.
-Nurses' notes dated 2/11/18 that documented Systane, Lidocaine, Pred Forte, Amlodipine and Plavix were unavailable to administer.
- Nurses' notes dated 2/24/18 that documented Systane and Plavix were unavailable to administer.
-Nurses' notes dated 2/25/18 that documented Systane and Plavix were unavailable to administer.

Review of Resident #56's March 2018 MAR revealed the following:
-The code "9- Other/See Nurse Notes" was documented in regards to administration of all four doses of Systane on 3/10/18 and 3/11/18.
-The code "9" was documented in regards to administration of the 5:00 p.m. and 9:00 p.m. doses of Systane on 3/24/18 and 3/25/18.
Further review of Resident #56's clinical record revealed nurses' notes dated 3/10/18, 3/11/18, 3/24/18 and 3/25/18 that documented Systane was unavailable to administer.

Review of Resident #56's April 2018 MAR revealed the following:
-The code "9-Other/See Nurse Notes" was documented in regards to administration of the 5:00 p.m. dose of Hydralazine and the 5:00 p.m. dose of Systane on 4/10/18. Nurses' notes dated 4/10/18 documented the Hydralazine and Systane was pending pharmacy delivery.

Review of Resident #56's May 2018 MAR

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F 656	Continued From page 160 revealed the following: -The code "9-Other/See Nurse Notes" was documented in regards to the administration of the 9:00 a.m. dose of Dorzolamide on 5/19/18. A nurse's note dated 5/19/18 documented, "Medication not in building, on order." On 6/4/18 at 10:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to explain the purpose of the care plan. LPN #1 stated, "To inform the nursing personnel and health care (staff) and to make sure that they (the residents) are being monitored in a way to achieve the goals they are set for." When asked how staff ensures residents' care plans are implemented and followed, LPN #1 stated, "It depends on what it is." LPN #1 stated the care plan is constantly being updated. LPN #1 stated she is familiar with the residents she cares for but she also glances at their care plans. On 6/4/18 at 2:43 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked the process to ensure medications are available for administration. LPN #3 stated medication refills are supposed to be ordered when there is a three-day supply of the medication left. LPN #3 was asked what should be done if a medication is not available for administration. LPN #3 stated she always documents that the medication is not available and she contacts the pharmacy. LPN #3 stated she calls the pharmacy and reads off a list of needed medications after she completes her medication pass. LPN #3 stated the pharmacy is located in town so medications can be delivered within an hour if she tells the pharmacy to "STAT it over (send immediately)."	F 656		

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On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) Pred Forte is used to treat eye inflammation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682794.html

(2) Systane is used to treat dry eyes. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3130915/

(3) Latanoprost is used to treat glaucoma. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010869/?report=details

(4) Lidocaine gel is used to treat pain. This information was obtained from the website: https://medlineplus.gov/ency/article/003059.htm

(5) Plavix is used to prevent life-threatening problems with the heart and blood vessels in people who have had a heart attack or stroke. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601040.html

(6) Hydralazine is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682246.html

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(7) Dorzolamide is used to treat glaucoma. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697049.html

(8) Amlodipine Besylate is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a692044.html

9. The facility staff failed to implement Resident #18's care plan for medication administration.

Resident #18 was admitted to the facility on 4/25/11. Resident #18's diagnoses included but were not limited to legal blindness, high cholesterol and paralysis. Resident #18's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/23/18, coded the resident's cognitive skills for daily decision-making as severely impaired.

Resident #18's care plan dated 6/18/09 and 3/26/18 documented, "Erythromycin Ointment related to LEGAL BLINDNESS, for 3 months. Administer as ordered by MD (medical doctor)...potential for Pain due to osteo, general hx (history) spasams (sic). Administer pain medication as per MD orders..."

Review of Resident #18's clinical record revealed the following physician's orders:
-8/27/14- Baclofen (1) 5 mg (milligrams) by mouth two times a day for pain.
-1/22/18- Erythromycin (2) ointment 5mg/gm (gram) - instill 0.5 strip in left eye two times a day

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for three months for legal blindness.

Review of Resident #18's January 2018 MAR (medication administration record) revealed the following:
-The code "9- Other/See Nurse Notes" was documented in regards to Baclofen administration at 9:00 a.m. on 1/12/18 and 1/14/18
-The code "9" was documented in regards to Erythromycin ointment administration on 1/22/18 at 5:00 p.m.
-The code "5- Hold/See Nurse Notes" was documented in regards to Erythromycin ointment administration on 1/29/18 at 9:00 a.m.

Further review of Resident #18's clinical record revealed the following nurses' notes:
-1/12/18 "Baclofen Tablet- Give 5 mg by mouth two times a day for pain- not on hand will re order from pharmacy."
-1/14/18 "Baclofen Tablet. Medication unavailable."
-1/22/18 "Erythromycin Ointment 5 MG/GM. Instill 0.5 strip in left eye two times a day related to LEGAL BLINDNESS, AS DEFINED IN USA for 3 Months 1/2 ribbon to OD (right eye). Medication on order from pharmacy."
-1/29/18 "Erythromycin Ointment 5 MG/GM. Instill 0.5 strip in left eye two times a day related to LEGAL BLINDNESS, AS DEFINED IN USA for 3 Months 1/2 ribbon to OD (right eye)- awaiting medication from pharmacy, MD (medical doctor) and RP (responsible party) nnotified (sic)."

Review of Resident #18's April 2018 MAR revealed the following:
-The code "9- Other/See Nurse Notes" was documented in regards to Erythromycin administration at 5:00 p.m. on 4/9/18 and 4/14/18.

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Further review of Resident #18's clinical record revealed the following nurses' notes:
-4/9/18 "Erythromycin Ointment 5 MG/GM. Instill 0.5 strip in left eye two times a day related to LEGAL BLINDNESS, AS DEFINED IN USA for 3 Months 1/2 ribbon to OD (right eye) - Medication not located in med cart or at bedside. Medication reordered. Awaiting delivery from pharmacy."
-4/14/18 "Erythromycin Ointment 5 MG/GM. Instill 0.5 strip in left eye two times a day related to LEGAL BLINDNESS, AS DEFINED IN USA for 3 Months 1/2 ribbon to OD (right eye)- Medication not present in facility. Medication ordered from pharmacy. Awaiting delivery."

On 6/4/18 at 10:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to explain the purpose of the care plan. LPN #1 stated, "To inform the nursing personnel and health care (staff) and to make sure that they (the residents) are being monitored in a way to achieve the goals they are set for." When asked how staff ensures residents' care plans are implemented and followed, LPN #1 stated, "It depends on what it is." LPN #1 stated the care plan is constantly being updated. LPN #1 stated she is familiar with the residents she cares for but she also glances at their care plans.

On 6/4/18 at 2:43 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked the process to ensure medications are available for administration. LPN #3 stated medication refills are supposed to be ordered when there is a three-day supply of the medication left. LPN #3 was asked what should be done if a medication is not available for administration. LPN #3 stated she always

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documents that the medication is not available and she contacts the pharmacy. LPN #3 stated she calls the pharmacy and reads off a list of needed medications after she completes her medication pass. LPN #3 stated the pharmacy is located in town so medications can be delivered within an hour if she tells the pharmacy to "STAT it over (send immediately)."

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) Baclofen is used to treat muscle spasms. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682530.html

(2) Erythromycin is used to treat infections. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=erythromycin&_ga=2.141112693.691240467.1528283828-139120270.1477942321

10. The facility staff failed to implement Resident #83's care plan for oxygen administration.

Resident #83 was admitted to the facility on 5/9/18. Resident #83's diagnoses included but were not limited to presence of cardiac pacemaker, morbid obesity and anemia. Resident #83's most recent MDS (minimum data set), a quarterly assessment with an ARD

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(assessment reference date) of 5/21/18, coded the resident as cognitively intact. Section G documented Resident #83 as requiring extensive assistance of two or more staff with bed mobility/transfers and as requiring extensive assistance of one staff with locomotion/dressing.

Review of Resident #83's clinical record revealed a physician's order dated 5/10/18 for oxygen at two liters per minute. Resident #83's care plan dated 5/17/18 documented, "Cardiac disease related to Hypertension (high blood pressure), Pacemaker...Administer oxygen as ordered..."

On 5/30/18 at 1:27 p.m., observation of Resident #83 was conducted. The resident had a nasal cannula (device used to deliver oxygen) in her nose. The nasal cannula was attached to an oxygen concentrator. The oxygen was administered to Resident #83 at a rate in between three and three and a half liters as evidenced by the middle of the ball in the concentrator flow meter positioned between the three-liter line and the three and a half liter line. Resident #83 stated her oxygen was supposed to be set at a rate of two liters.

On 6/1/18 at 8:48 a.m., observation of Resident #83 was conducted. The resident had a nasal cannula in her nose. The nasal cannula was attached to an oxygen concentrator. The oxygen was administered to Resident #83 at a rate in between one and a half liters and two liters as evidenced by the middle of the ball in the concentrator flow meter positioned between the one and a half liter line and the two-liter line. Another surveyor confirmed this observation.

On 6/4/18 at 10:20 a.m., an interview was

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conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to explain the purpose of the care plan. LPN #1 stated, "To inform the nursing personnel and health care (staff) and to make sure that they (the residents) are being monitored in a way to achieve the goals they are set for." When asked how staff ensures residents' care plans are implemented and followed, LPN #1 stated, "It depends on what it is." LPN #1 stated the care plan is constantly being updated. LPN #1 stated she is familiar with the residents she cares for but she also glances at their care plans. LPN #1 was asked where the ball in an oxygen concentrator flow meter should be positioned if a resident has a physician's order for two liters. LPN #1 stated the middle of the ball should be positioned on the two-liter line.

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

11. The facility staff failed to implement Resident #351's care plan for tube feeding/flush administration.

Resident #351 was admitted to the facility on 5/22/18. Resident #351's diagnoses included but were not limited to difficulty swallowing, diabetes and a stroke. Resident #351's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/29/18, coded the resident's cognitive skills for daily decision-making as moderately impaired. Section K documented Resident #351 had a feeding tube (1).

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Resident #351's care plan dated 5/29/18 documented, "Need for feeding tube/potential for complications of feeding tube use related to swallowing impairment...Administer tube feeding formula, hydration, and flushes per order..."

Further review of Resident #351's clinical record revealed a physician's order dated 5/29/18 for Glucerna 1.2 at a rate of 70 cc/hr (cubic centimeters/hour) times 20 hours and to flush the feeding tube with 100 cc every four hours.

On 5/30/18 at 12:55 p.m. and 5/31/18 at 4:10 p.m., observation of Resident #351 was conducted. The resident was receiving tube feeding. The machine that was delivering the tube feeding and flushes was set at a rate of 60 ml of tube feeding and a rate of 50 ml of flushes every four hours.

On 6/1/18 at 12:39 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked the process for ensuring residents are administered the correct physician ordered tube feedings and flushes. LPN #4 stated, "I'm gonna double check with the orders and make sure he gets his flushes on my shift. I'll also look back to make sure the dietician didn't make any changes." LPN #4 was asked to review Resident #351's physician orders for tube feedings and flushes. LPN #4 stated the physician's order was for Glucerna 1.2 at a rate of 70 cc's an hour times 20 hours and to flush the feeding tube with 100 cc's every four hours. LPN #4 was asked to observe Resident #351's tube feeding with this surveyor. LPN #1 and this surveyor entered the resident's room and reviewed the tube-feeding machine. LPN #1

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F 656	Continued From page 169 stated the tube feeding was running at a rate of 60 cc's an hour and the flushes were 50 cc's. LPN #1 stated the tube feeding should have been running at a rate of 70 cc's and the flushes should have been 100 cc's. On 6/4/18 at 10:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to explain the purpose of the care plan. LPN #1 stated, "To inform the nursing personnel and health care (staff) and to make sure that they (the residents) are being monitored in a way to achieve the goals they are set for." When asked how staff ensures residents' care plans are implemented and followed, LPN #1 stated, "It depends on what it is." LPN #1 stated the care plan is constantly being updated. LPN #1 stated she is familiar with the residents she cares for but she also glances at their care plans. On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. (1) A feeding tube is a soft plastic tube placed into the stomach to deliver nutrition. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000333.htm	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658	**F-658** *It is the intended practice of this facility to ensure that services provided meet professional standards of quality.*	

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F 658	Continued From page 170 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for four of 50 residents in the survey sample (Residents #85, #21, #87 and #90) and for one of six residents in the medication administration observation, Resident #85. 1. The facility staff failed to clarify Resident #85's physician order for oxygen to determine when the oxygen should be administered in relation to a low oxygen saturation level. 2. The facility staff failed to clarify the physician order for pain medications for Resident #21. 4. The facility staff failed to clarify the physician orders for pain medications for Resident #87. 5. The facility staff failed to clarify the physician orders for pain medication for Resident #90. 6. The facility staff failed to administer Resident #85's medications in a timely manner. The findings include: 1. The facility staff failed to clarify Resident #85's physician order for oxygen to determine when the oxygen should be administered in relation to a low oxygen saturation level. Resident #85 was admitted to the facility on 4/18/18. Resident #85's diagnoses included but	F 658	Criteria 1 For R85 the Physician discontinued the oxygen order. Clarification orders for pain medications have been written for R21, R87, and R90. R85 is receiving medications as ordered and timely. Criteria 2 Residents that have physician orders for oxygen, multiple pain medications and residents receiving medications have the potential to be affected. Resident with oxygen and multiple pain medication orders, have been reviewed and clarified as needed. Medication pass observations are being completed to ensure timeliness of medication administration. Criteria 3 Licensed nursing staff were re-educated by DON/Designee on the orders matrix and writing orders correctly for pain medications and oxygen. In addition timeliness of medication administration.	

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were not limited to heart failure, anemia and major depressive disorder. Resident #85's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 5/16/18, coded the resident as cognitively intact

Review of Resident #85's clinical record revealed a physician's order dated 4/26/18 that documented, "o2 (Oxygen) @ (at) 2 liters per minute via N/C (nasal cannula [a device used to deliver oxygen]) every shift for low o2 stats (oxygen saturation level)." Resident #85's care plan dated 4/18/18 documented, "The resident has altered cardiovascular status r/t (related to) heart failure...Give oxygen as ordered by the physician..."

On 6/4/18 at 10:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was shown the above physician's order. LPN #1 stated, "Where are the parameters? Normally we set parameters depending on what the doctor wants but it's usually 92 percent." When asked to clarify what a low oxygen saturation level was, LPN #1 stated, "Anything below 92 percent for me and for most doctors, below 92 percent." When asked how a nurse would know when to administer oxygen to Resident #85, LPN #1 stated she hoped that if someone were in doubt, he/she would check with another nurse. When asked if the order should be clarified, LPN #1 stated, "Yes."

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

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Criteria 4

DON or designee will randomly audit, new pain medication and oxygen orders for correctness, and complete medication pass observations for timeliness, daily x5 days, weekly x2 weeks and monthly x2 months for compliance. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed.

Criteria 5

The facility's alleged date of compliance is 7/10/18.

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The facility document titled, "MEDICATION AND TREATMENT ADMINISTRATION GUIDELINES" documented, "MEDICATION AND TREATMENT ORDERS: A complete medication order includes:
date and time
name of the patient
name of the medication
form, formula, and route of administration
dosage or strength
frequency, including end date orders if applicable
directions for use including the reason for use, diagnoses, or clinical indication
medication specific parameters, if applicable
name of the authorized medical practitioner giving the order
signature of medical practitioner if the order is written
name, title, and signature of the nurse transcribing/entering the order...
Orders are transcribed or electronically entered then noted by the licensed nurse. The licensed nurse noting an order is responsible for accurate transcription and initiation of orders..."

No further information was presented prior to exit.
3. The facility staff failed to clarify the physician orders for as needed pain medications for Resident #21.

Resident #21 was admitted to the facility on 12/21/15 with diagnoses that included but were not limited to: heart failure, diabetes, high blood pressure, dementia, and gout (a disease in which a defect in uric acid metabolism cause the acid and its salts to accumulate in the blood and joints, causing pain and swelling of the joints, sometimes accompanied by fever and chills). (1)

The most recent MDS (minimum data set)

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assessment, a quarterly assessment, with an assessment reference date of 3/27/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions.

The physician order renewed on 4/10/18, documented, "Tramadol Tablet (used to treat moderate to moderately severe pain) (2) 50 MG (milligram); give 50 mg by mouth every 6 hours as needed for pain give 1-2 tabs (tablets). Tylenol Tablet; give 650 mg by mouth every 4 hours as need for pain."

Review of the March 2018, MAR (medication administration record) documented, "Tramadol Tablet 50 MG; give 50 mg by mouth every 6 hours as needed for pain give 1-2 tabs. Tylenol Tablet; give 650 mg by mouth every 4 hours as need for pain." Both the Tramadol and Tylenol were documented as administered in March 2018 as follows:
- Tramadol was administered on: 3/1/18 at 2.04 p.m., 3/4/18 at 9:46 a.m., 3/4/18 at 6:21 p.m., 3/5/18 at 2:20 a.m., 3/6/18 at 11:49 a.m. 3/7/18 at 1:48 p.m., 3/8/18 at 4:35 p.m., 3/9/18 at 10:27 a.m., 3/10/18 at 10:00 a.m., 3/12/18 at 10:27 a.m. , 3/15/18 at 12:20 p.m., 3/18/18 at 9:47 a.m. 3/20/18 at 4:50 p.m., 3/25/18 at 6:05 p.m. and 3/30/18 at 9:19 a.m.

- The Tylenol was documented as having been administered on 3/14/18 at 2:54 a.m. and 3/20/18 at 2:02 a.m. The Tramadol documentation does not indicate if the resident got one or two tablets when it was administered. The physician orders do not differentiate which medication to give when.

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Review of the eMAR notes and nurse's notes do not document how many tablets of Tramadol was given.

The April 2018, MAR documented, "Tramadol Tablet (used to treat moderate to moderately severe pain) (2) 50 MG; give 50 mg by mouth every 6 hours as needed for pain give 1-2 tabs (tablets). Tylenol Tablet; give 650 mg by mouth every 4 hours as need for pain." Only the Tramadol had been administered in April 2018, on the following dates: 4/6/18 at 6:59 p.m., 4/12/18 at 9:19 a.m.,4/18/18 at 12:48 p.m., 4/19/18 at 9:28 a.m. and 6:19 p.m. and on 4/29/18 at 11:49 a.m. The Tramadol documentation does not indicate if the resident got one or two tablets when it was administered. The physician orders do not differentiate which medication to give when.

Review of the eMAR notes and nurse's notes do not document how many tablets of Tramadol was given.

The May 2018, MAR documented, "Tramadol Tablet (used to treat moderate to moderately severe pain) (2) 50 MG; give 50 mg by mouth every 6 hours as needed for pain give 1-2 tabs (tablets). Tylenol Tablet; give 650 mg by mouth every 4 hours as need for pain." Only the Tramadol had been administered in May on the following dates: 5/4/18 at 5:02 a.m., 5/7/18 at 8:49 a.m., 5/16/18 at 5:44 p.m., 5/22/18 at 3:26 p.m., 5/24/18 at 9:51 a.m. and 6:00 p.m., and 5/28/18 at 10:47 p.m. The Tramadol documentation does not indicate if the resident got one or two tablets when it was administered.

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The physician orders do not differentiate which medication to give when.

An interview was conducted on 6/1/18 at 10:02 a.m. with LPN (licensed practical nurse) #4. The orders above were reviewed with LPN #4. When asked how the nurse knows which medication to give, LPN #4 stated, "The orders needs to be clarified." When asked how the nurse would know how many Tramadol to give, based on the physician order, LPN #4 stated, "It should be two separate orders. These orders all need to be clarified."

An interview was conducted with ASM (administrative staff member) #4, on 6/1/18 at 10:32 a.m. ASM #4 was asked to read the orders for Tramadol and Tylenol. When asked if the orders specified which medication to administer if the resident complains of pain, ASM #4 stated, "No Ma'am." When asked if the orders for Tramadol and Tylenol need to be clarified, ASM #4 stated, "Yes, definitely."

The administrator, ASM #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/4/18 at 5:40 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 252.
(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012486/?report=details.

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4. The facility staff failed to clarify the physician orders for pain medications for Resident #87.

Resident #87 was admitted to the facility on 5/22/15 with a recent readmission on 3/23/18 with diagnoses that included but were not limited to: dementia, high blood pressure, depression, diabetes, and muscle weakness.

The most recent MDS (minimum data set) assessment, a Medicare 60 day assessment, with an assessment reference date of 5/18/18, coded the resident as scoring an "11" on the BIMS (brief interview for mental status) score, indicating he is moderately impaired to make daily cognitive decisions. Resident #87 was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of his activities of daily living.

The physician order dated, 3/23/18, documented, "Tramadol Tablet 50 mg (milligram); give 50 mg by mouth every 12 hours as needed for pain. Tylenol Tablet (used to treat mild pain and fevers) (1); give 650 mg by mouth every 8 hours as needed for pain."

Review of the March, April and May 2018 MAR (medication administration record) documented the resident had received both the Tramadol and the Tylenol for pain. There was no specific instructions from the physician as to which medication should be given depending on the pain levels.

Review of the March, April and May 2018 MAR (medication administration record) documented

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the resident had received both the Tramadol and the Tylenol for pain. There was no specific instructions from the physician as to which medication should be given depending on the pain levels. The Tramadol was documented as having been administered on the following dates: 4/1/18 at 3:46 p.m. for a pain level of "6" and 4/10/18 for a pain level of "7." The Tylenol was documented as administered on the following dates: 4/9/18 at 1:23 p.m. for a pain level of "2," 4/10/18 at 9:27 a.m. for a pain level of "10," 4/20/18 at 7:12 a.m. for a pain level of "7," 4/24/18 at 8:50 a.m. for a pain level of "6," 4/25/18 at 5:14 p.m. for pain level of "5", 4/26/18 at 1:15 a.m. for a pain level of "5," and on 4/28/18 for a pain level of "10."

The comprehensive care plan dated, 1/19/17 and revised on 8/11/17, documented in part, "Focus: Potential for Pain." The "Interventions" documented in part, "Administer pain medication per physician order."

An interview was conducted with RN (registered nurse) #4; on 6/1/18 at 10:47 a.m., RN #4 was asked to review the orders for Tramadol and Tylenol. When asked which as needed pain medication should be administered, RN #4 stated, "The Tylenol should designate as to what pain level, mild say 1-5 (on the pain scale). I would start with the mild medication and if it's ineffective give the Tramadol. RN #4 stated, "That order needs to be clarified, I don't like that order. It needs to be more specific."

The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were

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F 658	Continued From page 178 made aware of the above findings on 6/4/18 at 5:40 p.m. No further information was provided prior to exit. 5. The facility staff failed to clarify the physician orders for pain medication for Resident #90. Resident #90 was admitted to the facility 4/5/18 with a recent readmission on 4/20/18 with diagnoses that included but were not limited to: Subdural hematoma (a collection of blood beneath the dura mater and above the arachnoid membrane of the brain) (1), history of colon cancer, fractures of the ribs, depression, anxiety, and legally blind. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 5/18/18, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating he is severely impaired to make daily cognitive decisions. The resident was coded as requiring limited to extensive assistance of one staff member for most of his activities of daily living. He was dependent upon the staff for his nutritional needs. The physician order dated, 4/26/18, documented, "Tylenol Extra Strength Tablet 500 mg (milligram); give 500 mg via PEG-Tube (Percutaneous endoscopic gastrostomy [feeding tube] (2)) every 6 hours as needed for pain. The physician order dated 4/21/18, documented, "Oxycodone-Acetaminophen (treats moderate to moderately severe pain) (3) 5/325 mg; Give 1 tablet by mouth every 6 hours as needed for	F 658		

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F 658	Continued From page 179 pain." An interview was conducted with RN (registered nurse) #4, on 6/1/18 at 10:47 a.m. RN #4 was asked to review the orders for Oxycodone and Tylenol. When asked which as needed pain medication the nurse administer, RN #4 stated, "The Tylenol should designate as to what pain level, mild say 1-5 (on the pain scale). I would start with the mild medication and if it's ineffective give the Oxycodone. RN #4 stated, "That order needs to be clarified, I don't like that order. It needs to be more specific." The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/4/18 at 5:40 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 549 and 265. (2) This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm (3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011543/ 6. The facility staff failed to administer Resident #85's medications in a timely manner. Resident #85 was admitted to the facility on 4/18/18 with the diagnoses of but not limited to	F 658		

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spinal stenosis, heart failure, depression, high blood pressure, diabetes, alcoholic cirrhosis of the liver, and polyneuropathy. The most recent MDS (Minimum Data Set) was an Admission/5-day assessment with an ARD (Assessment Reference Date) of 4/25/18. The resident was coded as being cognitively intact in ability to make daily life decisions.

On 6/04/18 at 11:12 a.m., RN #2 (Registered Nurse) was observed preparing and administering the following medications to Resident #85:
- Oxycodone [1] 5 mg (milligrams) 2 tabs, ordered as PRN (as needed)
- Neurontin [2] 400 mg, 1 tab, ordered TID (three times daily)
- Baclofen [3] 10 mg, 1 tab, ordered TID
- Xifaxan [4] 550 mg, 1 tab, ordered TID
- Mag Ox [5] 400 mg, 1 tab, ordered QD (once daily)
- Oyster shell calcium [6] 500 mg with 200 units of Vitamin D [7], 1 tab, ordered BID (twice daily)
- Zoloft [8] 100 mg, 1 tab, ordered QD
- Aldactone [9] 100 mg, 1 tab, ordered QD
- Lactulose [10] 15 ml (milliliters), ordered TID.

A review of the physician's orders for June 2018 revealed the above medications were to be administered at the intervals documented above (QD, BID, TID).

A review of the June 2018 MAR (Medication Administration Record) revealed that the above medications were all to be given at 9:00 AM (not including the PRN Oxycodone).

On 6/05/18 at 1:12 p.m., in an interview with RN #2, she stated, "I had a patient with a bone

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infection in his leg and he has been draining through the dressings. I was dealing with that, getting his antibiotic up and get him ready for 11a.m., appointment. When you have to spend 30 minutes with one person it makes you late for everyone else." RN #2 stated she did not notify anyone that she needed assistance with medication administration to ensure the other residents medications were timely.

The above medications that were ordered more than once a day (BID, TID), which included the Neurontin, Baclofen, Xifaxan, Calcium with D, and Lactulose, were considered to be late.

A review of the facility policy, "Medication and Treatment Administration Guidelines" documented, "Medications are administered in accordance with standards of practice and state specific and federal guidelines.....Medications are administered in accordance with the following "rights" of medication administration: right patient, right medication, right dose, right route, right time, right documentation, right of patient to refuse, right clinical indication...."

On 6/5/18 at approximately 2:30 PM, the administrator and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

References:

According to Fundamentals of Nursing, Craven and Hirnle; Lippincott, Williams &Wilkins page 566; Many institutions consider a medication to

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be given "on time" if it is administered within 30 minutes to 1 hour before or after the scheduled dose time."

According to Lippincott, Williams and Wilkins, Fundamentals of Nursing, 2007, page 181 reads "Nurses carry a great deal of responsibility for making sure that patients get the right drugs at the right time..."

Sources:

[1] Oxycodone is used to relieve moderate to severe pain.
Information obtained from
https://medlineplus.gov/druginfo/meds/a682132.html

[2] Neurontin (Gabapentin) is "used to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles). Gabapentin extended-release tablets (Horizant) are used to treat restless legs syndrome (RLS; a condition that causes discomfort in the legs and a strong urge to move the legs, especially at night and when sitting or lying down). Gabapentin is in a class of medications called anticonvulsants. Gabapentin treats seizures by decreasing abnormal excitement in the brain. Gabapentin relieves the pain of PHN by changing the way the body senses pain. It is not known exactly how gabapentin works to treat restless legs syndrome."
Information obtained from

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https://medlineplus.gov/druginfo/meds/a694007.html

[3] Baclofen "acts on the spinal cord nerves and decreases the number and severity of muscle spasms caused by multiple sclerosis or spinal cord diseases. It also relieves pain and improves muscle movement."
Information obtained from
https://medlineplus.gov/druginfo/meds/a682530.html

[4] Xifaxan (Rifaximin) is "used to treat traveler's diarrhea caused by certain bacteria in adults and children at least 12 years of age....
Rifaximin....used to prevent episodes of hepatic encephalopathy (changes in thinking, behavior, and personality caused by a build-up of toxins in the brain in people who have liver disease) in adults who have liver disease and to treat irritable bowel syndrome (with diarrhea) in adults.
Rifaximin is in a class of medications called antibiotics. Rifaximin treats traveler's diarrhea and irritable bowel syndrome by stopping the growth of the bacteria that cause diarrhea.
Rifaximin treats hepatic encephalopathy by stopping the growth of bacteria that produce toxins and that may worsen liver disease..."
Information obtained from
https://medlineplus.gov/druginfo/meds/a604027.html

[5] Mag Ox - "Magnesium is an element your body needs to function normally. Magnesium oxide may be used for different reasons. Some people use it as an antacid to relieve heartburn, sour stomach, or acid indigestion. Magnesium oxide also may be used as a laxative for short-term, rapid emptying of the bowel (before

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surgery, for example). It should not be used repeatedly. Magnesium oxide also is used as a dietary supplement when the amount of magnesium in the diet is not enough. Magnesium oxide is available without a prescription." Information obtained from https://medlineplus.gov/druginfo/meds/a601074.html

[6] and [7] Oyster shell calcium* 500 mg with 200 units of Vitamin D* - "Calcium is needed for our heart, muscles, and nerves to function properly and for blood to clot. Inadequate calcium significantly contributes to the development of osteoporosis. Many published studies show that low calcium intake throughout life is associated with low bone mass and high fracture rates. National nutrition surveys have shown that most people are not getting the calcium they need to grow and maintain healthy bones.....The body needs vitamin D to absorb calcium. Without enough vitamin D, one can ' t form enough of the hormone calcitriol (known as the "active vitamin D"). This in turn leads to insufficient calcium absorption from the diet. In this situation, the body must take calcium from its stores in the skeleton, which weakens existing bone and prevents the formation of strong, new bone." Information obtained from https://www.bones.nih.gov/health-info/bone/bone-health/nutrition/calcium-and-vitamin-d-important-every-age

[8] Zoloft (Sertraline) "is used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks),

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posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). It is also used to relieve the symptoms of premenstrual dysphoric disorder, including mood swings, irritability, bloating, and breast tenderness. Sertraline is in a class of antidepressants called selective serotonin reuptake inhibitors (SSRIs). It works by increasing the amounts of serotonin, a natural substance in the brain that helps maintain mental balance."
Information obtained from
https://medlineplus.gov/druginfo/meds/a697048.html

[9] Aldactone (Spironolactone) "is used to treat certain patients with hyperaldosteronism (the body produces too much aldosterone, a naturally occurring hormone); low potassium levels; heart failure; and in patients with edema (fluid retention) caused by various conditions, including liver, or kidney disease. It is also used alone or with other medications to treat high blood pressure. Spironolactone is in a class of medications called aldosterone receptor antagonists. It causes the kidneys to eliminate unneeded water and sodium from the body into the urine but reduces the loss of potassium from the body."
Information obtained from
https://medlineplus.gov/druginfo/meds/a682627.html

[10] Lactulose - "Lactulose is a synthetic sugar used to treat constipation. It is broken down in the colon into products that pull water out from the

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F 658	Continued From page 186 body and into the colon. This water softens stools. Lactulose is also used to reduce the amount of ammonia in the blood of patients with liver disease. It works by drawing ammonia from the blood into the colon where it is removed from the body." Information obtained from https://medlineplus.gov/druginfo/meds/a682338.html	F 658		
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review it was determined the facility staff failed to have qualified staff pronounce death for one of 50 residents in the survey sample, Resident #101B. The facility staff failed to have a registered nurse pronounce the death of Resident #101B and document the pronouncement. The findings include: Resident #101B was admitted to the facility on 2/28/18 with diagnoses that included but were not limited to: stroke, high blood pressure, heart failure, and dysphagia.	F 659	**F- 659** *It is the intended practice of this facility to have qualified staff pronounce death in the facility.* Criteria 1 Resident 101B is discharged. Criteria 2 Residents in facility with a DNR order have the potential to be affected. Two registered nurses may pronounce the death of resident with a DNR in place. Criteria 3 Nursing staff were re-educated by DON/Designee on pronouncing death in the facility for residents with active DNR orders.	

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F 659 Continued From page 187

The most recent MDS (minimum data set) assessment, a five day assessment, with an assessment reference date of 3/7/18, coded the resident as scoring a 10 on the BIMS (brief interview for mental status score), indicating the resident was moderately impaired cognitively to make daily decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living.

The physician order dated, 2/28/18 documented, "DNR (do not resuscitate)." The physician order dated 3/7/18, documented, "Comfort measures only every shift."

The comprehensive care plan dated, 3/7/18 documented in part, "Focus: DNR." The "Interventions" documented, "Honor advanced directives."

The nurse's note dated, 3/8/18 at 6:10 p.m. documented, "CNA (certified nursing assistant) was taking dinner in to resident. She came and got this writer. The resident was found without a pulse or respiration. RN (registered nurse) called. Death declared at 5:45 p.m." LPN (licensed practical nurse) #2 signed this note.

LPN #2 was unavailable for interview during the survey process after many attempts by the survey team and the administration.

An interview was conducted with LPN #6 on 6/5/18 at 1:08 p.m., regarding the process staff follows when a resident is found without a pulse or not breathing. LPN #6 stated, "We check the code status, if a full code we initiate CPR (cardiopulmonary resuscitation). If a DNR, we

F 659

Criteria 4

DON/ designee will audit deaths that occur in the facility to ensure compliance with the pronouncement requirements, daily x5 days, weekly x2 weeks and monthly x2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed.

Criteria 5

The facility's alleged date of compliance is 7/10/2018.

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notify the doctor, the family, and ask which funeral home they would like to use. Then we get an order to release the body to the funeral home. Oh, the RN has to chart that the patient was found without a heartbeat or pulse." When asked if a LPN can pronounce the death of a resident, LPN #6 stated, "No."

An interview was conducted with RN (registered nurse) #2, on 6/5/18 at 1:13 p.m. regarding the process staff follows when a resident is found without a pulse or not breathing. RN #2 stated, "We initiate CPR then have someone else check the code status. When asked who pronounces a resident as expired, RN #2 stated, "I don't know the policy but I know I've always done it with two RNs or a doctor and assess for breathing and heartrate for a full minute. Not sure of the policy here." When asked who writes the note when a resident is pronounced, RN #2 stated, "The RN should definitely write the note." When asked if an LPN can pronounce the death of a resident, RN #2 stated, "No, Ma'am."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing on 6/5/18 at 1:25 p.m. regarding the process for pronouncement of death in the facility. ASM #2 stated, "My understanding is that two RNs must pronounce. The second nurse verifies the absence of vital sign for a full minute." When asked who writes the note, ASM #2 stated, "The RN that is assigned to patient, the first RN that found the resident, the second nurse is just to verify the death. If a physician or nurse practitioner is in the building we can have them pronounce also." When asked if a LPN can pronounce death, ASM #2 stated, "No, Ma'am." ASM #2 reviewed the nurse's note written by the

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F 659	Continued From page 189 LPN for the death of Resident #101B. ASM #2 then stated, "That note does not state the RN pronounced or a second RN was asked to validate it." When asked who should write the note that they pronounce the death of a resident, ASM #2 stated, "Definitely the RN." A copy of the policy on pronouncement was requested at this time. ASM #2, returned on 6/5/18 at 1:47 p.m. and stated, "(Corporate name) does not have a policy as it practices in many states. We follow the professional nurse practice act in the state the facility is in." ASM #2 presented an excerpt from the nurse practice act for the Commonwealth of Virginia. It documented in part, "A registered nurse or a physician assistant who practices under the supervision of a physician may pronounce death if the following criteria are satisfied...works at a nursing home." ASM #2 made aware of the above concern. No further information was provided prior to exit.	F 659		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 684	**F-684** *It is the intended practice of this facility to ensure residents receive treatment and services in accordance with professional standards of practice and the comprehensive care plan.*	

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F 684	Continued From page 190 document review, clinical record review, and during the course of a complaint investigation, it was determined that the facility staff failed to provide care and treatments in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices for five of 50 residents in the survey sample, Residents #56, #23, #96 #87 and # 101 A. 1. The facility staff failed to administer a blood pressure medication to Resident #56 per physician's order on 2/11/18. 2. The facility staff failed to administer the correct physician prescribed treatment to Resident #23's ear. 3. The facility staff failed to follow the physician's order for the administration of insulin for Resident #96. 4. a. The facility staff failed to obtain the physician ordered daily weights for Resident #87. 4.b. The facility staff failed to administer a long acting insulin per the physician order for Resident #87. 5. The facility staff failed to follow physicians orders for administration of sliding scale insulin to Resident #101 A. On four occasions during December 2017, the facility staff administered the physician sliding scale insulin to Resident #101 A outside of the scheduled time frame. The findings include: 1. The facility staff failed to administer a blood	F 684	Criteria 1 Resident 101A is discharged. Resident #56, 23, 96, 87, and 101A suffered no adverse outcomes. Physicians of R56, R23, R96 and R87 have been notified. Physician orders are currently being followed Criteria 2 Residents who receive blood pressure medication, wound treatments, insulin, daily weights, and insulin have the potential to be affected. Criteria 3 Licensed nursing staff were re-educated by the DON/Designee on following physician's orders. Criteria 4 DON of designee will audit MARs/TARs for administration of blood pressure medication, wound treatments, insulin, daily weights, and insulin daily x5 days, weekly x2 weeks and monthly x2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed.	

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pressure medication to Resident #56 per physician's order on 2/11/18.

Resident #56 was admitted to the facility on 6/5/15 and readmitted on 4/10/18. Resident #56's diagnoses included but were not limited to high cholesterol, diabetes and paralysis. Resident #56's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/1/18, coded the resident's cognition as moderately impaired.

Resident #56's comprehensive care plan dated 6/15/15 documented, "Cardiac disease related to Hypertension (high blood pressure), hyperlipidemia (high cholesterol). Administer medication per physician orders..."

Review of Resident #56's clinical record revealed a physician's order dated 12/28/17 for Amlodipine Besylate (1) - 10 mg (milligrams) by mouth one time a day for high blood pressure. Further review of Resident #56's clinical record revealed a nurse's notes dated 2/11/18 that documented Amlodipine Besylate were unavailable to administer.

Review of the facility STAT (Immediate) box (a box that contains various medications that can be accessed if a medication is not available) list revealed five tablets of Amlodipine 2.5 mg was available in the box.

The nurse responsible for administering Amlodipine to Resident #56 on 2/11/18 was not available for interview.

On 6/4/18 at 2:43 p.m., an interview was conducted with LPN (licensed practical nurse) #3.

Criteria 5
Facility's alleged date of compliance is 7/10/2018.

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LPN #3 was asked about the process staff follows to ensure medications are available for administration. LPN #3 stated medication refills are supposed to be ordered when there is a three-day supply of the medication left. LPN #3 was asked what should be done if a medication is not available for administration. LPN #3 stated she always documents that the medication is not available and she contacts the pharmacy. LPN #3 stated she calls the pharmacy and reads off a list of needed medications after she completes her medication pass. LPN #3 stated the pharmacy is located in town so medications can be delivered within an hour if she tells the pharmacy to "STAT it over (send immediately)." When asked if the she utilizes the facility STAT box, LPN #3 stated she checks the box but it only contains certain medications.

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility/pharmacy policy titled, "7.0 Medication Shortages/Unavailable Medications" documented, "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 the 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 this 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

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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 (STAT box) to administer the dose..."

No further information was presented prior to exit.

(1) Amlodipine Besylate is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a692044.html

2. The facility staff failed to administer the correct physician prescribed treatment to Resident #23's ear.

Resident #23 was admitted to the facility on 10/11/17. Resident #23's diagnoses included but were not limited to GERD (gastro-esophageal reflux disease), dementia (1) and a pressure injury (2). Resident #23's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/28/18, coded the resident's cognitive skills for daily decision-making as severely impaired.

Review of Resident #23's clinical record revealed a nurse's note dated 5/30/18 that documented a wound on the resident's right ear. The note documented, "Wound 2: right ear measuring 2 cm (centimeters) X (times) 0.5 cm with red tissue base, current tx (treatment) for TAO (triple antibiotic ointment) and leave open to air." The wound was not documented as a pressure injury.

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A physician's order dated 5/30/18 documented, "Wound Care for right ear; Cleanse with NS (normal saline); Apply TAO and leave open to air. PRN (as needed) as needed for wound."

Resident #23's May 2018 and June 2018 TARs (treatment administration records) documented the above order.

Resident #23's care plan dated 6/4/18 documented, "Area to right ear. Administer treatment per physician orders..."

On 5/30/18 at 1:33 p.m., Resident #23 was observed lying in bed. A tan foam dressing was observed on the resident's right ear.

On 6/4/18 at 9:18 a.m., Resident #23 was observed lying in bed. A tan foam dressing was observed on the resident's right ear.

On 6/4/18 at 10:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1 (the nurse caring for Resident #23). LPN #1 was asked to describe the area on Resident #23's ear. LPN #1 stated she was not sure but it looked like the area may have come from a wrinkle in the pillowcase. LPN #1 stated the area was open and she cleaned the area and completed the treatment to the area this morning. When asked what treatment was ordered by the physician for the area, LPN #1 stated normal saline and a dry dressing was ordered. LPN #1 stated she put a dressing on the area because the area had previously been scabbed but the scab came off and the area was wet. When asked if she had spoken to the physician today regarding the area, LPN #1 stated she had not. When asked if a

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physician's order was required for a dressing, LPN #1 stated it depended on the kind of dressing. LPN #1 stated she was in the process of speaking to the physician and obtaining an order for Resident #23's dressing.

On 6/4/18 at 11:00 a.m., LPN #1 stated she obtained a physician's order for Resident #23's dressing.

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "SKIN PRACTICE GUIDE" documented, "Dressing changes are performed using non-sterile, clean techniques unless otherwise ordered by the attending physician. In general, the following guidelines are considered when performing treatments...ensure the best size and shape dressing is selected- consider location of wound, size, type of wound, peri-skin condition, amount and type of exudate, product specifications, physician orders..."

No further information was presented prior to exit.

(1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-

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meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.240726468.691240467.1528283828-139120270.1477942321

(2) "A pressure sore (injury) is any redness or break in the skin caused by too much pressure on your skin for too long a period of time." This information was obtained from the website: http://sci.washington.edu/info/pamphlets/pressure_sores.asp
3. The facility staff failed to follow the physician's order for the administration of insulin to Resident #96.

Resident #96 was admitted to the facility on 3/28/18 with a recent readmission on 6/2/18 with diagnoses that included but were not limited to: heart failure, end stage renal disease requiring hemodialysis (A procedure used in toxic conditions and renal [kidney] failure in which wastes and impurities are removed from the blood by a special machine (1)), asthma, and diabetes.

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 5/22/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions.

The physician order dated, 3/28/18, documented, "Novolog Solution (a fast acting insulin used to treat diabetes (3)) 100unit/ML (milliliters) inject as per sliding scale: if 150 - 200 (blood sugar) = 4 units, 201 - 250 = 6 units, 251 - 300 = 8 units, 301 - 350 = 10 units, 351 - 400 = 12 units

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subcutaneously before meals and at bedtime for DM (diabetes mellitus). Blood sugar greater than 400 give 15 units and notify MD (medical doctor)."

The MAR (medication administration record) for April 2018 documented, "Novolog Solution 100unit/ML inject as per sliding scale: if 150 - 200 = 4 units, 201 - 250 = 6 units, 251 - 300 = 8 units, 301 - 350 = 10 units, 351 - 400 = 12 units subcutaneously before meals and at bedtime for DM. Blood sugar greater than 400 give 15 units and notify MD." The MAR documented on 4/4/18 at 4:30 p.m., the resident's blood sugar was 498.

Review of the nurse's note dated, 4/4/18 at 4:45 p.m. documented, "BS (blood sugar) 498." There was no note or documentation evidencing the doctor was notified of the blood sugar being over 400 as per the physician order.

The comprehensive care plan dated, 3/29/18, documented in part, "Focus: The resident is on insulin r/t (related to) diabetes." The "Interventions" documented in part, "Monitor blood sugar, lab (laboratory) results as ordered by physician."

An interview was conducted with LPN (licensed practical nurse) #9 on 6/4/18 at 11:07 a.m. LPN #9 was asked to review the Novolog insulin order above. When asked what the nurse should do if the resident's blood sugar is 498, LPN #9 stated, "Give 15 units and call the doctor." When asked where this is documented, LPN #9 stated, "It should be in the progress notes."

An interview was conducted with RN (registered nurse) #4, the unit manager; on 6/4/18 at 11:21 a.m., RN #4 was asked to review the above

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Novolog order. Once the order was reviewed, RN #4 was asked what the staff should do if the resident's blood sugar is 498, RN #4 stated, "You give the 15 units and call the doctor." When asked where this notification is documented, RN #4 stated, "It should be in the progress note." The eMAR (electronic medication administration record) notes were shown to RN #4. RN #4 stated if it's not documented it was not done.

The facility policy, "Medication and Treatment Administration Guidelines" documented in part, "Laboratory values are validated and recorded prior to the administration of laboratory dependent medication in accordance with medical practitioner's orders."

The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/4/18 at 5:40 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.
(2)) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010726/?report=details.

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4. a. The facility staff failed to obtain the physician ordered daily weights for Resident #87.

Resident #87 was admitted to the facility on 5/22/15 with a recent readmission on 3/23/18 with diagnoses that included but were not limited to: dementia, high blood pressure, depression, diabetes, and muscle weakness.

The most recent MDS (minimum data set) assessment, a Medicare 60 day assessment, with an assessment reference date of 5/18/18, coded the resident as scoring an "11" on the BIMS (brief interview for mental status) score, indicating he is moderately impaired to make daily cognitive decisions. Resident #87 was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of his activities of daily living.

The physician order dated, 5/14/18, documented, "Daily weights x (times) 2 weeks. Notify MD/NP (medical doctor/nurse practitioner) if weight gain > (greater than) 3 LBS (pounds) in one day or 5 LBS in 1 week. In the morning related to hypertension (high blood pressure) for 14 days."

Review of the TAR (treatment administration record) for May documented, "Daily weights x 2 weeks. Notify MD/NP if weight gain > 3 LBS in one day or 5 LBS in 1 week. In the morning related to hypertension for 14 days." The weights were documented on five of the 14 days. There were no weights documented from 5/15/18 through 5/23/18.

Review of the "Weights" tab in the electronic record, documented nine of the weights for the 14 day period. Leaving six days that the weights

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were not obtained.

An interview was conducted with RN (registered nurse) #1, the unit manager, on 6/4/18 at 1:42 p.m. When asked if a physician has ordered daily weights, what is the expectation of the nurse, RN #1 stated, "I expect the do get the daily weights and follow the physician's order."

An interview was conducted with LPN (licensed practical nurse) #8 on 6/4/18 at 2:08 p.m. When asked if the physician orders daily weights with parameters, what is your role and where are they documented, LPN #8 stated, "The weights are recorded in the point of care (POC) for the CNA (certified nursing assistants). If it's not on my MAR (medication administration record) or TAR then the CNAs document in POC." LPN #8 was asked to review the physician orders for the daily weights with parameters. When asked who is responsible for reviewing the weights, LPN #8 stated the nurses were responsible. The missing weights on the TAR and the Weight sheet from the computer were reviewed with LPN #8. When asked what should be done, LPN #8 stated she would need to contact the physician to determine if he wants to extend the order.

The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/4/18 at 5:40 p.m.

4.b. The facility staff failed to administer a long acting insulin per the physician order for Resident #87.

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The physician order dated, 2/28/18, documented, "Lantus Solution (a long acting insulin used to treat diabetes (1)) 100Units/ML (milliliters); inject 20 units subcutaneously at bedtime for DM (diabetes mellitus)."

The March 2018 MAR (medication administration record) documented, Lantus Solution 100Units/ML (milliliters); inject 20 units subcutaneously at bedtime for DM (diabetes mellitus). The dose for 3/4/18 was documented as not given.

The nurse's note for 3/4/18 documented, "Accucheck (brand of glucometer used to obtain blood sugar check) 98. There was no further documentation regarding why the medication was not administered and no documentation evidencing the physician was notified the insulin was held.

The physician order dated, 3/23/18, documented, "Insulin Glargine Solution (Lantus insulin) 100Unit/ML; inject 20 units subcutaneously at bedtime for DM."

The May 2018 MAR documented, "Insulin Glargine Solution (Lantus insulin) 100Unit/ML; inject 20 units subcutaneously at bedtime for DM." The dose for 5/29/18 was documented as not having been administered. The eMAR (electronic medication administration record) dated 5/29/18, documented, "Held for low glucose." The medication is scheduled for 9:00 p.m. The blood sugar at 9:00 p.m. was documented as 118.

The comprehensive care plan dated, 1/30/17 documented in part, "Endocrine System related

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to: dm (diabetes mellitus)," The "Interventions" documented in part, "Administer medications per the physician order."

On 6/4/18 at 1:42 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to review the Lantus insulin order, and was then asked if there was any reason staff would hold or not administer the medication. RN #1 stated, "I would be dependent upon the blood sugar. If it was way below the normal range, you would hold the Lantus and call the doctor." RN #1 reviewed the May 2018 MAR for Resident # 87 documenting that the Lantus was held for a blood sugar of 118. RN #1 stated, "That (the Lantus insulin) shouldn't have been held. It's a long acting insulin."

The nurses that held the insulin on the two days documented above were unavailable for interview.

An interview was conducted with LPN (licensed practical nurse) #8 on 6/4/18 at 2:08 p.m., regarding when she would hold Lantus insulin, LPN #8 stated, "I would hold it if the blood sugar is low." When asked to describe low, LPN #8 stated, "Below 60 and call the doctor." When asked if she would hold Lantus insulin for a blood sugar of 118, LPN #8 stated, "No, Lantus peaks later. It's not a short acting insulin."

The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/4/18 at 5:40 p.m.

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No further information was provided prior to exit.
(1) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=B861FDD9-E134-436E-8C0C-A60DD0006DD3.
5. The facility staff failed to follow physicians orders for administration of sliding scale insulin to Resident #101 A. On four occasions during December 2017, the facility staff administered the physician sliding scale insulin to Resident #101 A outside of the scheduled time frame.

Resident #101A was admitted to the facility on 12/15/17 and discharged to the hospital on 1/1/18. The resident had the diagnoses of but not limited to diabetes, seizures, heart disease, depression, glaucoma, dysphagia, and stroke, benign prostatic hyperplasia. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 12/22/17. The resident was coded as being moderately impaired in the ability to make daily life decisions. The resident required total care for bathing; extensive care for transfers, bed mobility, dressing, toileting, and hygiene; supervision for eating; and was continent of bowel and incontinent of bladder.

A review of the clinical record revealed a physician's order dated 12/15/17 for "Novolog [1] FlexPen Solution Pen-Injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 151-200 = 2 unit; 201-250 = 6 units; 251+ = 8 units, subcutaneously before meals and at bedtime..."

A review of the December 2017 MAR (Medication Administration Record) revealed 13 occasions

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between 12/15/17 and 12/31/17 where the resident required the sliding scale insulin. Of these 13 occasions, 4 were documented on the EMAR (Electronic Medication Administration Record) notes at a time outside of the scheduled time frame. They were as follows:

- 12/16/17 6:00a.m. dose was documented as administered at 9:22a.m.
- 12/17/17 4:30p.m. dose was documented as administered at 7:11p.m.
- 12/18/17 4:30p.m. dose was documented as administered at 5:50p.m.
- 12/30/17 11:30a.m. dose was documented as administered at 1:00p.m.

Further review of the clinical record failed to reveal any evidence of the resident's glucose levels becoming "dangerously low" or that any "immediate treatment" was required as a result of the insulin being administered at the incorrect time.

On 6/5/18 at approximately 12:30p.m., an interview was conducted with LPN #5 (Licensed Practical Nurse) who the facility stated was responsible for one of the above administrations, although the MAR does not reflect his initials as being one that administered one of the above doses. In the interview, LPN #5 stated that he always administers insulin on time.

No other staff who worked with Resident #101 was able to be contacted. One other staff member could not be reached. The Assistant Director of Nursing, ASM (administrative staff member #4 stated that the other staff were no longer at the facility.

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F 684	Continued From page 205 A review of the facility policy, "Medication and Treatment Administration Guidelines" documented, "Medications are administered in accordance with standards of practice and state specific and federal guidelines.....Medications are administered in accordance with the following "rights" of medication administration: right patient, right medication, right dose, right route, right time, right documentation, right of patient to refuse, right clinical indication...." No further information was provided prior to exit. Complaint deficiency	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide treatment and services, consistent with professional standards	F 686	**F-686** *It is the intended practice of this facility to ensure that residents receives care, consistent with professional standards of practice, to prevent pressure ulcers and receives necessary treatment and services, consistent with professional standards of practice.* Criteria 1 Resident #36 and #21 suffered no adverse outcome. R36 is receiving wound treatment per physician order. R21 is receiving preventative skin treatment per physician order.	

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F 686	Continued From page 206 of practice, to promote healing of a pressure injury for two of 50 residents in the survey sample, Residents #36 and #21. 1. Resident #36 was readmitted to the facility on 3/14/18 with a pressure injury. The facility staff failed to implement treatment for the pressure injury until 3/16/18. 2. The facility staff failed to administer the physician ordered treatment for the prevention of pressure ulcers for Resident #21 The findings include: 1. Resident #36 was readmitted to the facility on 3/14/18 with a pressure injury. The facility staff failed to implement treatment for the pressure injury until 3/16/18. Resident #36 was admitted to the facility on 12/22/17. Resident #36's diagnoses included but were not limited to stroke, diabetes and seizures. Resident #36's most recent MDS (minimum data set), a 60 day Medicare assessment with an ARD (assessment reference date) of 5/9/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section M coded Resident #36 as having an unstageable deep tissue pressure injury (1). Review of Resident #36's clinical record revealed the resident was transferred to the hospital on 3/5/18 and readmitted on 3/14/18. A readmission assessment dated 3/14/18 documented, "Left heel 5X5 DEEP TISSUE INJURY." Further review of Resident #36's clinical record failed to reveal a treatment order for the pressure injury to the resident's left heel until 3/16/18. A nurse's	F 686	Criteria 2 Residents with pressure ulcers and residents with preventative skin treatments have the potential to be affected. Like residents have been reviewed to ensure orders are in place and treatments are provided as ordered. Criteria 3 Licensed nurses were re-educated by DON/Designee on obtaining pressure ulcer treatment orders timely and following physician orders for preventative skin care. Criteria 4 DON or designee will audit new admits, residents with new pressure ulcers and residents requiring preventative skin treatments to ensure treatment orders are obtained timely and administered per physician orders, daily x5 days, weekly x2 weeks and monthly x2 months, Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed. Criteria 5 The facility's alleged date of compliance is 7/10/2018.	

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note dated 3/16/18 documented, "Skin assessment completed: Fluid filled blister on left heel. New order for skin prep Q (every) shift until healed..." A physician's order dated 3/16/18 documented, "Skin prep to left heel every shift for skin treatment apply to close (sic) area on left heel."

Resident #36's care plan dated 3/14/18 documented, "Resident has a pressure ulcer to left heel. Pressure redistributing support surface. Repositioning during ADLs (activity of daily living). Skin barrier..."

The former wound care nurse was not available for interview.

On 6/1/18 at 9:46 a.m., an interview was conducted with ASM (administrative staff member) #4 (the assistant director of nursing). ASM #4 was asked what should be done when a resident is readmitted with a pressure injury. ASM #4 stated, "Assess and make sure a treatment is in place." When asked if treatment should be implemented on the day of readmission, ASM #4 stated, "Absolutely." ASM #4 was made aware of the above concern.

On 6/4/18 at 11:37 a.m., ASM #2 (the director of nursing) confirmed that there was no evidence to conclude treatment was implemented to Resident #36's left heel pressure injury before 3/16/18.

On 6/4/18 at 5:44 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern.

The facility document titled, "SKIN PRACTICE GUIDE" documented, "If an alteration in skin

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integrity is identified on admission, a designated member of the wound team evaluates the status of the wound (ideally within 24-hours of admission) and collaborates with the licensed nurse, physician, or ARNP (advanced registered nurse practitioner) to determine the type of alteration present. Treatment orders are obtained, noted and initiated."

No further information was presented prior to exit.

(1) "Pressure Injury:
A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue...
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia,

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muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions." This information was obtained from the website: http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/

2. The facility staff failed to administer the physician ordered treatment for the prevention of pressure ulcers for Resident #21.

Resident #21 was admitted to the facility on 12/21/15 with diagnoses that included but were not limited to: heart failure, diabetes, high blood pressure, dementia, and gout (a disease in which a defect in uric acid metabolism cause the acid and its salts to accumulate in the blood and joints, causing pain and swelling of the joints, sometimes accompanied by fever and chills). (1)

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/27/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. Section M - Skin Conditions, coded the resident as being at risk for developing pressure ulcers.

The comprehensive care plan dated, 12/21/15 and revised on 3/8/16 documented in part, "Focus: At risk for alteration in skin integrity

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related to: h/o (history of) pressure ulcers, impaired mobility, incontinence, decreased activity, nutritional impairment, friction and shear, DM (diabetes), HTN (high blood pressure), dementia, and dry skin." The "Interventions" documented in part, "Provide preventative skin care routinely and prn (as needed)."

The physician order dated, 5/24/17, documented, "Skin Prep* to left heel every day and evening shift for preventive." *SKIN-PREP is a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films. SKIN-PREP can also be used to prepare skin attachment sites for drainage tubes, external catheters, surrounding ostomy sites and adhesive dressings."(2)

The Treatment Administration Record (TAR) for March 2018 documented, "Skin Prep to left heel every day and evening shift for preventive." The TAR failed to evidence administration of the treatment on 8 out of 62 opportunities. The treatment was not administered on 3/6/18, 3/10/18, 3/13/18, 3/16/18, 3/26/18, 3/29/18 and 3/31/18 at the scheduled time of 3:15 p.m. The treatment was not documented as administered on 3/16/18 at 7:15 a.m.

The Treatment Administration Record (TAR) for April 2018 documented, "Skin Prep to left heel every day and evening shift for preventive." The TAR failed to evidence administration of the treatment on three out of 60 opportunities. The treatment was not administered on 4/5/18, 4/8/18 and 4/12/18 all at the 3:15 p.m. scheduled time.

The Treatment Administration Record (TAR) for

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May 2018 documented, "Skin Prep to left heel every day and evening shift for preventive." The TAR failed to evidence administration of the treatment on two out of the 61 opportunities. The treatment was not administered on 5/13/18 at 7:15 a.m. and 5/19/18 at 3:15 p.m. scheduled time.

Observation was made of Resident #21's left heel on 6/1/18 at 10:18 a.m. with LPN (licensed practical nurse) #3. The left heel blanched without difficulty. The foot was noted to have dry flakey skin. This was confirmed with LPN #3.

An interview was conducted with LPN #4 on 6/1/18 at 10:21 a.m. LPN #4 was asked to review the TARs for March, April and May 2018 for Resident #21's skin prep treatment. When asked what the blanks on the TAR indicated, LPN #4 stated, "If it's not documented, it's not done."

An interview was conducted with ASM (administrative staff member) #4, the assistant director of nursing, on 6/1/18 at 10:29 a.m. The TARs for Resident #21 were reviewed. When asked what the blanks on the TAR indicated, ASM #4 stated, "It's not documented, therefore I don't know if it was done."

On 6/1/18 at 1:12 p.m., an interview was conducted with RN (registered nurse) #2, one of the nurses that worked during these months that failed to document the treatment. RN #2 was asked to review the TARs for Resident #21. When asked what the blanks on the TAR meant, RN #2 stated, "I didn't document it. If there is a blank, there would be a question if it were done or not. I can't remember specific days and times. If its' not documented, I can't remember if I did it or

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not. If it is not documented, it's not done. That's what would stand up in court. I am new and the program is new to me too."

The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4 were made aware of the above findings on 6/4/18 at 5:40 p.m. At this time, a request was made for any information regarding Resident #21's history of a pressure ulcer on her left heel.

On 6/5/18 at approximately 10:30 a.m. ASM #4 presented nurse's notes from 4/27/17 that documented, "Left heel dark red in color and slowly blanches, skin intact, no odor, no drainage, skin prep applied." The nurse's note dated, 5/11/17 documented, "Left heel measuring 4.0 cm (centimeters) X (by) 3.5 cm as whole with 2.0 cm x 1.5 cm x 0.1 cm open area present to base of wound bed, would bed light pink in color, no odor noted, scant amount of clear drainage present, surrounding skin remains dark red in color, slowly blanches." The nurse's note dated, 5/24/18, documented, "Left heel no longer has pressure ulcer, area healed, light pink in color, skin prep placed preventatively."

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 252.

(2) This information was obtained from the following website:
http://www.smith-nephew.com/professional/products/advanced-wound-management/skin-prep/

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F 689 Free of Accident Hazards/Supervision/Devices
SS=D CFR(s): 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined, the facility staff failed to ensure a smoking assessment was completed, prior to smoking, for two, of 50 residents in the survey sample, (Residents #355 and #27); and failed to prevent hazards with the use of a non-medical grade power strip in one of 70 resident rooms, room 137A.

1. Resident #355 was smoking at the facility since admission on 5/26/18. The facility staff failed to complete a smoking assessment to determine safety risks until 5/30/18.

2. Resident #27, a smoker, was admitted on 3/9/18, the facility staff failed to complete a smoking assessment to determine safety risks 4/13/18.

3. The facility staff failed to maintain non-medical grade power strips outside the patient vicinity, which is defined as seven feet above the bed and six feet around the bed, in resident room 137A.

The findings include:

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It is the intended practice of this facility to ensure the resident environment remains as free of accident hazards as possible, and each resident receives adequate supervision and assistance devices to prevent accidents.

Criteria 1

Resident #355 is discharged.
Resident #27 has a completed current smoking assessment.
Upon notification from surveyor about non-medical grade power strip in room 137 it was removed immediately by maintenance director

Criteria 2

Residents who smoke and resident rooms that have non-medical grade power strips have the potential to be affected. Resident smokers have been reviewed to ensure a smoking assessment has been completed. Room rounds were completed to remove any non-medical grade power strips.

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1. Resident #355 was smoking at the facility since admission on 5/26/18. The facility staff failed to complete a smoking assessment to determine safety risks until 5/30/18.

Resident #355 was admitted to the facility on 5/26/18. Resident #355's diagnoses included but were not limited to heart failure, high blood pressure and difficulty in walking. Resident #355's admission MDS (minimum data set) assessment was not complete. An admission assessment dated 5/26/18 documented the resident was able to communicate needs and was oriented to time, person and situation. The admission assessment documented Resident #355 was a current smoker in a non-smoking facility.

Resident #355's care plan dated 5/27/18 documented, "History of smoking in community...Educate/review non smoking (sic) status of the center. Complete Smoking Evaluation per facility guidelines."

Review of Resident #355's clinical record revealed a smoking assessment to determine safety risks with smoking was not completed until 5/30/18. The form titled, "Smoking Facility-Smoking Evaluation" documented the following:
"1. Cognitive Function:
1a. Short term memory is ok; recall after 5 minutes- Yes
1b. Long term memory is OK: recall of long past events- Yes
1c. Adequate memory/recall ability: recall of activities over last 7 days- Yes
1d. Able to make decisions regarding tasks of

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Criteria 3

Licensed nurses and Social work staff were re-educated by the DON/Designee on timely completion of smoking assessments for new admissions prior to residents smoking.
Director of plant OPS was re-educated by Administrator on completing scheduled rounds to identify and remove non-medical grade power strips and other environmental hazards.

Criteria 4

DON or designee will complete random audits of new admissions to ensure smoking assessments are completed for resident smokers, daily x5 days, weekly x2 weeks and monthly x2 months.
Admin will complete room rounds to ensure environmental safety, daily x5 days, weekly x2 weeks and monthly x2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed.

Criteria 5

The facility's alleged date of compliance is 7/10/2018.

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F 689	Continued From page 215 daily life (e.g., decisions are consistent and reasonable) - Yes 2. Visual Function: 2a. Patient sees adequately, e.g., sees regular newsprint without difficulty- Yes 3. Communication Function 3a. Patient is able to make needs known verbally- Yes 4. Physical Function: 4a. Patient is free of physical limitations interfering with the ability to perform safe smoking techniques, e.g., able to grasp and handle cigarette, lighter or matches without assistance- Yes 5. Patient Interview 5a. Patient understands that smoking may only take place at designated times in designated smoking areas- Yes 5b. Patient understands that smoking accessories (cigarettes, lighter, matches, etc.) must be returned to and kept under the control of the center staff when not in use- Yes 5c. Patient is able to communicate the safety risks associated with smoking- Yes 6. Patient Observation: 6a. Patient demonstrates safe smoking techniques: holding cigarette, lighting cigarette, extinguishing matches, lighter & cigarette after use and disposal of ashes- Yes 6b. Patient remains alert during the course of smoking- Yes 6c. Patient is free from evidence of burn injuries or holes noted on clothing or wheelchair- Yes 7. Determination: 7a. Independent Smoker: Capable and independent, requires no supervision to smoke- Yes 7a1. Proceed to care plan Focus: History of smoking in	F 689		

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F 689	Continued From page 216 community/Inappropriate smoking related to: Focus: History of smoking in community/Inappropriate smoking related to: Goal: Will remain compliant with center smoking procedure and individual smoking restrictions Intervention: Complete Smoking Evaluation per facility guidelines. 7b. At risk smoker- No. 8. Additional Information 8a. Comments: (blank)." On 6/1/18 at 10:01 a.m., an interview was conducted with ASM (administrative staff member) #4 (the assistant director of nursing) and ASM #2 (the director of nursing) regarding the facility processes in place for new admissions who smoke. ASM #2 stated a smoking assessment is completed on admission if facility staff knows a resident smokes. ASM #2 stated sometimes residents who smoke do not smoke when they are first admitted then choose to smoke later during their stay. ASM #2 stated a smoking assessment should be completed before a resident smokes at the facility. On 6/1/18 at 10:47 a.m., an interview was conducted with Resident #355. Resident #355 stated he had been smoking at the facility since his admission. On 6/1/18 at 11:09 a.m., an interview was conducted with ASM #2. ASM #2 stated to her knowledge, Resident #355 had smoked at the facility since admission. On 6/4/18 at 5:44 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above findings.	F 689		

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The facility document titled, "SMOKING GUIDELINES" documented, "PURPOSE: To determine if a patient is an Independent Smoker or an At Risk Smoker before the patient exercises the privilege to smoke while residing within the center and to establish guidelines for all patients that desire to smoke, as well as non-smokers...Evaluate patients that smoke utilizing the Smoking Evaluation tool either: (a) upon admission; (b) when a previous non-smoking patient takes up smoking; (c) if unsafe smoking practices are observed in a current smoker; or, (d) when a patient that smokes has a significant change in medical condition..."

No further information was presented prior to exit.
2. Resident #27, a smoker, was admitted on 3/9/18, the facility staff failed to complete a smoking assessment to determine safety risks 4/13/18.

Resident #27 was admitted to the facility on 3/9/18, with diagnoses that included but were not limited to: low back pain, diabetes, difficulty in walking, and muscle weakness.

The most recent MDS (minimum data set) assessment, a 30 day Medicare assessment, with an ARD (assessment reference date) of 4/4/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating that she had no cognitive impairment. Resident #27 was coded as always understanding others and always making herself understood. Resident #27 was coded as requiring one person physical assistance for bed mobility and transfers, and staff supervision/set up for toileting, personal hygiene, bathing and

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dressing.

The group interview was conducted on 5/31/18 at 11:30 a.m. with seven residents participating. During the discussion of dignity and resident rights, Resident #27 stated the staff "treated her like a baby" when she went on her smoking breaks. Resident #27 stated they have made her wear the vest/apron ever since she was admitted on 3/9/18. She stated that she had smoked since she was eighteen years old and she has never burned her clothes by dropping ashes.

During a record review on 5/31/18 at 1:48 p.m., it was noted that Social Services documented on 3/13/18 in part, "Patient stated she has a history of smoking". It was also noted that a "Smoking Assessment" was not performed on Resident #27 until 4/13/18. Based on the "Smoking Assessment", Resident #27 was documented as being an "Independent Smoker: Capable and independent, requires no supervision to smoke".

Resident #27's comprehensive care plan, dated 4/13/18, documented in part, "Focus: History of smoking in community". The "Interventions" documented in part, "Secure the smoking materials at nurses' station ...Discuss smoking habits with patient/family and develop an agreed upon smoking plan".

During an interview with ASM #4, (administrative staff member), the assistant director of nursing, on 6/1/18 at 9:45 a.m., ASM #4 confirmed that the smoking assessment was performed on 04/13/18. ASM #4 stated that the smoking assessment should be done at admission; however, if they don't say they smoke on admission, the assessment will be done prior to

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the resident being allowed to go out to smoke. When asked if a resident can smoke without an assessment, she stated, "The smoking assessment must be done".

An interview was conducted with Resident #27 on 6/1/18 at 10:09 a.m. Resident #27 stated that she has smoked from the day she got to the facility. She stated she has been smoking since she was eighteen years old.

An interview was conducted with LPN (licensed practical nurse) #4 on 6/1/18 at 10:43 a.m. When asked about the procedure for smokers, she stated, "Smokers are assessed and given the rules".

A review of the facility's "Smoking Guidelines" was performed. The "purpose" of the guidelines is "To determine if a patient is an Independent Smoker or an At Risk Smoker before the patient exercises the privilege to smoke while residing at the center".

ASM #1, the administrator, ASM #2, the director of nursing, ASM #4, the assistant director of nursing, and ASM #5, the quality assurance consultant, were made aware of the above concerns on 6/4/18 at 5:30 p.m.

No further information was provided prior to exit.
3. The facility staff failed to maintain non-medical grade power strips outside the patient vicinity, which is defined as seven feet above the bed and six feet around the bed, in resident room 137A.

Observation was made of room 137A on 5/30/18 at 10:49 a.m. A power strip was observed next to the dresser, approximately three feet from the

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foot of the bed. A television was plugged into the power strip and the power strip was secured to the cobase with Velcro.

A second observation was made of room 137A on 5/31/18 at 1:31 p.m. with other staff member (OSM) #4, the director of plant operations. When asked if the power strip was a medical grade power strip, OSM #4 stated, "No, it's not." OSM #4 stated he was not aware of it being in the building. When asked if he was aware of the safety hazard for this power strip, OSM #4 stated, "Yes." When asked about the policy for having power strips in the nursing home, OSM #4 stated he would have to check. When asked if the residents are allowed to have power strips, OSM #4 stated they were not allowed in the resident areas unless it's approve by the state fire marshal. A policy was requested for the use of power strips in the facility.

On 6/1/18 at 8:56 a.m., administrative staff member (ASM) #1, the administrator and ASM #7, a corporation administrator, were made aware of the above concern. ASM #7 informed this writer the facility did not have a policy on power strips, the facility defers to the regulations.

No further information was obtained prior to exit.

In its Standard for Health Care Facilities (NFPA 99), (1) NFPA defines a patient care area as "any portion of a health care facility wherein patients are intended to be examined or treated." For equipment intended to be used within these areas-which include patient, examining, and treatment rooms, as well as any similar areas in which the patient is likely to come into contact with electrical devices-NFPA specifies that

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		

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§483.25(e) Incontinence.
§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review it was determined that the facility staff failed to

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It is the intended practice of this facility to ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

Criteria 1

For R#20, Urinary catheter order, including medical necessity and care orders obtained. Urinary assessment completed. Securement device is in place.
R#30's urinary catheter is being maintained in a privacy bag, staff are ensuring tubing is not touching the floor and maintained below bladder level with securement device in place.

Criteria 2

Residents with urinary catheters have the potential to be affected, and were reviewed to ensure, catheter orders, assessment, medical necessity, privacy bag, securement device and infection control practices are in place.

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provide care and services for the use of an indwelling urinary catheter for two of 50 residents in the survey sample, Residents # 20 and # 30.

1. The facility staff failed to provide evidence of a physician's order or the assessment for the use of an indwelling urinary catheter for Resident #20.

2. The facility staff failed to ensure Resident #30's Foley catheter bag and tubing were not on the floor to prevent infections.

The findings include:

1. The facility staff failed to provide evidence of a physician's order or the assessment for the use of an indwelling urinary catheter for Resident #20.

Resident #20 was admitted to the facility on 8/8/17, with a most recent readmission date of 5/1/18. Diagnoses included but were not limited to: diabetes, high blood pressure, right total hip replacement, and atrial fibrillation (irregular heartbeat) (1).

The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 3/23/18, coded the resident as scoring a 3 on the BIMS (brief interview for mental status) score, indicating that she has severe cognitive impairment. Resident #20 was coded as requiring extensive assistance from one or more person for bed mobility, transfers, toileting, personal hygiene, bathing and dressing. In Section H - Bladder and Bowel, the resident was coded as having an indwelling catheter during the look back period.

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Criteria 3

Facility nursing staff were re-educated on the facility urinary catheter policy.

Criteria 4

DON/Designee will audit residents with urinary catheters to ensure the facility policy is followed, daily x5 days, weekly x2 weeks, and monthly x2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed.

Criteria 5

The facility's alleged date of compliance is 7/10/2018.

Heartland | Hospice Care

10800 Midlothian Turnpike
Suite 303
Richmond, VA 23235
Phone: 804-288-0235
Fax: 804-288 4380

Urgent

TIME SENSITIVE

To: Dr. Sabina Ali
From: Wendy Fritz
Fax: 804-262-1872
Date: 7-6-18
Total # of pages including cover: 6
Sender's Pone: 288-0235

Dear Dr. Ali,

Attached is paperwork for your patient Mattie White

Please review and sign/date where indicated by arrows then fax back to 804-288-4380 by 7-6-18

Attached for your review are:

- Initial orders and Plan of care
- VA DMAS form
- Attending Physician Certification
- DNR

If you do not receive each of the above mentioned forms or if you need to discuss further, please contact Wendy at 288-0235

Thank you in advance for your prompt attention to this request.

Heartland 11922727

INITIAL PLAN OF CARE

☐ Home Care ☐ Home Health Care ☒ Hospice Services ☐ Infusion Services

Patient Name: (Last, First, MI) White, Mattie
CR#:

FOR OFFICE USE ONLY

Certification: 6/28/18 to 9/25/18
SOC Date: 6/28/18
DOB: 5/9/1920
Has this patient received hospice services in the past? ☐ Yes ☒ No

ADMISSION STATUS

Level of Care: ☒ Routine Home Care ☐ Respite ☐ General Inpatient for:
☐ Continuous Care for:

Caregiver Name: Roxanne Brinson **Relationship:** Daughter

☐ **Priority code (A) Visit if at all possible.**
☒ **Priority code (B) Visit within 72 hours.**
☐ **Priority code (C) Health and welfare can be maintained for 5-7 days.**

Medications: ***See Attached Medication Sheet***

☐ Allergies:

☐ Oxygen ____ L/min. per nasal cannula ☐ PRN ☐ Continuous ☒ O_2 Sats PRN to assess clinical status
☒ Notify physician when saturation below 89 % or when patient is in distress ☐ Physician ordered not to be notified of saturation reading

Persons authorized to administer medication:
☐ Patient ☒ Facility Nurse ☐ Caregiver ☐ Family

Foley Catheter: ☐ Foley currently in place ☒ Foley PRN for retention or comfort
16 French Foley catheter with 10 cc balloon. Change q 30 days and PRN for pain, leakage, discomfort
May Irrigate Foley catheter PRN ____ for obstruction with 30 cc NSS. If unable to maintain patency with irrigation, replace catheter.

DISCIPLINES AND FREQUENCY

☒ **Nurse:** First week: 1 visits 1 PRN visits
Middle weeks: 1 visits/week beginning 1st Thurs. after SOC and 1 PRN visits/week
Last week: 1 visits 1 PRN visits

Nurse assigned *(if known)*: Jessica Hancock

☒ Nursing assessment of patient/caregiver needs
☒ Evaluation of patient/caregiver response to effectiveness of interventions
☒ Development of patient/caregiver care plan/interventions in collaboration with IDG

Treatments/Wound Care:

☐ **PT/OT/SLP:** ☐ Evaluation as needed for Palliative Symptom Management/Safety ☒ Declined ☐ N/A
☐ Specify Therapy ____ Therapist assigned *(if known)*:

☒ **Hospice Aide:** First week: 2 visits ☐ Declined ☐ N/A
Middle weeks: 2 visits/week beginning 1st Thurs. after SOC
Last week: 2 visits
☒ Personal Care ☐ Homemaker Aide assigned *(if known)*: Diane

☒ **Social Worker:** ☒ Evaluation Frequency ____ visits every month and ____ PRN visits/month
Social Worker assigned *(if known)*: Lindsay
☐ Assessment ☐ Coping of patient/caregiver ☐ Community resources ☐ Intervention of patient ☐ Communication ☐ Anticipatory grief needs

☒ **Spiritual Care Coordinator:** ☒ Evaluation Frequency __ visits every month and ____ PRN visits/month
Spiritual Care Coordinator assigned *(if known)*: Dana
☐ Assessment ☐ Intervention of spiritual needs ☐ Anticipatory grief ☐ Coping of patient/caregiver

☒ **Bereavement Services:** ☒ Evaluation

☒ **Volunteer:** ☒ Evaluation
☒ Alternative Therapy: Music Therapy ☐ Declined ☐ N/A

☐ **Dietary/Nutritional Evaluation as needed for:** ☒ Declined ☐ N/A
☐ Diet:

DME: ☐ None used
☐ Bedside commode ☐ Elevated toilet seat ☒ Wheelchair ☐ Splint ☒ Hospital beds ☐ Specialty mattress
☐ Cane ☐ Tub/Shower bench ☐ Walker ☐ Grab bars ☐ Transfer equipment ☐ Other

Reorder From: DSSI / MED-PASS

Heartland

INITIAL PLAN OF CARE

☐ Home Care ☐ Home Health Care ☒ Hospice Services ☐ Infusion Services

Patient Name: (Last, First, MI) White, Mattie | CR#:

IMMEDIATE PLAN OF CARE PROBLEMS: Blank = Assessed/No Problem ✓ = New Problem Identified

☐ 1 Anticipate death 72 hrs or less	☒ 9 Dysphagia/Anorexia/Stomatitis	☐ 17 Depression	☐ 25 Need for Volunteer
☒ 2 Disease Process/HC Directives	☐ 10 Respiratory Function	☐ 18 Alteration Coping-Pt	☐ 26 Spiritual Needs
☒ 3 Pain/Discomfort	☐ 11 Cardiac/Circulatory	☐ 19 Alteration Coping-Caregiver	☐ 27 LOC: Sx Mgmt
☒ 4 Functional Ability	☐ 12 Impaired Skin Integrity	☐ 20 Mental Illness of Patient	☐ 28 LOC: Inpt Respite
☐ 5 Insomnia	☐ 13 Diabetes	☐ 21 Communication Issues	☐ 29 Potential Discharge
☐ 6 Nausea/Vomiting	☐ 14 Central Venous Line	☐ 22 Anticipatory Grief	☒ 30 Facility Coordination
☐ 7 Constipation/Diarrhea	☐ 15 Infection	☐ 23 Financial Limitations	☐ 31 Other ____
☒ 8 Incontinence of Bowel/Bladder	☒ 16 Neuro Status	☒ 24 Patient Safety in Home	☐ 32 Auxiliary Aids

First IDG: This Plan of Care was developed through the communication and input from the following interdisciplinary team members:

Victoria Batsch, RN	6/28/18	Dr. Attoey Miranda	6/28/18
Admitting Nurse Name	*Date*	*Hospice Physician Name*	*Date*
		Dr. Sabina Ali	6/28/18
Social Worker Name	*Date*	*Attending Physician Name*	*Date*
Spiritual Care Name	*Date*	*RN Case Manager Name*	*Date*

Check only one: ☐ Collaborated with Hospice NP as attending ☐ Collaborated with Hospice Physician as attending

DNR: ☒ Yes ☐ No **Advance Directives:** ☐ Yes ☒ No

☒ This plan of care has been discussed with the patient/representative and caregiver(s).

Level of understanding: ☒ Good understanding ☐ Partial understanding ☐ Do not understand

Level of involvement in developing plan of care: ☒ Very involved ☐ Moderate involvement ☐ Declined involvement

Level of agreement: ☒ Complete agreement ☐ Partial agreement ☐ Minimal agreement

Areas of disagreement, noninvolvement and/or lack of understanding: ____________

This Hospice Plan of Care includes:
- ✓ Initial orders and Plan of Care
- ✓ Medication Profile
- ✓ Hospice Aide Assignment
- ✓ Plan of Care Problems (identified in assessments)
- ✓ Hospice Principal and Other Diagnoses ICD-10 Form

I have reviewed and agree with the Hospice Plan of Care that includes Initial Orders and Plan of Care, Medication Profile and Plan of Care Problems (identified in assessments) and admission to hospice.

[signature] 7.5.18
Physician Signature *Date by Physician*

RN Signature: Victoria Batsch, RN Date: 6/28/18

Reorder From: DSSI / MED-PASS

Heartland
Home Health, Hospice, IV Care

ATTENDING PHYSICIAN CERTIFICATION

☐ Health Care ☐ Home Health Care ☒ Hospice (or Hospice Care) ☐ IV (or IV Care)

Patient Name: White (Last) Mattie (First) S (MI) CR#:

ATTENDING PHYSICIAN: Dr. Sabina Ali Verbal Certification Date: 6/28/18

Certification Read Back to Physician/Agent of Physician?: Y ☒ N ☐

For Office Use:
Certification from: 6/28/18 to 9/25/18 SOC 6/28/18

THE FOLLOWING STATEMENT HAS BEEN READ AND AGREED TO BY: Heather McIntueff, NP - Agent of Dr. Ali

I CERTIFY THAT THE ABOVE NAMED PATIENT IS CONSIDERED TERMINALLY ILL WITH A LIFE EXPECTANCY OF SIX (6) MONTHS OR LESS IF THE ILLNESS RUNS ITS NORMAL COURSE.
VERBAL CERTIFICATION RECEIVED BY:

RN Signature Victoria Batsch, RN Date 6/28/18
RN Print Name Victoria Batsch, RN

SIGN & DATE

CERTIFICATION OF TERMINAL ILLNESS

I CERTIFY THAT THE ABOVE NAMED PATIENT IS CONSIDERED TERMINALLY ILL WITH A LIFE EXPECTANCY OF SIX (6) MONTHS OR LESS BASED ON CURRENT CLINICALLY RELEVANT INFORMATION, IF THE TERMINAL ILLNESS RUNS IT'S NORMAL COURSE.

ATTENDING PHYSICIAN SIGNATURE Date:

Dr. Sabina Ali

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VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Request for Hospice Benefits

NAME: Mattie S. White DATE OF BIRTH: 5 / 09 / 1920
ADDRESS: 1717 Bellevue Ave. Richmond, VA 23227

MEDICAID NUMBER: ________ (12 digits) MEDICARE NUMBER 231-20-9724
OTHER INSURANCE: ________ POLICY NO: ________

SECTION I: ELECTION OF HOSPICE BENEFITS

I, Mattie S. White, elect to participate in the Medicaid Hospice Benefit.

The hospice that I have chosen is Heartland Hospice

I am aware of the prognosis of my illness and I understand that treatment is palliative rather than curative. I consent to the management of the symptoms of my disease as prescribed by my Attending Physician and/or the Hospice Medical Director. My family and I will help to develop and will participate in a plan of care based on our special needs.

I may receive benefits that include home nursing visits, counseling, medical social work services, drugs and biologicals, and medical supplies and equipment. If needed, I may also receive home health aides/homemakers, physical therapy, occupational therapy, speech/language pathology, inpatient care for acute symptoms, medical procedures ordered by my physicians and hospice, and continuous nursing care in the home during acute medical crises. I may request volunteer services, when available and appropriate. I realize that my family and I have the opportunity for limited respite or relief care in an approved inpatient facility.

In accepting these services, which are more comprehensive than regular Medicaid benefits, I waive my right to regular Medicaid services that are duplicative of services required to be provided by the Hospice except for payment to my Attending Physician or treatment for medical conditions unrelated to my terminal illness. I understand that I can revoke this benefit at any time and return to regular Medicaid benefits. I understand that the Hospice Benefit consists of benefit periods-two ninety-day periods, subsequent sixty-day periods extending until I am no longer in the Hospice Benefit. I may be responsible for hospice charges if I become ineligible for Medicaid services.

I understand that at the end of either the first ninety-day period or the second, because of an improvement in my condition, I may choose to save the remainder of the benefit period(s). I may revoke the Hospice Benefit at that time. I also understand that if I choose to do so, I am still eligible to receive the remaining benefit period(s). I am aware, that if I choose to revoke Hospice Benefits during a benefit period, I am not entitled to coverage for the remaining days of that benefit period.

I understand that if I choose to do so, once during each election period, I may change the designations of the particular hospice from which hospice care is provided by filing a statement with the hospice from which care has been provided and with the newly designated hospice. I understand that a change of hospice providers is not a revocation of the remainder of that election period.

I understand that, unless I revoke the Hospice Benefit, hospice coverage will continue.

I understand that if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefit.

Check one:

✓ I am a Medicare recipient and have elected the Medicare Hospice Benefit.
My Medicare eligibility for hospice benefits begins 6/28/18 (date).

____ I am not a Medicare recipient.

[signature] 6/26/18
Witness' Signature/Date

Hospice Recipient Signature/Date

X [signature] 6/26/18
Hospice Recipient's Authorized Representative Signature/Date (If applicable)

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

REQUEST FOR HOSPICE BENEFITS-CONTINUED

SECTION II: HOSPICE PROVIDER INFORMATION

Hospice Provider: Heartland Hospice

Hospice Address: 10800 Midlothian Turnpike Suite 303 North Chesterfield VA 23235

NPI Number (10 digits): 1891727053 Telephone: 804-288-0235

Facility Contact Person : Shantih Hughes 804-288-0235

SECTION III: PHYSICIAN CERTIFICATION

Recipient's Name: Mattie White

I certify that, in my best judgment, the reasonable, medical predictable life expectancy for this patient is 6 months or less. Based on this medical prognosis I am requesting Medicaid Hospice Benefits for this recipient beginning 6/28/18 (date). I understand that unless the recipient revokes Hospice Benefits, hospice services will continue as long as the recipient remains eligible for Medicaid.

Dr Sabina Ali
Attending Physician (typed or printed)

Dr Althony Mirander
Hospice Medical Director (typed or printed)

Attending Physician (Signature/Date)

[signature] 7.5.18
Hospice Medical Director (Signature/Date)

SECTION IV: NOTICE OF RE-ELECTION OF HOSPICE BENEFIT

I certify that, in my best judgment, the reasonable, medical predictable life expectancy for this patient is 6 months or less. Based on this medical prognosis, I am requesting Medicaid hospice benefits for this recipient beginning ______ (date). I understand that unless the recipient revokes hospice benefits, hospice services will continue as long as the recipient remains eligible for Medicaid.

Benefit Period From ______ to ______

Hospice Medical Director's (Typed or Printed Name) ______

Hospice Medical Director's Signature/Date ______

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING ______ B. WING ______	C 06/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-IMPERIAL	1719 BELLEVUE AVENUE RICHMOND, VA 23227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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On 5/30/18 at 1:45 p.m., Resident #20 was observed sitting up in her wheelchair. A urinary catheter bag, (tubing used to drain the bladder into a drainage bag) (2), was observed hanging from the bottom of her wheelchair.

On 5/31/18 at 8:45 a.m., Resident #20 was observed in bed. A urinary catheter bag was observed hanging off of the side of her bed and clear yellow urine was noted draining into the bag.

A review of Resident #20's May 2018, physician's orders on failed to evidence an order for a urinary catheter. Additional review of the Resident's eTAR (electronic treatment administration record) failed to evidence care or treatment of a urinary catheter.

On 5/31/18 02:10 p.m., Resident #20 was observed in her room sitting up in her wheelchair. A urinary catheter bag was observed hanging from under her wheelchair.

On 6/1/18 at 10:28 a.m., Resident #20 was observed sleeping in her bed with a urinary catheter bag hanging from her bed.

An interview was conducted on 6/1/18 at 10:30 a.m. with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the process followed when a resident needs a urinary catheter. LPN #1 stated that they perform a bladder scan (a process to measure the amount of urine left in the bladder after urinating) (3) and then contact the physician to obtain a MD (medical doctor) order to insert the urinary catheter. LPN #1 was asked to show evidence of a urinary catheter order for Resident #20. LPN#1 stated she did not see an order and she was going to get the unit manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RN (registered nurse) #1 to assist her. ASM (administrative staff member) #2, the director of nursing, was also at the nursing station at that time and stated she would also look for the MD order.

An interview was conducted with RN #1 on 6/1/18 at 10:45 a.m. RN #1 stated that Resident #20 went to the hospital in April and returned on 5/1/18. She stated the urinary catheter is documented in the admission assessment but that the MD order must not have carried over. RN #1 confirmed that there was no physical order for an indwelling urinary catheter at that time. She further stated that the resident has had a urinary catheter for "a long time because she [Resident #20] has urinary retention (the inability to empty the bladder completely) (4)".

On 6/1/18 at 11:10 a.m., an interview was conducted with ASM #2 who stated the order must have dropped off when Resident #20 was readmitted on 5/1/18. She stated it is the responsibility of the charge nurse to reconcile and double check that all orders are continued from month to month. She stated that it was not done in this situation.

A review of the comprehensive care plan dated 10/27/17, with a most recent revision on 1/18/18, documented in part, "Focus: Use of indwelling urinary catheter". In the Interventions section of this focus it is documented in part, "Maintain drainage bag below bladder ...secure catheter with securement device".

ASM (administrative staff member) #1, the administrator, ASM #2, ASM #4, the assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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director of nursing, and ASM #5, the quality assurance consultant, were made aware of the above concerns on 6/4/18 at 5:30 p.m. At that time the administrative team present was asked to provide and urinary incontinence assessments or documentation regarding Resident #20's urinary retention diagnosis.

No further information was provided prior to exit.

1) This information was obtained from the following website: https://medlineplus.gov/atrialfibrillation.html

2) This information was obtained from the following website: https://medlineplus.gov/ency/article/003981.htm

3) This information was obtained from the following website: https://medlineplus.gov/ency/article/003143.htm

4) This information was obtained from the following website: https://medlineplus.gov/ency/article/002238.htm

2. The facility staff failed to ensure Resident #30's Foley* catheter bag and tubing were not on the floor to prevent infections.

Resident #30 was admitted to the facility on 9/27/17 with the diagnoses of but not limited to stroke, high cholesterol, atrial fibrillation, chronic obstructive pulmonary disease, dementia, gastrostomy feeding tube, neurogenic bladder, depression, high blood pressure, cataracts, and benign prostatic hyperplasia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment

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Reference Date) of 4/5/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living and as incontinent of bowel and had an indwelling catheter for bladder.

Observations were made of Resident #30 on 5/30/18 at 1:47 p.m. and 5/30/18 at 3:48 p.m. During each observation, the Foley bag was not in a privacy bag and one end of the bag was directly on the floor. On 5/31/18 at 9:37 a.m., the Foley bag was in a privacy bag but part of the tubing was directly on the floor.

A review of the clinical record revealed physician's orders as follows:
- One dated 2/20/18 for changing the suprapubic dressing on the 14th of every month
- One dated 3/9/18 for changing the suprapubic catheter on the 15th of every month
- One dated 1/17/18 for flushing the supra pubic catheter with 30 cc (cubic centimeters, equivalent of ml - milliliters) every 8 hours as needed.

Further review of the clinical record revealed the following orders had at one time been in effect:
- Cephalexin [1] 250 mg (milligrams)/5ml, give 10 ml tid (three times daily) for UTI (urinary tract infection). Order started 1/9/18 and ended 1/16/18.
- Augmentin [2] 875-125 mg bid (twice daily) for UTI. Order started 2/21/18 and ended 2/28/18.
- Cipro [3] 500 mg bid for UTI. Order started 3/8/18 and ended 3/14/18.
- Macrobid [4] 100 mg bid for UTI. Order started 3/12/18 and ended 3/17/18.

A review of the care plan revealed one for "Use of

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indwelling supra pubic needed due to neurogenic bladder." This care plan was dated 9/27/17. The care plan did not include any interventions for maintain the catheter in a sanitary manner to prevent infections.

On 6/5/18 at 10:42 a.m., in an interview with CNA #4 (Certified Nursing Assistant), she stated that Foley catheters should be in a dignity bag, hanging on side of bed and that no part should be touching the floor.

On 6/5/18 at 10:45 a.m., in an interview with LPN #6 (Licensed Practical Nurse) she stated that the Foley catheter should be in a dignity bag and not on the floor.

On 6/5/18 at 10:56 a.m., in an interview with RN #1 (Registered Nurse) she stated that the Foley should not be touching the floor.

A review of the facility policy, "Catheter Care: Indwelling Catheter" documented, "14. Check that tubing is not looped, kinked, clamped or positioned above the level of the bladder and off the floor - place bag in catheter bag holder if appropriate."

On 6/5/18 at approximately 12:30 p.m., the administrator and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

References:

*According to Fundamentals of Nursing Lippincott Williams and Wilkins page 593.

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"An indwelling urinary catheter also called a Foley catheter, provides the patient with continuous urine drainage. It is a latex or silicone tube which is inserted into the bladder and a small balloon is inflated at the catheter's distal end to prevent it from slipping out. A catheter is used for numerous reasons, but usually when there is a problem resulting in the inability to pass urine, such as in an obstruction or neurological (nerve, brain or spinal cord) disease or injury..."

According to Lippincott Manual of Nursing Practice, Eighth Edition 2006, chapter 21, Renal and Urinary Disorders, page 757, "Maintaining a Closed Urinary Drainage System: Many UTI's are due to extrinsically acquired organisms transmitted by cross-contamination. 2. c. Keep the drainage bag off the floor to prevent bacterial contamination".

Sources:

[1] Cephalexin - "is used to treat certain infections caused by bacteria such as pneumonia and other respiratory tract infections; and infections of the bone, skin, ears, , genital, and urinary tract." Information obtained from https://medlineplus.gov/druginfo/meds/a682733.html

[2] Augmentin - "The combination of amoxicillin and clavulanic acid is used to treat certain infections caused by bacteria, including infections of the ears, lungs, sinus, skin, and urinary tract. Amoxicillin is in a class of medications called penicillin-like antibiotics. It works by stopping the growth of bacteria. Clavulanic acid is in a class of medications called beta-lactamase inhibitors. It works by preventing bacteria from destroying

F 690 Continued From page 230 F 690

amoxicillin."
Information obtained from
https://medlineplus.gov/druginfo/meds/a685024.html

[3] Cipro - "Ciprofloxacin is used to treat or prevent certain infections caused by bacteria such as pneumonia; gonorrhea (a sexually transmitted disease); typhoid fever (a serious infection that is common in developing countries); infectious diarrhea (infections that cause severe diarrhea); and infections of the skin, bone, joint, abdomen (stomach area), and prostate (male reproductive gland), Ciprofloxacin is also used to treat or prevent plague (a serious infection that may be spread on purpose as part of a bioterror attack) and inhalation anthrax (a serious infection that may be spread by anthrax germs in the air on purpose as part of a bioterror attack). Ciprofloxacin may also be used to treat bronchitis, sinus infections, or urinary tract infections but should not be used for bronchitis and sinus infections, or certain types of urinary tract infections if there are other treatment options. Ciprofloxacin extended-release (long-acting) tablets are used to treat kidney and urinary tract infections; however, some types of urinary tract infections should only be treated with ciprofloxacin extended release tablets if no other treatment options are available. Ciprofloxacin is in a class of antibiotics called fluoroquinolones. It works by killing bacteria that cause infections."
Information obtained from
https://medlineplus.gov/druginfo/meds/a688016.html

[4] Macrobid (Nitrofurantoin) "is used to treat urinary tract infections. Nitrofurantoin is in a class of medications called antibiotics. It works by

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

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killing bacteria that cause infection."
Information obtained from
https://medlineplus.gov/druginfo/meds/a682291.html

F 693 SS=D Tube Feeding Mgmt/Restore Eating Skills
CFR(s): 483.25(g)(4)(5)

§483.25(g)(4)-(5) Enteral Nutrition
(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide physician ordered feeding tube services for one of 50 residents in the survey sample, Resident #351.

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It is the intended practice of this facility to ensure a resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skill and to prevent complications of enteral feeding including but not limited to, facility staff administering the tube feeding as ordered by the physician.

Criteria 1

Upon notification from surveyor a clarification was obtained for the tube feeding and water flush order for resident # 351.

Criteria 2

Residents requiring enteral feeding have the potential to be affected. Those identified residents have been reviewed to ensure tube feed and flush orders are correct.

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

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F 693	Continued From page 232 The facility staff failed to administer tube feeding formula and flushes to Resident #351 per the physician prescribed rate/amount. The findings include: Resident #351 was admitted to the facility on 5/22/18. Resident #351's diagnoses included but were not limited to difficulty swallowing, diabetes and a stroke. Resident #351's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/29/18, coded the resident's cognitive skills for daily decision-making as moderately impaired. Section K documented Resident #351 had a feeding tube (1). Review of Resident #351's clinical record revealed a nutrition assessment signed by the registered dietician on 5/29/18. The assessment documented, "Patient with diabetes admitted post cerebral infarction (stroke). Patient NPO (nothing by mouth) on Jevity 1.2 (brand of tube feeding formula) at 60ml/hr (milliliters/hour). Recommend to change TF (tube feeding) to Glucerna 1.2 (brand of tube feeding formula) at 70 ml/hr X (times) 20 hours per day to provide 1680 calories, 84 grams protein and 1127 ml (milliliters) water. Recommend water flushes 100 ml Q (every) 4 hours. RD (Registered dietician) to continue to follow up per policy or PRN (as needed)..." Further review of Resident #351's clinical record revealed a physician's order dated 5/29/18 for Glucerna 1.2 at a rate of 70 cc/hr (cubic centimeters/hour) times 20 hours and to flush the feeding tube with 100 cc every four hours. Resident #351's care plan dated 5/29/18	F 693	Criteria 3 Licensed nursing staff were re-educated on the facility policy for enteral feeding and the use of the enteral feeding pump. Criteria 4 DON/Designee will audit new enteral feeding/flush orders, and complete observations of enteral feeding pump settings, x5 days, weekly x2 weeks and monthly x2 months to ensure compliance. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed. Criteria 5 The facility's alleged date of compliance is 7/10/2018.	

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documented, "Need for feeding tube/potential for complications of feeding tube use related to swallowing impairment...Administer tube feeding formula, hydration, and flushes per order..."

On 5/30/18 at 12:55 p.m. and 5/31/18 at 4:10 p.m., observation of Resident #351 was conducted. The resident was receiving tube feeding. The machine that was delivering the tube feeding and flushes was set at a rate of 60 ml of tube feeding and a rate of 50 ml of flushes every four hours.

On 6/1/18 at 12:39 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked the process for ensuring residents are administered the correct physician ordered tube feedings and flushes. LPN #4 stated, "I'm gonna double check with the orders and make sure he gets his flushes on my shift. I'll also look back to make sure the dietician didn't make any changes." LPN #4 was asked to review Resident #351's physician orders for tube feedings and flushes. LPN #4 stated the physician's order was for Glucerna 1.2 at a rate of 70 cc's an hour times 20 hours and to flush the feeding tube with 100 cc's every four hours. LPN #4 was asked to observe Resident #351's tube feeding with this surveyor. LPN #1 and this surveyor entered the resident's room and reviewed the tube-feeding machine. LPN #1 stated the tube feeding was running at a rate of 60 cc's an hour and the flushes were 50 cc's. LPN #1 stated the tube feeding should have been running at a rate of 70 cc's and the flushes should have been 100 cc's.

On 6/1/18 at 1:28 p.m., an interview was conducted with OSM (other staff member) #3 (the

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registered dietician). OSM #3 was asked why Resident #351's tube feeding and flush orders were recently changed. OSM #3 stated Resident #351 was having a lot of high blood sugars so she changed the tube feeding to a diabetic carbohydrate controlled formula. OSM #3 stated the resident's tube feeding was previously continuously running but she changed the amount of time from continuous to 20 hours a day so the resident could bathe and go to therapy. OSM #3 stated she increased the rate of the tube feeding since she decreased the amount of running time. OSM #3 stated she increased the amount of flushes to meet Resident #351's fluid needs since she increased the amount of tube feeding formula.

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "ENTERAL TUBES: INTERMITTENT (PUMP) FEEDINGS" documented, "PROCEDURE: 1. Verify physician's order for formula, rate, route and frequency..."

No further information was presented prior to exit.

(1) A feeding tube is a soft plastic tube placed into the stomach to deliver nutrition. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000333.htm

F 695 SS=E Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) F 695

§ 483.25(i) Respiratory care, including

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tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide respiratory care and services for six of 50 residents in the survey sample; Residents #30, #99, #47, #85, #83, and #87.

1. The facility staff failed to administer oxygen to Resident #30 at the physician ordered rate.

2. The facility staff failed to administer oxygen to Resident #99 at the physician ordered rate.

3. The facility staff failed to follow the physician's order for the administration of oxygen for Resident #47.

4. The facility staff failed to store Resident #85's oxygen tubing in a sanitary manner.

5. The facility staff failed to administer oxygen to Resident #83 at the physician prescribed rate of two liters.

6. The facility staff failed to store a nebulizer machine in a sanitary manner for Resident #87.

The findings include:

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It is the intended practice of this facility to ensure 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 resident's goals and preferences.

Criteria 1
Resident # 30, #99, #47 and #83 physician/NP was notified of the failing to follow the physician order for oxygen administration. Resident #85, and #87 physician/NP notified of staff failing to store oxygen tubing or nebulizer machine in a sanitary manner. Residents suffered no adverse outcomes related to the criteria above.

Criteria 2
Residents with orders for oxygen and nebulizer treatments have the potential to be affected. Affected residents are receiving oxygen per physician order, and oxygen tubing and nebulizers are stored properly in a sanitary manner.

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1. The facility staff failed to administer oxygen to Resident #30 at the physician ordered rate.

Resident #30 was admitted to the facility on 9/27/17 with the diagnoses of but not limited to stroke, high cholesterol, atrial fibrillation, chronic obstructive pulmonary disease, dementia, gastrostomy feeding tube, neurogenic bladder, depression, high blood pressure, cataracts, and benign prostatic hyperplasia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 4/5/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed an order dated 1/16/18 for "O2 (oxygen) on @ (at) 2 lit (liters) via nasal cannula every shift for COPD (Chronic Obstructive Pulmonary Disease)."

Observations made of Resident #30 on 5/30/18 at 1:47 p.m., 5/30/18 at 3:48 p.m., 5/31/18 at 9:37 a.m., 5/31/18 at 11:02 a.m., and 5/31/18 at 11:50 p.m., revealed the resident in bed with the nasal cannula in place and the oxygen concentrator set at 3.5 liters per minute. Another surveyor verified this observation.

On 6/5/18 at approximately 10:50 a.m., in an interview with LPN #6 (Licensed Practical Nurse), she stated that nurses should be checking the oxygen rates.

On 6/5/18 at 10:56 a.m., in an interview with RN #1 (Registered Nurse) she stated that the nurses should be checking the oxygen.

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Criteria 3

Licensed nurses were re-educated on following physician orders for oxygen administration. Nursing staff were re-educated on infection control practices for storage of oxygen and nebulizer dispensing equipment.

Criteria 4

DON/designee will audit residents with orders for oxygen and or nebulizer treatment orders to ensure compliance with facility policies, daily x5 days, weekly x2 weeks and monthly x2 months. Results of the QAA audits will be reviewed by the facility's QAA Committee. Recommendations will be discussed and implemented as needed

Criteria 5

The facility's alleged date of compliance is 7/10/2018.

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A review of the care plan revealed one dated 4/11/18 for "Cardiac disease related to hyperlipidemia, Hypertension, A FIB (atrial fibrillation)." The interventions included one dated 4/11/18 for "Administer oxygen as ordered." In addition, the care plan included one dated 4/11/18 for "At risk for respiratory impairment related to COPD." This care plan included an intervention dated 4/11/18 for "Administer oxygen as per physician order."

A review of the facility policy, "Oxygen Administration" documented, "Procedure: 1. Verify Physician's order."

On 6/5/18 at approximately 12:30 p.m., the administrator and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

2. The facility staff failed to administer oxygen to Resident #99 at the physician ordered rate.

Resident #99 was admitted to the facility on 2/7/14 with the diagnoses of but not limited to Parkinson's disease, chronic kidney disease, pressure ulcer, obstructive uropathy, anxiety disorder, dysphagia, adrenocortical insufficiency, atrial fibrillation, hypothyroidism, dementia, and prostate cancer. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/4/18. The resident was coded as being moderately impaired in ability to make daily life decisions.

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A review of the clinical record revealed an order dated 4/28/18 for "2L (2 liters) O2 (Oxygen) Nasal Cannula PRN (as needed) for SOB (shortness of breath)/wheezing."

Observations made of the Resident #99 on 5/31/18 at 9:30 a.m., 5/31/18 at 12:40 p.m., and 5/31/18 at 12:45 p.m. revealed the resident's nasal cannula was in place and the oxygen concentrator rate was set at 1.75 liters per minute. Another surveyor verified this observation.

On 6/5/18 at approximately 10:50 a.m., in an interview with LPN #6 (Licensed Practical Nurse), she stated that nurses should be checking the oxygen rates.

On 6/5/18 at 10:56 a.m., in an interview with RN #1 (Registered Nurse) she stated that the nurses should be checking the oxygen.

A review of the care plan revealed one dated 3/28/15 for "Cardiac disease related to hypotension, atrial fib (atrial fibrillation)." The interventions included one dated 3/28/15 for "Administer oxygen as ordered."

A review of the facility policy, "Oxygen Administration" documented, "Procedure: 1. Verify Physician's order."

On 6/5/18 at approximately 12:30 p.m., the administrator and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

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3. The facility staff failed to follow the physician's order for the administration of oxygen to Resident #47.

Resident #47 was admitted to the facility on 8/24/01, with diagnoses that included but were not limited to: multiple sclerosis (a disease that affects the brain and spinal cord by blocking messages from the brain to the body due to damages to the material that surrounds and protects the nerve cells) (1), dementia, muscle spasms, chronic obstructive pulmonary disease (lung disease that makes it difficult to breathe) (2), and difficulty swallowing.

The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 4/21/18, coded the resident as scoring a 9 on the BIMS (brief interview for mental status) score, indicating that she had moderate cognitive impairment. She was coded as usually understanding others and always making herself understood. Resident #47 was coded as totally dependent on staff, requiring one or more person physical assistance for bed mobility, transfers, toileting, personal hygiene, bathing and dressing. In Section O - Special Treatments, the resident was coded as using oxygen during the look back period.

During initial rounds on 5/30/18 at 10:49 a.m., Resident # 47 was observed up in her wheelchair with oxygen on via nasal cannula (a plastic tube with two prong that are inserted just inside the nose) connected to an oxygen concentrator set at 3.5 L/min (liters/minute).

A review of Resident #47's clinical record documented the MD (medical doctor) order dated

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10/19/15, stating "oxygen 4L NC (nasal cannula) to keep stats [sic] (saturation) greater than 90% cont (continuous)".

On 5/31/18 at 08:41 a.m., Resident #47 was observed with O2 via nasal cannula on the face although prongs of that supply the oxygen via the nose were noted to be on her cheek and not in her nose. The oxygen concentrator was set at 3.5 L/min.

On 5/31/18 at 09:35 a.m., Resident #47 was observed with the nasal cannula prongs in nose. The oxygen concentrator was set at 3.5 L/min.

On 5/31/18 at 12:45 p.m., Resident #47 was observed sitting up in bed eating lunch. Resident #47's nasal cannula was not observed on her. When asked where the oxygen nasal cannula was, Resident #47 stated, I do not know". At that, time the oxygen tubing was observed hanging over the oxygen concentrator, unbagged with nasal cannula directly on floor and the oxygen concentrator set at 3.5 L/min.

On 5/31/18 at 02:20 p.m., Resident #47 was observed sitting up in bed, the oxygen tubing was still draped over concentrator and the nasal cannula was still lying on floor.

On 5/31/18 04:04 p.m., another surveyor observed that Resident #47's oxygen via nasal cannula was now on Resident # 47's face.

A review of the comprehensive care plan dated 2/18/10, with a most recent revision on 11/24/15, documented in part, "Focus: Has respiratory impairment...Resident receives O2 (oxygen) via nasal cannula". In the Interventions, section of

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this focus it is documented in part, "Administer oxygen per physician order".

On 6/1/18 at 9:15 a.m., Resident #47 was sitting up in bed. Receiving oxygen via nasal cannula with oxygen concentrator setting noted to be between 3.5 and 4 L/min. ASM (administrative staff member) #4, the assistant director of nursing, was made aware of the above concern.

On 6/4/18 at 9:30 a.m., Resident #47 was observed sitting up in bed receiving oxygen via nasal cannula. LPN, (licensed practical nurse) #3 was observed in the resident's room. LPN #3 was asked her to confirm the oxygen flow rate for Resident #47. The oxygen flow rate on the oxygen concentrator was observed set at 4 L/min. When LPN #3 was asked how she read the oxygen setting via the oxygen concentrator flowmeter, LPN #3 stated, "The center of the ball should be at the appropriate setting line".

The facility policy, "Oxygen Administration" documented in part, "Procedure: 1. Verify Physician's order...Preparation of Equipment: 3. For oxygen concentrator ...set flow meter to correct flow rate".

Section 5 of the PlatinumTM series oxygen concentrator's operating instructions state, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the knob until the ball rises to the line. Now, center the ball on the L/min prescribed".

ASM (administrative staff member) #1, the administrator, ASM #2, ASM #4 and ASM #5, the quality assurance consultant, were made aware of the above concerns on 6/4/18 at 5:30 p.m.

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No further information was provided prior to exit.

1) This information was obtained from the following website:
https://medlineplus.gov/multiplesclerosis.html

2) This information was obtained from the following website:
https://medlineplus.gov/ency/article/000091.htm
4. The facility staff failed to store Resident #85's oxygen tubing in a sanitary manner.

Resident #85 was admitted to the facility on 4/18/18. Resident #85's diagnoses included but were not limited to heart failure, anemia and major depressive disorder. Resident #85's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 5/16/18, coded the resident as cognitively intact. Section G documented Resident #85 as requiring extensive assistance of two or more staff with bed mobility/transfers and as requiring extensive assistance of one staff with locomotion/dressing.

Review of Resident #85's clinical record revealed a physician's order dated 4/26/18 for oxygen at two liters per minute every shift for low oxygen "stats. (saturations)." Resident #85's care plan dated 4/18/18 documented, "The resident has altered cardiovascular status r/t (related to) heart failure...Give oxygen as ordered by the physician..." The care plan failed to document information regarding the storage of oxygen tubing.

On 5/30/18 at approximately 11:00 a.m. and 5/31/18 at 3:55 p.m., observation of Resident #85

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was conducted. The resident was not using oxygen. The oxygen tubing was exposed to air and hanging on a bottle of humidified water attached to the oxygen concentrator.

On 6/4/18 at 10:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked about the process for storage of oxygen tubing. LPN #1 stated, "If it's not in use, it's dated and stored in a plastic bag with the date on it and the resident's room number." When asked why, LPN #1 stated, "Because it could fall on the floor. It protects it from being contaminated." When asked if oxygen tubing should be hanging off a bottle of humidified water attached to an oxygen concentrator, LPN #1 stated, "No."

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "OXYGEN ADMINISTRATION" documented, "2. When not in use, store oxygen tubing and nasal cannula or mask in separate, labeled plastic bag..."

No further information was presented prior to exit.

5. The facility staff failed to administer oxygen to Resident #83 at the physician prescribed rate of two liters.

Resident #83 was admitted to the facility on 5/9/18. Resident #83's diagnoses included but were not limited to presence of cardiac pacemaker, morbid obesity and anemia.

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Resident #83's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/21/18, coded the resident as cognitively intact. Section G documented Resident #83 as requiring extensive assistance of two or more staff with bed mobility/transfers and as requiring extensive assistance of one staff with locomotion/dressing.

Review of Resident #83's clinical record revealed a physician's order dated 5/10/18 for oxygen at two liters per minute. Resident #83's care plan dated 5/17/18 documented, "Cardiac disease related to Hypertension (high blood pressure), Pacemaker...Administer oxygen as ordered..."

On 5/30/18 at 1:27 p.m., observation of Resident #83 was conducted. The resident had a nasal cannula (device used to deliver oxygen) in her nose. The nasal cannula was attached to an oxygen concentrator. The oxygen was administered to Resident #83 at a rate in between three and three and a half liters as evidenced by the middle of the ball in the concentrator flow meter positioned between the three-liter line and the three and a half liter line. Resident #83 stated her oxygen was supposed to be set at a rate of two liters.

On 6/1/18 at 8:48 a.m., observation of Resident #83 was conducted. The resident had a nasal cannula in her nose. The nasal cannula was attached to an oxygen concentrator. The oxygen was administered to Resident #83 at a rate in between one and a half liters and two liters as evidenced by the middle of the ball in the concentrator flow meter positioned between the one and a half liter line and the two-liter line. Another surveyor confirmed this observation.

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On 6/4/18 at 10:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked where the ball in an oxygen concentrator flow meter should be positioned if a resident has a physician's order for two liters. LPN #1 stated the middle of the ball should be positioned on the two-liter line.

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The oxygen concentrator manufacturer's instructions documented, "Flowrate: 1. Turn the flowrate knob to the setting prescribed by your physician or therapist. NOTE: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liter/minute) line prescribed."

The facility document titled, "OXYGEN ADMINISTRATION" documented, "PREPARATION OF EQUIPMENT...3. For oxygen concentrator, plug in power cord, turn unit on and set flow meter to correct flow rate..."

No further information was presented prior to exit.

6. The facility staff failed to store a nebulizer machine in a sanitary manner for Resident #87.

Resident #87 was admitted to the facility on 5/22/15, with a recent readmission on 3/23/18 with diagnoses that included but were not limited to: dementia, high blood pressure, depression, diabetes, and muscle weakness.

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The most recent MDS (minimum data set) assessment, a Medicare 60 day assessment, with an assessment reference date of 5/18/18, coded the resident as scoring an "11" on the BIMS (brief interview for mental status) score, indicating he is moderately impaired to make daily cognitive decisions. In Section O - Special Treatments, Procedures and Programs, the resident was not coded for any respiratory treatments.

Observation was made of Resident #87 on 6/4/18 at 10:02 a.m. A nebulizer machine with the nebulizer mask was noted on the nightstand. The tubing and mask for the nebulizer was sitting on the nightstand, not covered.

Observation was made on 6/4/18 at 11:44 a.m. of Resident #87's room. The nebulizer mask and the tubing were still located sitting on the nightstand, not covered.

The physician order dated, 4/24/18, "DuoNeb Solution (is used to help control symptoms of lung disease, such as asthma, chronic bronchitis and emphysema) (1) 0.5 - 2.5 MG/3ML (milligrams per three milliliters) 1 application inhale orally every 8 hours as needed for congestion."

The April 2018 MAR (medication administration record) documented, "DuoNeb Solution 0.5 - 2.5 MG/3ML 1 application inhale orally every 8 hours as needed for congestion." The MAR documented the resident last received the nebulizer treatments on 4/25/18 and 4/26/18. Review of the MAY 2018 MAR failed to evidence documentation for the administration of the DuoNeb.

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Review of the comprehensive care plan dated 2/21/17 and revised on 5/22/18, failed to evidence documentation for the use of a nebulizer.

An interview was conducted with LPN (licensed practical nurse) #8 on 6/4/18 at 11:50 a.m. LPN #8 was asked to view Resident #87's nebulizer tubing. After observing the nebulizer tubing, LPN #8 stated, "That's a problem. That (nebulizer tubing) should be in a bag and covered."

The facility policy, "Respiratory: Nebulizer Mist Therapy" documented in part, "16. Switch aerosol unit off when treatment complete...Rinse excess mist and medication from nebulizer, t-piece, mouthpiece or mask. 19. Store dried nebulizer, t-piece, mouthpiece or mask in separate, labeled plastic bag."

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment."

The administrator, administrative staff member (ASM) #1, ASM # 7, an administrator from another corporate building, and ASM #5, the Quality Assurance Consultant, were made aware of the above concern on 6/5/18 at 12:36 p.m.

(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010776/?report=details

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CFR(s): 483.25(k)

§483.25(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide a complete pain management program for eleven of 50 residents in the survey sample, Resident #'s 96, 21, 87, 90, 42, 100, 75, 51, 32, 18 and 56.

1. The facility staff failed to document the location of Resident #96's pain and failed to offer non-pharmacological interventions prior to the administration of pain medication.

2. The facility staff failed to document the location of Resident #21's pain and non-pharmacological interventions attempted prior to the pain medication administration.

3. The facility staff failed to document the location of Resident #87's pain and failed to offer non-pharmacological interventions prior to the administration of the medication.

4. The facility staff failed to document the location of Resident #90's pain and any non-pharmacological interventions attempted prior to the administration of the medication.

5. The facility staff failed to document the location of Resident #42's pain and failed to document the

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It is the intended practice of this facility to ensure pain management is provided to residents who require such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Criteria 1

Resident #'s 96, 21, 87, 90, 42, 100, 75, 51, and 32 suffered no adverse outcomes related to not documenting non-pharmacological interventions and/or location of pain. Prior to pain medication being administered. Resident #'s 18 and 56 there were no adverse outcomes related to not receiving pain medication as prescribed. Staff trained on administering pain medication at prescribed scheduled times, assessing the location of pain and attempting non-pharmacological interventions prior to the use of pain medication.

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non-pharmacological interventions that were attempted prior to the administration of medication.

6. The facility staff failed to attempt non-pharmacological interventions prior to the use of prn (as needed) pain medication for Resident # 100.

7. The facility staff failed to attempt non-pharmacological interventions prior to the use of prn (as needed) pain medication for Resident # 75.

8. The facility staff failed to attempt non-pharmacological interventions prior to the use of prn (as needed) pain medication for Resident # 51.

9. The facility staff failed to assess the location of Resident #32's the pain and failed to attempt non-pharmacological interventions prior to administering as needed pain medication.

10. The facility staff failed to administer physician prescribed scheduled pain medication to Resident #18 on multiple dates in January 2018.

11. The facility staff failed to administer physician prescribed scheduled pain medication to Resident #56 on multiple dates in February 2018.

The findings include:

1. The facility staff failed to document the location of Resident #96's pain and failed to offer non-pharmacological interventions prior to the administration of pain medication.

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Criteria 2

Residents who are prescribed pain medication/ PRN pain medication have the potential to be affected. Residents are being assessed for non-pharm interventions and location prior to receiving prn pain medications. Residents with scheduled pain medication are receiving medications as ordered.

Criteria 3

Licensed nurses were re-educated on non-pharmacological interventions, assessing the location of pain and following physician orders for scheduled administration of pain medications.

Criteria 4

DON or designee will audit MARs/nurses notes x5 days, weekly x2 weeks and monthly x2 months to ensure compliance.

Criteria 5

The facility's alleged date of compliance is 7/10/2018.

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Resident #96 was admitted to the facility on 3/28/18, with a recent readmission on 6/2/18 with diagnoses that included but were not limited to: heart failure, end stage renal disease requiring hemodialysis (A procedure used in toxic conditions and renal [kidney] failure in which wastes and impurities are removed from the blood by a special machine.) (1), asthma, chronic pain, sleep apnea, diabetes, and COPD (chronic obstructive pulmonary disease - a general term for chronic, nonreversible lung disease that is usually a combination of chronic bronchitis and emphysema) (2).

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 5/22/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions. The resident was coded as requiring supervision with set up assistance for all of her activities of daily living.

The physician order dated 4/25/18, documented, "Roxicodone Tablet (Oxycodone) (used to treat moderate to severe pain) (3); Give 5 mg (milligram) every 8 hours as needed for moderate to severe pain."

The March 2018 MAR (medication administration record) documented, "Roxicodone Tablet; Give 5 mg every 8 hours as needed for moderate to severe pain." The medication was documented as having been administered on 3/29/18 for a pain level of 8."

Review of the eMAR (electronic medication

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administration) notes for March 2018 failed to evidence any documentation of the location of Resident # 96's pain, and that non-pharmacological interventions were provided prior to the administration of the pain medication.

Review of the April 2018 MAR documented, "Roxicodone Tablet; Give 5 mg every 8 hours as needed for moderate to severe pain." The medication was documented as having been administered on 4/6/18 for a pain level of 10."

Review of the eMAR (electronic medication administration) notes for April 2018 failed to evidence documentation of the location of Resident # 96's pain or that non-pharmacological interventions were provided prior to the administration of the pain medication.

Review of the May 2018 MAR documented, "Roxicodone Tablet; Give 5 mg every 8 hours as needed for moderate to severe pain." The medication was documented as having been administered on 5/15/18 and 5/17/18 for a pain level of 10 and 8."

Review of the eMAR (electronic medication administration) notes for May 2018 failed to evidence documentation of the location of Resident # 96's pain and that non-pharmacological interventions were provided prior to the administration of the pain medication.

The comprehensive care plan dated, 3/28/18, documented in part, "Focus: Pain to back evidenced by chronic pain related to arthritis." The "Interventions" documented in part, "Administer pain medications per physician orders. Encourage/assist to reposition frequently

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to position of comfort."

On 6/4/18 at 10:58 a.m., in an interview LPN (licensed practical nurse) #9 regarding pain management. LPN #8 stated first assess the pain location, assess the area around the pain, ask the resident to rate the pain if able, and ask what works and what does not work for them. LPN #8 stated she would then give the pain medication. When asked where she would document the completed assessment with pain levels, LPN #8 stated, "The eMAR pops open a box for the pain level. You can write directly into the notes in the eMAR or write in the progress notes." When asked if staff attempt anything else prior to giving the medication, LPN #8 stated, "You should do the non-pharmacological interventions." When asked where staff document the non-pharmacological interventions attempted, LPN #8 stated, "Should document in the progress note."

On 6/4/18 at 11:15 a.m., an interview was conducted with RN (registered nurse) #1, the unit manager, regarding the process staff follows when a resident complains of pain. RN #4 stated she would assess where the pain is. Have the resident rate the pain, if possible. How long has the pain been going on, is the pain new. I give the medication per the physician orders. When asked where staff document this assessment, RN #4 stated, "The pain level is on the eMAR it will pop up with the pain level. You can justify it in the progress notes." When asked if staff attempt anything else prior to giving the medication, RN #4 stated, "Yes, we would attempt non-pharmacological interventions, repositioning, and possibly compresses or even just talk to the resident." When asked where staff document the

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non-pharmacological interventions attempted, what worked and did not work, RN #4 stated, "The nurse should document in the progress notes." The above missing documentation, in the progress notes, for the administration of pain medication was shown to RN #4. RN #4 stated, "There should be more documentation. I will have to educate the nurses."

According to Fundamentals of Nursing, Fifth Edition, 2007, Lippincott Williams & Wilkins, page 1176 to 1207. "Pain, one of the most complex human experiences, is an invisible phenomenon influenced by the interaction of affective (emotional), behavioral, cognitive, and physiologic-sensory factors. Because pain is a highly individual experience, the basis for pain management is simply the client's description of pain. Pain exists whenever the person says it does...Typically, people describe pain by its location, intensity, quality, and temporal pattern. Sensory components of the pain experience are subjective but can be measured using standardized tools...Assessment: An accurate assessment focusing on pain's cause is essential for determining proper therapy. Ongoing assessment also is important for implementing an effective pain management plan...Document pain assessment information in an accessible location. Even the best pain assessment conducted by the one nurse is of limited value unless he or she shares the information with other healthcare professionals responsible for the client's care. Subjective Data: In an attempt to assess the client's pain, obtain answers to the following questions: Where is the pain located? What is the magnitude or intensity (level) of the pain? What level of pain would the client like to have? What level of pain would the client be willing to

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tolerate? How does the pain feel to the client; how is it described (its quality)? How does the pain change with rest, activity, or time (its temporal pattern)?...Inadequate or poor pain assessment is a leading factor in poor pain control...Objective data....Physiologic responses to pain are the result of the activation of the autonomic nervous system. With acute pain, the general responses observed include tachycardia, elevated blood pressure, increased respiratory rate, diaphoresis, and gastric distress. With persistent chronic pain, these responses may be modified or absent...Related symptoms may give additional clues about pain. Nausea and vomiting, fatigue, anorexia, and withdrawal are common with pain...Observe the client's facial expressions and body movements. Wincing, frowning, and grimacing can indicate pain...Body movements may represent protective actions to decrease the pain. Body movements such as rubbing, splinting, guarding, immobilizing, elevating the painful extremity, or changing positions frequently may increase with pain..."

The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/4/18 at 5:40 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

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F 697	Continued From page 255 (3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0001326/ 2. The facility staff failed to document the location of Resident #21's pain and non-pharmacological interventions attempted prior to the pain medication administration. Resident #21 was admitted to the facility on 12/21/15 with diagnoses that included but were not limited to: heart failure, diabetes, high blood pressure, dementia, and gout (a disease in which a defect in uric acid metabolism cause the acid and its salts to accumulate in the blood and joints, causing pain and swelling of the joints, sometimes accompanied by fever and chills.) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/27/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. The physician order renewed on 4/10/18, documented, "Tramadol Tablet (used to treat moderate to moderately severe pain) (2) 50 MG (milligram); give 50 mg by mouth every 6 hours as needed for pain give 1-2 tabs (tablets)." The March 2018, MAR (medication administration) documented, "Tramadol Tablet 50 MG; give 50 mg by mouth every 6 hours as needed for pain give 1-2 tabs." The Tramadol	F 697		

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was documented as having been given on the following dates: 3/1/18, 3/5/18, 3/6/18, 3/7/18, 3/9/18, 3/10/18, 3/12/18, 3/15/18, 3/20/18, 3/25/18 and 3/30/18. The pain level was documented between a four and eight.

The eMAR (electronic medication administration) notes and nurse's notes for March 2018, failed to evidence documentation of the location of Resident #21's pain and the non-pharmacological interventions attempted on 3/1/18, 3/5/18, 3/6/18, 3/7/18, 3/9/18, 3/10/18, 3/12/18, 3/15/18, 3/20/18, 3/25/18 and 3/30/18.

The April 2018, MAR documented, "Tramadol Tablet 50 MG; give 50 mg by mouth every 6 hours as needed for pain give 1-2 tabs." The Tramadol was documented as having been given on 4/4/18, 4/7/18, 4/11/18, 4/15/18, 4/22/18, 4/24/18 (two doses), and 4/28/18.

The eMAR notes and nurse's notes for April 2018 failed to evidence documentation of the location of Resident #21's pain and the non-pharmacological interventions attempted on the following dates: 4/4/18, 4/7/18, 4/11/18, 4/15/18, 4/22/18, 4/24/18, and 4/28/18.

The May 2018, MAR documented, "Tramadol Tablet 50 MG; give 50 mg by mouth every 6 hours as needed for pain give 1-2 tabs." The Tramadol was documented as administered on 5/12/18, 5/18/18, and 5/29/18.

The eMAR notes and nurse's notes for May 2018 failed to evidence documentation of the non-pharmacological interventions attempted prior to the administration of medication on

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F 697	Continued From page 257 5/12/18. The eMAR notes and nurse's notes for May 2018 failed to evidence documentation of the location of the pain and that non-pharmacological interventions were attempted prior to the administration of medication on 5/18/18 and 5/29/18. The comprehensive care plan dated, 12/21/15 and revised on 1/10/18, documented, "Focus: Potential Pain related to impaired mobility." The "Interventions" documented, "Notify physician if pain frequency/intensity is worsening or if current analgesia regiment has become ineffective." On 6/4/18 at 11:15 a.m., an interview was conducted with RN (registered nurse) #1, the unit manager, regarding the process staff follows when a resident complains of pain. RN #4 stated she would assess where the pain is. Have the resident rate the pain, if possible. How long has the pain been going on, is the pain new. I give the medication per the physician orders. When asked where staff document this assessment, RN #4 stated, "The pain level is on the eMAR it will pop up with the pain level. You can justify it in the progress notes." When asked if staff attempt anything else prior to giving the medication, RN #4 stated, "Yes, we would attempt non-pharmacological interventions, repositioning, and possibly compresses or even just talk to the resident." When asked where staff document the non-pharmacological interventions attempted, what worked and did not work, RN #4 stated, "The nurse should document in the progress notes." The above missing documentation, in the progress notes, for the administration of pain medication was shown to RN #4. RN #4 stated,	F 697		

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"There should be more documentation. I will have to educate the nurses."

The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/4/18 at 5:40 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 252.

(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012486/?report=details.

3. The facility staff failed to document the location of Resident #87's pain and failed to offer non-pharmacological interventions prior to the administration of the medication.

Resident #87 was admitted to the facility on 5/22/15 with a recent readmission on 3/23/18 with diagnoses that included but were not limited to: dementia, high blood pressure, depression, diabetes, and muscle weakness.

The most recent MDS (minimum data set) assessment, a Medicare 60 day assessment, with an assessment reference date of 5/18/18, coded the resident as scoring an "11" on the BIMS (brief interview for mental status) score, indicating he is moderately impaired to make daily cognitive decisions. Resident #87 was

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coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of his activities of daily living.

The physician order dated, 3/23/18, documented, "Tramadol Tablet 50 mg (milligram); give 50 mg by mouth every 12 hours as needed for pain. Tylenol Tablet (used to treat mild pain and fevers) (1); give 650 mg by mouth every 8 hours as needed for pain."

The March 2018, MAR (medication administration record) documented, "Tramadol Tablet 50 mg; give 50 mg by mouth every 12 hours as needed for pain." The Tramadol was documented as having been administered on 3/31/18.

Review of the eMAR notes and nurse's notes failed to evidence documentation of the location of Resident #87's pain and any non-pharmacological interventions attempted prior to the administration of the medication.

The April 2018, MAR documented, "Tramadol Tablet 50 mg; give 50 mg by mouth every 12 hours as needed for pain." The Tramadol was documented as having been administered on 4/8/18 and 4/10/18.

Review of the eMAR notes and nurse's notes failed to evidence documentation of the location of Resident # 87's pain on 4/8/18 and any non-pharmacological interventions attempted prior to the administration of the medication on 4/8/18 and 4/10/18.

The April 2018, MAR documented, "Tylenol Tablet; give 650 mg by mouth every 8 hours as needed for pain." The Tylenol was documented

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F 697	Continued From page 260 as administered on 4/9/18, 4/10/18, 4/20/18. 4/24/18, 4/25/18, 4/26/18 and 4/28/18. Review of the April 2018, eMAR notes and nurse's notes failed to evidence documentation of the location of Resident #87's pain on 4/9/18, 4/10/18, 4/25/18 and 4/26/18. The April 2018, eMAR and nurses notes failed to evidence the documentation of any non-pharmacological interventions prior to the administration of medication on 4/9/18, 4/10/18, 4/20/18, 4/24/18, 4/25/18, 4/26/18 and 4/28/18. The May 2018, MAR documented, "Tramadol Tablet 50 mg; give 50 mg by mouth every 12 hours for pain. The Tramadol was documented as having been administered on 5/9/18. Review of the May 2018, eMAR notes and nurse's notes failed to evidence the documentation of the non-pharmacological interventions attempted prior to the administration of the medication on 5/9/18. The May 2018, MAR documented, "Tylenol Tablet 650 mg by mouth every 8 hours as needed for pain. The Tylenol was documented as having been administered on 5/8/18, 5/11/18, 5/13/18, 5/15/18 and 5/19/18. Review of the May 2018, eMAR notes and nurse's notes failed to evidence the documentation of the non-pharmacological interventions attempted prior to the administration of the medication on 5/8/18, 5/11/18, 5/13/18, 5/15/18 and 5/19/18. Review of the May 2018, eMAR notes and nurse's notes failed to evidence documentation of	F 697		

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F 697	Continued From page 261 the location of Resident # 87's pain on 5/19/18. The comprehensive care plan dated, 1/19/17 and revised on 8/11/17, documented in part, "Focus: Potential for Pain." The "Interventions" documented in part, "Administer pain medication per physician orders. Encourage/assist to reposition frequently to position of comfort. Notify physician if pain frequency. intensity is worsening or if current analgesia regimen has become ineffective." On 6/4/18 at 11:15 a.m., an interview was conducted with RN (registered nurse) #1, the unit manager, regarding the process staff follows when a resident complains of pain. RN #4 stated she would assess where the pain is. Have the resident rate the pain, if possible. How long has the pain been going on, is the pain new. I give the medication per the physician orders. When asked where staff document this assessment, RN #4 stated, "The pain level is on the eMAR it will pop up with the pain level. You can justify it in the progress notes." When asked if staff attempt anything else prior to giving the medication, RN #4 stated, "Yes, we would attempt non-pharmacological interventions, repositioning, and possibly compresses or even just talk to the resident." When asked where staff document the non-pharmacological interventions attempted, what worked and did not work, RN #4 stated, "The nurse should document in the progress notes." The above missing documentation, in the progress notes, for the administration of pain medication was shown to RN #4. RN #4 stated, "There should be more documentation. I will have to educate the nurses." The administrator, ASM (administrative staff	F 697		

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member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/4/18 at 5:40 p.m.

No further information was provided prior to exit.

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

4. The facility staff failed to document the location of Resident #90's pain and any non-pharmacological interventions attempted prior to the administration of the medication.

Resident #90 was admitted to the facility 4/5/18 with a recent readmission on 4/20/18 with diagnoses that included but were not limited to: Subdural hematoma (a collection of blood beneath the dura mater and above the arachnoid membrane of the brain) (1), history of colon cancer, fractures of the ribs, depression, anxiety, and legally blind.

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 5/18/18, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating he is severely impaired to make daily cognitive decisions. The resident was coded as requiring limited to extensive assistance of one staff member for most of his activities of daily living. He was dependent upon the staff for his

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F 697	Continued From page 263 nutritional needs. The physician order dated, 4/26/18, documented, "Tylenol Extra Strength Tablet 500 mg (milligram); give 500 mg via PEG-Tube (Percutaneous endoscopic gastrostomy [feeding tube] (2)) every 6 hours as needed for pain." The May 2018, MAR (medication administration record) documented, "Tylenol Extra Strength Tablet 500 mg; give 500 mg via PEG-Tube every 6 hours as needed for pain." The MAR documented the medication was administered on 5/6/18, 5/22/18 and 5/29/18. The review of the May 2018, eMAR (electronic medication administration record) and the nurse's notes failed to evidence documentation of non-pharmacological interventions prior to the administration of the pain medication on 5/6/18, 5/22/18 and 5/29/18. The May 2018, eMAR failed to evidence documentation of the location of Resident #90's pain being treated on 5/22/18 and 5/29/18. The comprehensive care plan dated, 4/5/18 and revised on 4/17/18, documented in part, "Focus: Potential for pain r/t (related to) colon cancer." The "Interventions" documented in part, "Administer pain medication per physician orders." On 6/4/18 at 11:15 a.m., an interview was conducted with RN (registered nurse) #1, the unit manager, regarding the process staff follows when a resident complains of pain. RN #4 stated she would assess where the pain is. Have the resident rate the pain, if possible. How long has the pain been going on, is the pain new. I give the	F 697		

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medication per the physician orders. When asked where staff document this assessment, RN #4 stated, "The pain level is on the eMAR it will pop up with the pain level. You can justify it in the progress notes." When asked if staff attempt anything else prior to giving the medication, RN #4 stated, "Yes, we would attempt non-pharmacological interventions, repositioning, and possibly compresses or even just talk to the resident." When asked where staff document the non-pharmacological interventions attempted, what worked and did not work, RN #4 stated, "The nurse should document in the progress notes." The above missing documentation, in the progress notes, for the administration of pain medication was shown to RN #4. RN #4 stated, "There should be more documentation. I will have to educate the nurses."

The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/4/18 at 5:40 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 549 and 265.

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

5. The facility staff failed to document the location of Resident #42's pain and failed to document the non-pharmacological interventions that were

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attempted prior to the administration of medication.

Resident # 42 was admitted to the facility on 1/9/18 with a recent readmission on 3/12/18 with diagnoses that included but were not limited to: high blood pressure, heart disease, dementia, stroke, and atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output) (1).

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 4/18/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of his activities of daily living.

The physician order dated, 3/11/18, documented, "Tramadol Tablet 50 mg (milligram); give 50 mg via PEG-tube ((Percutaneous endoscopic gastrostomy [feeding tube] (2)) every 12 hours as needed for pain."

The March 2018 MAR (medication administration record) documented, "Tramadol Tablet 50 mg; give 50 mg via PEG-tube every 12 hours as needed for pain." The Tramadol was documented as administered on 3/17/18, 3/17/18, 3/26/18. 3/29/18, 3/30/18 and 3/31/18.

Review of the March 2018, eMAR (electronic medication administration) notes and the nurse's

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notes failed to evidence the location of Resident #42's pain being treated on 3/26/18. Further review of the March 2018, eMAR and nurse's notes failed to evidence the documentation of non-pharmacological interventions prior to the administration of the medication on 3/17/18, 3/17/18, 3/26/18. 3/29/18, 3/30/18 and 3/31/18.

The April 2018 MAR documented, "Tramadol Tablet 50 mg; give 50 mg via PEG-tube every 12 hours as needed for pain." The Tramadol was documented as administered on 4/6/18, 4/25/18 and 4/27/18.

Review of the April 2018 eMAR and nurse's notes failed to evidence the documentation of non-pharmacological interventions prior to the administration of the medication and failed to evidence the documentation of the location of Resident #42's pain being treated.

The May 2018 MAR documented, "Tramadol Tablet 50 mg; give 50 mg via PEG-tube every 12 hours as needed for pain." The Tramadol was documented as administered on 5/4/18.

Review of the May 2018, eMAR and nurse's notes failed to evidence the documentation of the location of Resident #42's pain and the non-pharmacological interventions prior to the administration of the medication.

The comprehensive care plan dated, 2/10/18, documented, "Focus: Pain generalized evidenced by related to recent CVA (cerebrovascular accident - stroke)." The "Interventions" documented, "Administer pain medications per physician orders."

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 697	Continued From page 267 On 6/4/18 at 11:15 a.m., an interview was conducted with RN (registered nurse) #1, the unit manager, regarding the process staff follows when a resident complains of pain. RN #4 stated she would assess where the pain is. Have the resident rate the pain, if possible. How long has the pain been going on, is the pain new. I give the medication per the physician orders. When asked where staff document this assessment, RN #4 stated, "The pain level is on the eMAR it will pop up with the pain level. You can justify it in the progress notes." When asked if staff attempt anything else prior to giving the medication, RN #4 stated, "Yes, we would attempt non-pharmacological interventions, repositioning, and possibly compresses or even just talk to the resident." When asked where staff document the non-pharmacological interventions attempted, what worked and did not work, RN #4 stated, "The nurse should document in the progress notes." The above missing documentation, in the progress notes, for the administration of pain medication was shown to RN #4. RN #4 stated, "There should be more documentation. I will have to educate the nurses." The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/4/18 at 5:40 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 697		

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(2) This information was obtained from the website:
https://medlineplus.gov/ency/article/002937.htm
6. The facility staff failed to attempt non-pharmacological interventions prior to the use of prn (as needed) pain medication for Resident # 100.

Resident # 100 was admitted to the facility on 03/02/18 with a readmission of 05/30/18 with diagnoses that included but were not limited to heart failure, hypertension (1), gastroesophageal reflux disease (2), diabetes mellitus (3), dementia (4) and seizure disorder (5).

Resident # 100's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 100 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions. Resident # 100 was coded as being totally dependent of one staff member for activities of daily living. Section "J0300 Pain Presence" coded Resident # 100's pain as frequently at a level five.

The physician's orders dated March 2018 for Resident # 100 documented, "Oxycodone (6) Tablet 5 MG (milligram) Give 2.5 mg via (by) PEG (percutaneous endoscopic gastrostomy (8)) Tube every 6 (six) hours as needed for pain. Start Date: 3/2/2018. End date: 4/5/2018."

The physician's orders dated April 2018 for Resident # 100 documented, "Oxycodone (6) Tablet 5 MG (milligram) Give 2.5 mg via (by) PEG (percutaneous endoscopic gastrostomy)

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Tube every 6 (six) hours as needed for pain. Start Date: 4/5/2018. End date: 4/18/2018."

The physician's orders dated May 2018 for Resident # 100 documented, "Tylenol (7) Tablet (Acetaminophen) Give 650 mg via PEG Tube every 4 (four) hours as needed for pain. Start Date: 5/11/2018. End date: 5/26/2018."

The eMAR (electronic medication administration record) dated March 2018 for Resident # 100 documented, "Oxycodone Tablet 5 MG. Give 2.5 mg via (by) PEG Tube every 6 hours as needed for pain. D/C (discontinue) Date: 04/05/2018. Review of the eMAR revealed oxycodone was administered to Resident # 100:
- On 03/03/18 at 1813 (6:13 p.m.) with a pain level of 7 (seven).
- On 03/06/18 at 635 (6:35 a.m.) with a pain level of 5 (five).
- On 03/07/18 at 1612 (6:12 p.m.) with a pain level of 9 (nine).
- On 03/08/18 at 532 (5:32 a.m.) with a pain level of 5 (five).
- On 03/09/18 at 1733 (5:33 p.m.) with a pain level of 9 (nine).
- On 03/10/18 at 1122 (11:22 a.m.) with a pain level of 9 (nine).
- On 03/12/18 at 0349 (3:49 a.m.) with a pain level of 5 (five) and at 2248 (10:48 p.m.) with a pain level of 9 (nine).
- On 03/13/18 at 1231 (12:31 p.m.) with a pain level of 2 (two).
- On 03/14/18 at 0900 (9:00 a.m.) with a pain level of 2 (two) and at 1731 (5:31 p.m.) with a pain level of 7 (seven).
- On 03/15/18 at 0028 (12:28 a.m.) with a pain level of 5 (five).
- On 03/16/18 at 0005 (12:05 a.m.) with a pain

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F 697	Continued From page 270 level of 5 (five) and at 0922 (9:22 a.m.) with a pain level of 8 (eight). - On 03/17/18 at 0313 (3:13 a.m.) with a pain level of 4 (four). - On 03/20/18 at 0125 (1:25 a.m.) with a pain level of 6 (six). - On 03/21/18 at 1111 (11:11 a.m.) with a pain level of 7 (seven). - On 03/22/18 at 2005 (8:05 p.m.) with a pain level of 6 (six). - On 03/23/18 at 0701 (7:01 a.m.) with a pain level of 6 (six). - On 03/26/18 at 2054 (8:54 p.m.) with a pain level of 6 (six). - On 03/28/18 at 0151 (1:51 a.m.) with a pain level of 9 (nine) and at 0840 (8:40 a.m.) with a pain level of 2 (two). - On 03/29/18 at 0227 (2:27 a.m.) with a pain level of 5 (five). - On 03/30/18 at 0338 (3:38 a.m.) with a pain level of 5 (five). - On 03/31/18 at 1653 (4:53 p.m.) with a pain level of 7 (seven). Further review of the eMAR dated March 2018 failed to evidence documentation of non-pharmacological interventions prior to the administration of oxycodone. The eMAR dated April 2018 for Resident # 100 documented, "Oxycodone Tablet 5 MG. Give 2.5 mg via PEG Tube every 6 hours as needed for pain. D/C (discontinue) Date: 04/05/2018. Review of the eMAR revealed oxycodone was administered to Resident # 100: On 04/01/18 at 0925 (9:25 a.m.) with a pain level of 2 (two). The eMAR dated April 2018 for Resident # 100 documented, "Oxycodone Tablet 5 MG. Give 2.5 mg via PEG Tube every 6 hours as needed for	F 697		

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F 697	Continued From page 271 pain. D/C (discontinue) Date: 04/18/2018. Review of the eMAR revealed oxycodone was administered to Resident # 100: - On 04/06/18 at 0211 (2:11 a.m.) with a pain level of 4 (four). - On 04/12/18 at 0028 (12:28 a.m.) with a pain level of 3 (three). - On 04/13/18 at 0924 (9:24 a.m.) with a pain level of 10. - On 04/14/18 at 0050 (12:50 a.m.) with a pain level of 4 (four). - On 04/15/18 at 0127 (1:27 a.m.) with a pain level of 6 (six). Further review of the eMAR dated April 2018 failed to evidence documentation of non-pharmacological interventions prior to the administration of oxycodone. The eMAR dated May 2018 for Resident # 100 documented, "Tylenol Tablet (Acetaminophen) Give 650 mg via PEG Tube every 4 hours as needed for pain. D/C (discontinue) Date: 05/26/2018. Review of the eMAR revealed Tylenol was administered to Resident # 100: - On 05/11/18 at 1206 (12:06 p.m.) with a pain level of 4 (four). - On 05/12/18 at 0930 (9:30 a.m.) with a pain level of 2 (two). - On 05/16/18 at 0807 (8:07 a.m.) with a pain level of 6 (six), at 1307 (1:37 p.m.) with a pain level of 3 (three) and at 2106 (9:06 p.m.) with a pain level of 5 (five). - On 05/17/18 at 1225 (12:50 p.m.) with a pain level of 2 (two). - On 05/21/18 at 1109 (11:09 a.m.) with a pain level of 2 (two). Further review of the eMAR dated May 2018 failed to evidence documentation of non-pharmacological interventions prior to the	F 697		

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F 697	Continued From page 272 administration of Tylenol. Review of the Nurse's "Progress Notes" dated 03/02/18 through 05/30/18 failed to evidence documentation of non- pharmacological interventions prior to the administration of oxycodone and Tylenol. On 06/05/18 at 10:40 a.m., an interview was conducted with RN (registered nurse) # 3, nurse supervisor. When asked to describe the procedure and documentation when administering prn (as needed) pain medication, RN # 3 stated, "Assess the resident, ask if they are having pain, where the pain is, try non-pharmacological approaches before giving the medication, ask the severity of the pain on a scale of 1 to 10, and the location of the pain. Document pain level before administering the pain medication, location of pain; if the non-pharmacological did not work then give the medication. I would document the non-pharmacological approach in the progress notes." After reviewing the eMARs (electronic medication administration records) dated March, April and May 2018 and the "Progress Notes" dated 03/02/18 through 05/30/18 for Resident # 100, RN # 3 confirmed that non-pharmacological approaches were not attempted on the dates the oxycodone and Tylenol were administered to Resident # 100. On 06/04/18 at approximately 5:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	F 697		

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F 697	Continued From page 273 References: (1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (4) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (5) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (6) Oxycodone is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html. (7) Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats,	F 697		

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toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html.

(8) This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm

7. The facility staff failed to attempt non-pharmacological interventions prior to the use of prn (as needed) pain medication for Resident # 75.

Resident # 75 was admitted to the facility on 02/15/17 with a readmission of 06/01/18 with diagnoses that included but were not limited to hypertension (1), gastroesophageal reflux disease (2), diabetes mellitus (3), anxiety (4) and peripheral vascular disease (5).

Resident # 75's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/14/18, coded Resident # 75 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 75 was coded as being independent with setup or assistance of one staff member for activities of daily living. Section

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"J0300 Pain Presence" coded Resident # 75 as not having any pain at the time of the assessment.

The physician's orders dated February 2018 for Resident # 75 documented, "Norco (6) Tablet 5-325 MG (Hydrocodone-Acetaminophen). Give 1 (one) tablet by mouth every 4 (four) hours as needed for Pain. Start Date: 02/17/2018. End date 4/9/2018."

The physician's orders dated April 2018 for Resident # 75 documented, "Norco Tablet 7.5-325 MG (Hydrocodone-Acetaminophen). Give 1 (one) tablet by mouth every 4 (four) hours a needed for Pain. Start date: 4/9/2018. End date: 4/30/2018."

The physician's orders dated May 2018 for Resident # 75 documented, "Hydrocodone-Acetaminophen Tablet 7.5-325 MG. Give 1 (one) tablet by mouth every 4 (four) hours a needed for Pain. Start Date: 5/2/2018. End Date: 5/27/2018."

The eMAR (electronic medication administration record) dated April 2018 documented:
"Norco Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 (one) tablet by mouth every 4 (four) hours a needed for Pain. D/C (discontinue) 04/09/18."
"Norco Tablet 7.5-325 MG (Hydrocodone-Acetaminophen) Give 1 (one) tablet by mouth every 4 (four) hours a needed for Pain. D/C (discontinue) 04/30/18."
Review of the eMAR revealed Norco 5-325 mg was administered to Resident # 75 as follows:
- On 04/02/18 at 1050 (10:50 a.m.) with a pain level of 5 (five)

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F 697	Continued From page 276 - Norco 7.5-325 mg was administered to Resident # 75, on 04/10/18 at 1029 (10:29 a.m.) with a pain level of 8 (eight) and at 2032 (8:32 p.m.) with a pain level of 3 (three). - On 04/13/18 at 2018 (8:18 p.m.) with a pain level of 6 (six). Further review of the eMAR dated April 2018 failed to evidence documentation of non-pharmacological interventions prior to the administration of Norco. The eMAR (electronic medication administration record) dated May 2018 documented, "Hydrocodone-Acetaminophen Tablet 7.5-325 MG. Give 1 (one) tablet by mouth every 4 (four) hours a needed for Pain. D/C (discontinue) 05/27/18." Review of the eMAR revealed hydrocodone-acetaminophen tablet 7.5-325 mg was administered to Resident # 75 on 05/14/18 at 1925 (7:25 p.m.) with a pain level of 3 (three). Further review of the eMAR dated May 2018 failed to evidence documentation of non-pharmacological interventions prior to the administration of Norco. Review of the Nurse's "Progress Notes" dated 04/01/18 through 05/30/18 failed to evidence documentation of non- pharmacological interventions prior to the administration of Norco and hydrocodone-acetaminophen. On 06/05/18 at 10:40 a.m., an interview was conducted with RN (registered nurse) # 3, nurse supervisor. When asked to describe the procedure and documentation when administering prn (as needed) pain medication, RN # 3 stated, "Assess the resident, ask if they are having pain, where the pain is, try	F 697		

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non-pharmacological approaches before giving the medication, ask the severity of the pain on a scale of 1 to 10, and the location of the pain. Document pain level before administering the pain medication, location of pain; if the non-pharmacological did not work then give the medication. I would document the non-pharmacological approach in the progress notes." After reviewing the eMARs (electronic medication administration records) dated April and May 2018 and the "Progress Notes" dated 04/02/18 through 05/30/18 for Resident # 75, RN # 3 confirmed that non-pharmacological approaches were not attempted on the dates the Norco and hydrocodone-acetaminophen were administered to Resident # 75.

On 06/04/18 at approximately 5:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

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

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

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

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001214.htm.

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

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

(6) Hydrocodone is an opioid pain medication. An opioid is sometimes called a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone. The combination of acetaminophen and hydrocodone is used to relieve moderate to severe pain. This information was obtained from the website: https://www.rxlist.com/norco-5-325-drug/patient-images-side-effects.htm.

8. The facility staff failed to attempt non-pharmacological interventions prior to the use of prn (as needed) pain medication for Resident # 51.

Resident # 51 was admitted to the facility on 08/25/17 with a readmission of 10/16/18 with diagnoses that included but were not limited to hypertension (1), Barrett's esophagus (2),

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diabetes mellitus (3), cirrhosis of the liver (4) and depression (5).

Resident # 51's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/24/18, coded Resident # 51 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 51 was coded as being independent with setup or limited assistance of one staff member for activities of daily living. Section "J0300 Pain Presence" coded Resident # 51's pain as frequently at a level eight.

The POS (physician's order sheet) dated June 2018 for Resident # 51 documented, "Oxycodone (6) Tablet 5 MG (milligram). Give 5 mg by mouth every 6 (six) hours as needed for abdominal cramps/pain. Order date: 10/16/2017. Start Date: 10/16/2017."

The eMAR (electronic medication administration record) dated March 2018 documented, "Oxycodone Tablet 5 MG. Give 5 mg by mouth every 6 (six) hours as needed for abdominal cramps/pain. Review of the eMAR revealed oxycodone 5 mg was administered to Resident # 51:
- On 03/01/18 at 1804 (6:04 p.m.) with a pain level of 5 (five).
- On 03/02/18 at 0818 (8:18 a.m.) with a pain level of 8 (eight) and at 2009 (8:09 p.m.) with a pain level of 4 (four).
- On 03/04/18 at 1048 (10:48 a.m.) with a pain level of 9 (nine) and at 2100 (9:00 p.m.) with a pain level of 8 (eight).
- On 03/05/18 at 1907 (7:09 p.m.) with a pain level of 5 (five).

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F 697	Continued From page 280 - On 03/07/18 at 1616 (4:16 p.m.) with a pain level of 5 (five). - On 03/08/18 at 0100 (1:00 a.m.) with a pain level of 3 (three) and at 1326 (1:26 p.m.) with a pain level of 7 (seven). - On 03/09/18 at 1550 (3:50 p.m.) with a pain level of 4 (four). - On 03/11/18 at 2017 (8:17 p.m.) with a pain level of 6 (six). - On 03/16/18 at 1204 (12:04 p.m.) with a pain level of 8 (eight) and at 2204 (10:24 p.m.) with a pain level of 7 (seven). - On 03/17/18 at 0826 (8:26 a.m.) with a pain level of 6 (six) and at 2309 (11:09 p.m.) with a pain level of 3 (three). - On 03/18/18 at 0537 (5:37 a.m.) with a pain level of 5 (five) and at 1311 (1:11 p.m.) with a pain level of 7 (seven). - On 03/19/18 at 0901 (9:01 a.m.) with a pain level of 6 (six). - On 03/21/18 at 1345 (1:45 p.m.) with a pain level of 7 (seven). - On 03/23/18 at 0804 (8:04 a.m.) with a pain level of 7 (seven). - On 03/29/18 at 0808 (8:08 a.m.) with a pain level of 8 (eight). - On 03/30/18 at 1828 (6:28 p.m.) with a pain level of 3 (three). - On 03/31/18 at 1018 (10:18 a.m.) with a pain level of 8 (eight). Further review of the eMAR dated March 2018 failed to evidence documentation of non-pharmacological interventions prior to the administration of oxycodone. Review of the Nurse's "Progress Notes" dated 03/01/18 through 03/30/18 failed to evidence documentation of non- pharmacological interventions prior to the administration of	F 697		

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oxycodone.

On 06/05/18 at 10:40 a.m., an interview was conducted with RN (registered nurse) # 3, nurse supervisor. When asked to describe the procedure and documentation when administering prn (as needed) pain medication, RN # 3 stated, "Assess the resident, ask if they are having pain, where the pain is, try non-pharmacological approaches before giving the medication, ask the severity of the pain on a scale of 1 to 10, and the location of the pain. Document pain level before administering the pain medication, location of pain; if the non-pharmacological did not work then give the medication. I would document the non-pharmacological approach in the progress notes." After reviewing the eMAR (electronic medication administration records) dated March 2018 and the "Progress Notes" dated 03/01/18 through 03/30/18 for Resident # 51, RN # 3 confirmed that non-pharmacological approaches were not attempted on the dates the oxycodone was administered to Resident # 51.

On 06/04/18 at approximately 5:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

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

(2) A disorder in which the lining of the

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esophagus is damaged by stomach acid. The esophagus is also called the food pipe or swallowing tube. This information was obtained from the website: https://medlineplus.gov/ency/article/001143.htm.

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

(4) A scarring of the liver and poor liver function. It is the last stage of chronic liver disease. Cirrhosis is the end result of chronic liver damage caused by chronic (long-term) liver disease. Common causes of chronic liver disease in the United States are: Hepatitis B or hepatitis C infection or alcohol abuse. This information was obtained from the website: https://medlineplus.gov/ency/article/000255.htm.

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

(6) Oxycodone is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

9. The facility staff failed to assess the location of

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Resident #32's the pain and failed to attempt non-pharmacological interventions prior to administering as needed pain medication.

Resident #32 was admitted to the facility on 6/12/15 with the diagnoses of but not limited to fractured right femur, chronic embolism and thrombosis of lower extremity, and dementia. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 4/6/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for transfers, dressing, eating and hygiene; and as incontinent of bowel and bladder.

A review of the clinical record revealed a physician's order sheet for June 2018, which documented an order dated 3/29/18 for "Tylenol [1] Give 650 mg (milligrams) by mouth every 6 hours as needed for Pain..."

A review of the April 2018 MAR (Medication Administration Record) revealed an additional order for "Oxycodone [2] 5 mg tablet, give 2.5 mg by mouth every 6 hours as needed for pain." This order was documented as having been discontinued on 4/27/18. Order date was not documented on the MAR.

April 2018, Oxycodone:
- A review of the April 2018 MAR revealed that Resident #32 received the Oxycodone on 4/3/18 at 4:30p.m., 4/4/18 at 4:52p.m., 4/5/18 at 8:08p.m., and on 4/12/18 at 7:42p.m.
A review of the Nurse's notes revealed pre and post administration pain ratings were

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F 697	Continued From page 284 documented, and that the medication was "effective." However, the location of the pain was not documented as having been assessed, and non-pharmacological interventions were not documented as having been offered. April 2018, Tylenol: - A review of the April 2018 MAR revealed that Resident #32 received the Tylenol on 4/6/18 at 6:07p.m., 4/7/18 at 7:44p.m., 4/18/18 at 12:33p.m., 4/20/18 at 7:57a.m., 4/21/18 at 6:02p.m., 4/26/18 at 8:02p.m., and 4/29/18 at 8:00a.m.. A review of the Nurse's notes revealed that pre and post administration pain ratings were documented, and that the medication was "effective." However, the location of the pain was not documented as having been assessed (with the exception of 4/18/18), and any non-pharmacological interventions attempted were not documented as having been offered. May 2018, Tylenol: - A review of the May 2018 MAR revealed that Resident #32 received the Tylenol on 5/2/18 at 7:49p.m., 5/3/18 at 6:51p.m., 5/5/18 at 6:36p.m., and 5/26/18 at 6:18p.m.. A review of the Nurse's notes revealed pre and post administration pain ratings were documented, and that the medication was "effective." However, the location of the pain was not documented as having been assessed and any non-pharmacological interventions attempted were not documented as having been offered. On 6/5/18 at 10:45 a.m., in an interview with LPN #6 (Licensed Practical Nurse), LPN #6 stated that a pain assessment should include the location of the pain, the pain level, what makes it worse or	F 697		

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better, and that non-pharmacological interventions should be attempted. When asked if all this should be documented, LPN #6 stated it should be.

On 6/5/18 at 10:56 a.m., in an interview with RN #1 (Registered Nurse) RN #1 stated that staff should assess the resident's pain location, severity, type of pain, attempt non-pharmacological (interventions), and document if the resident refused non-pharmacological. When asked if the full pain assessment should be documented, RN #1 stated that it should be.

A review of the care plan revealed one dated 6/12/15 and revised on 3/26/18 for "Pain rt (right) hip evidenced by complaint related to fracture." The interventions did not include anything about offering or attempting non-pharmacological interventions. A second care plan, dated 11/9/15 and revised on 4/12/15 for "Potential for pain due to fracture.

On 6/5/18 at approximately 12:30 p.m., the administrator and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

Sources:

[1] Tylenol (Acetaminophen) is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the

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pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body.
Information obtained from
https://medlineplus.gov/druginfo/meds/a681004.html

[2] Oxycodone is used to relieve moderate to severe pain.
Information obtained from
https://medlineplus.gov/druginfo/meds/a682132.html
10. The facility staff failed to administer physician prescribed scheduled pain medication to Resident #18 on multiple dates in January 2018.

Resident #18 was admitted to the facility on 4/25/11. Resident #18's diagnoses included but were not limited to legal blindness, high cholesterol and paralysis. Resident #18's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/23/18, coded the resident's cognitive skills for daily decision-making as severely impaired.

Review of Resident #18's clinical record revealed a physician's order dated 8/27/14 for Baclofen (1) 5 mg (milligrams) by mouth two times a day for pain.

Resident #18's January 2018 MAR (medication administration record) documented the resident's pain level as a zero on 1/12/18 at 7:15 a.m. and the resident's pain level as a three on 1/14/18 at 7:15 a.m.

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F 697	Continued From page 287 Further review of Resident #18's January 2018 MAR revealed the following: -The code "9- Other/See Nurse Notes" was documented in regards to Baclofen administration at 9:00 a.m. on 1/12/18 and 1/14/18. Further review of Resident #18's clinical record revealed the following nurses' notes: -1/12/18 "Baclofen Tablet- Give 5 mg by mouth two times a day for pain- not on hand will re order from pharmacy." -1/14/18 "Baclofen Tablet. Medication unavailable." Resident #18's care plan dated 6/18/09 documented, "Potential for Pain due to osteo, general hx (history) spasams (sic). Administer pain medication as per MD (medical doctor) orders..." On 6/4/18 at 2:43 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked about the process to ensure medications are available for administration. LPN #3 stated medication refills are supposed to be ordered when there is a three-day supply of the medication left. LPN #3 was asked what should be done if a medication is not available for administration. LPN #3 stated she always documents that the medication is not available and she contacts the pharmacy. LPN #3 stated she calls the pharmacy and reads off a list of needed medications after she completes her medication pass. LPN #3 stated the pharmacy is located in town so medications can be delivered within an hour if she tells the pharmacy to "STAT (immediate) it over (send immediately)." On 6/4/18 at 5:44 p.m., ASM (administrative staff	F 697		

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member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "PAIN PRACTICE GUIDE" documented, "FYI (For your information)...A fundamental principle of analgesic treatment for moderate to severe recurrent pain is the regular, NOT PRN (as needed), administration of at least one medication."

No further information was presented prior to exit.

(1) Baclofen is used to treat muscle spasms. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682530.html

11. The facility staff failed to administer physician prescribed scheduled pain medication to Resident #56 on multiple dates in February 2018.

Resident #56 was admitted to the facility on 6/5/15, and readmitted on 4/10/18. Resident #56's diagnoses included but were not limited to high cholesterol, diabetes and paralysis. Resident #56's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/1/18, coded the resident's cognition as moderately impaired.

Review of Resident #56's clinical record revealed a physician's order dated 12/28/17 for Lidocaine (1) 2% gel- apply topically to knees two times a day for pain.

February 2018, MAR (medication administration record) and TAR (treatment administration

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record) for Resident #56 failed to document any pain evaluations.
Further review of Resident #56's February 2018 TAR revealed the following:
-The code "9- Other/See Nurse Notes" was documented in regards to administration of the 5:00 p.m. dose of Lidocaine on 2/3/18.
-The code "9" was documented in regards to administration of the 5:00 p.m. dose of Lidocaine on 2/4/18.
-The code "9" was documented in regards to the administration of both doses of Lidocaine on 2/11/18.

Nurses' notes dated 2/3/18, 2/4/18 and 2/11/18 documented Lidocaine was unavailable to administer.

Resident #56's comprehensive care plan dated 6/5/15 documented, "Potential for pain due to decreased mobility, dm (diabetes mellitus). Administer pain medication per physician orders..."

On 6/4/18 at 2:43 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked about the process to ensure medications are available for administration. LPN #3 stated medication refills are supposed to be ordered when there is a three-day supply of the medication left. LPN #3 was asked what should be done if a medication is not available for administration. LPN #3 stated she always documents that the medication is not available and she contacts the pharmacy. LPN #3 stated she calls the pharmacy and reads off a list of needed medications after she completes her medication pass. LPN #3 stated the pharmacy is located in town so medications can be delivered

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within an hour if she tells the pharmacy to "STAT (immediate) it over (send immediately)."

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) Lidocaine gel is used to treat pain. This information was obtained from the website: https://medlineplus.gov/ency/article/003059.htm

F 755 SS=E — Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) — F 755

§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-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

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It is the intended practice of this facility to ensure facility provides routine and emergency drugs and biologicals to its residents, or obtain them under an agreement.

Criteria 1
Resident's #'s 23, 18, 56 and 42 suffered no adverse outcomes related to the availability of prescribed medications. Licensed nursing staff trained on the protocols for unavailable medications.

Criteria 2
Residents who receive medication in the facility have the potential to be affected. Residents will receive medications as ordered or the MD and responsible party will be notified for new orders.

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§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, facility document review and clinical record review, it was determined that the facility staff failed to provide pharmacy services for four of 50 residents in the survey sample, Residents #23, #18, #56 and #42.

1. The facility staff failed to ensure physician prescribed medications for Resident #23 were available for administration on multiple dates in February 2018.

2. The facility staff failed to physician prescribed medications for Resident #18 available for administration on multiple dates in January 2018 and April 2018.

3. The facility staff failed to ensure physician prescribed medications for Resident #56 were available for administration on multiple dates beginning in February 2018 through May 2018.

4. The facility staff failed to ensure medications were available for administration per the physician orders for Resident #42.

The findings include:

1. The facility staff failed to ensure physician

Provider's Plan of Correction:

Criteria 3
Licensed nurses were re-educated on the procedures related to medication availability.

Criteria 4
DON or designee will audit MARs x5 days, weekly x2 weeks and monthly x2 months to ensure compliance.

Criteria 5
The facility's alleged date of compliance is 7/10/2018.

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prescribed medications for Resident #23 were available for administration on multiple dates in February 2018.

Resident #23 was admitted to the facility on 10/11/17. Resident #23's diagnoses included but were not limited to GERD (gastro-esophageal reflux disease), dementia (1) and a pressure injury (2). Resident #23's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/28/18, coded the resident's cognitive skills for daily decision-making as severely impaired.

Review of Resident #23's clinical record revealed the following physician's orders:
-10/11/17- Protonix (3) 40 mg (milligrams) one time a day for GERD.
-10/18/17- Nystatin (4) 100,000 unit per milliliter- 5 milliliters three times a day for oral care.

Review of Resident #23's February 2018 MAR (medication administration record) revealed the following:
-The code "9- Other/See Nurse Notes" was documented in regards to the administration of Protonix and all three doses of Nystatin on 2/11/18.
-The code "9" was documented in regards to the administration of all three doses of Nystatin on 2/24/18.
-The code "9" was documented in regards to the administration of all three doses of Nystatin on 2/25/18.

Further review of Resident #23's clinical record revealed the following nurses' notes:
-Nurses' notes dated 2/11/18 that documented Nystatin was on order and Protonix was

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F 755	Continued From page 293 unavailable to administer. -Nurses' notes dated 2/24/18 and 2/25/18 that documented Nystatin was on order. Resident #23's care plan dated 10/12/17 documented, "GI (Gastrointestinal) distress r/t (related to) GERD. Administer medications per physician orders..." Review of the facility STAT (immediate) box (a box that contains various medications that can be accessed if a medication is not available) list revealed Protonix and Nystatin were not available in the STAT box. On 6/4/18 at 2:43 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked about the process to ensure medications are available for administration. LPN #3 stated medication refills are supposed to be ordered when there is a three-day supply of the medication left. LPN #3 was asked what should be done if a medication is not available for administration. LPN #3 stated she always documents that the medication is not available and she contacts the pharmacy. LPN #3 stated she calls the pharmacy and reads off a list of needed medications after she completes her medication pass. LPN #3 stated the pharmacy is located in town so medications can be delivered within an hour if she tells the pharmacy to "STAT it over (send immediately)." On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility/pharmacy policy titled, "7.0 Medication	F 755		

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F 755	Continued From page 294 Shortages/Unavailable Medications" documented, "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 the 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 this 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 (STAT box) 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. 3. If a medication shortage is discovered after normal pharmacy hours: 3.1 A licensed facility nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency delivery; or, 3.2.2 Use of an emergency (back-up) third party pharmacy." No further information was presented prior to exit. (1) "Dementia is the name for a group of	F 755		

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symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.240726468.691240467.1528283828-139120270.1477942321

(2) "A pressure sore (injury) is any redness or break in the skin caused by too much pressure on your skin for too long a period of time." This information was obtained from the website: http://sci.washington.edu/info/pamphlets/pressure_sores.asp

(3) "Pantoprazole (Protonix) is used to treat gastroesophageal reflux disease (GERD), a condition in which backward flow of acid from the stomach causes heartburn and possible injury of the esophagus (the tube between the throat and stomach)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601246.html

(4) Nystatin is used to treat fungal infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682758.html

2. The facility staff failed to administer physician prescribed medications to Resident #18 on

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multiple dates in January 2018 and April 2018.

Resident #18 was admitted to the facility on 4/25/11. Resident #18's diagnoses included but were not limited to legal blindness, high cholesterol and paralysis. Resident #18's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/23/18, coded the resident's cognitive skills for daily decision-making as severely impaired.

Review of Resident #18's clinical record revealed the following physician's orders:
-8/27/14- Baclofen (1) 5 mg (milligrams) by mouth two times a day for pain.
-1/22/18- Erythromycin (2) ointment 5mg/gm (gram) - instill 0.5 strip in left eye two times a day for three months for legal blindness.

Review of Resident #18's January 2018 MAR (medication administration record) revealed the following:
-The code "9- Other/See Nurse Notes" was documented in regards to Baclofen administration at 9:00 a.m. on 1/12/18 and 1/14/18
-The code "9" was documented in regards to Erythromycin ointment administration on 1/22/18 at 5:00 p.m.
-The code "5- Hold/See Nurse Notes" was documented in regards to Erythromycin ointment administration on 1/29/18 at 9:00 a.m.

Further review of Resident #18's clinical record revealed the following nurses' notes:
-1/12/18 "Baclofen Tablet- Give 5 mg by mouth two times a day for pain- not on hand will re order from pharmacy."
-1/14/18 "Baclofen Tablet. Medication

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unavailable."
-1/22/18 "Erythromycin Ointment 5 MG/GM. Instill 0.5 strip in left eye two times a day related to LEGAL BLINDNESS, AS DEFINED IN USA for 3 Months 1/2 ribbon to OD (right eye). Medication on order from pharmacy."
-1/29/18 "Erythromycin Ointment 5 MG/GM. Instill 0.5 strip in left eye two times a day related to LEGAL BLINDNESS, AS DEFINED IN USA for 3 Months 1/2 ribbon to OD (right eye)- awaiting medication from pharmacy, MD (medical doctor) and RP (responsible party) nnotified (sic)."

Review of Resident #18's April 2018 MAR revealed the following:
-The code "9- Other/See Nurse Notes" was documented in regards to Erythromycin administration at 5:00 p.m. on 4/9/18 and 4/14/18.

Further review of Resident #18's clinical record revealed the following nurses' notes:
-4/9/18 "Erythromycin Ointment 5 MG/GM. Instill 0.5 strip in left eye two times a day related to LEGAL BLINDNESS, AS DEFINED IN USA for 3 Months 1/2 ribbon to OD (right eye) - Medication not located in med cart or at bedside. Medication reordered. Awaiting delivery from pharmacy."
-4/14/18 "Erythromycin Ointment 5 MG/GM. Instill 0.5 strip in left eye two times a day related to LEGAL BLINDNESS, AS DEFINED IN USA for 3 Months 1/2 ribbon to OD (right eye)- Medication not present in facility. Medication ordered from pharmacy. Awaiting delivery."

Review of the facility STAT (immediate) box (a box that contains various medications that can be accessed if a medication is not available) list revealed Baclofen and Erythromycin were not available in the STAT box.

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Resident #18's care plan dated 6/18/09 and 3/26/18 documented, "Erythromycin Ointment related to LEGAL BLINDNESS, for 3 months. Administer as ordered by MD (medical doctor)...potential for Pain due to osteo, general hx (history) spasams (sic). Administer pain medication as per MD orders..."

On 6/4/18 at 2:43 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked about the process to ensure medications are available for administration. LPN #3 stated medication refills are supposed to be ordered when there is a three-day supply of the medication left. LPN #3 was asked what should be done if a medication is not available for administration. LPN #3 stated she always documents that the medication is not available and she contacts the pharmacy. LPN #3 stated she calls the pharmacy and reads off a list of needed medications after she completes her medication pass. LPN #3 stated the pharmacy is located in town so medications can be delivered within an hour if she tells the pharmacy to "STAT it over (send immediately)."

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) Baclofen is used to treat muscle spasms. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682530.html

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(2) Erythromycin is used to treat infections. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=erythromycin&_ga=2.141112693.691240467.1528283828-139120270.1477942321

3. The facility staff failed to administer physician prescribed medications to Resident #56 on multiple dates beginning in February 2018 through May 2018.

Resident #56 was admitted to the facility on 6/5/15 and readmitted on 4/10/18. Resident #56's diagnoses included but were not limited to high cholesterol, diabetes and paralysis. Resident #56's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/1/18, coded the resident's cognition as moderately impaired.

Review of Resident #56's clinical record revealed the following physician's orders:
-12/28/17- Pred Forte (1) eye drops (no strength) - four drops in the left eye four times a day for infection.
-12/28/17 and 4/10/18- Systane (2) 0.4/0.3% eye drops- one drop in both eyes four times a day for dry eyes.
-12/28/17- Latanoprost (3) eye drops- one drop in both eyes at bedtime for glaucoma.
-12/28/17- Lidocaine (4) 2% gel- apply topically to knees two times a day for pain.
-12/28/17- Plavix (5) - 75 mg by mouth one time a day for stroke.
-1/5/18- Hydralazine (6) - 50 mg by mouth three times a day for high blood pressure.

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-4/10/18- Dorzolamide (7) 22.3/6.8 mg/ml (milliliters) eye drops- one drop in both eyes two times a day for glaucoma.

Review of Resident #56's February 2018 MAR (medication administration record) revealed the following:
-The code "9- Other/See Nurse Notes" was documented in regards to administration of Latanoprost, the 5:00 p.m. and 9:00 p.m. dose of Pred Forte, the 5:00 p.m. and 9:00 p.m. dose of Systane and the 5:00 p.m. dose of Lidocaine on 2/3/18.
-The code "9" was documented in regards to administration of Latanoprost, the 5:00 p.m. and 9:00 p.m. dose of Pred Forte, the 5:00 p.m. and 9:00 p.m. dose of Systane and the 5:00 p.m. dose of Lidocaine on 2/4/18.
- The code "9" was documented in regards to the administration of the 1:00 p.m. dose of Pred Forte and the 1:00 p.m. dose of Systane on 2/10/18.
-The code "9" was documented in regards to the administration of Plavix, the 9:00 a.m., 1:00 p.m. and 9:00 p.m. dose of Pred Forte, all four doses of Systane and both doses of Lidocaine on 2/11/18.
-The code "9" was documented in regards to the administration of Plavix and all four doses of Systane on 2/24/18.
-The code "9" was documented in regards to the administration of Plavix and all four doses of Systane on 2/25/18.

Further review of Resident #56's clinical record revealed the following nurses' notes:
-Nurses' notes dated 2/3/18 that documented Pred Forte, Latanoprost, Systane and Lidocaine was unavailable to administer.
-Nurses' notes dated 2/4/18 that documented

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Lidocaine, Systane, Latanoprost and Pred Forte was unavailable to administer.
-Nurses' notes dated 2/10/18 that documented Pred Forte and Systane was unavailable.
-Nurses' notes dated 2/11/18 that documented Systane, Lidocaine, Pred Forte, and Plavix were unavailable to administer.
- Nurses' notes dated 2/24/18 that documented Systane and Plavix were unavailable to administer.
-Nurses' notes dated 2/25/18 that documented Systane and Plavix were unavailable to administer.

Review of Resident #56's March 2018 MAR (medication administration record) revealed the following:
-The code "9- Other/See Nurse Notes" was documented in regards to administration of all four doses of Systane on 3/10/18 and 3/11/18.
-The code "9" was documented in regards to administration of the 5:00 p.m. and 9:00 p.m. doses of Systane on 3/24/18 and 3/25/18.

Further review of Resident #56's clinical record revealed nurses' notes dated 3/10/18, 3/11/18, 3/24/18 and 3/25/18 that documented Systane was unavailable to administer.

Review of Resident #56's April 2018 MAR revealed the following:
-The code "9-Other/See Nurse Notes" was documented in regards to administration of the 5:00 p.m. dose of Hydralazine and the 5:00 p.m. dose of Systane on 4/10/18. Nurses' notes dated 4/10/18 documented the Hydralazine and Systane was pending pharmacy delivery.

Review of Resident #56's May 2018 MAR

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revealed the following:
-The code "9-Other/See Nurse Notes" was documented in regards to the administration of the 9:00 a.m. dose of Dorzolamide on 5/19/18. A nurse's note dated 5/19/18 documented, "Medication not in building, on order."

Review of the facility STAT (immediate) box (a box that contains various medications that can be accessed if a medication is not available) list revealed Pred Forte, Systane, Latanoprost, Lidocaine, Plavix, Hydralazine and Dorzolamide were not available in the STAT box.

Resident #56's comprehensive care plan dated 6/5/15, 6/15/15 and 6/1/17 documented, "Cardiac disease related to Hypertension (high blood pressure), hyperlipidemia (high cholesterol). Administer medication per physician orders...eye prophalactic (sic). Administer medication per physician orders...ASA (Aspirin) and Plavix At risk for adverse effects. Administer per physician orders...potential for pain due to decreased mobility, dm (diabetes mellitus). Administer pain medication per physician orders...impaired vision as related to glaucoma. Eye meds as on mars..."

On 6/4/18 at 2:43 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked about the process to ensure medications are available for administration. LPN #3 stated medication refills are supposed to be ordered when there is a three-day supply of the medication left. LPN #3 was asked what should be done if a medication is not available for administration. LPN #3 stated she always documents that the medication is not available and she contacts the pharmacy. LPN #3 stated she calls the pharmacy and reads off a list of

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needed medications after she completes her medication pass. LPN #3 stated the pharmacy is located in town so medications can be delivered within an hour if she tells the pharmacy to "STAT it over (send immediately)."

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) Pred Forte is used to treat eye inflammation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682794.html

(2) Systane is used to treat dry eyes. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3130915/

(3) Latanoprost is used to treat glaucoma. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010869/?report=details

(4) Lidocaine gel is used to treat pain. This information was obtained from the website: https://medlineplus.gov/ency/article/003059.htm

(5) Plavix is used to prevent life-threatening problems with the heart and blood vessels in people who have had a heart attack or stroke. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601040.html

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(6) Hydralazine is used to treat high blood pressure. This information was obtained from the website:
https://medlineplus.gov/druginfo/meds/a682246.html

(7) Dorzolamide is used to treat glaucoma. This information was obtained from the website:
https://medlineplus.gov/druginfo/meds/a697049.html
4. The facility staff failed to ensure medications were available for administration per the physician orders for Resident #42.

Resident # 42 was admitted to the facility on 1/9/18 with a recent readmission on 3/12/18 with diagnoses that included but were not limited to: high blood pressure, heart disease, dementia, stroke, and atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output) (1).

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 4/18/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of his activities of daily living.

The nurse's note dated, 4/9/18 at 2:47 p.m. documented in part, "Lab (laboratory) result in and reading (+) (positive) for C-Diff (clostridium difficile)."

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Clostridium difficile is a gram-positive anaerobic bacterium most often associated with antibiotic-associated diarrhea. Symptoms may range from asymptomatic carrier states to severe pseudomembranous colitis and are caused by toxins produced by the organism. Although c-difficile infection can be caused by almost any antibiotic that disrupts the intestinal flora, it's classically associated with clindamycin use. Patients at high risk for this disorder include those that are taking many kinds of antibiotics immunosuppressed individuals, and those in nursing homes. C-difficile may be transmitted directly from patient to patient via contaminated hands of facility personnel (most common) or indirectly through contaminated equipment such as bedpans, urinals, call bells, ...and surfaces such as bedrails, floors, and toilet seats ...because spores of c-difficile are resistant to most commonly used facility disinfectants the patients room may be contaminated even after the patient has been discharged. (2)

The physician order dated, 4/8/18 documented, "Vancomycin solution (an antibiotic when taken orally is used to treat C-Diff) (3) 50MG/ML (milligrams per milliliter); Give 5 ML via PEG-tube (Percutaneous endoscopic gastrostomy [feeding tube] (7)) four times a day for C-Diff for 10 days."

The nurse's eMAR (electronic medication administration record) note dated, 4/12/18 at 6:41 p.m., documented in part, "Unavailable to administer." The nurse's eMAR note dated, 4/12/18 at 9:02 p.m. documented, "Unavailable to administer."

The physician order dated, 3/12/18, documented,

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"Floranex Tablet (is a probiotic used to treat various forms of diarrhea) (4) Give 1 tablet via PEG - Tube in the morning for diarrhea."

The nurse's eMAR note dated, 4/13/18 at 5:10 a.m. documented, "On order."
The nurse's eMAR note dated, 4/14/18 at 5:41 a.m. documented, "waiting for pharmacy delivery."

The physician order dated, 3/12/18 documented, "Atorvastatin Calcium Tablet 40 MG; give 40 mg via PEG-Tube at bedtime for hyperlipidemia (elevated lipids in the blood, such as cholesterol and triglycerides) (5).

The nurse's eMAR note dated, 4/28/18 at 8:08 p.m. documented, "Medication not present in facility. Medication reordered. Awaiting delivery."

The physician order dated, 5/23/18, documented, "Vasolex Ointment (VASOLEX (Trademark) OINTMENT is used to promote wound healing and the treatment of decubitus ulcers, varicose ulcers and dehiscent wounds) (6); apply to groin and scrotum topically every shift for itching."

The nurse's eMAR note dated, 5/24/18 at 5:52 a.m. documented, "Awaiting pharmacy delivery."
The nurse's eMAR note dated, 5/24/18 at 1:50 p.n. documented, "Awaiting delivery."

An interview was conducted with RN (registered nurse) #2 on 6/5/18 at 11:09 a.m. When asked about the process staff follows when medications are not available at the scheduled time of administration, RN #2 stated, "I double-check my cart. Then I call the pharmacy. Oh, I have to check the emergency box. Then I call the

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pharmacy and ask them to deliver them stat (Immediately)." When asked what steps take if the medication is not delivered and not available in the STAT box, RN #2 stated, "I let the resident know what is going on. I call the doctor that the medication is not available for this dose." When asked where is the notification is documented, RN #2 stated it would be documented in a nursing note or under the eMAR notes that you spoke with the doctor or nurse practitioner. I would have to call the resident representative also."

An interview was conducted with RN # 4, the unit manager, on 6/5/18 at 11:15 a.m. When asked about the process staff follow if a scheduled medication is not available on the medication cart, RN #4 stated, "I expect them to search their cart. Talk to the other nurses to make sure it didn't get on another cart by accident. Go to the med (medication) room and search there. Let the patient know you don't have the medication. Call the doctor and the pharmacy. Let the pharmacy know it's (medication) not here and get the ETA (estimated time of arrival) of when it will be here. I still call the doctor and inform them the medication is not available and await their instructions." When asked if the facility had an emergency drug box, RN #4 stated, "Yes, I would check that before calling the pharmacy." When asked where all this is documented, RN #4 stated it should be in a nurse's note or in the medication record notes.

The administrator, administrative staff member (ASM) #1, ASM #5, the quality assurance consultant and AM #7, the administrator from another corporate facility, were made aware of the above concern on 6/5/18 at 12:36 p.m.

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F 755	Continued From page 308 No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (2) Springhouse Handbook of Diseases- Causes, Signs and Symptoms, Patient Care- 2007 Springhouse Corporation pages 217-219. (3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012602/?report=details. (4) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2838518/ (5) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009143/?report=details. (6) This information was obtained from the following website: https://www.drugs.com/pro/vasolex-ointment.html . (7) This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761	**F-761** *It is the intended practice of this facility to store medication in a safe manner in accordance with 483.45(h)(1)(2).*	

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applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to ensure that one of 6 medication carts were secured, (Unit one medication cart) ; and that one of 6 medication carts and one of 2 medication rooms, (Unit One medication room and medication cart) were free of expired medications.

1. While obtaining Resident #36's blood glucose level, the facility staff left the Unit One medication cart unlocked in the hallway, out of line of sight.

2a. The facility staff failed to ensure expired medications and supplies were not available for use in the Unit One medication room and medication cart.

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Criteria 1
Upon notification from surveyor that medication cart was unlocked, it was locked immediately and when expired medications and supplies were found they were removed immediately. The identified nurse were educated related to locking medication carts and expired medications.

Criteria 2
Current residents' receiving medication has the potential to be affected.

Criteria 3
Facility staff re-educated on proper storage of drugs and biologicals and securing of medication and treatment carts.

Criteria 4
DON or designee will audit medication carts and medication storage rooms to ensure carts are locked and expired medications are not present x5 days, weekly x2 weeks and monthly x2 months to ensure compliance.

Criteria 5
The facility's alleged date of compliance is 7/10/2018.

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2b. The facility staff failed to ensure expired medications and supplies were not available for use in the Unit One medication cart.

The findings include:

1. While obtaining the blood glucose level of Resident #36, the facility staff left the Unit One medication cart unlocked in the hallway, out of line of sight.

Resident #36 was admitted to the facility on 12/22/17 with the diagnoses of but not limited to stroke, brain cancer, seizures, high blood pressure, diabetes, and encephalopathy. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 4/9/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions.

On 6/04/18 11:30 at a.m., LPN #3 was observed performing a blood glucose check on Resident #36. After obtaining the supplies from the Unit One medication cart, LPN #3 entered the resident's room. The resident was in her chair next to her bed, which was the window bed. The medication cart was outside the room to the side of the door and not in the doorway, and was out of LPN #3's line of sight. The front of the cart was facing into the hallway and not against the wall. LPN #3 exited the room at 11:34a.m. The medication cart had been unlocked the entire time LPN #3 was in the room. The lock was in the fully extended position, not partially pushed in, and LPN #3 made no attempt to obtain keys from her pocket to get into the cart. She opened the drawer to return the supplies to the drawer. The

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medication cart was left unlocked and unsupervised for approximately three minutes. During this time the narcotics contained in the cart were, not secured under a double lock system, and the non-narcotic medications, syringes and other supplies were not secured at all. During this observation, there were no staff or residents observed passing by the unsecured medication cart.

On 6/04/18 at 11:37 a.m., in an interview with LPN #3, when asked if the cart should have been locked, LPN #3 stated it should have been.

On 6/5/18 at approximately 12:30 p.m., the administrator and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. ASM #2 stated that she was aware of the unlocked cart, that LPN #3 had reported it after the surveyor observation. ASM #2 stated the company that manages the carts checked the cart and the lock was replaced, stating that it was bad. ASM #1 and ASM #2 were notified that the observations did not reveal LPN #3 making any effort to use a key to get into the cart, indicating she was aware it was unlocked. ASM #1 and ASM #2 were notified that the lock was observed in a fully extended position, indicating there was no effort to push the lock in to lock the cart; and that LPN #3 did not state that there was an issue with the lock when interviewed immediately after. ASM #2 stated that these details were not the version of the scenario she was provided and prior to this observation, there were no reports from nursing staff that there were issues with the lock on this cart. ASM #2 stated that the scenario and observations reported by the surveyor evidenced that LPN #3 failed to attempt to lock

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the cart before leaving it unsupervised.

A review of the facility policy, "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" documented, "3.3 The Community should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room, inaccessible by residents and visitors."

A review of the facility policy, "Medication And Treatment Administration Guidelines" documented, "Controlled substances are securely stored using a double-lock system...a separately keys controlled substance drawer in medication cart..."

No further information was provided by the end of the survey.

2a. The facility staff failed to ensure expired medications and supplies were not available for use in the Unit One medication room and medication cart.

On 05/31/18 at 9:55 a.m., the facility's medication room on Unit 1 (one) was observed with LPN (licensed practical nurse) # 4. The following medications and supplies were found to be expired and available for use:
One open multi dose vial of Tuberculin (1) vaccine found in the refrigerator with approximately one-third remaining and no date of when it was opened.
Six full bottles of Zinc Sulfate (2) 100 tablets, 220 mg (milligrams) each tablet found in the cabinet with an expiration date of 02/2018.
Three full 16-ounce bottles of "Liquid Pain Relief

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F 761	Continued From page 313 Acetaminophen" (3) found in the cabinet with an expiration date of 01/18. One 100 ml (milliliter) multi dose vial of Novolin (4) insulin found in a zip lock bag, inside a grocery bag, which was lying in a basket on a shelving unit. The vial was opened, with approximately two-thirds remaining with no open dated. Further observation of the zip lock bag revealed an unpackaged syringe. Further observation of the syringe revealed 12 units of an unknown substance inside the syringe. LPN # 4 was asked to examine the syringe and verbally agreed there was 12 units of an unknown substance inside the syringe. One 100 ml (milliliter) multi dose vial of Novolin insulin found in a zip lock bag, inside a grocery bag, which was lying in a basket on a shelving unit. The vial was opened, with approximately one-third remaining with no open dated. Further observation of the zip lock bag revealed two unpackaged syringes. Further observation of the syringes revealed 10 units of an unknown substance inside the syringe. LPN # 4 was asked to examine the syringes and verbally agreed there was 10 units of an unknown substance inside the syringe. Observation of another shelving unit inside the medication room on unit 1 revealed a metal box lying on the top shelf. Observation of the box revealed a key positioned in the lock on the top of the box. Further observation of the lock revealed it to be in the unlocked position. Observation of the top of the box revealed a note that documented, "This box belongs to Dr. (doctor) Q. Do not touch or remove." When asked who Dr Q was, LPN # 4 stated, "I never heard of him." Observation of the inside of the box revealed the	F 761		

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following contents:
Two unopened multi dose, 20ml (milliliter) vials of Lidocaine (5) with an expiration date of "Nov (November)2017" and "4/1/18" with a pharmacy label that documented, "House Stock."
One opened multi dose, 20ml (milliliter) vials of Lidocaine with an expiration date of "Nov 2017" and no open date with a pharmacy label that documented, "House Stock."
One 5ml multi dose vial of Kenalog (6), opened with no open date and an expiration date of "Jan (January) 2018."
One 5ml multi dose vial of Kenalog, opened, dated 10/26/16 and an expiration date of "Jan 2018."
Two 5ml multi dose vials of Kenalog, unopened and an expiration date of "June 2017."
Three 5ml multi dose vials of Kenalog, unopened and an expiration date of "Jan 2018."
Two 3.5 fluid ounce bottles of "Topical Anesthetic Skin Refrigerant" (7) with approximately half remaining in each bottle with no open date."

On 05/31/18 at approximately 11:15 a.m., an interview was conducted with LPN # 4 regarding the above observations. When asked about the missing open dates, LPN # 4 stated, "If it is opened it should have an open date." LPN # 4 verified the Tuberculin, Novolin, Lidocaine, Topical Anesthetic Skin Refrigerant and the Kenalog did not contain open dates and that the "zinc sulfate," "Liquid Pain Relief Acetaminophen," "Lidocaine," and "Kenalog" were expired. When asked about the procedure for expired medications and supplies, LPN # 4 stated, "They should have been discarded."

On 05/31/18 at approximately 11:25 a.m., an interview was conducted with ASM (administrative

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staff member) # 2, director of nursing. When asked to describe the procedure when a medication is opened, ASM # 2 stated, "Anything that is opened should have an open date on it." When asked to describe the procedure to ensure expired medications are not available for use, ASM # 2 stated, "Everything is dated when it is opened and is discarded when it is expired. I don't know how often it is checked; I just started about five weeks ago. I don't know what the process has been." When asked about the Novolin and syringes found in the zip lock bags on the shelf in the medication room on Unit 1, ASM # 2 stated, "The meds (medication) should have gone home with the family when the resident was admitted or if he didn't have any family it should have been discarded. I would have discarded everything so that we could start fresh and we would know when the insulin was opened." When asked when the resident was admitted, ASM # 2 stated, "The resident was admitted on 05/12/18." When asked about who Dr. Q was ASM # 2 stated, "He was a physiatrist. He hasn't been here in about two years."

On 05/31/18 at approximately 12:00 p.m., ASM # 2 provided a copy of notes faxed from ASM # 3, physiatrist to the facility on 05/31/18. The note documented, "I, (ASM # 3), MD (medical doctor) last seen patient at (Name of Nursing Home) couple of years ago."

The facility's policy "2.2 Delivery and Storage of Medications and Supplies" documented, "7. Expiration dates will be checked and the oldest unexpired solutions/medications will be used first."

On 06/01/18 at approximately 1:55 p.m., ASM

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(administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) The tuberculin skin test is performed to evaluate whether a person has been exposed to tuberculosis. If there has been a prior exposure, antibodies are formed and remain in the body. During the skin test, the tuberculosis antigen is injected under the skin and if antibodies are present, the body will have an immune response. There will be an area of inflammation at the site of the injection. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/9991.htm.

(2) A mineral. It is called an "essential trace element" because very small amounts of zinc are necessary for human health. Since the human body does not store excess zinc, it must be consumed regularly as part of the diet. Common dietary sources of zinc include red meat, poultry, and fish. Zinc deficiency can cause short stature, reduced ability to taste food, and the inability of testes and ovaries to function properly. Zinc is taken by mouth for the treatment and prevention of zinc deficiency and its consequences, including stunted growth and acute diarrhea in children, slow wound healing, and Wilson's disease. This information was obtained from the website: https://medlineplus.gov/druginfo/natural/982.html.

(3) Pain relievers are medicines that reduce or relieve headaches, sore muscles, arthritis, or

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other aches and pains. There are many different pain medicines, and each one has advantages and risks. Some types of pain respond better to certain medicines than others. Each person may also have a slightly different response to a pain reliever. Over-the-counter (OTC) medicines are good for many types of pain. There are two main types of OTC pain medicines: acetaminophen (Tylenol) and nonsteroidal anti-inflammatory drugs (NSAIDs). Aspirin, naproxen (Aleve), and ibuprofen (Advil, Motrin) are examples of OTC NSAIDs. This information was obtained from the website:
https://medlineplus.gov/painrelievers.html.

(4) Insulin aspart is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. In patients with type 1 diabetes, insulin aspart is usually used with another type of insulin, unless it is used in an external insulin pump. In patients with type 2 diabetes, insulin aspart also may be used with another type of insulin or with oral medication(s) for diabetes. Insulin aspart is a short-acting, manmade version of human insulin. Insulin aspart works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. This information was obtained from the website:
https://medlineplus.gov/druginfo/meds/a605013.html.

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(5) Lidocaine Hydrochloride Injection, USP is a sterile, nonpyrogenic solution of lidocaine hydrochloride in water for injection for parenteral administration in various concentrations. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=C7A7D3D2-7638-4570-9EB8-A5E2BEC82B5D.

(6) Kenalog®-40 Injection (triamcinolone acetonide injectable suspension, USP) is a synthetic glucocorticoid corticosteroid with anti-inflammatory action. THIS FORMULATION IS SUITABLE FOR INTRAMUSCULAR AND INTRA-ARTICULAR USE ONLY. THIS FORMULATION IS NOT FOR INTRADERMAL INJECTION. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=CF970688-CD77-B95C-4BD9-C541590E9722.

(7) Topical anesthetic skin refrigerant is intended to control the pain associated with injections, starting IV's and venipuncture, minor surgical procedures, and the temporary relief of minor sports injuries. Gebauer's Ethyl Chloride is available in several spray patterns to allow for slight differences in indications and to provide medical professionals with a choice based on their preferred mode of delivery. This information was obtained from the website: https://www.medline.com/product/Gebauers-Ethyl-Chloride-by-Gebauer-Company/Anesthetics/Z05-PF53104.

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2b. The facility staff failed to ensure expired medications and supplies were not available for use in the Unit One medication cart.

On 05/31/18 at 11:25 a.m., the facility's medication cart on Unit 1 (one) was observed with LPN (licensed practical nurse) # 3. The following medications and supplies were expired and available for use:
- One 16 ounce bottle of "Liquid Pain Relief Acetaminophen" (1) approximately two-thirds full found in the medication cart drawer with an expiration date of 01/18.

On 05/31/18 at approximately 11:25 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the procedure to ensure expired medications are not available for use, ASM # 2 stated, "Everything is dated when it is opened and is discarded when it is expired. I don't know how often it is checked; I just started about five weeks ago. I don't know what the process has been."

On 05/31/18 at approximately 11:35 a.m., an interview was conducted with LPN # 3. When asked about the expired "Liquid Pain Relief Acetaminophen" in the medication cart LPN # 3 stated, "It should have been removed."

On 06/01/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 320 1) Pain relievers are medicines that reduce or relieve headaches, sore muscles, arthritis, or other aches and pains. There are many different pain medicines, and each one has advantages and risks. Some types of pain respond better to certain medicines than others. Each person may also have a slightly different response to a pain reliever. Over-the-counter (OTC) medicines are good for many types of pain. There are two main types of OTC pain medicines: acetaminophen (Tylenol) and nonsteroidal anti-inflammatory drugs (NSAIDs). Aspirin, naproxen (Aleve), and ibuprofen (Advil, Motrin) are examples of OTC NSAIDs. This information was obtained from the website: https://medlineplus.gov/painrelievers.html.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812	**F-812** *It is the intended practice of this facility to serve food in a sanitary manner* Criteria 1 Resident #'s 14 and 46 suffered no adverse outcomes related to staff serving food in an unsanitary manner. Staff trained on serving food in a sanitary manner. Criteria 2 Current Residents who require set up assistance for meals are at risk.	

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F 812	Continued From page 321 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to serve food in a sanitary manner for two of 50 residents in the survey sample, Residents #14 and #46. 1. The facility staff failed to serve food to Resident #14 in a sanitary manner. CNA (certified nursing assistant) #2 touched the food cart with a bare hand then touched a hamburger bun with the same bare hand and served the hamburger to Resident #14. 2. The facility staff failed to serve food to Resident #46 in a sanitary manner. CNA (certified nursing assistant) #3 touched the food cart with a bare hand then touched a hamburger bun with the same bare hand and served the hamburger to Resident #46. The findings include: 1. The facility staff failed to serve food to Resident #14 in a sanitary manner. CNA (certified nursing assistant) #2 touched the food cart with a bare hand then touched a hamburger bun with the same bare hand and served the hamburger to Resident #14. Resident #14 was admitted to the facility on 7/31/14. Resident #14's diagnoses included but were not limited to high blood pressure, difficulty sleeping and difficulty swallowing. Resident #14's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/15/18, coded the resident's cognition as severely impaired.	F 812	Criteria 3 Facility staff were re-educated on handling food in a sanitary manner. Criteria 4 DON or designee will audit dinning services to ensure that food is served in a sanitary manner. Daily x5 days, weekly x2 weeks and monthly x2 months to ensure compliance. Criteria 5 The facility's alleged date of compliance is 7/10/2018.	

F 812 Continued From page 322 F 812

On 5/30/18 at 12:27 p.m., CNA #2 was observed serving meal trays. CNA #2 applied hand sanitizer, opened the food cart with her bare hand and removed a tray from the meal cart. CNA #2 placed the meal tray on the table in front of Resident #14. CNA #2 touched the hamburger bun on the meal tray with the same bare hand used to open the food cart, while placing condiments on the hamburger then served the hamburger to Resident #14.

On 6/1/18 at 12:56 p.m., an interview was conducted with CNA #2. CNA #2 was asked the process for ensuring sanitary handling of food. CNA #2 stated, "We have hand sanitizer that we use before passing trays out and then after each tray. Most of the time we have to cut up their food so it's best to use hand sanitizer before we move on to the next tray." When asked if she ever touches residents' food with her bare hands, CNA #2 stated, "Try not to. Most of the time we use gloves." When asked if it is sanitary to touch the food cart with a bare hand then touch food with the same bare hand, CNA #2 stated, "I use the utensils." When again asked if it is sanitary to touch the food cart with a bare hand then touch food with the same bare hand, CNA #2 stated, "No. You have re-contaminated your hands."

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "MEAL SERVICE: IN PATIENT ROOM" documented to perform hand hygiene and failed to document specific information regarding the above concern.

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F 812 Continued From page 323 F 812

No further information was presented prior to exit.

2. The facility staff failed to serve food to Resident #46 in a sanitary manner. CNA (certified nursing assistant) #3 touched the food cart with a bare hand then touched a hamburger bun with the same bare hand and served the hamburger to Resident #46.

Resident #46 was admitted to the facility on 4/14/17. Resident #46's diagnoses included but were not limited to high cholesterol, epilepsy (1) and paranoid schizophrenia (2). Resident #46's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 4/20/18, coded the resident's cognition as severely impaired.

On 5/30/18 at 12:31 p.m., CNA #3 was observed serving meal trays. CNA #3 applied hand sanitizer, opened the food cart with her bare hand and removed a tray from the meal cart. CNA #3 placed the meal tray on the table in front of Resident #46. CNA #3 touched the hamburger bun on the meal tray with the same bare hand used to open the food cart, while placing condiments on the hamburger then served the hamburger to Resident #46.

On 6/4/18 at 10:04 a.m., an interview was conducted with CNA #3. CNA #3 was asked the process for ensuring sanitary handling of food. CNA #3 stated she washes her hands before she goes into the dining room and there is hand sanitizer and wipes in the dining room. When asked if it is sanitary to touch the food cart with a bare hand then touch food with the same bare hand, CNA #3 stated, "That's not sanitary."

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F 812

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On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

No further information was provided prior to exit.

(1) "Epilepsy is a brain disorder that causes people to have recurring seizures." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=epilepsy&_ga=2.135831030.691240467.1528283828-139120270.1477942321

(2) "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=schizophrenia

F 842 SS=D

Resident Records - Identifiable Information
CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted

F 842

F-842

It is the intended practice of this facility for resident records to be complete, accurately documented, readily accessible and systematically organized.

Criteria 1

Resident # 30 had no adverse outcomes related to the oxygen administration. Resident #356 suffered no adverse outcomes

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F 842	Continued From page 325 to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential 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	F 842	related to not documenting non-pharmacological interventions. Current licensed nurses trained on following physicians ordered oxygen rate and documenting non-pharmacological interventions. Criteria 2 Current residents who use oxygen and those residents who have pain medication prescribed have the potential to be affected. Criteria 3 Facility licensed staff re-educated on following physician's orders related to oxygen and using non-pharmacological approaches before administering pain medication. Criteria 4 DON or Designee will audit MAR's x5 days, weekly x2 weeks and monthly x2 months. Criteria 5 The facility's alleged date of compliance is 7/10/2018.	

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(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate clinical record for two of 50 residents in the survey sample; Residents #30 and #356.

1. For Resident #30 the facility staff documented the oxygen as being administered at the physician ordered rate when in fact it was not.

2. The facility staff failed to document non-pharmacological interventions provided for Resident #356 during May 2018.

The findings include:

1. For Resident #30 the facility staff documented the oxygen as being administered at the

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physician ordered rate when in fact it was not.

Resident #30 was admitted to the facility on 9/27/17 with the diagnoses of but not limited to stroke, high cholesterol, atrial fibrillation, chronic obstructive pulmonary disease, dementia, gastrostomy feeding tube, neurogenic bladder, depression, high blood pressure, cataracts, and benign prostatic hyperplasia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 4/5/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed an order dated 1/16/18 for "O2 (oxygen) on @ (at) 2 lit (liters) via nasal cannula every shift for COPD (Chronic Obstructive Pulmonary Disease)."

Observations made of Resident #30 on 5/30/18 at 1:47 p.m., 5/30/18 at 3:48 p.m., 5/31/18 at 9:37 a.m., 5/31/18 at 11:02 a.m., and 5/31/18 at 11:50 p.m., revealed the resident in bed with the nasal cannula in place and the oxygen concentrator set at 3.5 liters per minute. Another surveyor verified this observation.

A review of the May 2018 MAR (Medication Administration Record) revealed a line item for "O2 on @ 2 lit via nasal canula every shift for COPD." Under the column for 3/30/18 and 3/31/18, staff had signed off that the oxygen was at the correct rate on each row assigned to a shift (day shift documented as 7:15A), evening shift (documented as 3:15P) and night shift (documented as 11:15 P), when in fact it was observed at 3.5 liters for 2 days.

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On 6/5/18 at approximately 10:50 a.m., in an interview with LPN #6 (Licensed Practical Nurse), she stated that nurses should be checking the oxygen rates before signing off that it is at the correct rate.

On 6/5/18 at 10:56 a.m., in an interview with RN #1 (Registered Nurse) she stated that the nurses should be checking the oxygen before signing off that it is at the correct rate.

A review of the care plan revealed one dated 4/11/18 for "Cardiac disease related to hyperlipidemia, Hypertension, A FIB (atrial fibrillation)." The interventions included one dated 4/11/18 for "Administer oxygen as ordered." In addition, the care plan included one dated 4/11/18 for "At risk for respiratory impairment related to COPD." This care plan included an intervention dated 4/11/18 for "Administer oxygen as per physician order."

A review of the facility policy, "Oxygen Administration" documented, "Procedure: 1. Verify Physician's order."

A review of the facility policy, "Documentation" documented, "General Guidelines: Clinical records are maintained on each patient that are complete, readily accessible and systematically organized....Documentation in the clinical record is expected to be timely and to accurately reflect each patient's condition...."

On 6/5/18 at approximately 12:30 p.m., the administrator and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the

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F 842	Continued From page 329 survey. 2. The facility staff failed to document non-pharmacological interventions provided for Resident #356 during May 2018. Resident #356 was admitted to the facility on 5/23/18. Resident #356's diagnoses included but were not limited to muscle weakness, diabetes and abdominal aortic aneurysm (1). Resident #356's admission MDS (minimum data set) assessment was not complete. An admission screen dated 5/23/18 documented Resident #356 was able to communicate needs. Review of Resident #356's clinical record revealed a physician's order dated 5/23/18 for acetaminophen/codeine (2)300/30 mg (milligrams)- one tablet every six hours as needed for osteoarthritis of both knees. Review of Resident #356's May 2018 MAR (medication administration record) revealed acetaminophen/codeine was administered to Resident #356 from 5/27/18 through 5/31/18. Further review of Resident #356's clinical record (including nurses' notes from 5/27/18 through 5/31/18) failed to reveal non-pharmacological interventions were offered to Resident #356 each time as needed acetaminophen/codeine was administered (except for a nurse's note dated 5/31/18 that documented, "Pt (Patient) alert to self, c/o [complains of] pain in her back that is relieved with prn [as needed] medication, and repositioning...") Resident #356's care plan dated 5/23/18 documented, "Pain generalized, as evidenced by verbalization or symptomatic...Administer pain medication per physician orders..."	F 842		

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On 6/4/18 at 2:58 p.m., an interview was conducted with RN (registered nurse) #2 (a nurse who administered acetaminophen/codeine to Resident #356). RN #2 was asked what she does prior to/in addition to administering as needed pain medication. RN #2 stated she repositions the resident, offers the resident a sip of water, and tries to distract the resident a little bit. When asked where attempted non-pharmacological interventions should be documented, RN #2 stated, "In a progress note." When asked if she provides non-pharmacological interventions to Resident #356, RN #2 stated she does but does not always document.

On 6/4/18 at 3:33 p.m., an interview was conducted with LPN (licensed practical nurse) #2 (another nurse who administered acetaminophen/codeine to Resident #356). LPN #2 stated she repositions Resident #356 prior to administering acetaminophen/codeine. When asked if she documents this, LPN #2 stated, "Sometimes at least, not always."

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "MEDICATION AND TREATMENT ADMINISTRATION GUIDELINES" documented, "DOCUMENTATION: Administration of PRN medications include the specific reason for the medication, any non-pharmacological interventions utilized, and the medication effectiveness..."

No further information was presented prior to exit.

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F 842	Continued From page 331 (1) "Abdominal aortic aneurysm (AAA) occurs when atherosclerosis or plaque buildup causes the walls of the abdominal aorta to become weak and bulge outward like a balloon. An AAA develops slowly over time and has few noticeable symptoms. The larger an aneurysm grows, the more likely it will burst or rupture, causing intense abdominal or back pain, dizziness, nausea or shortness of breath." This information was obtained from the website: https://www.radiologyinfo.org/en/info.cfm?pg=abdoaneurysm (2) Acetaminophen/codeine is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601005.html	F 842		
F 880 SS=F	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 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	F 880	**F-880** *It is the intended practice of this facility to maintain infection control practices in accordance with 483.80(a)(1)(2)(4)€(f).* Criteria 1 Upon notification from surveyor regarding Legionella protocol, a test kit was immediately ordered. Resident # 47's and Resident # 85's oxygen tubing was changed and stored appropriately. The ice machine (Unit II) was fixed immediately by the maintenance director. Criteria 2 Current residents have the potential to be affected.	

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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.

§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.

F 880

Criteria 3

Nursing staff were re-educated on storage of oxygen in a sanitary manner. The maintenance director was in-serviced on the auditing of the ice machines and having a legionella test kit by the administrator/designee.

Criteria 4

DON or designee will audit oxygen storage x5 days, weekly x2 weeks and monthly x2 months. Administrator/designee will Audit ice machine drain is maintained in a sanitary manner. The administrator/designee will validate the legionella test kit is present and that the ice machines hose is not touching the drains x5 days, weekly x2 weeks and monthly x2 months.

Criteria 5

The facility's alleged date of compliance is 7/10/2018.

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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, clinical record review, it was determined that the facility staff failed to ensure a complete infection control program and follow infection control practices for two residents, (Resident #'s 47 and 85); and for one of two ice machines, (the Unit 2 ice machine) .

1. The facility staff failed to develop a Legionella protocol.

2. The facility staff failed to follow infection control practices in the administration of oxygen for Resident #47.

3. The facility staff failed to store Resident #85's oxygen tubing in a sanitary manner.

4. The facility staff failed to maintain an ice machine drainage system in a sanitary manner for one of two ice machines, the Unit 2 ice machine.

The findings include:

1. The facility staff failed to develop a Legionella protocol.

On 05/31/18 at approximately 4:00 p.m., an interview was conducted with OSM (other staff

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member) # 4, director of maintenance regarding the facility's water management program and legionella protocol. When asked for the facility's water management program, OMS # 4 provided this surveyor with a document entitled "Water Management Program Plan TEMPLATE." Further review of the "Water Management Program Plan TEMPLATE" revealed it was an outline for the development of a water management program and failed to evidence documentation of the facility's legionella protocol.

On 05/31/18 at 4:20 p.m., an interview was conducted with OSM # 4. When asked if the facility had developed a water management program and a legionella protocol, OSM # 4 stated, "No. We are in the process of developing it and we are using the template to develop them."

On 06/04/18 at approximately 5:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.
2. The facility staff failed to follow infection control practices in the administration of oxygen for Resident #47.

Resident #47 was admitted to the facility on 8/24/01, with diagnoses that included but were not limited to: multiple sclerosis (a disease that affects the brain and spinal cord by blocking messages from the brain to the body due to damages to the material that surrounds and protects the nerve cells) (1), dementia, muscle spasms, chronic obstructive pulmonary disease (lung disease that makes it difficult to breathe)

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F 880	Continued From page 335 (2), and difficulty swallowing. The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 4/21/18, coded the resident as scoring a 9 on the BIMS (brief interview for mental status) score, indicating that she had moderate cognitive impairment. She was coded as usually understanding others and always making herself understood. Resident #47 was coded as totally dependent on staff, requiring one or more person physical assistance for bed mobility, transfers, toileting, personal hygiene, bathing and dressing. In Section O - Special Treatments, the resident was coded as using oxygen during the look back period. On 5/31/18 at 12:45 p.m., Resident #47 was observed sitting up in bed eating lunch. It was noted that Resident #47's nasal cannula was not on her. When asked where the nasal cannula was, Resident #47 stated, I do not know". At that, time the oxygen tubing was observed hanging over the oxygen concentrator, unbagged with nasal cannula directly on floor. On 5/31/18 at 02:20 p.m., Resident #47 was observed sitting up in bed. The oxygen tubing was still draped over concentrator. The nasal cannula was unbagged and still on floor. On 5/31/18 at 02:25 p.m., another surveyor made an observation that the oxygen tubing remained draped over concentrator with the nasal cannula on the floor. On 5/31/18 04:04 p.m., another surveyor observed that Resident #47's oxygen via nasal cannula was now on Resident # 47's face.	F 880		

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On 6/4/18 at 9:30 a.m., Resident #47 was observed sitting up in bed receiving oxygen via nasal cannula. LPN, (licensed practical nurse) #3, was in the resident's room. LPN #3 was asked about the process followed when a resident oxygen tubing and nasal cannula was not being used. LPN #3 stated the tubing and the cannula should be wrapped up and placed in a bag to keep it clean. LPN #3 was asked if it was okay to have the nasal cannula lying on the floor. LPN #3 stated, "No that should be thrown away as it is now dirty".

The facility policy, "Oxygen Administration" documented in part, "2. When oxygen not in use, store oxygen tubing and nasal cannula or mask in separate, labeled plastic bag".

Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc.; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment.

ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, ASM #4, assistant director of nursing, and ASM #5, the quality assurance consultant, were made aware of the above concerns on 6/4/18 at 5:30 p.m.

No further information was provided prior to exit.

1) This information was obtained from the following website: https://medlineplus.gov/multiplesclerosis.html

2) This information was obtained from the

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F 880	Continued From page 337 following website: https://medlineplus.gov/ency/article/000091.htm 3. The facility staff failed to store Resident #85's oxygen tubing in a sanitary manner. Resident #85 was admitted to the facility on 4/18/18. Resident #85's diagnoses included but were not limited to heart failure, anemia and major depressive disorder. Resident #85's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 5/16/18, coded the resident as cognitively intact. Section G documented Resident #85 as requiring extensive assistance of two or more staff with bed mobility/transfers and as requiring extensive assistance of one staff with locomotion/dressing. Review of Resident #85's clinical record revealed a physician's order dated 4/26/18 for oxygen at two liters per minute every shift for low oxygen "stats." Resident #85's care plan dated 4/18/18 documented, "The resident has altered cardiovascular status r/t (related to) heart failure...Give oxygen as ordered by the physician..." On 5/30/18 at approximately 11:00 a.m. and 5/31/18 at 3:55 p.m., observation of Resident #85 was conducted. The resident was not using oxygen. The oxygen tubing was exposed to air and hanging on a bottle of humidified water attached to the oxygen concentrator. On 6/4/18 at 10:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the process for storage of oxygen tubing. LPN #1 stated, "If it's not in use,	F 880		

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it's dated and stored in a plastic bag with the date on it and the resident's room number." When asked why, LPN #1 stated, "Because it could fall on the floor. It protects it from being contaminated." When asked if oxygen tubing should be hanging off a bottle of humidified water attached to an oxygen concentrator, LPN #1 stated, "No."

On 6/4/18 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "OXYGEN ADMINISTRATION" documented, "2. When not in use, store oxygen tubing and nasal cannula or mask in separate, labeled plastic bag..."

No further information was presented prior to exit.
4. The facility staff failed to maintain an ice machine drainage system in a sanitary manner for one of two ice machines, the Unit 2 ice machine.

Observation was made of the ice machine on Unit 2 on 5/31/18 at 8:12 a.m. with other staff member (OSM) #4, the director of plant operations. The drainpipe was not visible with an opening of two inches above the surface of the drain. A black rubber flange had been attached to the drain. OSM #4 stated the facility was having trouble with splashing from the drainpipe causing water on the floor, thus having a hazard. The end of the drainpipe was not visible, thus the drainage pipe from the ice machine was not above the surface of the drain and could have backflow of water into the drainage pipe. OSM #4 stated he had cut the rubber flange on the one on the other

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F 880	Continued From page 339 unit but failed to cut the flange on this unit. He cut a piece out of the rubber flange to the floor drain so that if the drain were to overflow it would not be in contact with the ice machine drainpipe. When asked how long ago he had placed the rubber flange to the drains, OSM #4 stated he had don't that about a month ago. On 5/31/18 at 8:20 a.m., the administrator was made aware of the above finding. A request was made for the policy on the ice machine drain. On 6/1/18 at 8:56 a.m. ASM (administrative staff member) # 7, the administrator from another corporate building informed this writer that the facility did not have a policy on the ice machine drain. No further information was obtained prior to exit.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883	**F-883** *It is the intended practice of this facility to maintain and implement an influenza program, including but not limited to, obtaining consent for administered influenza vaccinations.* Criteria 1 Resident number #47 suffered no adverse outcomes related to not receiving the influenza vaccine. Medical director contacted regarding resident #47 not being offered flu vaccine and he stated that it is no longer necessary to offer flu vaccines because we are no longer at risk for the flu.	

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documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record

F 883

Criteria 2
Current residents who did not receive the influenza vaccine have the potential to be affected. Residents here during the upcoming flu season will be offered the influenza vaccine.

Criteria 3
Current facility licensed nursing staff re-educated on obtaining consent for influenza vaccination and documentation related to resident education on influenza vaccination record.

Criteria 4
DON or designee will audit documentation of consent and education for resident's receiving influenza vaccination x5 days, weekly x2 weeks and monthly x2 months to ensure compliance.

Criteria 5
The facility's alleged date of compliance is 7/10/2018.

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review, it was determined that the facility staff failed to offer the influenza vaccine for one of five residents in the survey sample, Resident # 47.

The facility staff failed to offer the influenza vaccine to Resident # 47 during the 2017 influenza season.

The findings include:

Resident # 47 was admitted to the facility on 08/11/15 with a readmission of 08/24/01 with diagnoses that included but were not limited to multiple sclerosis (1), gastroesophageal reflux disease (2), hypertension (3), dementia (4) and anemia (5).

Resident # 47's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 04/21/18, coded Resident # 47 as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 (nine) - being moderately impaired of cognition for making daily decisions. Resident # 47 was coded as being totally dependent of one staff member for activities of daily living.

A review of the Resident # 47's clinical record revealed the facility's "Patient Immunization Record" for Resident # 47. The "Patient Immunization Record" for Resident # 47 documented, "Influenza Vaccine. Date Administered Outside 10/8/12." Further review of the clinical record for Resident # 47 failed to evidence Resident # 47 was offered the influenza vaccine during the 2017 influenza season.

On 06/01/18 at 11:00 a.m., a review of the Resident # 47's clinical record was conducted

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with ASM (administrative staff member) # 4, assistant director of nursing. The review failed to evidence documentation of the influenza vaccine being offered during the 2017 influenza season. ASM # 4 stated she would look further for documentation regarding Resident # 47's influenza vaccine.

On 06/04/18 at 10:15 a.m., an interview was conducted with ASM # 4, ASM #4 stated, "I cannot find any documentation of Resident # 47 being offered or receiving the flu vaccine this past season." After reviewing the facility's "Patient Immunization Record" for Resident # 47 with ASM # 4 she agreed that the last time Resident # 47 was offered and received the influenza vaccine was on 10/8/12 outside the facility.

The facility's policy "Chapter 9: Screening and Immunization" documented in part, "Annual immunization against influenza is recommended for all adults."

On 06/01/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, trouble with coordination and balance, sensations

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such as numbness, prickling, or "pins and needles" and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html.

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

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

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

(5) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html