STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495045	A. BUILDING _____ B. WING _____	C 02/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-RICHMOND	2125 HILLIARD ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/14/17 through 2/15/17. Complaints were investigated during this survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 194 certified bed facility was 161 at the time of the survey. The survey sample consisted of 26 current residents reviews (Residents #1 through #22, and #26 through #29), and 3 closed record reviews (Residents #23 through #25).	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	3/31/17
F 156 SS=E	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -	F 156	F-156 *It is the intent of this facility to inform the resident both orally and in writing in a language that the resident understands of his/her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.*	3/31/17

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3/8/2017

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

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F 156	Continued From page 1 (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older	F 156	*Also, it is the intent of this facility to provide each resident with the notice of the State developed under1919(e)(6) of the act. It is the intent of this facility that such notification be made prior to or upon admission and during the resident's stay. Receipt of such information, and an amendments to it, must be acknowledged in writing.* Criteria 1 Upon notification from surveyor resident #18 was signed but late. Resident #1 was signed but late. Resident #3 was signed but late. Resident #21 was signed but late. Resident #23 was signed but late. Criteria 2 Any and all residents have the potential to be affected. Criteria 3 The admission team will be re-educated on need to inform all residents and their responsible parties of their rights, rules and regulations governing their conduct and responsibilities during their stay in the facility within two business days of admission.	3/31/17

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Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to

Criteria 4
Administrator or designee will audit admission contracts daily x5days, three days weekly x3 weeks, and monthly x2 months.

Criteria 5
The facility's alleged date of compliance is 3/31/2017.

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residents, resident representatives:

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident

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understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(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 paragraphs (g)(17)(i)(A) and (B) of this section.

(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

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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 representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.

v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to inform five of 29 sampled

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residents, (Resident #23, Resident #18, Resident #1, Resident #3 and Resident #21), at the time of admission of their rights, and the rules and their responsibilities during their stay at the facility.

1. Resident #23 was admitted to the facility on 8/3/16 and was not presented with, and did not sign an admission contract, which explained care to be provided and the expenses for such care, until 10/26/16.

2. For Resident #18, facility staff failed to inform the resident and RP (responsible party) of her rights, rules, and responsibilities of her stay at the facility at the time she was admitted on 7/20/16.

3. Resident #1 was admitted to the facility on 10/21/16. The resident's admission agreement containing consent for treatment, facility responsibilities, resident responsibilities and responsible party responsibilities was not signed by the resident's responsible party until 11/18/16.

4. For Resident #3 the resident's admission agreement containing consent for treatment, facility responsibilities, resident responsibilities and responsible party responsibilities was not signed until six days after admission.

5. For Resident #21, facility staff failed to inform the resident and RP (responsible party) of her rights, rules, and responsibilities of her stay at the facility at the time she was admitted on 1/24/17.

The findings include:

1. Resident #23 was admitted to the facility on 8/3/16 and was not presented with, and did not

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sign an admission contract, which explained care to be provided and the expenses for such care, until 10/26/16.

Resident #23 was admitted to the facility on 8/3/16 with diagnoses that included, but were not limited to; a heart attack, back pain, peripheral vascular disease, diabetes and difficulty walking.

Resident #23's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/9/16. Resident #23 was coded on the MDS as having a BIMS (brief interview for mental status) score of 13 out of 15. The RAI (resident assessment instrument) manual documents that a score of 13 indicates that the resident's cognition is intact.

A review of Resident #23's clinical record revealed, in part, that Resident #23 was not provided with an admission agreement at the time of admission from the hospital into the facility. The admission agreement signed by Resident #23 and facility staff member OSM (other staff member) #12, the business development specialist, was signed on 10/26/16 and included the following documentation;

Resident #23's "Admission Agreement between Patient and Center" documented,
"Your Signature is Required
Name ('Patient' or 'Resident'): (Resident #23's name)
Responsible Party Name (if applicable): (Name of Resident #23 entered)
Your Admission Agreement is with ('center') (name of facility) doing business as (name of facility)
Signature of Patient or Responsible Party:

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(signature of Resident #23). Date: 10/26/16.
We have summarized the key provisions of the Admission Agreement ('Agreement') on this first page. For complete information, please read the entire Agreement. This Agreement includes this document and the center Supplement and Patient Information Handbook. By signing above, you agree to the terms of the Agreement and you acknowledge that you have received the materials indicated below.
4 Key Items:
1. Consent (Section 1; Page 2) - You consent to allow us to treat you to maintain your well-being.
2. Our Responsibilities (Section 2; Page 2) - We are required to:
" Provide care and services to you.
" Notify you of our rates.
" Refund any amounts owed to you.
3. Resident's Responsibilities (Section 3; Page 2) - You are required to:
" Pay us for our services.
" Notify us of changes in your health coverage.
" Assign us the right to bill and receive payment directly from your insurance or government payer.
4. Responsible Party's Responsibilities (Section 4; Page 3) - Your responsible party is required to:
" Use the Patient's income and resources to pay for the Patient's stay.
" Cooperate with us to secure payment from another payer, if necessary.
Patient Information Handbook and Center Supplement- These items describe many of our services, including but not limited to:
" Resident Rights
" Notice of Information Practices
" Medicare and Medicaid Information
Other Documents that require your signature:
" Receipt of Notice of Information Practices

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" Resident Trust Fund Authorization
" Skilled Nursing Facility Determination, if applicable
" Sex Offender Registry Notice
" Voluntary Arbitration Agreement, if elected

If you have questions about this Agreement, please contact our Administrator at (phone number)

[PAGE TWO]

1. CONSENT

You consent to allow us to:

A. Use and disclose your health information for purposes of treatment, payment, or health care operations.

B. Treat you to maintain your well-being.

C. Photograph you for identification purposes.

2. CENTER'S RESPONSIBILITIES

We will:

A. Provide you with a basic room, board, common facilities, housekeeping, laundered bed linens, general nursing care, personal assessment, social services, and other services. At the request, direction and control of the Center, administrative and other services may be provided through (name of employment services company).

B. Apply your deposit, if any, to your first one or two months of your stay at the Center.

C. Refund any amounts owed to you within 30 days or within the time frame required by state law after your discharge or transfer.

3. RESIDENT'S RESPONSIBILITIES

You will:

A. Pay us:

1. The room and board rate for all days that you reside at the Center including the day of admission. Unless you are covered under

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Medicaid or an insurance plan that prohibits it, we may bill you for a late fee if you do not leave the Center before 12:00 p.m. on the day of your discharge. The late fee will reflect any charges accrued by you while in the Center after 12:00 p.m. on the day of your discharge. If we change the room and board rate, we will notify you in writing 30 days before the change. (Room and Board Rates are listed in the Center Supplement).
2. All additional ancillary charges accrued by you while in the Center. (Ancillary charges are described in the Center Supplement).
3. Any co-insurance, deductibles or reimbursement you receive for non-covered services if you are eligible for any insurance or governmental program including Medicare, Medicaid, or Veteran's Administration.
4. Any additional or denied charges that are not covered by your insurance company's benefit or third party payer.
5. Within 30 days of the date on the bill. If we hire a collection agency or attorney to collect payment on your account, you will pay for these collection costs.
B. Pay other providers, including your attending physician, directly for care they provide to you.
C. Notify us of your coverage under any insurance plans or government programs.
D. Notify us within writing 5 days if your coverage under any insurance plans or government programs changes while you are at the Center.
E. Assign us the right to bill and receive money directly from your insurance or government payer. You authorize the Center and holder of medical or other information to release such information to the Centers for Medicare & Medicaid Services and its agents and to third party payers any information needed to determine your benefits

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and our right to receive payment.

[PAGE FOUR]

If you do not want us to bill your insurance company or their provider, and decide to pay privately, you will notify us in writing of this request.
F. Pay for any damage you cause to any person or property on the Center grounds.
G. Abide by our policies and procedures.
4. RESPONSIBLE PARTY'S RESPONSIBILITIES
You will:
A. Have legal access to the Patient's income or resources and deliver any documents supporting such authority to the Center.
B. Pay for all charges that Patient incurs while at the Center from the Patient's income or resources.
C. Notify us immediately and in writing if the Patient's financial resources are depleted.
D. Secure Medicaid in a timely and proper manner.
E. Cooperate with us by providing information about the Patient's finances.
F. Transfer and accept the Patient when it is medically appropriate to discharge the Patient from the Center.
G. Abide by our policies and procedures.
H. Not misappropriate the Patient's income or resources or use them for the benefit of someone other than the Patient. If you misappropriate the Patient's income or resources you may be personally liable for the payment of all charges.
5. VENUE NOTICE
All claims relating to this agreement, or any past, present or future admission of the Patient to the Center, including any claim to enforce this

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Agreement or any claim relating in any way to the care and treatment provided to the Patient, will be brought in the Court of the County and State where the Center is located. Nothing in this Venue Notice section prevents the Patient from filing a complaint with the Center or an appropriate governmental agency or from seeking allowable review of any decision to involuntarily discharge or transfer the Patient. If you agree to the Voluntary Arbitration Agreement, which is a separate agreement from this Agreement, the Voluntary Arbitration Agreement will control. If, however the Voluntary Arbitration Agreement is not signed or it is not enforced for any reason, this Venue Notice section will control. If you do not agree to this Venue Notice section, please initial here: (blank)

6. PHYSICIANS

Physicians providing services to you at the Center are not employees, agents, or apparent agents of the Center but are independent medical practitioners who have been permitted to use the Center to care and treat you.

7. TERM AND TERMINATION

7.1 Term

This Agreement begins on the day you are admitted to the Center and ends on the day you are discharged from the Center unless you are re-admitted within 15 days of your discharge date. If you are re-admitted within 15 days of being discharged from the Center, this Agreement will continue in effect as of the date of your re-admission.

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7.2 Termination

A. By you:

You may terminate this Agreement:

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1. immediately if you leave the Center because of an emergency; or
2. by providing 7 days written notice of your intent to leave the Center

B. By the Center:
We may terminate this Agreement and discharge you from the Center by notifying you in writing. Where legally required, we will notify you at least 30 days prior to your transfer or discharge. In cases where the safety or health of you or other individuals in the Center may be endangered, or if other legal reasons exist, we will notify you as soon as practicable before transfer or discharge. We can terminate the Agreement for any of the following reasons;

1. Your needs cannot be met in the Center;
2. Your health has sufficiently improved so that you no longer need our services;
3. The safety of other individuals in the Center is endangered;
4. The health of other individuals in the Center is endangered;
5. After appropriate notice, you have failed to pay for your stay at the Center; or
6. We cease to operate the Center.

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RECEIPT OF NOTICE OF INFORMATION PRACTICES
Patient's Name: (Name of Resident #23)
I acknowledge receipt of (Name of facility) Notice of Information Practices which is included in the Patient Information Handbook.
I _____ agree _____ object (a check mark by agree) to including (name of Resident #23's) location in the facility, general condition and religious affiliation (available to clergy only) in the Facility Directory.

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I _____ agree _____ object (a check mark by agree) to disclose of (name of Resident #23's) health information to a family member or close personal friend, including clergy, who is involved in my care.

Signed by Resident #23, dated 10/26/16

Further review of Resident #23's clinical record revealed a hospital discharge summary that contained, in part, the following documentation; "8/3/26 VSS (vital signs stable), found sitting in chair (referring to Resident #23) in no acute distress. Pt (patient) cannot read / write, has never been to school. Pt will need continuous teaching while at (name of facility) and close follow up with PCP (primary care physician)."

The facility was unable to provide any evidence that the above contract was provided to Resident #23 in a language that the resident was able to understand.

A review of Resident #23's business file revealed, in part, that beginning on 8/23/17 Resident #23 began to accrue charges at the facility, these charges constituted the 10% co-payment ($161.00 per day) required by Medicare after day 20 of services. A review of Resident #23's transaction history, provided by the business office, revealed that Resident #23's outstanding bill at discharge was $12,892.00. The business office was unable to provide any evidence that Resident #23 was provided information regarding the change in charges which started on 8/23/16.

The business office was unable to provide any evidence prior to 10/26/16 that Resident #23 was offered any information regarding the

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requirements and procedures for establishing eligibility for Medicaid.

An interview was conducted on 2/15/17 at approximately 8:30 a.m. with OSM #9, the business office manager. OSM #9 was asked to describe the process of the business office when a resident is admitted to the facility. OSM #9 stated, "We check their (the resident's) payer type and provide a welcome letter outlining the expectations of insurance coverage." A copy of the welcome letter was provided and revealed, in part, the following documentation; "We have checked your coverage benefits with your insurance and your estimated responsibility is listed below." The welcome letter had signature lines for the resident to indicate receipt and understanding of the information provided. OSM #9 stated that Resident #23 did not have a signed welcome letter in his business office file. OSM #9 was asked when the Medicaid process / application would be presented to a resident. OSM #9 stated, "We would anticipate Medicaid need and begin the Medicaid process on admission, asking the family to help with the process." OSM #9 was asked about residents who did not have family members, OSM #9 stated, "We would obtain guardianship for the resident in need." OSM #9 was asked what would be done for a resident who was unable to read / write and had a low level of comprehension. OSM #9 stated, "If a resident can't read / write then we (the business office) would go over the form in depth and ask the resident to make a mark to witness comprehension." OSM #9 was asked whether or not this process was started for Resident #23. OSM #9 stated that the first note by the business office occurred on 10/19/16 which stated that

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someone (not identified) from the business office had been to Resident #23's room to start the Medicaid application process.

On 2/15/17 at 9:10 a.m. an interview was conducted with OSM #4, the admissions director. OSM #4 was asked to describe the process when a resident was admitted to the facility. OSM #4 stated that a "welcome" package was left in the resident room and the resident or the responsible party would be provided with an admissions agreement. OSM #4 was asked if she remembered providing an admissions agreement to Resident #23. OSM #4 stated that she was not in admissions at the time of his entry so could not speak to whether or not Resident #23 had been provided an admissions agreement.

On 2/15/17 at 10:15 a.m., an interview was conducted with OSM #12, the business development specialist. OSM #12 was asked to describe her role in regards to having residents sign the admission agreement. OSM #12 stated, "I have filled in to have the residents sign the admission agreement." OSM #12 further stated that she hadn't filled in very often but "they" (the facility) had a back log and "needed to get caught up." OSM #12 was asked how she presented the admission agreement to the residents. OSM #12 stated, "I hand them the agreement to look over and then ask them to sign it." OSM #12 was asked how she ensured that the residents understood the agreement. OSM #12 stated that she asked them if they had any questions and if not then she took their word and their signature as affirmation that the agreement was understood. OSM #12 was asked how she was made aware of a resident's level of comprehension or ability to read and / or write.

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OSM #12 stated that she was not made aware. OSM #12 further stated, "I have never had a resident say that they couldn't read a document." OSM #12 was shown the admission agreement signed by Resident #23. OSM #12 was asked why the contract was signed on 10/26/16 when Resident #23 had been admitted on 8/3/16. OSM #12 stated, "I was just helping out." OSM #12 further stated that she did not know why the admission agreements were not done at the time of the admission. OSM #12 was asked whether or not she was aware that Resident #23 was unable to read or write and had never received any education. OSM #12 stated that she was not aware of that. OSM #12 was asked if she read the entire agreement to Resident #23 word for word. OSM #12 stated that she did not, but she was sure that she would have given a summary of the document. OSM #12 was asked how she verified that Resident #23 understood the agreement. OSM #12 stated, "His signature confirmed that he understood the document. I vaguely remember the resident (Resident #23) but I can't say that I knew he could not read."

On 2/15/17 at 10:45 a.m. an interview was conducted with OSM #13, the rehabilitation director. OSM #13 was asked about Resident #23's ability to comprehend. OSM #13 stated, "Everything had to be simplified and repeated as he (Resident #23) had difficulty understanding. Even the pain scale was a difficult concept for him (Resident #23) and would have to use the visual scale (a series of facial expressions that demonstrated pain free to worst pain ever experienced) to determine whether or not he (Resident #23) was in pain and even then it was a struggle." OSM #13 further stated that the therapy staff had to re-iterate directions a lot in

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order to ensure comprehension, and information had to be provided in very simplistic terms.

On 2/15/17 at 11:05 a.m. an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 was asked what the facility did differently to provide information, such as the admission agreement, to a resident who could not read or write and was known to have low comprehension. ASM #1 stated, "We would communicate orally if they were alert and oriented and explain any documents that needed to be signed, go through the documents and explain the contents." ASM #1 was asked what the signature on the admission agreement meant. ASM #1 stated that the admission agreement was a description of the care that would be provided by the facility and the responsibilities of the resident. ASM #1 further stated, "The signature signifies that the resident understands and consents to the cost of care and the care to be provided." ASM #1 was asked if he was aware that Resident #23 was unable to read or write and that the admission agreement was not read to him word for word and that he was not provided the admission agreement until 10/26/16, 84 days after his date of admission to the facility. ASM #1 stated that was a problem and he would look into it.

On 2/15/17 at approximately 2:30 p.m. a meeting was conducted with ASM #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the concern that Resident #23 had not been informed of his rights and his financial obligations at the time of his admission on 8/3/16. Resident #23 had not been provided with an admissions agreement that outlined his rights and responsibilities until

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10/26/16. A policy was requested at this time regarding the admission process. ASM #1 stated at this time that the $12,892.00 outstanding balance owed by Resident #23 would be written off.

On 2/15/17 at 5:10 p.m. an interview was conducted with OSM #4, the admissions director with ASM #1 in attendance. OSM #4 was asked to state at what point an admissions agreement was presented to a newly admitted resident. OSM #4 stated either immediately prior to admission or when they arrived at the facility. OSM #4 was asked what to explain the purpose of the admissions agreement. OSM #4 stated, "It is an agreement for treatment and billing along with notification of other facility requirements (for example the sex offender policy), along with trust fund account information and voluntary arbitration agreement." OSM #4 was asked to explain the purpose of the resident signature on the admission agreement. OSM #4 stated, "When the resident signs the admission agreement they are accepting of the rules." OSM #4 was asked to describe the process for someone who is unable to read or write. OSM #4 stated, "The contract is read to them. Their signature is confirmation that they have understood the document and contents."

A review of the facility policy titled "Financial Policy" revealed, in part, the following documentation; "3. The admission staff completes the Financial Information Worksheet in the Admission Agreement with input from the patient responsible party. (Note - This form must not be given to the patient / responsible party to complete). The purpose of the Financial Information Worksheet is to provide information

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supporting the payer selection at admission and to serve as a basis for financial counseling with the business office. 4. At admission and in detail by the business office during financial counseling, the patient is made aware of their legal obligation to pay their estimated private portion amount when billed with receipt of funds reasonably assured. 8. The admission staff has a signed and dated admission agreement with attachments on file."

No further information was provided prior to the end of the survey process.

Complaint Deficiency

2. For Resident #18, facility staff failed to inform the resident and RP (responsible party) of her rights, rules, and responsibilities of her stay at the facility at the time she was admitted on 7/20/16.

Resident #18 was admitted to the facility on 7/20/16 with diagnoses that included but were not limited to Type 1 diabetes, heart failure, atrial fibrillation, Wernicke's encephalopathy [1], difficulty in walking and dementia with behavioral disturbance. Resident #18's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/26/17. Resident #18 was coded as being moderately cognitively impaired in the ability to make daily decisions scoring 09 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #18 was coded as requiring supervision only with walking, and locomotion; limited assistance with dressing, eating, and personal hygiene; extensive assistance with toileting and total dependence on staff with bathing.

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On 2/15/17 at approximately 2:30 p.m., Resident #18's admission agreement was requested from the business office.

On 2/15/17 at 10:50 a.m., an interview was conducted with OSM (other staff member) #4, the admissions director. OSM #4 stated that she did not start working as an admission director until December of 2016. OSM #4 stated that she was the social worker prior to that position. When asked when residents and the RP (responsible party) are given an admission contract, OSM #4 stated that residents are given the contract a few days before admission during a scheduled conference or upon admission to the facility. She stated that if the patient is able to sign she will have them sign the contract after she goes over the contract with the resident and/or family. OSM #4 stated that if she cannot reach the family, and the resident cannot understand his/her rights, she will send the contract by certified mail. OSM #4 stated that she has never sent the contract by mail yet. OSM #4 stated that the previous admissions director no longer works at the facility.

On 2/15/17 at 3:20 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) stated, "We cannot locate her old admission agreement. Admissions are trying to get in touch with the RP to come in and sign a new one. If I find the old contract I will show it to you."

On 2/15/17 at 5:00 p.m., ASM #2, the DON stated that they could not find Resident #18's admission agreement.

On 2/15/17 at 5:15 p.m., an interview was conducted with ASM #1, the administrator and OSM (other staff member) #4, the admissions

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director. When asked the purpose of the admission contract, OSM #4 stated, "It addresses several different components." OSM #4 stated that the admission contract had an agreement for treatment and billing, notification of the sex offender policy, trust fund account information, and a voluntary arbitration agreement. When asked if she would document that she went over the admissions contract with the resident and/or RP, OSM #4 stated, "No." OSM #4 stated, "The signature page of the contract is saying that they received and understand what they are signing." OSM #4 stated that there was no other documented acknowledgement that the resident and/or RP received the admissions contract. OSM #4 stated that a patient handbook is also placed in the resident's room that addresses resident rights and the bed hold policy. OSM #4 stated that the handbook is set up upon arrival. ASM #1 stated that admissions will read the handbook to those residents who cannot read if the family is not present.

On 2/15/17 at 5:00 p.m., ASM #2, the DON was made aware of the above concern. No further information was presented prior to exit.

[1] Wernicke encephalopathy is an acute neuropsychiatric disease with symptoms including changes in mental status, ataxia and ocular abnormalities; if left untreated, these symptoms can lead to morbidity and even to mortality. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmed/25856744.

3. Resident #1 was admitted to the facility on

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10/21/16. The resident's admission agreement containing consent for treatment, facility responsibilities, resident responsibilities and responsible party responsibilities was not signed until 11/18/16.

Resident #1 was admitted to the facility on 10/21/16. Resident #1's diagnoses included but were not limited to: major depressive disorder and diabetes. Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/15/17, coded the resident's cognition as being severely impaired.

Review of Resident #1's "Admission Agreement between Patient and Center" regarding "4 Key Items" that included consent for treatment, facility responsibilities, resident responsibilities and responsible party responsibilities was not signed by the resident's responsible party until 11/18/16.

On 2/15/17 at 10:50 a.m., an interview was conducted with OSM (other staff member) #4 (admissions director- employed in that position since December 2016). OSM #4 was asked the process for meeting with residents/responsible parties and having the admission agreement signed. OSM #4 stated once she confirms a resident is being admitted, she reaches out to the resident's family and schedules an appointment to meet with them as soon as possible. OSM #4 stated she had met with a few residents' families before admission but she tries to have the admission agreement signed within a few days of admission. OSM #4 stated if the resident's family is difficult to get in touch with and the resident is unable to sign the agreement then she can send the agreement to the family by certified mail. At

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this time, OSM #4 was made aware Resident #1 was admitted to the facility on 10/21/16 and her admission agreement was not signed by her responsible party until 11/18/16. OSM #4 was asked to provide any further information as to why the admission agreement wasn't signed until 11/18/16.

On 2/15/17 at 11:37 a.m., OSM #4 returned to this surveyor. OSM #4 stated there was no official admissions director at the facility from October 2016 to December 2016. OSM #4 stated she had no further information regarding Resident #1's admission agreement.

On 2/15/17 at 5:10 p.m., OSM #4 was asked the purpose of the admission agreement. OSM #4 stated the admission agreement contained several components that included an agreement for treatment and billing, notifications regarding the sex offender policy and trust fund account, and the voluntary arbitration agreement. OSM #4 stated in addition to the information provided in the admission agreement, patient handbooks are placed in residents' rooms on admission. OSM #4 stated the handbook contains information regarding rights, rules, and information specific to the facility. OSM #4 was asked if any form was signed by residents/responsible parties to evidence the handbook was provided upon admission. OSM #4 stated there were no other forms that were signed other than the admission agreement and the signature by the residents/responsible parties was verification that the information was received and understood.

On 2/15/17 at 2:03 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the

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above concern.

No further information was presented prior to exit.

4. For Resident #3 the resident's admission agreement containing consent for treatment, facility responsibilities, resident responsibilities and responsible party responsibilities was not signed until six days after admission.

Resident # 3 and/or Resident # 3's responsible party were not informed of the rules, their rights, and responsibilities prior to or at admission as evidenced by the admission contract not being signed until six days after admission. Resident # 3 was admitted on 9/1/16 and the Admission Contract was signed on 9/7/16.

Resident # 3 was admitted to the facility on 9/1/16 and was most recently readmitted on 12/7/16 with diagnosis that included but are not limited to: anemia, pneumonia, Alzheimer's Disease, depression, coronary artery disease, leukemia (cancer of the blood cells), and adult failure to thrive. On the most recent MDS (minimum data set), a quarterly assessment with ARD (assessment reference date) of 12/13/16, Resident # 3 was coded as being severely impaired cognitively.

During a review of Resident # 3's admission contract it was documented to have been signed on 9/7/16, six days after admission.

During an interview on 2/15/17 at 10:50 a.m. with OSM (other staff member) # 4, the admissions director, OSM # 4 was asked what the admission

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process was. At this time OSM # 4 stated that she had only held this position (Admissions Director) since 12/20/16, and could not speak to anything prior to that date. OSM # 4 stated that if a Resident is confused then a time is scheduled with the family to fill out the paper work as soon as possible. This usually occurs a few days before admission or a few days after admission. If the Resident is competent then they (the Resident) signs the admission contract. Many times since there is a lot going on with the admission she reaches out to the family first. If for some reason the Resident is not competent and she cannot reach the family then the admission contract is sent by certified mail. At this time OSM was given the name of Resident # 3 and asked if there was any documentation as to why there was a delay in the signing of the Resident's admission contract.

During an interview on 2/15/17 at 11:37 a.m. with OSM # 4, OSM # 4 stated that the person that did the Resident's admission contract was no longer at the facility. OSM # 4 stated that she could find no notes concerning the delay in signing of the contract.

During an interview on 2/15/17 at 2:00 p.m. with ASM (Administrative Staff Member) # 1, the administrator, ASM # 2, the director of nurses, and ASM # 4, the corporate quality assurance staff, the lateness of the signing of Resident # 3's Admission Contract was reviewed.

During an interview on 2/15/17 at 5:10 p.m. with ASM # 1 and OSM # 4, the lateness of the Admission Contract signatures was discussed. OSM # 4 was also asked what the purpose of the Admission Contract was. OSM # 4 stated it had

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several components which included the following information: Treatment, Billing, Resident Trust Fund, and Voluntary Arbitrator Agreement to name a few. OSM # 4 stated at the time the contract is signed the Resident gets a Welcome Package. This package is put into the Resident's room and includes the Patient Handbook, Resident's Rights, Bed Hold Policy, and advises of the rules of the facility. OSM # 4 stated that she follows up with the admission contract and has it signed. The Signature is verification that they have received and understand the contract. OSM # 4 stated that if a Resident cannot read the contract, all the literature is read to the Resident.

Nothing further was presented prior to exit.

5. For Resident #21, facility staff failed to inform the resident and RP (responsible party) of her rights, rules, and responsibilities of her stay at the facility at the time she was admitted on 1/24/17.

Resident #21 was admitted to the facility on 1/24/17 with the diagnoses of but not limited to colon cancer, pressure sore, prostate hyperplasia and was on Hospice services. The most recent MDS (Minimum Data Set) was the admission assessment with an ARD (Assessment Reference Date) of 1/31/17. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident required extensive assistance with bathing; limited assistance with transfers and dressing; supervision for eating and hygiene; and had an ostomy for bowel and catheter for bladder.

A review of the nurse's notes revealed an admission note dated 1/24/17 at 2:30 p.m., which documented, "Patient admitted to unit from

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(hospital) via stretcher accompanied by sister...."

A review of the admission contract revealed the admission paperwork was signed by the sister (POA - power of attorney) on 2/1/17; approximately 8 days after admission.

On 2/15/17 at 4:00 p.m., an interview was conducted with OSM #4 (Other Staff Member #4) the admissions director. She stated that there was a previous admissions person who had left and the department had been behind in completing the admission forms. She could not speak to or specifically recall this particular incident.

As the administrator (Administrative Staff Member #1) was present during the above interview, he was aware of the findings.

On 2/15/17 at 5:15 p.m., an interview was conducted with ASM #1 and OSM #4. When asked the purpose of the admission contract, OSM #4 stated, "It addresses several different components." OSM #4 stated that the admission contract had an agreement for treatment and billing, notification of the sex offender policy, trust fund account information, and a voluntary arbitration agreement. When asked if she would document that she went over the admissions contract with the resident and/or RP, OSM #4 stated, "No." OSM #4 stated, "The signature page of the contract is saying that they received and understand what they are signing." OSM #4 stated that there was no other documented acknowledgement that the resident and/or RP received the admissions contract. OSM #4 stated that a patient handbook is also placed in the resident's room that addresses resident rights

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F 156	Continued From page 29 and the bed hold policy. OSM #4 stated that the handbook is set up upon arrival. ASM #1 stated that admissions will read the handbook to those residents who cannot read if the family is not present. No further information was provided by the end of the survey.	F 156		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. 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 that the facility staff failed to assess a resident prior to medication self-administration for one of 29 residents in the survey sample, Resident #14. The facility staff failed to assess Resident #14 to ensure the resident was capable of self-administering medicated topical creams. The findings include: Resident #14 was admitted to the facility on 4/27/12. Resident #14's diagnoses included but were not limited to: cerebrovascular disease (stroke), chronic pain syndrome and high blood pressure. Resident #14's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/27/17, coded the resident as being cognitively intact.	F 176	F-176 *It is the intended practice of this facility to honor a resident's right to self-administer drugs if the interdisciplinary team, as defined by 483.20(d)(2)(ii), has determined that this practice is safe.* Criteria 1 Upon notification from surveyor, all medications were removed from the resident #14 possession. MD notified, orders clarified resident #14 assessed and found to be able to administer medications as ordered self-administration form completed and plan of care revised.	3/31/17

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Section G coded Resident #14 as requiring supervision with one person physical assist with bed mobility, transfers, eating and toilet use. The resident was coded as requiring limited one person physical assist with dressing and supervision with setup help only with personal hygiene.

Resident #14's current physician order summary documented orders including but not limited to: benzoyl peroxide (1) 5% gel to be topically applied to the resident's scalp lesions every day, Nystop powder (2) 100,000 unit/one gram to be applied to the resident's groin twice daily as needed and Proctozone (3) 2.5% cream to be applied four times daily as needed for hemorrhoids. There was no current physician's order for nystatin cream (4) or triamcinolone cream (5).

Resident #14's February 2017 TAR (treatment administration record) documented physician's orders including but not limited to: benzoyl peroxide 5% gel to be topically applied to the resident's scalp lesions every day, Nystop powder 100,000 unit/one gram to be applied to the resident's groin twice daily as needed and Proctozone 2.5% cream to be applied four times daily as needed for hemorrhoids. There was no documented order for nystatin cream or triamcinolone cream.

Resident #14's comprehensive care plan revised on 2/8/17 documented, "Focus: Recurrent Yeast Rash at groin area...Interventions: Administer treatment per physician orders...Focus: At risk for alteration in skin integrity related to: incontinence, impaired mobility. Resident has reoccurring lesions to scalp...Interventions: Apply

Criteria 2

Any and all residents who are alert and oriented x4 have the potential to be affected.

Criteria 3

All licensed nurses will be re-educated on the nursing procedures for medication self-administration and clarification of MD orders.

Criteria 4

DON or designee will randomly audit 5 residents rooms daily x5 days, 3 times weekly x3 weeks, monthly x2 months to ensure that resident who have medications in the rooms have the orders, assessments completed and meets self-administration requirements.

Criteria 5

The facility's alleged date of compliance is 3/31/2017.

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ointment/cream to resident scalp per md (medical doctor) orders..." The care plan failed to document information regarding self-administration of medicated creams.

Further review of Resident #14's clinical record failed to reveal evidence that Resident #14 had been assessed for medication self-administration.

On 2/14/17 at 11:04 a.m. during the initial tour of the facility, multiple tubes of medicated cream were observed on Resident #14's sink.

On 2/14/17 at 4:50 p.m., Resident #14 was sitting in a wheelchair in his room watching television. Four tubes of medicated cream were observed on Resident #14's sink.

On 2/15/17 at 11:05 a.m., Resident #14 was sitting in a wheelchair in his room. With the resident's permission, this surveyor inspected the four tubes of medicated cream that remained on the resident's sink. The following was observed:
-One 3/4 full tube of triamcinolone 0.1% cream and one 1/2 full tube of Nystatin 100,000 unit/one gram cream. Resident #14 stated the creams were for his groin and he learned how to mix the creams up and put them on himself.
-One 1/3 full tube of benzoyl peroxide 5% gel and one 3/4 full tube of Proctozone 2.5% cream. Resident #14 stated he used those creams for lesions on his head.
-Also noted were two plastic spoons with dried cream residue.

During the above observation, Resident #14 confirmed he applies the medicated creams himself. When asked if nurses had ever watched him apply the creams or had educated him about

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application of the creams, the resident stated nurses used to come into the room but they knew that he knew how to mix the creams and put the creams on himself.

On 2/15/17 at 11:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1 (Resident #14's nurse). LPN #1 was asked the facility process regarding storage of medicated creams and resident self-administration of medicated creams. LPN #1 stated medicated creams are kept stored in the treatment cart but nurses can obtain a physician's order to keep the medication at the bedside. LPN #1 was asked if residents were allowed to apply medicated creams if there was an order to keep the creams at the bedside. LPN #1 stated, "Yes because they are cognitive enough." LPN #1 was asked if nurses conduct an assessment prior to allowing a resident self-administer medications. LPN #1 stated there was no form but nurses talk to the residents, explain the process to them and then have the residents explain the process back to them. At this time, LPN #1 was made aware this surveyor observed medicated creams in Resident #14's room and the resident stated he had been applying the creams himself. LPN #1 stated Resident #14's medicated creams should have been kept in the treatment cart and should not have been in the resident's room because she thought the resident did not have an order to keep the creams at the bedside. LPN #1 was asked if the nurses ever administered the creams to Resident #14. LPN #1 stated sometimes nurses did and the creams may have accidentally been left in the room. LPN #1 was asked if Resident #14 had ever been assessed to see if he was capable of self-administration of medicated creams. LPN #1 stated, "As far as

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seeing him, I have seen him go to the bathroom and clean himself up." When asked if that meant the resident was capable of self-administration, LPN #1 stated, "I'm still going to say he is capable because we have been in the room. I'm not going to say it's documented but say he can say based on what I've seen." LPN #1 stated she was going to call the nurse practitioner to see if the medicated creams could be left at Resident #14's bedside.

On 2/15/17 at 2:03 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 regarding medication self-administration documented, "I have been advised of my rights to self-administer medication, when the Interdisciplinary Team has determined that this practice is safe. I have been cautioned on the risks involved with self-administration and have been informed that procedures are established to properly monitor my drug regimen. To comply with Federal regulation, please indicate choice of medication administration. (Please check appropriate box below): (Two options to check) I wish to have my medication(s) administered to me (or) I wish to self-administer my medication(s) if this practice is determined, by the Interdisciplinary team, to be safe." A signature and date line for the "Patient" and "Facility Representative" was documented. Page two of the form documented, "STEP II ASSESSMENT OF PATIENT'S ABILITY TO SELF-MEDICATE- To evaluate the safety of this practice, a nurse will conduct the following test. If the patient is unable to demonstrate knowledge to assure safe self-administration of medications,

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self-administration of medication will not be allowed. DIRECTIONS: Hand the patient each currently prescribed medication, ask the following questions for each medication, and record the patient's response: WHAT IS THE STRENGTH OF THIS DRUG? HOW OFTEN DO YOU TAKE THIS DRUG? WHAT TIME OF DAY DO YOU TAKE THIS DRUG? WHY DO YOU TAKE THIS DRUG?...STEP III SEVEN DAY EVALUATION OF PATIENT SELF ADMINISTERING MEDICATION- To evaluate the patient's ability to consistently take their medication at the appropriate time, a nurse will observe the patient taking their medication for a seven day period. The nurse will initial the MAR to indicate that the medication was taken and will write a note on the back if the patient had to be reminded or could not manage opening or pouring the medication..."

Note- the above form for Resident #14 was not present in the clinical record or presented by facility staff.

No further information was presented prior to exit.

(1) Benzoyl peroxide is used to treat acne and other skin conditions. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009244/?report=details

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

(3) Proctozone is used to treat itching and swelling caused by hemorrhoids. This

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F 176	Continued From page 35 information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=fb5746ff-3ff1-4874-a827-4694133641b9 (4) Nystatin cream is used to treat fungal infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682758.html (5) Triamcinolone is used to treat itching, redness and inflammation of the skin. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601124.html	F 176		
F 247 SS=D	483.10(e)(6) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE (e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. 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 orient one of 29 sampled residents, (Resident #1) to a new room prior to moving the resident. The facility staff failed to orient Resident #1 to a new room and introduce the new roommate prior to a room change on 1/6/17. The findings include: Resident #1 was admitted to the facility on 10/21/16. Resident #1's diagnoses included but	F 247	3/31/17 **F-247** *It is the intent of this facility to honor a resident's right to receive notice before the resident's room is changed or roommate in the facility is changed.* Criteria 1 Staff has followed up with resident #1, her responsible party and roommates to ensure that this change did not affect them mentally or socially. And all involved are fine and prefer to continue to room together.	

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were not limited to: pressure ulcer (1), major depressive disorder and diabetes. Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/15/17, coded the resident's cognition as being severely impaired. Section G documented, Resident #1 required extensive assistance of two or more staff with transfers and was totally dependent of one staff with locomotion on the unit.

Resident #1's January 2017 ADL (activity of daily living) records documented the resident required extensive assistance of one staff with transfers during some days in January 2017; was totally dependent of one staff with transfers during some days in January 2017 and was totally dependent of two or more staff with transfers during some days in January 2017.

Review of Resident #1's clinical record revealed a nurse's note dated 1/6/17 that documented, "Resident transferred from the Parc unit to room (room number) the third bed today." Further review of nurse's notes and social services notes failed to reveal Resident #1 was afforded the opportunity to see the new room or meet the new roommate prior to the move. The notes also failed to document the resident's responsible party was notified of the room change.

Review of Resident #1's comprehensive care plan initiated on 10/21/16 and revised on 2/15/17 failed to document information regarding a room change.

On 2/15/17 at 9:37 a.m., an interview was conducted with OSM (other staff member) #10 (the social services director- employed at the

Criteria 2

Any and all residents have the potential to be affected.

Criteria 3

The interdisciplinary team will be re-educated on the residents' rights to notice before room/roommate change. To include but not limited to introduction, orientation to room/roommate.

Criteria 4

DON or designee will audit notification assessments for new admissions and all room/roommate changes via Eagle room dailyx5days, 3times weeklyx3weeks, monthlyx2months.

Criteria 5

The facility's alleged date of compliance is 3/31/2017.

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facility for one month) and OSM #8 (the social services coordinator). OSM #10 was asked the facility process regarding room changes. OSM #10 stated the social services staff notifies the resident, the resident's responsible party and the resident residing in the room the other resident is moving into. OSM #10 stated the social services staff also shows the resident the new room introduces the resident to the new roommate and asks for feedback from the residents. At this time, OSM #8 was asked if this process was completed when Resident #1 moved on 1/6/17. OSM #8 stated she notified Resident #1 and the resident's responsible party of the room change. OSM #8 stated she had to call the resident's responsible party at the time because the responsible party was out of town. OSM #8 confirmed she didn't document notification. When asked if Resident #1 was afforded the opportunity to see the new room and meet the new roommate prior to the room change, OSM #8 stated the resident was bed bound so she probably wasn't shown the new room or allowed to meet the new roommate. When asked how she knew the resident was bed bound, OSM #8 stated facility staff said the resident had wounds and couldn't get out of bed. When asked who told her this, OSM #8 stated she couldn't remember.

On 2/15/17 at 9:45 a.m., an interview was conducted with RN (registered nurse) #2 (Parc unit manager). RN #2 was asked if Resident #1 was bed bound during the time period of 1/6/17 when the resident moved to a new room. RN #2 stated the resident had a sacral wound (wound on the resident's bottom) and would get up in a chair an hour at a time but was in bed a lot. When asked if it would have been possible for the

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resident to be wheeled to her new room and meet her new roommate, RN #2 stated, "Possibly."

On 2/15/17 at 9:50 a.m., an interview was conducted with RN (registered nurse) #7 (wound care nurse). RN #7 was asked if Resident #1 was bed bound during the time period of 1/6/17 when the resident moved to a new room. RN #7 stated although the resident refused to get out of bed at times, the resident was occasionally getting up into a "Geri chair" (a special reclining chair) for one to two hours a day.

On 2/15/17 at 9:55 a.m., another interview was conducted with OSM #8. OSM #8 confirmed that to her knowledge, Resident #1 was not taken to see her new room or meet her new roommate prior to the 1/6/17 room change because she thought the resident was bed bound. OSM #8 stated the reason for the room change was because the resident had to move to a long term care bed because her Medicare benefits had exhausted. At this time, OSM #8 was made aware this surveyor had spoken to other staff who stated Resident #1 was not bed bound during the time period of 1/6/17. OSM #8 had no further comments.

On 2/15/17 at 2:03 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 social service manual documented in part, "Social Service Role: Reasonably accommodate patient preferences when considering a change in room or roommate. Assist with notification to the patient or responsible party of the change, the reason for

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F 247	Continued From page 39 the change and respond to questions. Introduce the patient with the room before the move. Introduce the patient to the new roommate..." No further information was presented prior to exit. (1) "A pressure injury (pressure ulcer) is localized damage to the skin and 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." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/	F 247		
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to provide medically related social services for two of 29 residents in the survey sample, Resident # 23 and Resident #1. 1. On admission the facility staff was aware that Resident #23 was unable to read or write and	F 250	3/31/17 **F-250** *It is the intended practice of this facility to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.*	

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there was no evidence in the clinical record that the social services staff assisted Resident #23 with understanding the admissions contract or assisted him with the Medicaid application process.

2. The social services staff failed to introduce Resident #1 to a new room and new roommate prior to a room change on 1/6/17.

The findings include:

1. On admission the facility staff was aware that Resident #23 was unable to read or write and there was no evidence in the clinical record that the social services staff assisted Resident #23 with understanding the admissions contract or assisted him with the Medicaid application process.

Resident #23 was admitted to the facility on 8/3/16 with diagnoses that included, but were not limited to; a heart attack, back pain, peripheral vascular disease, diabetes and difficulty walking.

Resident #23's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/9/16. Resident #23 was coded on the MDS as having a BIMS (brief interview for mental status) score of 13 out of 15. The RAI (resident assessment instrument) manual documents that a score of 13 indicates that the resident's cognition is intact.

A review of Resident #23's clinical record revealed a hospital discharge summary that contained, in part, the following documentation; "8/3/26 VSS (vital signs stable), found sitting in

Criteria 1

Upon notification from surveyors, resident #23 has been discharged from facility, social workers and admission director have been re-educated to help residents understand admission contracts and social workers to help with Medicaid application process as needed. Social services staff has followed up and assessed resident #1's physical, mental and psychosocial well-being as it relates to her new room and roommates. Resident#1 and

roommates are transitioning well together.

Criteria 2

Any and all residents have a potential to be affected.

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chair (referring to Resident #23) in no acute distress. Pt (patient) cannot read / write, has never been to school. Pt will need continuous teaching while at (name of facility) and close follow up with PCP (primary care physician)."

Further review of Resident #23's clinical record revealed, in part, a facility form "Social Service Assessment & (and) History" that was completed on 8/9/2016 following admission of Resident #23 on 8/3/16. Under the area named "Dignity Factors" Resident #23 was checked as having "Chronic disabling medical / psychological condition." There were no areas checked under "Social Factors" and there were no other areas related to Resident #23's inability to read or write.

Further review of Resident #23's clinical record revealed that the social services director documented two meetings with Resident #23 that occurred on 10/20/16 and 11/8/16. Both meetings discussed Resident #23's discharge plan.

A review of Resident #23's comprehensive care plan dated 8/3/16 did not reveal any information regarding Resident #23's inability to read or write and / or the need for staff to read documents to Resident #23 and ensure comprehension.

There was no documentation in the clinical record that evidenced the social services staff provided ongoing support to ensure that Resident #23 was aware of the admission contract requirements and the billing changes. There was no documentation in the clinical record that evidenced the social services department provided assistance to Resident #23with the Medicaid application process.

Criteria 3

Social workers have been re-educated on providing residents with social services need that meet physical, mental and psychosocial wellbeing not limited to room changes and ensuring that resident /RP understand information provided and will continue monitoring of these services to ensure prevision for all potential residents.

Criteria 4

Administrator or designee will interview new admissions for understanding of the information provided in the admission contracts, oriented to rooms/roommates daily x5 days, three days weekly x3 weeks, and monthly x2 months.

Criteria 5

The facility's alleged date of compliance is 3/31/2017.

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On 2/15/17 at 8:47 a.m. an interview was conducted with OSM #10, the social services director. OSM #10 was asked to describe the process of the social services department for a new admission from the hospital. OSM #10 stated, "We start with an admission assessment. If the resident is going to a skilled unit we anticipate the needs of the resident, d/c (discharge) planning, and family support, medical and physical needs once they return to their home. We get a general sense of the length of time they (the resident) will be here." OSM #10 was asked the role of the social services department if the resident is a candidate for long term care placement. OSM #10 stated, "We focus on the financial aspect, we will start the Medicaid process, we guide the resident and explain where to apply. The business office takes the lead." OSM #10 was unable to discuss anything about Resident #23 as she was not employed at the facility during Resident #23's stay.

On 2/15/16 at 9:09 a.m. an interview was conducted with OSM #4, the admissions director (formerly the social services director). OSM #4 was asked if she remembered Resident #23. OSM #4 stated that she did, but not remember the details. OSM #4 asked to review Resident #23's case and then get back to this surveyor. OSM #4 did not return to this surveyor with any specific information regarding Resident #23's situation.

On 2/15/17 at 9:45 a.m. an interview was conducted with OSM #8, the social services coordinator. OSM #8 was asked if she remembered working with Resident #23 during

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his stay at the facility. OSM #8 stated that she "worked closely with the resident on discharge planning." OSM #8 was asked when she started working with Resident #23. OSM #8 stated, "Around September." OSM #8 was asked whether or not Resident #23 was able to read or write. OSM #8 stated, "I am not sure, he did verbalize understanding when I spoke with him." OSM #8 was asked if she helped Resident #23 with an admission contract or with initiating a Medicaid application. OSM #8 stated, "I think that the business office started something, but I don't remember." OSM #8 stated that she had talked to Resident #23 "a lot" and when asked whether or not she documented the conversations, OSM #8 stated that she documented in the computer system and that all notes would be found in the computer system. OSM #8 was shown the two handwritten documents that were provided to this writer and then asked to review the computer documentation. OSM #8 stated, "If the notes are not in PCC then it wasn't documented."

On 2/15/17 at 11:05 a.m. an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 was made aware of the above findings. ASM #1 stated he was not aware that Resident #23 could not read or write and if that was the case then information should have been provided orally and documented. ASM #1 was asked what should happen when a resident is admitted to the facility to ensure that the care is provided to meet the resident's highest practicable level of function. ASM #1 stated that the staff would go over their (the resident's) plan of care, financial information, perform a welcome meeting and provide the admissions package. ASM #1 was made aware at this time that although a care plan was

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completed there was no evidence that Resident #23 received information about the financial aspect of his stay or any other information regarding his care at the facility. At this time a policy regarding the admissions process was requested along with a job description for the social services department staff.

A review of the facility job description titled "Social Worker" revealed, in part, the following documentation; "Social Worker Responsibilities. Provides assistance with the resident's / patient's admission to assure a smooth transition; Contacts the new resident / patient and / or family as needed to ensure that needs are being met and that difficulties are being resolved. Informs resident / patient family or legal representative of Medicare / Medicaid program benefits and assists with application for these alternative funding programs for nursing home care."

A review of the "Social Service Manual" provided by the facility, revealed, in part, the following documentation; "Social Service Role and Regulations: The skills of those providing social services are used to evaluate and clarify patients' psychosocial needs and to obtain, provide or coordinate the delivery of medically related social services. This could involve actions that include, but are not limited to the following: advocating for the rights of each patient from admission through discharge. New Admission: The social service staff plays a significant role in a newly admitted patient's adjustment to the center."

No further information was provided prior to the end of the survey process.

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2. The social services staff failed to orient Resident #1 to a new room and introduce the new roommate prior to a room change on 1/6/17.

Resident #1 was admitted to the facility on 10/21/16. Resident #1's diagnoses included but were not limited to: pressure ulcer (1), major depressive disorder and diabetes. Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/15/17, coded the resident's cognition as being severely impaired. Section G documented, Resident #1 required extensive assistance of two or more staff with transfers and was totally dependent of one staff with locomotion on the unit.

Resident #1's January 2017 ADL (activity of daily living) records documented the resident required extensive assistance of one staff with transfers during some days in January 2017; was totally dependent of one staff with transfers during some days in January 2017 and was totally dependent of two or more staff with transfers during some days in January 2017.

Review of Resident #1's clinical record revealed a nurse's note dated 1/6/17 that documented, "Resident transferred from the Parc unit to room (room number) the third bed today." Further review of nurse's notes and social services notes failed to reveal Resident #1 was afforded the opportunity to see the new room or meet the new roommate prior to the move. The notes also failed to document the resident's responsible party was notified of the room change.

Review of Resident #1's comprehensive care plan initiated on 10/21/16 and revised on 2/15/17

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failed to document information regarding a room change.

On 2/15/17 at 9:37 a.m., an interview was conducted with OSM (other staff member) #10 (the social services director- employed at the facility for one month) and OSM #8 (the social services coordinator). OSM #10 was asked the facility process regarding room changes. OSM #10 stated the social services staff notifies the resident, the resident's responsible party and the resident residing in the room the other resident is moving into. OSM #10 stated the social services staff also shows the resident the new room introduces the resident to the new roommate and asks for feedback from the residents. At this time, OSM #8 was asked if this process was completed when Resident #1 moved on 1/6/17. OSM #8 stated she notified Resident #1 and the resident's responsible party of the room change. OSM #8 stated she had to call the resident's responsible party at the time because the responsible party was out of town. OSM #8 confirmed she didn't document notification. When asked if Resident #1 was afforded the opportunity to see the new room and meet the new roommate prior to the room change, OSM #8 stated the resident was bed bound so she probably wasn't shown the new room or allowed to meet the new roommate. When asked how she knew the resident was bed bound, OSM #8 stated facility staff said the resident had wounds and couldn't get out of bed. When asked who told her this, OSM #8 stated she couldn't remember.

On 2/15/17 at 9:45 a.m., an interview was conducted with RN (registered nurse) #2 (Parc unit manager). RN #2 was asked if Resident #1

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was bed bound during the time period of 1/6/17 when the resident moved to a new room. RN #2 stated the resident had a sacral wound (wound on the resident's bottom) and would get up in a chair an hour at a time but was in bed a lot. When asked if it would have been possible for the resident to be wheeled to her new room and meet her new roommate, RN #2 stated, "Possibly."

On 2/15/17 at 9:50 a.m., an interview was conducted with RN (registered nurse) #7 (wound care nurse). RN #7 was asked if Resident #1 was bed bound during the time period of 1/6/17 when the resident moved to a new room. RN #7 stated although the resident refused to get out of bed at times, the resident was occasionally getting up into a "Geri chair" (a special reclining chair) for one to two hours a day.

On 2/15/17 at 9:55 a.m., another interview was conducted with OSM #8. OSM #8 confirmed that to her knowledge, Resident #1 was not taken to see her new room or meet her new roommate prior to the 1/6/17 room change because she thought the resident was bed bound. OSM #8 stated the reason for the room change was because the resident had to move to a long term care bed because her Medicare benefits had exhausted. At this time, OSM #8 was made aware this surveyor had spoken to other staff who stated Resident #1 was not bed bound during the time period of 1/6/17. OSM #8 had no further comments.

On 2/15/17 at 2:03 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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F 250	Continued From page 48 The facility social service manual documented in part, "Social Service Role: Reasonably accommodate patient preferences when considering a change in room or roommate. Assist with notification to the patient or responsible party of the change, the reason for the change and respond to questions. Introduce the patient with the room before the move. Introduce the patient to the new roommate..." No further information was presented prior to exit. (1) "A pressure injury (pressure ulcer) is localized damage to the skin and 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." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/	F 250		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification	F 278	F-278 *It is the intended practice of this facility to have an assessment that accurately reflects the resident's status.*	3/31/17

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(1) A registered nurse must sign and certify that the assessment is completed.

(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(j) Penalty for Falsification
(1) Under Medicare and Medicaid, an individual who willfully and knowingly-

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to maintain an accurate MDS (minimum data set) assessment for three of 29 residents in the survey sample, Resident # 9, Resident # 11 and Resident # 12.

1. The facility staff failed to correctly code Resident # 9's height on the quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/24/16.

2. a. The facility staff failed to correctly code

Criteria 1

Upon notification from surveyor residents #9's height has been modified and resubmitted.
Resident#11's weight has been modified and resubmitted

Resident #11 sections O has been modified and resubmitted
Resident #12 section H has be modified and resubmitted

Criteria 2

All residents have the potential to be affected.

Criteria 3

MDS staff and dieticians will be re-educated on ensuring that all residents are assessed and MDS codes correctly.

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Resident #11 as having a weight loss instead of a weight gain on the 14 day minimum data set (MDS) assessment with an ARD date of 11/16/16.

b. The facility staff coded Resident #11, in section O of the 14 day MDS assessment with an assessment reference date of 11/16/16, as receiving oxygen therapy. The resident did not have physician orders for and was not receiving oxygen.

3. The facility staff failed to correctly code Resident #12's continence status on the quarterly MDS (minimum data set) assessment, with an assessment reference date of 12/24/16.

The findings include:

1. The facility staff failed to correctly code Resident # 9's height on the quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/24/16.

Resident # 9 was admitted to the facility on 02/23/11 and readmitted on 09/15/11 with diagnoses that included but were not limited to: hypertension (1), heart failure, umbilical hernia (2), dementia (3), gastroesophageal reflux disease (4) and gout (5).

Resident # 9's most recent comprehensive MDS (minimum data set) a significant change assessment, with an assessment reference date (ARD) of 01/23/17, coded the resident as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being moderately impaired of cognition for daily decision making. Resident # 9 was coded as requiring limited

Criteria 4

The administrator or designee will audit sections K, O and H of the MDS to ensure accurate assessment and coding daily x5 days, three times weekly x3 weeks and monthly x2 months to ensure

Criteria 5

The facility's alleged date of compliance is 3/31/2017.

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assistance of one staff member for activities of daily living. In Section K: Swallowing/Nutritional Status, under K0200: Height and Weight, Resident # 9's height was documented as 66 inches.

Resident # 9's MDS (minimum data set) a quarterly assessment, with an ARD of 11/24/16 coded the resident as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact for daily decision making. Resident # 9 was coded as requiring limited assistance with activities of daily living. In Section K: Swallowing/Nutritional Status, under K0200: Height and Weight, Resident # 9's height was documented as 68 inches.

On 02/22/16 at 9:45 a.m. an interview was conducted with RN (registered nurse) # 4, MDS coordinator regarding the discrepancy in documentation of Resident # 9's height on the significant change and quarterly MDS assessments above. RN # 4 stated, "The height on the quarterly MDS was coded incorrectly. The height should have been 66 inches." When asked what guidance they use to complete MDS assessments, LPN # 4 stated, "We follow the RAI (resident assessment instrument) manual."

CMS's (Centers of Medicare/Medicaid) RAI (resident assessment instrument) Version 3.0 Manual CH 3: MDS Items [K] documented, "K0200: Height and Weight. K0200: Height and Weight (cont.) Item Rationale. Health-related Quality of Life. Diminished nutritional and hydration status can lead to debility that can adversely affect health and safety as well as quality of life. Planning for Care. Height and weight measurements assist staff with assessing

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the resident's nutrition and hydration status by providing a mechanism for monitoring stability of weight over a period of time. The measurement of weight is one guide for determining nutritional status. Steps for Assessment for K0200A, Height. 1. Base height on the most recent height since the most recent admission/entry or reentry. Measure and record height in inches. 2. Measure height consistently over time in accordance with the facility policy and procedure, which should reflect current standards of practice (shoes off, etc.). 3. For subsequent assessments, check the medical record. If the last height recorded was more than one year ago, measure and record the resident's height again. Coding Instructions for K0200A, Height. Record height to the nearest whole inch. Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches and a height of 62.4 inches would be rounded to 62 inches."

On 02/15/17 at approximately 2:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, the director of nursing, were made aware of the findings.

No further information was provided prior to exit.

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) An umbilical hernia is an outward bulging (protrusion) of the lining of the abdomen or part of the abdominal organ(s) through the area around the belly button. This information was obtained from the website: https://medlineplus.gov/ency/article/000987.htm.

(3) Dementia is 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.

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

(5) A type of arthritis. It occurs when uric acid builds up in blood and causes inflammation in the joints. This information was obtained from the website: https://medlineplus.gov/ency/article/000422.htm.

2. a. The facility staff failed to correctly code Resident #11 as having a weight loss instead of a weight gain on the MDS (minimum data set), a 14 day assessment with an ARD (assessment reference date of 11/16/16.

Resident #11 was admitted to the facility on 10/21/15 and was readmitted on 11/3/16 with diagnoses that included but were not limited to: stroke, heart disease, irregular heartbeat, high blood pressure and dementia.

The most recent MDS, a 14 day assessment, with an ARD of 11/16/16 coded the resident as having a nine out of 15 on the BIMS indicating the

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resident was moderately cognitively impaired. The resident was coded as needing assistance from staff for activities of daily living except for eating which the resident could do once the meal tray was prepared. In section O: the resident was coded as receiving oxygen. In section K0200 Height and Weight the resident was coded as weighing 159 pounds. In section K0300 Weight Loss a "0" was documented in the box indicating that a weight loss did not occur or was unknown. In section K0310 Weight Gain a "2" was documented in the box indicating that the resident had had a weight gain.

Review of the MDS, an annual assessment, with an ARD date of 11/9/16 documented in section K0200 Height and Weight that the resident was coded as weighing 166 pounds. This indicated Resident #11 was seven pounds heavier than documented on the 11/16/16 14 day MDS assessment.

An interview was conducted on 2/15/17 at 9:50 a.m. with OSM (other staff member) #11, the dietitian. When asked who completed section K of the MDS assessments, OSM #11 stated, "We do." When asked how weights were obtained to enter into the MDS assessment, OSM #11 stated, "I review the weights and my notes. I don't review the MDS assessments." When asked to review section K on Resident #11's annual MDS assessment with an ARD of 11/9/16 and the 14 day MDS assessment with an ARD of 11/16/16, OSM #11 stated, "Okay, I see the issue. It looks like the 166 pound weight was not accurate. The MDS needs to be updated." When asked why the resident was coded as having a weight gain instead of the seven pound weight loss as documented, OSM #11 did not have an

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explanation. When asked what reference they used to complete the MDS assessment, OSM #11 stated, "The RAI (resident assessment instrument)."

On 2/15/17 at 2:03 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

b. The facility staff coded Resident #11, in section O of the 14 day MDS assessment with an ARD of 11/16/16, as receiving oxygen therapy. The resident did not have physician orders for and was not receiving oxygen.

An observation of Resident #11 was made on 2/14/17 at 2:30 p.m., Resident #11 was sitting on the side of the bed. The resident was not wearing oxygen and there was no oxygen in the room.

An observation was made of Resident #11 on 2/15/17 at 7:30 a.m., Resident #11 was walking around the room. There was no oxygen observed in the room.

Review of the physician's orders dated and signed on 1/28/17 did not evidence documentation regarding an oxygen order.

Review of the November and December 2016 TARs (treatment administration records) and the January 2017 TAR did not evidence documentation regarding oxygen.

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An interview was conducted on 2/15/17 at 9:40 a.m. with RN (registered nurse) #6, the MDS coordinator. When asked how information was obtained to complete the MDS assessments, RN #6 stated the information was located in the clinical record or through resident interview. When asked to review Resident #11's 14 day MDS assessment with an ARD of 11/16/16, that coded Resident #11 as receiving oxygen, RN #6 stated, "I don't see it in the notes. It might have been a coding error. Why I went back and checked it I don't know." When asked what document they used to complete the MDS assessments, RN #6 stated, "The RAI."

On 2/15/17 at 2:03 p.m. ASM #1 and ASM #2 were made aware of the findings.

No further information was provided prior to exit.

3. The facility staff failed to correctly code Resident #12's continence status on the quarterly MDS (minimum data set) assessment, with an assessment reference date of 12/24/16.

Resident #12 was admitted to the facility on 6/21/15 with diagnoses that included but were not limited to: bladder cancer, chronic obstructive pulmonary disease (COPD), cataracts, and has a pacemaker (an electrical device used to maintain a normal heart rhythm (1)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 12/24/16, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring supervision, or as independent for all of his activities of daily living. In Section H - Bladder

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and Bowel, Resident #12 was coded as having an ostomy (a surgical procedure in which an opening is made to allow the passage of urine from the bladder or feces from the intestines (2)). In Section H0300 - Urinary Continence, the resident was coded with a "0" indicating the resident was always continent.

The quarterly MDS assessment, with an ARD of 9/24/16, was reviewed and compared to the quarterly assessment with an ARD date of 12/24/16. The quarterly MDS assessment, with an ARD of 9/24/16, coded the resident as having an ostomy. In Section H0300 - Urinary Continence, the resident was coded with a "9" indicating "not rated, resident had a catheter (indwelling or condom), urinary ostomy or no urine output for the entire 7 days."

An interview was conducted on 2/15/17 at 9:07 a.m. with RN (registered nurse) #4, the MDS nurse. RN #4 was asked to review the two quarterly MDS assessments, with an ARD of 9/24/16 and 12/24/16. RN #4 stated, "That's wrong (quarterly MDS assessment with and ARD of 12/24/16 coding the resident as continent in section H0300). It should not be coded as continent, he has an ileal conduit (Urinary diversion is a surgical procedure that reroutes the normal flow of urine out of the body when urine flow is blocked (3)). That's my fault, I coded that wrong."

The administrator, the director of nursing, and the corporate quality assurance nurse were made aware of the above findings on 2/15/17 at 2:00 p.m.

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(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader 5th edition, Rothenberg and Chapman; page 429
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader 5th edition, Rothenberg and Chapman; page 424
(3) This information was obtained from the following website: https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-diversion.

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483.20
(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable

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It is the intended practice of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

Criteria 1
Upon notification from surveyor Resident#1's care plan was reviewed and up dated to reflect cognitive loss/dementia status

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F 279	Continued From page 59 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 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan from triggered areas in the CAA (care	F 279	Criteria 2 All residents have a potential to be affected. Criteria 3 MDS and social service staff will be re-educated to develop comprehensive care plans from triggered areas in the care area assessment. Criteria 4 The administrator or designee will audit section V of MDS to ensure comprehensive assessments have been developed for these triggered items dailyx5 days, three times weekly x3 weeks and monthly x2 months Criteria 5 The facility's alleged date of compliance is 3/31/2017. RECEIVED MAR 09 2017 VDH/OLC	3/31/17

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area assessment) section of the MDS (minimum data set) assessment for one of 29 residents in the survey sample, Resident #1.

The facility staff failed to develop Resident #1's care plan for the CAA triggered area of cognitive loss/dementia in Section V of the admission MDS assessment with an ARD (assessment reference date) of 10/28/16.

The findings include:

Resident #1 was admitted to the facility on 10/21/16. Resident #1's diagnoses included but were not limited to: pressure ulcer (1), major depressive disorder and diabetes. Resident #1's most recent MDS, a quarterly assessment with an ARD (assessment reference date) of 1/15/17, coded the resident's cognition as being severely impaired.

Resident #1's most recent comprehensive MDS was an admission assessment with an ARD of 10/28/16. Section V CAA (care area assessment) documented an "X" beside the triggered care area of cognitive loss/dementia and documented the area would be care planned. Resident #1's comprehensive care plan initiated on 10/21/16 failed to document any information regarding cognitive loss/dementia.

On 2/15/17 at 9:25 a.m., an interview was conducted with RN (registered nurse) #5 (MDS coordinator). RN #5 was asked to review Resident #1's comprehensive care plan and show this surveyor where cognition had been documented on the care plan. RN #5 reviewed Resident #1's comprehensive care plan and confirmed cognition was not documented on the

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care plan. RN #5 stated areas that trigger on the CAAs and are documented as needing to be care planned should be care planned. RN #5 stated she writes all the triggered areas on a form then checks the areas off as she care plans them. RN #5 stated she would add cognition to Resident #1's care plan on this day. RN #5 stated she references the CMS (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument) manual when care planning based on the CAAs.

On 2/15/17 at 2:03 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The CMS RAI manual documented the following: "Coding Instructions for V0200A, CAAs
·Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.
·For each triggered care area, Column B "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The "Care Planning Decision" column

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must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed."

No further information was presented prior to exit.

(1) "A pressure injury (pressure ulcer) is localized damage to the skin and 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." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

F 280 SS=D 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

F 280

F-280

3/31/17

483.10
(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type,

It is the intended practice of this facility to honor a resident's right to—unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state—participate in planning care and treatment or changes in care and treatment.

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amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

Criteria 1
Upon notification from surveyor Resident #8's indwelling urinary catheter was taken off the care plan and Resident #11's oxygen use was resolved off the care plan.

Criteria 2
Any and all residents have the potential to be affected.

Criteria 3
The interdisciplinary team will be re-educated to ensure that care plans are updated to reflect residents' current status.

Criteria 4
DON or designee will audit care plan via ER to ensure care plans are updated timely to reflect residents' current conditions daily x5days, 3 times weekly x3 weeks, and monthly x2 months.

Criteria 5
The facility's alleged date of compliance is 3/31/2017.

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(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews, facility document review and clinical record review, it was determined that facility staff failed to review and revise the comprehensive care plan for two of 29 residents in the survey sample, Resident #8 and Resident #11.

1. The facility staff failed to revise Resident #8's comprehensive care plan after the urinary catheter was discontinued on 2/2/17.

2. The facility staff failed to revise Resident #11's comprehensive care plan after oxygen was

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F 280	Continued From page 65 discontinued on 11/3/16.	F 280		

The findings include:

1. The facility staff failed to revise Resident #8's comprehensive care plan after the urinary catheter was discontinued on 2/2/17.

Resident #8 was admitted to the facility on 3/25/11 and readmitted on 12/24/16 with diagnoses that included but were not limited to: urinary incontinence, kidney disease, anemia, dementia and diabetes.

The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 11/18/16 coded the resident as having scored 10 out of 15 on the brief interview for mental status (BIMS) assessment indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as always being incontinent of urine.

An observation of Resident #8 was made on 2/14/16 at 2:35 p.m.; the resident was lying in bed watching television there was no urinary catheter seen.

An observation was made of Resident #8 on 2/15/16 at 7:20 a.m. and 9:15 a.m.; Resident #8 was awake and resting in bed. There was no urinary catheter observed.

Review of Resident #8's comprehensive care plan initiated on 12/25/16 documented, "Focus Use of indwelling catheter needed until seen by

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urologist. Interventions Report any changes in amount and color, or odor of urine."

Review of the 1/30/17 urologist note did not evidence documentation regarding the status of the urinary catheter.

Review of the physician's orders dated 2/2/17 documented, "Clarification order: DC (discontinue) Foley Cath (catheter)..."

Review of the January 2017 TAR (treatment administration record) documented, "Foley Catheter care qs (every shift)." Urinary catheter care was documented as being provided from 1/4/16 through 1/31/16."

Review of the February 2017 TAR did not evidence documentation regarding the urinary catheter.

An interview was conducted on 2/15/17 at 9:40 a.m. with RN (registered nurse) #6, the MDS coordinator. When asked who updates the care plans, RN #6 stated, "We do and the nursing staff does." RN #6 was asked when the comprehensive care plan would be updated. RN #6 stated, "We do it quarterly, on admission and any assessment if we have a change."

An interview was conducted on 2/15/17 at 10:46 a.m. with RN #3, the unit manager. When asked who used the care plan, RN #3 stated, "Everybody uses the care plan." RN #3 was asked when a resident care plan would be updated. RN #3 stated, "Care plans are updated on an ongoing basis, when orders change or the condition changes. So could be (updated) by any of the nurses." When asked why the care plans

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would be updated, RN #3 stated, "As (resident) conditions change so we can deliver appropriate care on an ongoing basis." When asked if the care plan would be updated if a resident had a urinary catheter removed, RN #3 stated, "Yes."

An interview was conducted on 2/15/17 with RN #7. RN #7 stated, "I think that (the urinary catheter) got resolved from the care plan." When asked to review Resident #8's care plan, RN #7 stated, "So no it's not resolved. I was wrong." When asked if the care plan should have been updated, RN #7 stated, "Yes."

On 2/15/17 at 2:03 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "INTERDISCIPLINARY CARE PLANNING" documented, "CARE PLANNING: The patient's care plan is a communication tool that guides members of the interdisciplinary healthcare team in how to meet each individual patient's needs. It also identifies the types and methods of care that the patient should receive. CARE PLAN COMPONENTS: Evaluating means monitoring patients' progress toward their goals. Evaluation may result in...adjusting treatment plans or interventions.

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of

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care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)

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

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

2. The facility staff failed to revise Resident #11's comprehensive care plan after the oxygen was discontinued on 11/3/16.

Resident #11 was admitted to the facility on 10/21/15 and was readmitted on 11/3/16 with diagnoses that included but were not limited to:

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stroke, heart disease, irregular heartbeat, high blood pressure and dementia.

The most recent MDS, a 14 day assessment, with an (assessment reference date) ARD of 11/16/16 coded the resident as having scored a nine out of 15 on the BIMS, indicating the resident was moderately cognitively impaired. The resident was coded as needing assistance from staff for activities of daily living except for eating which the resident could do once the meal tray was prepared. The resident was coded as receiving oxygen.

An observation of Resident #11 was made on 2/14/17 at 2:30 p.m.; Resident #11 was sitting on the side of the bed. The resident was not wearing oxygen and there was no oxygen in the room.

An observation of Resident #11 was made on 2/15/17 at 7:30 a.m.; Resident #11 was walking around the room. There was no oxygen observed in the room.

Review of the physician's orders dated and signed on 1/28/17 did not evidence documentation of an order for oxygen.

Review of the November and December 2016 TARs (treatment administration records) and the January and February 2017 MARs (medication administration record) did not evidence documentation regarding oxygen.

Review of Resident #11's care plan initiated on 10/2/15 and revised on 12/2/15 documented, "Focus Cardiac disease related to Hx (history) of MI (myocardial infarction, heart attack)....Interventions Administer oxygen as

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ordered, monitor o2 (oxygen) sats (saturations) every shift."

An interview was conducted on 2/15/17 at 2:45 p.m. with LPN (licensed practical nurse) #7, the resident's nurse. When asked if Resident #11 had an order for oxygen, LPN #7 stated, "He hasn't had oxygen in a long time. I'm thinking that order was d/c'd (discontinued)." When asked to locate the order, LPN #7 was unable to do so. When asked if oxygen was considered a medication and would be ordered and discontinued the same as any medicine, LPN #7 stated, "Yes." When asked if the care plan would be updated if the oxygen had been discontinued, LPN #7 stated, "Yes."

An interview was conducted on 2/15/17 at 3:20 p.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated, "(Name of Resident #11) had an order for prn (as needed) oxygen when he was admitted in February 2016 until he went to the hospital in November. It wasn't re-ordered when he came back." ASM #2 was asked when a resident care plan would be updated. ASM #2 stated, "We update any changes in condition, any deviation from the baseline." When asked if Resident #11's care plan should be updated to reflect the discontinuation of oxygen, ASM #2 stated, "Yes."

No further information was provided prior to exit.

F 281 SS=D 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

F 281

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It is the intended practice of this facility to provide services that meet professional standards of quality.

(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan,

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record). The TARs documented to change the catheter every month on the 25th and as needed.

Resident #1 was admitted to the facility on 10/21/16. Resident #1's diagnoses included but were not limited to: pressure ulcer (2), major depressive disorder and diabetes. Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/15/17, coded the resident's cognition as being severely impaired.

Review of Resident #1's clinical record revealed a physician's telephone order dated 11/29/16 and signed by the physician on 11/30/16 that documented, "Change Foley catheter today 11/29/16. Change Foley catheter monthly and PRN- monthly on 25th of every month. DX (diagnosis): wound healing." Further review of Resident #1's clinical record revealed a physician's order summary signed on 11/30/16 that documented, "CHANGE FOLEY CATH (catheter) #16F (French [size]) AS NEEDED 11-7 (11:00 p.m. to 7:00 a.m. shift)."

Resident #1's December 2016 TAR (treatment administration record) documented, "Change Foley catheter on the 25th & PRN (as needed)." Resident #1's January 2017 TAR documented, "CHANGE FOLEY CATH #16F EVERY MONTH AND AS NEEDED ON THE 25TH- DX: WOUND HEALING." Neither TAR documented the physician order to only change the catheter as needed per the physician's order summary signed on 11/30/16.

Resident #1's comprehensive care plan initiated on 10/21/16 documented, "Focus: Use of indwelling urinary catheter needed due to sacral

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wound...Interventions: Change catheter per physician order..."

On 2/15/17 at 4:00 p.m., an interview was conducted with RN (registered nurse) #9. RN #9 was asked which Foley catheter order for Resident #1 was supposed to be followed and whether staff was supposed to change the catheter every month on the 25th and as needed or to only change the catheter as needed. RN #9 stated the physician signed the telephone order dated 11/29/16 to change the catheter every month and as needed to acknowledge he had given that order on 11/29/16 but had signed the physician order summary dated 11/30/16 to indicate he wanted staff to only change the catheter as needed. RN #9 stated the nurses were supposed to follow the order on the physician's order summary and only change the catheter as needed. When asked why the December 2016 and January 2017 TARs documented to change the catheter every month on the 25th and as needed instead of to change the catheter as needed, RN #9 stated there was a transcription error and the TARs should have only documented to change the catheter as needed.

On 2/15/17 at 4:10 p.m., ASM (administrative staff member) #2 (the director of nursing) was made aware of the above concern. When asked what standard of practice the facility followed, ASM #2 stated the facility nurses followed the facility nursing procedures. ASM #2 was asked to provide a copy of their transcription procedure.

On 2/15/17 at 4:20 p.m., ASM #1 (the administrator) was made aware of the above concern.

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The facility document titled, "REQUIREMENTS AND GUIDELINES FOR CLINICAL RECORD CONTENT" documented, "Transcribing or Noting Orders: Physician orders that are written, telephone or faxed are noted by a licensed nurse. The nurse is responsible for the accuracy of transcription and signs and dates the orders as noted. The licensed nurse, noting the order, transcribes the new medication or treatment onto the patient's Medication Administration Record (MAR) or Treatment Administration Record (TAR). If a medication or treatment is discontinued by the physician, the licensed nurse discontinues the item from the MAR or TAR per center practice..."

No further information was presented prior to exit.

(1) A Foley catheter is a tube placed in the bladder and used to drain urine. This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm

(2) "A pressure injury (pressure ulcer) is localized damage to the skin and 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." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

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2. The facility staff failed to clarify physician's orders for nystatin cream and triamcinolone cream during the monthly order recapitulation reviewed by a facility nurse on 1/29/17 and signed by the nurse practitioner on 1/31/17, for Resident #14.

Resident #14 was admitted to the facility on 4/27/12. Resident #14's diagnoses included but were not limited to: cerebrovascular disease (stroke), chronic pain syndrome and high blood pressure. Resident #14's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/27/17, coded the resident as being cognitively intact.

Review of Resident #14's clinical record revealed a physician's order summary signed on 1/11/17 that documented orders including but not limited to: nystatin 100,000 unit/one gram cream to be topically applied to the resident's groin/neck/face twice daily as needed with triamcinolone cream and triamcinolone acetonide 0.1% cream to be applied to the resident's groin/neck/face twice daily as needed with nystatin cream. A physician's order summary signed on 1/31/17 failed to documented orders for nystatin cream and triamcinolone acetonide cream. Further review of Resident #14's clinical record failed to reveal physician's orders to discontinue the nystatin cream and triamcinolone acetonide cream.

Resident #14's January 2017 TAR (treatment administration record) documented physician's orders including but not limited to: nystatin 100,000 unit/one gram cream (1) to be topically applied to the resident's groin/neck/face twice daily as needed with triamcinolone cream and

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triamcinolone acetonide 0.1% cream (2) to be applied to the resident's groin/neck/face twice daily as needed with nystatin cream. Resident #14's February 2017 TAR did not document orders for nystatin cream or triamcinolone acetonide cream.

Resident #14's comprehensive care plan revised on 2/8/17 documented, "Focus: Recurrent Yeast Rash at groin area...Interventions: Administer treatment per physician orders..."

On 2/15/17 at 2:52 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to explain why Resident #14's physician order summary signed on 1/11/17 contained orders for nystatin cream and triamcinolone cream but the physician's order summary signed 1/31/17 did not contain those orders when there had not been an order to discontinue those creams. LPN #1 stated back in October 2016 Resident #14 had orders for nystatin cream and triamcinolone cream scheduled for two weeks then as needed. LPN #1 stated she thought at some point the nystatin cream had been switched to powder because the cream was not available. LPN #1 confirmed the physician order summary signed on 1/11/17 contained orders for nystatin cream and triamcinolone cream but the physician's order summary signed on 1/31/17 did not contain those order. LPN #1 also confirmed she did not see an order to discontinue those creams. LPN #1 stated the orders had "dropped off" the latest physician order summary. LPN #1 was asked about the review process for physician's orders during the monthly recapitulation. LPN #1 stated the new physician order summary should be reviewed and compared to the previous physician

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order summary and the telephone orders given between the previous and new physician order summaries. LPN #1 confirmed the discrepancies related to the nystatin cream and triamcinolone cream on the physician order summaries should have been noted during the monthly recapitulation and the physician and pharmacy should have been contacted.

On 2/15/17 at 4:10 p.m., ASM (administrative staff member) #2 (the director of nursing) was made aware of the above concern. ASM #2 was asked what standard of practice the facility followed and stated the facility nurses followed the facility nursing procedures. ASM #2 was asked to provide a copy of their monthly recapitulation procedure.

On 2/15/17 at 4:20 p.m., ASM #1 (the administrator) was made aware of the above concern.

The facility document titled, "REQUIREMENTS AND GUIDELINES FOR CLINICAL RECORD CONTENT" documented, "Transcribing or Noting Orders: Physician orders that are written, telephone or faxed are noted by a licensed nurse. The nurse is responsible for the accuracy of transcription and signs and dates the orders as noted. The licensed nurse, noting the order, transcribes the new medication or treatment onto the patient's Medication Administration Record (MAR) or Treatment Administration Record (TAR). If a medication or treatment is discontinued by the physician, the licensed nurse discontinues the item from the MAR or TAR per center practice...PHYSICIAN ORDER RECAP PROCESS: The Physician Order Recap process is completed monthly for both paper and

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electronic order centers. Paper physician order centers: the Medical Record professional collects the new month's Physician Order Recap Sheets and obtains physician signatures per center practice and per federal/state regulatory guidelines; the physician signed Physician Order Recap Sheet(s) are filed in the patient's medical record..."

No further information was presented prior to exit.

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

(2) Triamcinolone is used to treat itching, redness and inflammation of the skin. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601124.html

3. The facility staff failed to document a verbal telephone order and transcribe the order onto the MAR (medication administration record) for Resident #12.

Resident #12 was admitted to the facility on 6/21/15 with diagnoses that included but were not limited to: bladder cancer, chronic obstructive pulmonary disease (COPD), cataracts, and has a pacemaker (an electrical device used to maintain a normal heart rhythm (1)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/24/16, coded

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the resident as being cognitively intact to make daily decisions. The resident was coded as requiring supervision to independent for all of his activities of daily living.

The physician orders dated 6/22/15 and renewed by the physician on 12/26/16 and 1/22/17, documented, "MAPAP (Tylenol)(used to treat fever or mild to moderate pain (2)) 325 MG (milligrams) tablet; 2 tabs (tablets) (650 MG) by mouth every 4 hours as needed for temperature > (greater than) 100.5 (100.5 degrees Fahrenheit)."

Review of the February 2017 MAR (medication administration record) documented, "MAPAP (Tylenol) 325 MG tablet; 2 tabs (650 MG) by mouth every 4 hours as needed for temperature > 100.5." The MAR documented the resident to have received a dose of Tylenol on 2/9/17 at 9:25 p.m. and 2/11/17 at 4:50 p.m. The reverse side of the MAR documented, "2/9/17 9:25 p.m. (initials of nurse) Tylenol 650 mg headache - effective. 2/11/17 at 4:50 p.m. (initials of nurse) Tylenol 650 mg c/o (complaint of) H/A (headache) - effective."

Review of the nurse's notes did not reveal any nurse's notes for 2/9/17 and 2/11/17.

An interview was conducted with administrative staff member (ASM) #3, the assistant director of nursing; on 2/15/17 at 9:58 a.m. ASM #3 was asked to review the above physician order for Tylenol. When asked when a nurse can give the Tylenol, ASM #3 stated, "If the resident had a temperature greater than 100.5." When asked if a nurse can give the resident Tylenol if they complain of a headache, ASM #3 stated, "No, not the way that order is written. They would have to contact the physician."

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An interview was conducted with LPN (licensed practical nurse) #10, the nurse who administered both doses of Tylenol in February, on 2/15/17 at 2:27 p.m. When asked what steps she would take if a resident requested Tylenol, LPN #10 stated, "Well, first you have to find out why they want it. You would need a physician order to give it for anything other than what the orders says it's prescribed for. I would call the doctor and tell him of the resident's complaint of a headache and ask if I could give him the Tylenol. If the doctor gave me that order, then I'd have to write a verbal order and write a new order on the MAR." LPN #10 stated, "I try to follow the policies of the building I'm working in. I just started about three weeks ago at the facility. I keep notes of my shifts". LPN #10 stated she would check her notes and get back with this surveyor.

On 2/15/17 at 4:00 p.m. LPN #10 called this surveyor and stated, "I found my notes. I had called the doctor and got a new order for the Tylenol to give the resident (Resident #12) two Tylenol for headache every six hours PRN (as needed); not to exceed three to four grams in 24 hours." When asked if she should have documented the physician order, LPN #10 stated, "Yes, I should have." When asked if she should have transcribed the new order for Tylenol for headache onto the MAR, LPN #10 stated, "Yes, Ma'am, I should have but I guess I didn't if you don't see it there."

The facility policy, "Requirements and Guidelines for Clinical Record Content" documented in part, "A Physician's telephone order form is completed for each telephone or verbal order received...The qualified professional writes the order and reads it

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F 281	Continued From page 81 back, verbatim, to the initiation practitioner. The practitioner verbally confirms or corrects the order. This verification process applies to each verbal telephone or securely messaged order. Telephone orders are signed and dated by the attending physician within the period of time defined by state regulations." In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 336. "The physician or health care provider should write all orders. The nurse is responsible for transcribing correctly written orders. If a verbal order is necessary (e.g. during an emergency), have it written and signed by the physician or health care provider as soon as possible, usually within 24 hours." The administrator was made aware of the above concern on 2/15/17 at 4:35 p.m. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader 5th edition, Rothenberg and Chapman; page 429 (2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0000015/	F 281		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of	F 282	F-282 *It is the intended practice of this facility to ensure that services provided or arranged must be provided by qualified persons in accordance with each resident's written plan of care.*	3/31/17

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care.
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 follow the care plan for one of 29 residents in the survey sample, Resident #11.

Facility staff failed to follow the care plan to check the pulse oximetry saturations (1) each shift for Resident #11.

The findings include:

Resident #11 was admitted to the facility on 10/21/15 and was readmitted on 11/3/16 with diagnoses that included but were not limited to: stroke, heart disease, irregular heartbeat, high blood pressure and dementia.

The most recent MDS (Minimum Data Set), a 14 day assessment, with an ARD (Assessment Reference Date) of 11/16/16 coded the resident as having a nine out of 15 on the BIMS (Brief Interview for Mental Status) indicating the resident was moderately cognitively impaired. The resident was coded as needing assistance from staff for activities of daily living except for eating which the resident could do once the meal tray was prepared. The resident was coded as receiving oxygen.

Review of the physician's order dated 2/22/16 documented, "O2 prn (as needed)."

Review of Resident #11's care plan initiated on 10/2/15 and revised on 12/2/15 documented,

Criteria 1
Resident#11 was assessed for need of continuous pulse oximetry saturations check and it was clarified by MD that he does not need it at this time and care plan updated.

Criteria 2
All residents have a potential to be affected.

Criteria 3
The interdisciplinary team will be re-educated to ensure that care plans are followed.

Criteria 4
DON or designee will audit 5 Residents care plan to ensure that residents care plans are followed dailyx5 days, three times

weeklyx3weeks and
monthlyx2months

Criteria 5

The facility's alleged date of compliance is 3/31/2017.

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"Focus Cardiac disease related to Hx (history) of MI (myocardial infarction, heart attack)....Interventions Administer oxygen as ordered, monitor o2 sats (oxygen saturations) every shift."

Review of the TARs (treatment administration records) for February 2016 through November 2016 did not evidence documentation of the oxygen saturations.

Review of the nurse's notes did not evidence documentation of a pulse oximetry saturation done every shift.

An interview was conducted on 2/15/17 at 10:40 a.m., with RN (registered nurse) #3, the unit manager. When asked who used the care plan, RN #3 stated, "Everybody uses the care plan." When asked if nurses were expected to follow the care plan, RN #3 stated, "Absolutely." RN #3 was made aware of the findings at that time.

An interview was conducted on 2/15/17 at 3:20 p.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated, "(Name of Resident #11) had an order for prn (as needed) oxygen when he (Resident #11) was admitted in February 2016 until he went to the hospital in November. It wasn't re-ordered when he came back." When asked if the physician ordered oxygen and oxygen satuartions would be documented on the TARs from February 2016 to November 2016, ASM #2 stated they should be. When asked who used the care plan, ASM #2 stated the staff did. When asked if staff were expected to follow the care plan, ASM #2 stated they were. ASM #2 was made aware of the findings at that time.

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On 2/15/17 at 4:25 p.m. ASM #2 gave this surveyor nurse's notes dated from 3/29/16 to 11/3/16. There were five pulse oximetry's documented.

Review of the facility's policy titled, "INTERDISCIPLINARY CARE PLANNING" documented, "CARE PLANNING: The patient' d care plan is a communication tool that guides members of the interdisciplinary healthcare tram in how to meet each individual patient's needs. It also identifies the types and methods of care that the patient should receive. CARE PLANNING PROCESS: Implementation Once the care plan is developed, the staff must implement the interventions identified in the care plan. These may include, but is not limited to: administering treatments and medications, performing therapies..."

No further information was provided prior to exit.

(1) Pulse oximetry – Oxygen saturation by pulse oximetry is commonly used for monitoring critical patients. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed?term=Rev%20Esp%20Cardiol%5BJour%5D%20AND%2065%5Bvolume%5D%20AND%20879%5Bpage%5D&cmd=DetailsSearch

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(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:

(i) Provide foot care and treatment, in accordance

It is the intended practice of this facility to ensure that residents receive proper treatment and care for special services including but not limited to respiratory care and

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F 328	Continued From page 85 with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the	F 328	*that care be consistent with professional standards of practice, the comprehensive care plan, and the resident's goals and preferences.* Criteria 1 Upon notification from surveyor of resident #22 nebulizer mask being out bag, nebulizer mask was replaced and stored appropriately, the empty oxygen cylinder was removed immediately and stored properly in the designated oxygen storage rack. Criteria3 The interdisciplinary team including nursing staff, rehab and ancillary staff will be re-educated on the facility procedures of oxygen storage The nursing staff will be reeducated on nebulizer equipment storage to ensure safety and proper sanitary use. RECEIVED MAR 0 9 2017 VDH/OLC	3/31/17

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residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility document review it was determined that the facility staff failed to store oxygen equipment in a sanitary manner for one of 29 residents in the survey sample, Resident # 22 and failed to store oxygen in a safe manner in the facility oxygen storage room.

1. The facility staff failed store to a nebulizer mask in a sanitary manner for Resident # 22.

2. Facility staff failed to properly store an empty two liter oxygen cylinder of oxygen in the oxygen cylinder storage rack in the facility's oxygen storage room. The empty 2 liter oxygen cylinder was observed unsecured, lying on its side on top of the oxygen cylinder storage rack.

The findings include:

1. The facility staff failed to store a nebulizer mask in a sanitary manner for Resident # 22.

Resident # 22 was admitted to the facility on 07/17/09 and readmitted on 06/30/16 with diagnoses that included but were not limited to:

Criteria 4

DON or designee will audit resident rooms and oxygen designated area in facility to ensure proper storage of oxygen and proper sanitation of nebulizer masks dailyx5 days, three times weeklyx3weeks and monthlyx2months

Criteria 5

The facility's alleged date of compliance is 3/31/2017.

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altered mental status (1), history of a stab wound, HIV/AIDS (2), hypertension (3), pneumonia (4) benign prostatic hyperplasia (5), chronic kidney disease (6) and chronic obstructive pulmonary disease [COPD] (7).

Resident # 9's most recent comprehensive MDS (minimum data set) a significant change assessment, with an assessment reference date (ARD) of 11/18/16, coded the resident as scoring a five on the brief interview for mental status (BIMS) of a score of 0 - 15, five being severely impaired of cognition for daily decision making.

The POS (physician's order sheet) dated 02/01/17- 02/28/17 for Resident # 22 documented, "01/04/17 Routine. IPRAT-ALBUT [Ipratropium and Albuterol (8)] 0.5-3 mg (milligram) / 3 ML (milliliter) via (by) nebulizer three times daily - DX (diagnosis) COPD"

On 02/15/17 at 1:00 p.m. an observation of Resident # 22's room revealed a nebulizer (9) sitting on top of Resident # 22's bedside table. Observation of the nebulizer revealed the tubing running from the nebulizer was connected to a breathing mask. The mask was placed on the nebulizer uncovered and exposed to the environment.

On 02/15/17 at 1:26 p.m. an observation of Resident # 22's room revealed the nebulizer sitting on top of Resident # 22's bedside table. Observation of the nebulizer revealed the tubing running from the nebulizer was connected to a breathing mask. The mask was placed on the nebulizer uncovered and exposed to the environment.

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On 02/15/17 at approximately 2:09 p.m. an interview was conducted with LPN (licensed practical nurse) # 2. LPN #2 was asked to describe the procedure for storing a nebulizer mask when it's not in use. LPN # 2 stated, "It should be stored in a plastic bag if it's not in use."

On 02/15/17 at 2:10 p.m. an observation of Resident # 22's room was conducted with LPN # 2. Upon entering the room, LPN # 2 was asked to observe the nebulizer positioned on top of Resident # 22's bedside table. After observing the uncovered nebulizer mask, LPN # 2 stated, "That (the nebulizer mask) should be in a bag. I'm going to replace the mask."

The facility's policy "Respiratory: Nebulizer Mist Therapy" documented, "Procedure: 19. Store dried nebulizer, t-piece, mouthpiece or mask in separate, labeled plastic bag."

On 02/15/17 at approximately 2:00 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, the director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:

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."

(1) A changed level of awareness or mental state

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that falls short of unconsciousness. Examples AMS Confusion, disorientation, or stupor (which, if of sudden onset, constitutes a medical emergency). This information was obtained from the website: http://medical-dictionary.thefreedictionary.com/altered+mental+status.

(2) Human immunodeficiency virus (HIV) is the virus that causes AIDS (acquired immunodeficiency syndrome). When a person becomes infected with HIV, the virus attacks and weakens the immune system. As the immune system weakens, the person is at risk of getting life-threatening infections and cancers. When that happens, the illness is called AIDS. Once a person has the virus, it stays inside the body for life. This information was obtained from the website: https://medlineplus.gov/ency/article/000594.htm.

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

(4) An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. This information was obtained from the website: https://medlineplus.gov/pneumonia.html.

(5) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

(6) Kidneys are damaged and can't filter blood as

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they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html.

(7) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(8) The combination of albuterol and ipratropium is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Albuterol and ipratropium combination is used by people whose symptoms have not been controlled by a single inhaled medication. Albuterol and ipratropium are in a class of medications called bronchodilators. Albuterol and ipratropium combination works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html.

(9) Because you have asthma, COPD, or another lung disease, your doctor has prescribed medicine that you need to take using a nebulizer. A nebulizer is a small machine that turns liquid medicine into a mist. You sit with the machine and breathe in through a connected mouthpiece. Medicine goes into your lungs as you take slow, deep breaths for 10 to 15 minutes. It is easy and pleasant to breathe the medicine into your lungs

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F 328	Continued From page 91 this way. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000006.htm. 2. Facility staff failed to properly store an empty two liter oxygen cylinder of oxygen in the oxygen cylinder storage rack in the facility's oxygen storage room. The empty 2 liter oxygen cylinder was observed unsecured, lying on its side on top of the oxygen cylinder storage rack. On 02/15/16 at 2:45 p.m. an observation of the facility's oxygen storage room next to the "Lee Room (the activity room) was conducted with OSM (other staff member) # 6, Director of Plant Operations. Upon opening the door to the oxygen storage room a two liter portable oxygen cylinder was observed unsecured, lying on its side on top of the oxygen cylinder storage rack. Further observation of the portable oxygen cylinder with OSM # 6 confirmed that the cylinder was empty. OSM # 6 stated, "They should be secured in a rack." On 02/15/17 at approximately 3:15 p.m. ASM (administrative staff member) # 1 the administrator, was made aware of the findings. No further information was provided prior to exit.	F 328		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--	F 329	F-329 *It is the intended practice of this facility to ensure each resident's drug regimen is free from unnecessary drugs.*	3/31/17

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F 329	Continued From page 92	F 329	Criteria 1 MD was notified that resident received Tylenol for headache instead of fever as initially indicated.MD gave new orders for Tylenol for headache at this time. Criteria 2 Any and all residents have the potential to be affected. Criteria 3 Licensed nurses will be re-educated to ensure understanding of instruction and indication on MD orders Criteria 4 DON or designee will audit MAR daily x5 days, three times weekly x3 weeks and monthly x2 months. Criteria 5 The facility's alleged date of compliance is 3/31/2017.	3/31/17

(1) In excessive dose (including duplicate drug therapy); or

(2) For excessive duration; or

(3) Without adequate monitoring; or

(4) Without adequate indications for its use; or

(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure the drug regimen for one of 29 residents in the survey sample, (Resident #12) was free of unnecessary medications.

The facility staff administered Tylenol to Resident #12 without adequate indications for administration of the medication on two occasions in December 2016.

The findings include:

Resident #12 was admitted to the facility on 6/21/15 with diagnoses that included but were not limited to: bladder cancer, chronic obstructive pulmonary disease (COPD), cataracts, and has a pacemaker (an electrical device used to maintain a normal heart rhythm (1)).

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The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/24/16, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring supervision or was independent for all of his activities of daily living.

The physician orders dated 6/22/15 and renewed by the physician on 12/26/16 and 1/22/17, documented, "MAPAP (Tylenol)(used to treat fever or mild to moderate pain) (2) 325 MG (milligrams) tablet; 2 tabs (tablets) (650 MG) by mouth every 4 hours as needed for temperature > (greater than) 100.5 (100.5 degrees Fahrenheit)."

The December 2016 MAR (medication administration record) documented, "MAPAP (Tylenol) 325 MG tablet; 2 tabs (650 MG) by mouth every 4 hours as needed for temperature > (greater than) 100.5." The Tylenol was documented as having been administered on 12/19/16 at 8:00 p.m. and 12/21/16 at 6:00 p.m. The reverse side of the MAR was blank.

The "Temperature Logs" in the computer system did not document any temperatures taken on 12/19/16 or 12/21/16.

Review of the nurse's notes did not reveal any documentation on 12/19/16 or 12/21/16 regarding the administration of Tylenol to Resident #12.

An interview was conducted with RN (Registered nurse) #3, the unit manager; on 2/15/17 at 9:45 a.m. RN #3 was asked to review the above Tylenol order. When asked when a nurse could administer the Tylenol, RN #3 stated, "They can only give it for a fever greater than 100.5." The

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MAR for December 2016 was reviewed by RN #3. When asked if he could say why the Tylenol was given, RN #3 stated, "It should not have been given without clarification from the doctor. I will look in to this and get back with you."

An interview was conducted with administrative staff member (ASM) #3, the assistant director of nursing; on 2/15/17 at 9:58 a.m. ASM #3 was asked to review the above physician order for Tylenol. When asked when a nurse can give the Tylenol, ASM #3 stated, "If the resident had a temperature greater than 100.5." When asked if a nurse can give the resident Tylenol for any other reason than what was documented in the physicians order, ASM #3 stated, "No, they would have to contact the physician." ASM #3 was asked to locate the nurse who had given the Tylenol in December 2016.

On 2/15/17 at 11:02 a.m. ASM #3 informed this surveyor that the nurse who gave the Tylenol was no longer employed at the facility.

The facility policy, "Medication Administration: Medication Pass" documented in part, "Procedure: Read transcribed physician order on MAR; patient name, medication name, dosage, route and interval ordered: remove medication from cart, compare MAR with medication label for accuracy. If medication is new for patient, or if medication is unfamiliar or physician order is questioned: read original physician order, compare original physician order with MAR for accuracy, removed medication from cart, compare MAR with medication label for accuracy, verify allergy status, contact physician, if needed."

According to "Fundamentals of Nursing", Seventh

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Edition, 2009: by Perry and Potter Chapter 35 "Medication Administration" Chapter 35, pg. 707 read: "Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication, 2. The right dose, 3. The right client, 4. The right route, 5. The right time, and 6. The right documentation." Under the subheading Right Route (on pg. 708) "...When administering injections, precautions are necessary to ensure the nurse gives the medications correctly..."

The administrator, ASM #2, the director of nursing, and ASM #4, the corporate quality assurance nurse, were made aware of the above findings on 2/15/17 at 2:00 p.m.

No further information was provided prior to exit.

F 363 SS=E 483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED — F 363

F-363 — 3/31/17

(c) Menus and nutritional adequacy.

Menus must-

(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;

It is the intended practice of this facility to meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National

(c)(2) Be prepared in advance;

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(c)(3) Be followed;

(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;

(c)(5) Be updated periodically;

(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.
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 protein portions served were sufficient to meet the nutritional needs of residents on a regular diet.

The facility staff failed to serve the three ounce serving of barbeque beef and ham per the facility's planned menu for residents on regular diet at the 2/15/17 lunch meal.

The findings include:

An observation of tray preparation was made on 2/15/17 at 11:40 a.m. The server was observed placing the beef slices on the plates. The beef slices were of similar size and the server would place one slice on each plate except when the resident was to get double portions in which case

Criteria 1
Upon notification from surveyor CDM re-educated server of protocol related to portion control standards to ensure nutritional adequacy.

Criteria 2
Any and all residents have the potential to be affected.

Criteria 3
All dietary staff to be re-educated regarding nutritional adequacy including but not limited to policies and procedures related to serving/portion control equipment.

Criteria 4
Administrator or designee will audit tray line setup/serving process using tray line audit tool daily x3 for 2 weeks, then once daily for following 2 weeks, 2x weekly on an on-going basis.

Criteria 5
The facility's alleged date of compliance is 3/31/2017.

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the server placed two slices of beef on the plate. A new tray of beef was brought to the serving table and the slices were observed to be very thinly cut. The server was observed placing one to four slices of the beef on the plates with most of the servings to be one slice of beef. The server was observed placing a half a slice of ham on the plates with a half a slice of pineapple. The ham slices were different sizes.

On 2/15/17 at 12:10 p.m. at the end of the tray service a request was made to OSM (other staff member) #15, the director of dining services to weigh the beef and the ham. The beef slices weighed 1.75 ounces and the ham slice weighed 2 ounces. When asked how much beef or ham the residents were to receive, OSM #15 stated, "Four ounces." When asked if the residents had received the correct amount, OSM #15 stated, "No."

An interview was conducted on 2/15/17 at 1:35 p.m. with OSM #14, the cook who served the food. When asked how much meat the residents were to be served, OSM #14 stated, "Four ounces." When asked how she knew how much sliced meat to serve, OSM #14 stated, "Pork and beef comes in a log shape. I cut each portion the same." When asked if the portions were weighed, OSM #14 stated, "No." When asked why she gave some residents one slice of beef to four slices of beef, OSM #14 stated, "I gave four slices of beef for the residents getting double portions. With the thinner slices (of beef) I gave more to give them the portion size. I kinda eye-balled it." When asked why it was important that residents received the correct amount of meat, OSM #14 stated, "Its protein. It's for their nutrition."

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F 363	Continued From page 98 Review of the facility's menu documented, "BARBEQUE BEEF 3OZ (ounces) REG (regular diet) 4OZ. HAM W/ (with) PINEAPPLE 3OZ. REG 6OZ. On 2/15/17 at 2:03 p.m. ASM (administrative staff member) #1, the administrator and ASM #2 the director of nursing were made aware of the findings. An interview was conducted on 2/15/17 at 2:30 p.m. with OSM #11 and #16, the dietitians. OSM #11 and #16 were asked to review the menu. When asked what portion size of beef and ham the residents were to receive, OSM #11 stated, "Whatever is in the column (on the menu) should be on their plate." When asked what the three ounces and four ounces represented on the menu, OSM #11 stated, "Let us get back to you." When asked what potential consequence could occur if residents did not receive the correct amount of protein in their diets, OSM #16 stated, "Weight loss would be something that could occur." When asked what their rate of weight loss was, OSM #16 stated, "It's not very high." On 2/15/17 at 3:55 p.m. OSM #15, the director of dining services, OSM #11 and #16, the dietitians met with this surveyor. OSM #15 stated, "The four ounces on the menu means the resident should receive three ounces of meat and one ounce of gravy and for the ham, they should receive three ounces of ham and the pineapple slice (which would equal six ounces." No further information was provided prior to exit.	F 363		
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		

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It is the intended practice of this

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F 364	Continued From page 99 (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility document review, it was determined that the facility staff failed to serve food at a palatable temperature for residents. The facility staff failed to serve food at a palatable temperature for the lunch meal on 2/15/17. The findings include: A resident council meeting was held on 2/14/17 at 3:00 p.m. with five residents. When asked about the food temperature and quality, the residents stated that the food was cold and the taste could be better. An observation of the lunch tray preparation was made on 2/15/17 at 11:05 a.m. Food temperatures were taken by OSM (other staff member) #15, the director of dining services and were as follows: roast beef 188 degrees; hamburger 146 degrees; hot dog 165 degrees; chopped chicken 166 degrees; ham slice 183 degrees; rice 173 degrees; mixed vegetables 158 degree; pureed beef 178 degrees; pureed bread 178 degrees; pasta 169 degrees; ground beef	F 364	*facility to ensure that food is prepared by methods that conserve nutritive value, flavor and appearance; and that food is palatable, attractive, and at the proper temperature.* Criteria 1 Upon notification from surveyor regarding temperature of test tray, CDM re-educated staff regarding proper policies and procedures related to proper serving temperature. Criteria 2 Any and all residents have the potential to be affected. Criteria 3 All dietary staff to be re-educated regarding proper temperatures, utilizing the tray audit tool and reviewing policy and procedure related to tray service and transport. RECEIVED MAR 09 2017 VDH/OLC	3/31/17

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F 364	Continued From page 100	F 364	Criteria 4 Administrator or designee will audit proper temperature of food using tray audit tool daily x3 for 2 weeks, then once daily for following 2 weeks, 2x weekly on an on-going basis. Criteria 5 The facility's alleged date of compliance is 3/31/2017.	3/31/17

165 degrees; mashed potatoes 164 degrees; cabbage 169 degrees; gravy 166 degrees and barbeque sauce 204 degrees.

On 2/15/17 at 12:12 p.m. the last food cart was loaded with residents' trays, a request was made to OSM #15 to prepare a test tray. The food cart was followed to the unit by OSM #15 and two surveyors. At 12:38 p.m. all of the residents' trays had been delivered and residents had begun eating. At that time the test tray food temperatures were re-checked by OSM #15. The food temperatures on the test tray were as follows: roast beef 133 degrees; hamburger 125 degrees; hot dog 133 degrees; ham 113 degrees; rice 130 degrees; mixed vegetables 123 degrees, pureed beef 118 degrees; pureed bread 108 degrees; pureed bread 123 degrees; pasta 108 degrees; mashed potatoes 110 degrees and cabbage 128 degrees, chocolate ice cream 35 degrees and vanilla ice cream 22 degrees.

OSM #15 and the two surveyors tested the food. OSM #15 stated that he preferred his food cooler and did not mind the temperature; the two surveyors found most of the food to be too cool in temperature to be palatable but the taste of the food was very palatable. The ice cream was completely melted; it could be poured out of the container and tasted warm.

An interview was conducted on 2/15/17 at 12:50 p.m. with OSM #15. When asked what temperature he wanted food to be when delivered to the residents, OSM #15 stated, "140 degrees." When asked why, OSM #15 stated, "Well the residents are always a little colder and like warmer food."

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Review of the facility's policy titled, "FOOD TEMPERATURES AT POINT OF SERVICE" documented, "Food should be palatable, attractive and at the proper temperature as determined by the type of food to ensure patient's satisfaction.... Is food served at preferable temperatures (hot foods are served hot and cold foods are served cold) as discerned by the patient and customary practice? ...A temperature or range of temperatures at point of service is not defined in the regulation or Guidance to Surveyors. Patient acceptance is used as a guide and consideration is given to the time the food sits at temperatures between 135 (degrees) F and 41(degrees) F."

An interview was conducted on 2/15/17 at 1:50 p.m. with OSM #15. When asked if the 41 degrees noted in the facility's policy on food temperatures should be 141 degrees, OSM #15 stated, "I think that's for the cold food." When informed of the resident's concerns regarding the temperature of the food, OSM #15 stated, "So, if we need to re-heat it we should re-heat it." When asked if food temperatures were tested at the point of service, OSM #15 stated, "Not on a regular rounds."

On 2/15/17 at 2:03 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

F 387 SS=D	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	F 387	F-387	3/31/17

(c) Frequency of Physician Visits

It is the intended practice of this facility to ensure residents are

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F 387	Continued From page 102	F 387	*seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.*	3/31/17

(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.

(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure timely physicians visits for one of 29 residents in the survey sample; Resident #13.

For resident #13, the physician visited on 5/24/16 then not again till 8/28/16, approximately 96 days between visits; then not again till 11/13/16, approximately 77 days between visits.

The findings include:

Resident #13 was admitted to the facility on 10/5/12 with the diagnoses of but not limited to dementia, psychosis, depression, anxiety, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/30/16. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident required total care for bathing; extensive care for hygiene, transfers, and dressing; limited assistance for eating; and was incontinent of bowel and bladder.

A review of the clinical record revealed the physician visited on 5/24/16 then not again till 8/28/16, approximately 96 days between visits;

Criteria 1

At the time of notification resident#13's physician visits were up to date.

Criteria 2
Any and all residents have the potential to be affected.

Criteria 3
Medical records director and Physician involved will be re-

educated to ensure timely physician visits.

Criteria 4
Administrator or designee will audit physician visits daily x5 days, three times weekly x3 weeks and monthly x2 months.

Criteria 5
The facility's alleged date of compliance is 3/31/2017.

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F 387	Continued From page 103 then not again till 11/13/16, approximately 77 days between visits. On 2/15/17 at approximately 11:00 a.m., in an interview with OSM #5 (Other Staff Member #5) the unit secretary, who was filling in for medical records, OSM #5 stated that she was unable to locate any evidence that any visit occurred for Resident #13 in the questioned time frames. A review of the policy, "Monitoring Physician Visits and Documentation" documented, "patients are seen by a physician within 30 days of admission, every 30 days for the first 90 days after admission and at least once every 60 days thereafter or per state regulations. a physician visit is considered timely if it occurs within 10 days of the date the visit was required or as otherwise stipulated by state regulations." On 2/15/17 at 2:00 the Administrator (Administrative Staff Member #1) was made aware of the findings. No further information was provided by the end of the survey.	F 387		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 431	F-431 *It is the intended practice of this facility to employ or obtain the services of a licensed pharmacist to store all drugs and biological in accordance with state and federal laws.*	3/31/17

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dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(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.

(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

Criteria 1
Upon notification from surveyor, all tubes of medicated creams were removed from resident#14's room and stored in medication cart.MD was notified and orders obtained to leave medicated creams and nystatin powder at bedside medication stored in the locked compartment.

Criteria 2
Any and all residents have the potential to be affected.

Criteria 3
The nursing staff will be re-educated on the proper storage of drugs and biologicals in accordance to state and federal law to ensure that all resident needs are met.

Criteria 4
DON or designee will audit resident rooms to ensure proper Storage daily x5 days, three times weekly x3 weeks and monthly x2 months.

Criteria 5
The facility's alleged date of compliance is 3/31/2017.

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be readily detected.
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 that the facility staff failed to store medications in an appropriate manner for one of 29 residents in the survey sample, Resident #14.

Multiple tubes of medicated cream were observed on the sink in Resident #14's room on 1/14/17 and 1/15/17.

The findings include:

Resident #14 was admitted to the facility on 4/27/12. Resident #14's diagnoses included but were not limited to: cerebrovascular disease (stroke), chronic pain syndrome and high blood pressure. Resident #14's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/27/17, coded the resident as being cognitively intact. Section G coded Resident #14 as requiring supervision with one person physical assist with bed mobility, transfers, eating and toilet use. The resident was coded as requiring limited one person physical assist with dressing and supervision with setup help only with personal hygiene.

Resident #14's current physician order summary documented orders including but not limited to: benzoyl peroxide (1) 5% gel to be topically applied to the resident's scalp lesions every day, Nystop powder (2) 100,000 unit/one gram to be applied to the resident's groin twice daily as

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needed and Proctozone (3) 2.5% cream to be applied four times daily as needed for hemorrholds. There was no current physician's order for nystatin cream (4) or triamcinolone cream (5).

Resident #14's comprehensive care plan revised on 2/8/17 documented, "Focus: Recurrent Yeast Rash at groin area...Interventions: Administer treatment per physician orders...Focus: At risk for alteration in skin integrity related to: incontinence, impaired mobility. Resident has reoccurring lesions to scalp...Interventions: Apply ointment/cream to resident scalp per md (medical doctor) orders..." The care plan failed to document information regarding storage of medicated creams.

On 2/14/17 at 11:04 a.m. during the initial tour of the facility, multiple tubes of medicated cream were observed on Resident #14's sink.

On 2/14/17 at 4:50 p.m., Resident #14 was sitting in a wheelchair in his room watching television. Four tubes of medicated cream were observed on Resident #14's sink.

On 2/15/17 at 11:05 a.m., Resident #14 was sitting in a wheelchair in his room. With the resident's permission, this surveyor inspected the four tubes of medicated cream that remained on the resident's sink. The following was observed:
-One 3/4 full tube of triamcinolone 0.1% cream and one 1/2 full tube of Nystatin 100,000 unit/one gram cream. Resident #14 stated the creams were for his groin and he learned how to mix the creams up and put them on himself.
-One 1/3 full tube of benzoyl peroxide 5% gel and one 3/4 full tube of Proctozone 2.5% cream.

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Resident #14 stated he used those creams for lesions on his head.
-Also noted were two plastic spoons with dried cream residue.

On 2/15/17 at 11:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1 (Resident #14's nurse). LPN #1 was asked about the facility process for storage of medicated creams and resident self-administration of medicated creams. LPN #1 stated medicated creams are kept stored in the treatment cart but nurses can obtain a physician's order to keep the medication at the bedside. At this time, LPN #1 was made aware this surveyor observed medicated creams in Resident #14's room and the resident stated he had been applying the creams himself. LPN #1 stated Resident #14's medicated creams should have been kept in the treatment cart and should not have been in the resident's room because she thought the resident did not have an order to keep the creams at the bedside.

On 2/15/17 at 2:03 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, "MEDICATION ADMINISTRATION: TOPICAL" documented the procedure for topical medication administration and documented, "12. Return medication to medication cart..."

No further information was presented prior to exit.

(1) Benzoyl peroxide is used to treat acne and other skin conditions. This information was

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F 431	Continued From page 108 obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009244/?report=details (2) Nystop powder is used to treat fungal infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682758.html (3) Proctozone is used to treat itching and swelling caused by hemorrhoids. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=fb5746ff-3ff1-4874-a827-4694133641b9 (4) Nystatin cream is used to treat fungal infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682758.html (5) Triamcinolone is used to treat itching, redness and inflammation of the skin. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601124.html	F 431		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting,	F 441	F-441 *It is the intended practice of this facility to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.*	3/31/17

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investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions 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

Criteria 1

Upon notification, licensed nurse involved was re-educated on proper sanitation of the glucometer, remove gloves while in the room and perform hand hygiene and medication carts involved were properly sanitized. Resident #18's MD and RP were notified and incident report filed Resident #29 MD and RP were notified and incident report filed All linen was re-washed after cleaning the air vents and fans.

Criteria 2

All residents receiving blood sugar checks have the potential to be affected. All residents have the potential to be affected with improper linen handling.

Criteria 3

All licensed nurses will be re-educated on infection control practices for obtaining residents blood sugar. All individual who process, handle and clean linen will be re-educated on infection control practices involving what constitutes clean linen and proper handling and maintaining of clean air vents

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F 441	Continued From page 110	F 441	Criteria 4 DON or designee will audit daily x5 days, three times weekly x3 weeks and monthly x2 months to ensure proper infection control practices in these areas Criteria 5 The facility's alleged date of compliance is 3/31/2017.	3/31/17

contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to process and store linens in a sanitary manner and failed to follow infection control practices during the medication administration observation for two of five residents in the medication administration observation, Residents # 18 and #29.

1. The facility staff failed to keep clean linens off the floor when transporting and folding them and failed to keep air vent and fans free of dust when folding and storing clean linens.

2. The facility staff failed to follow infection control practices for obtaining resident blood sugar readings during the medication administration observation for Resident #18 and Resident #29.

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The findings include:

1. The facility staff failed to keep clean linens off the floor when transporting and folding them and failed to keep air vent and fans free of dust when folding and storing clean linens.

On 02/15/17 at 8:10 a.m. an observation of the facility's laundry room was conducted. The laundry room consisted of a dirty linen room that contained commercial clothes washer and soiled linens and soiled resident clothing. Another separate room adjacent to the soiled linen room contained four commercial clothes dryers and four clothes racks for residents' clean clothing. An observation of the facility's clothes dryer room of the facility's laundry room was conducted. Observation of the four clothes racks revealed that they were full of resident's clean clothing hanging on the racks. Further observation of the clothing racks revealed them to be open and uncovered. An observation of the ceiling in the clothes dryer room revealed two circular air vents approximately 12 inches in diameter with cool air blowing from the vents. Further observation of the vents revealed the vents were covered with dust and areas of brown rust. A third separate clean linen room, clean linen folding room, adjacent to the dryer room contained two six foot tables each with a table top fan on them.

Further observation of the clean linen folding room adjacent to the dryer room revealed one of the table top fans operating and blowing air from the back of the table forward. OSM (other staff member) # 2, a housekeeper, was observed in this room standing at the front of the table. The fan was blowing in the direction of OSM # 2 as they were folding clean blankets and setting them

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on the table in the direction of the blowing fan.

On 02/15/17 at 8:25 a.m. OSM # 3, the environmental supervisor, was observed removing clean linen from clothes dryers into a laundry bin. While OSM # 3 was removing the linen from the dryer, several pieces of linen fell out of the dryer onto the laundry room floor. OSM # 3 pick the linen up off the floor and placed them into the linen bin with the rest of the clean linen that was removed from the dryer. OSM # 3 then took the bin of clean linen into the clean linen folding room. OSM # 3 removed the clean linen from the bin and placed it in a pile on the table in front of the fan blowing across the table. OSM # 3 then proceeded to fold numerous pieces of linen in front of the fan. Further observation of OSM # 3 folding the linen revealed that while she was folding blankets OSM # 3 allowed sections of the blankets to fall onto the floor before lifting the sections up from the floor and folding them. OSM #3 then placed the folded blankets with the rest of the clean linens on the table in front of the blowing fan.

On 02/15/17 at approximately 8:35 a.m. an interview was conducted with OSM # 1, director of housekeeping and OSM # 3, environmental supervisor. When asked about the linens being dropped on the floor while they were being removed from the dryer OSM # 3 stated, "I don't remember that but if they did they should have been rewashed." When asked about sections of the blankets being dropped to the floor while OSM # 3 was folding them, OSM # 3 stated, "They didn't touch the floor that long." OSM # 1 stated that if any of the clean laundry falls to the floor or touches the floor while being folded, they should be rewashed immediately. When asked

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about the process of cleaning the fans and air vents OSM # 1 and OSM # 3 stated that they are cleaned as needed. OSM # 1 was asked to turn off the table top fan that was blowing in the clean linen folding room. An examination of the fan was then conducted by OSM # 1 and OSM # 3. When asked if the fan was clean, OSM # 1 and OSM # 3 stated no and agreed the fan blades and fan guards were covered in brown dirt and dust. When asked if the clean linens should have been folded in front of the dirty table top fan, OSM # 3 stated, "No." When informed of the observations of OSM # 2 and OSM # 3 folding clean linens in front of the dirty fan while it was operating, OSM # 1 stated, "The linens should have been rewashed and the fans cleaned." OSM # 1 was then asked to observe the ceiling air vents and the clothes racks in the dryer room. Upon observing the ceiling air vents OSM # 1 agreed there was rust on them and the vents were coated with dust. OSM # 1 further stated that the resident clothing racks should have been covered.

The facility policy "7.2 Laundry Room Cleaning" documented, "Policy Directives: Laundry staff will clean and disinfect the Laundry Room on a daily schedule. Procedures. Dust or vacuum: Floor fans. Surface of AC (air conditioning) Vents. Surface of Exhaust Vents."

On 02/15/17 at approximately 3:15 p.m. ASM (administrative staff member) # 1 the administrator, was made aware of the findings.

No further information was provided prior to exit.

2. The facility staff failed to follow infection control

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practices for obtaining resident blood sugar readings during the medication administration observation for Resident #29 and Resident #18.

Resident #29 was admitted to the facility on 1/10/17 with diagnoses that included but were not limited to: disorders of the brain, intracranial bleed, diabetes, dementia, high blood pressure, and muscle weakness.

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 1/17/17, coded the resident as being moderately impaired to make cognitive daily decisions. The resident was coded as requiring limited to extensive assistance of one or more staff members for her activities of daily living.

The physician order dated, 1/11/17 and signed by the doctor on 1/30/17, documented, "Humalog (a rapid acting human insulin (1)) 100UNIT/ML (milliliter); inject subcutaneously before meals and at bedtime per sliding scale for blood sugar - 150 - 199 give 2 units subQ (subcutaneously); 200 - 249 give 4 units subQ; 250 - 299 give 6 units subQ; 300 - 349 give 8 units subQ, 350 - 399 give 10 units subQ; 400 + or < (less than) 50 call MD (medical doctor) for DM (diabetes mellitus)."

Resident #18 was admitted to the facility on 8/11/16 with diagnoses that included but were not limited to: diabetes, heart failure, dementia, and Wernicke's encephalopathy (an inflammatory, degenerative disease of the brain characterized by double vision, lack of coordination and decreased mental status (2))

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The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/26/17, coded the resident as being moderately impaired to make daily decisions. The resident was coded as requiring limited to extensive assistance of one staff member for her activities of daily living.

The physician orders dated, 11/22/16, and signed by the physician on 2/12/17, documented, "Novolog (short acting insulin (3)) 100UNIT/ML (milliliters); inject 5 units subcutaneously with breakfast, with lunch, with dinner if (blood sugar) 0 - 250 = 0; 251 - 300 = 2 units (of insulin); 301 - 350 = 4 units; 351 - 400 = 6 units; 401 - 450 = 8 units; 451 - 500 = 10 units; 501 + (501 and higher) give 12 units and call MD (medical doctor) for DM (diabetes mellitus)."

Observation was made on 2/14/17 at 4:20 p.m. of LPN (licensed practical nurse) #9 checking Resident #29 and Resident #18's blood sugars. The glucometer (machine to check the blood sugar by finger stick) was observed sitting on top of the medication cart. LPN #9 was observed to use hand sanitizer on her hands. She gathered the glucometer, gloves, alcohol swab, testing strip and lancet (an instrument to lance the skin to obtain blood for the blood sugar). She did not clean the glucometer prior to entering the Resident #29's room. LPN #9 placed the supplies on the over bed table. She put on her gloves, wiped the resident's finger with an alcohol swab. LPN #9 then lanced Resident #29's finger, and was observed squeezing the resident's finger to obtain blood for testing. There was not enough blood to do the test. LPN #9 walked out of the room to the medication cart, with gloves on. Opened the bottle of testing strips and got

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another test strip out. She then grabbed another alcohol swab and proceeded back into Resident #29's room. She never discarded the gloves or used any form of hand sanitation. LPN #9 proceeded to perform the resident's blood sugar testing. She then removed her gloves, gathered her used supplies and emptied them in the appropriate receptacle. LPN #9 then exited Resident #29's room, and placed the glucometer on top of the medication cart. She was observed using hand sanitizer on her hands. LPN #9 then placed the glucometer inside the top drawer of the medication cart. She did not clean the glucometer.

LPN #9 then moved her medication cart to the next resident room, Resident #18. LPN #9 removed the glucometer out of the medication cart drawer and placed it on the top of the cart. She gathered her supplies and walked into Resident #18's room. She put the glucometer on the bedside table. LPN #9 then proceeded to obtain Resident #18's blood sugar. She put the glucometer back on the bedside table. LPN #9 then gathered her used supplies, removed her gloves and washed her hands. She then took the glucometer back to the medication cart and placed it on top of the cart. LPN #9 then cleaned the glucometer with a wipe made for cleaning the glucometer.

An interview was conducted with RN (registered nurse) #6 on 2/15/17 at 10:20 a.m. When asked how often a nurse should clean a glucometer machine, RN #6 stated, "You have to clean it before and after each patient."

An interview was conducted with LPN #9 on 2/15/17 at 2:45 p.m. The observation of LPN #9

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going into the hallway without changing gloves and getting a new test strip from the bottle and not cleaning the glucometer was shared at this time. LPN #9 stated, "I did go in the hallway without removing my gloves and that's correct. I realized I did it but it was too late to correct it." When asked if she cleaned the glucometer between (Resident #29 and Resident #18), LPN #9 stated, "No, I didn't do it between them but remembered to do it after (Resident #18).

An interview was conducted with RN #3, the unit manager, on 2/15/17 at 3:00 p.m. RN #3 was informed of the above observation of LPN #9 obtaining blood sugar readings for Resident #18 and Resident #29, and asked if LPN #9 had followed infection control practices. RN #3 stated, "No, she should have ungloved before going back to the med (medication) cart and used hand sanitizer or washed her hands. She should not have entered the hallway with dirty gloves." When asked how often the glucometer is to be cleaned, RN #3 stated, "Before and after each resident."

The facility policy, "Glucose Blood Monitoring (Finger Stick Blood Sugar)" documented in part, "Procedure: 5. Establish clean field. Unfold and lay flat a clean paper towel on over bed table or bedside stand surface. Place equipment on top of paper towel. 7. Apply latex free non-sterile gloves...18. Clean blood glucose meter utilizing an EPA (environmental protection agency) approved bleach wipe or approved germicidal disinfectant per the manufacturer instructions. 19. Remove gloves and perform hand hygiene...21. Return equipment to designated area after cleaning and disinfection. Discard disposable supplies."

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The "User Manual" for the type of glucometer used by LPN #9 documented in part, "Healthcare professionals should wear gloves when cleaning the Assure Platinum meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning and disinfecting the meter between patient use. Cleaning and disinfecting can be completed by using a commercially available EPA - registered disinfectant detergent or germicide wipe. To use a wipe, remove from container and follow product label instructions to disinfect the meter. Take extreme care not to get liquid in the test strip and key code ports of the meter. Many wipes act as both a cleaner and disinfectant, though if blood is visibly present on the meter, two wipes must be used; use one wipe to clean and a second wipe to disinfect."

CDC is alerting all persons who assist others with blood glucose monitoring and/or insulin administration of the following infection control requirements:
" Finger stick devices should never be used for more than one person
" Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared. (4)

The administrator was made aware of the above concern on 2/15/17 at 3:28 p.m.

(1)This information was taken from the following website:

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F 441	Continued From page 119 https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b34cd3ff-d0af-4852-b4ef-2a8b4a93aeae (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader 5th edition, Rothenberg and Chapman; page 611. (3) This information was taken from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3A1E73A2-3009-40D0-876C-B4CB2BE56FC5 (4) This information was obtained from the following website: https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html	F 441		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 514	F-514 *It is the intended practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are—(i) complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized. It is also the intended practice of this facility to ensure the clinical record contains (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The plan of care and services provided; (iv) The results of any preadmission screening conducted by the State; and (v) Progress notes.*	3/31/17

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F 514	Continued From page 120 (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 facility staff failed to maintain a complete and accurate clinical record for four of 29 residents in the survey sample, Resident #6, Resident #1, Resident #17 and Resident #5. 1. For Resident #6, facility staff failed to document blood pressures in the clinical record prior to the administration of Hydralazine [1] 25 mg (milligrams) during December 2016 and January 2017. 2. a. The facility staff failed to document Resident #1's responsible party was notified regarding a room change on 1/6/17. b. The facility staff failed to document pain assessments and non-pharmacological interventions provided to Resident #1 with administration of as needed pain medication for multiple dates in December 2016 and January 2017. 3. The facility staff failed to document non	F 514	Criteria 1 At the time of the notification from surveyor, resident#6's blood pressure parameters had been clarified and discontinued by MD Resident#6's MD has been notified of not documenting blood pressures before administration of b/p meds in December and January. Staff has followed up with resident #1's responsible party and documented the notification of the resident's room change, no concern noted Residents #1 has been assessed for use of pain medication and found it necessary to continue at prn basis, care plans have been up dated to include non-pharmacological interventions before use of prn pain medications. Resident #17 has been assessed for use of pain medication and found it necessary to continue at prn basis, care plans have been up dated to include non-pharmacological interventions before use of prn pain Other resident's lab result was removed from resident #5's chart and filed appropriately.	3/31/17

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pharmacological interventions provided, the pain assessment when administering as needed (PRN) medication to Resident #17 and failed to document follow up on the effectiveness of the medication administered on 2/14/17.

4. The facility staff filed another resident's laboratory results on Resident #5's clinical record.

The findings include:

1. For Resident #6, facility staff failed to document blood pressures in the clinical record prior to the administration of Hydralazine [1] 25 mg (milligrams) during December 2016 and January 2017.

Resident #6 was admitted to the facility on 7/23/2008 and readmitted on 4/7/16 with diagnoses that included but were not limited to paraplegia, muscle weakness, type two diabetes, high blood pressure, and chronic pain. Resident #6's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/8/16. Resident #6 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #6 was coded as requiring extensive assistance from one staff member with transfers, toileting, and bathing; limited assistance from one staff member with dressing, and personal hygiene; and independent with meals.

Review of Resident #6's POS (Physician Order Sheet) signed by the physician on 1/30/17 documented the following order: "Hydralazine HCL 25 mg (milligram) Tablet 1 tab (tablet) by

Criteria 2

Any and all residents have the potential to be affected.

Criteria 3

The interdisciplinary team will be re-educated on a complete individualized clinical record keeping.

Licensed nurses will be re-educated on the facility pain guide to include assessing resident, offer non- pharmacology interventions before and after pain medication administration. And document effectiveness following interventions.

Criteria 4

DON or designee will audit charts and MARs dailyx5days, three days a week x3weeks and then monthly x2months.

Criteria 5

The facility's alleged date of compliance is 3/31/2017.

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mouth every 8 hours; Hold for Blood Pressure less than 100/60." This order was initiated on 8/30/16 and discontinued on 1/13/17.

Resident #6's December 2016 MARS (Medication Administration Record) documented the following: "Hydralazine HCL 25 mg Tablet 1 tab by mouth every 8 hours, Hold if Blood Pressure less than 100/60." Administration times for Hydralazine were at 6 a.m., 2 p.m., and 10 p.m.

Review of the December 2016 MARS revealed that Resident #6's blood pressures were not documented for the 6 a.m. and 2 p.m. dose during the entire month of December.

Review of Resident #6's January 2017 MARS documented the following: "Hydralazine HCL 25 mg Tablet 1 tab by mouth every 8 hours, Hold if Blood Pressure less than 100/60." Administration times for Hydralazine were at 6 a.m., 2 p.m., and 10 p.m. This order was discontinued on 1/13/17.

Review of the January 2017 MARS revealed that Resident #6's blood pressures were not documented for the 6 a.m. and 2 p.m. dose from January 2nd until January 13th when the order was discontinued.

Further review of Resident #6's clinical record failed to show evidence that his blood pressures were being documented at 6 a.m. and 2 p.m.

On 2/15/17 at 11:09 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked about the process followed by staff prior to administering a blood pressure medication. LPN #2 stated that if the order has

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parameters, that she would take the blood pressure immediately before administering the blood pressure medication. LPN #2 stated she would either hold the medication or administer the medication depending on the blood pressure reading. When asked if blood pressure readings should be documented, LPN #2 stated yes. When asked where blood pressure readings would be documented, LPN #2 stated that it would be documented on the MAR. LPN #2 stated that she did not work with Resident #6. When asked if she could find the 6 a.m. or 2 p.m. blood pressure readings on the MAR for Resident #6, LPN #2 stated that she did not see them. LPN#2 stated that the blood pressure could have been taken but not documented. LPN #2 stated, "That I don't know."

On 2/15/17 at 11:28 a.m., an interview was conducted with LPN #3, a nurse who works on the same unit as Resident #6. When asked about the process followed by staff prior to administering a blood pressure medication, LPN #3 stated she would check the blood pressure prior to administering the medication if the order has parameters. LPN #3 stated that she would document the reading on the MAR right after she completed the check. LPN #3 stated that if the blood pressure is below parameters, she would hold the medication and notify the MD (medical doctor) if necessary. LPN #3 confirmed that she could find the 6 a.m. and 2 p.m. blood pressure readings. LPN #3 stated, "The nurse probably checked it, just might not have written it in."

On 2/15/17 at 11:46 a.m., an interview was conducted with LPN #4, the nurse who worked with Resident #6. When asked about the process followed by staff prior to administering a blood

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pressure medication with parameters, LPN #4 stated that he would take the blood pressure first and put the vital signs on the MAR. When asked if he would do this before every dose, LPN #4 stated, "Yes, before every dose." LPN #4 showed this writer where Resident #6's 9 a.m. and 10 p.m. blood pressure reading were recorded. When asked where Resident #6's blood pressure readings were recorded for his 2 p.m. and 6 a.m. dose, LPN #4 showed this writer a book of vital signs. When asked if this was part of Resident #6's clinical record, LPN #4 stated, "No. This is my personal book." When asked if his blood pressure readings should be recorded in the clinical record, LPN #4 stated, "Yes, it should be documented in the clinical record."

On 2/15/17 at 2:00 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #4, the corporate nurse, were made aware of the above concerns.

Facility policy titled, "Clinical Record System," documents in part, the following: "Clinical Records are maintained on each patient that are complete, readily accessible, and systemically organized. A complete clinical record reports the actual experience of the individual and contains sufficient information to validate patient status and outcomes of care provided."

No further information was presented prior to exit.

[1] Hydralazine-Used to treat high blood pressure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0022003/?report=details.

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2. a. The facility staff failed to document Resident #1's responsible party was notified regarding a room change on 1/6/17.

Resident #1 was admitted to the facility on 10/21/16. Resident #1's diagnoses included but were not limited to: major depressive disorder and diabetes. Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/15/17, coded the resident's cognition as being severely impaired.

Review of Resident #1's clinical record revealed a nurse's note dated 1/6/17 that documented, "Resident transferred from the Parc unit to room (room number) the third bed today." Further review of nurse's notes and social services notes failed to reveal documentation that the resident's responsible party was notified of the room change.

On 2/15/17 at 9:37 a.m., an interview was conducted with OSM (other staff member) #10 (the social services director- employed at the facility for one month) and OSM #8 (the social services coordinator). OSM #10 was asked the facility process regarding room changes. OSM #10 stated the social services staff notifies the resident, the resident's responsible party and the resident residing in the room the other resident is moving into. OSM #10 stated the social services staff also shows the resident the new room introduces the resident to the new roommate and asks for feedback from the residents. At this time, OSM #8 was asked if this process was completed when Resident #1 moved on 1/6/17.

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OSM #8 stated she notified Resident #1 and the resident's responsible party of the room change. OSM #8 stated she had to call the resident's responsible party at the time because the responsible party was out of town. OSM #8 confirmed she didn't document notification.

On 2/15/17 at 2:03 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 social service manual documented in part, "PROGRESS NOTES: Social service progress notes provide a review of the medically related social services that have been provided. The notes identify the patient's general psychosocial well-being, the effectiveness of care plan interventions, the patient's response to social service interventions and other noteworthy information..."

No further information was presented prior to exit.

b. The facility staff failed to document pain assessments and non-pharmacological interventions provided to Resident #1 with administration of as needed pain medication for multiple dates in December 2016 and January 2017.

Review of Resident #1's clinical record revealed a physician's order summary signed on 11/20/16 that documented an order for oxycodone (1) 5 mg (milligrams) - one tablet by mouth every four hours as needed.

Resident #1's December 2016 and January 2017

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MARs (medication administration records) revealed the resident was administered as needed oxycodone on the following dates:
12/16/16
12/25/16
12/26/16
12/27/16
12/28/16
12/29/16
12/30/16
1/7/17
1/8/17
1/9/17

Further review of Resident #1's clinical record (including nurses' notes and the back of the MARs) failed to reveal documentation that pain assessments and non-pharmacological interventions were provided to Resident #1 with the administration of as needed oxycodone for the above dates.

On 2/15/17 at 8:47 a.m., an interview was conducted with RN (registered nurse) #9. RN #9 was asked what nurses should do prior to and after the administration of as needed pain medication. RN #9 stated nurses assess the resident's pain, including the location and intensity of the pain, provide non-pharmacological interventions, give the pain medication and then re-assess the resident's pain. RN #9 stated nurses were completing this process but he wouldn't be surprised if the nurses had not documented their assessments or non-pharmacological interventions. RN #9 stated management had educated nurses on documentation of pain assessments and interventions and continued to do so.

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On 2/15/17 at 1:03 p.m., an interview was conducted with LPN (licensed practical nurse) #5 (the nurse responsible for administering as needed oxycodone to Resident #1 during several of the above dates). LPN #5 was asked what nurses should do prior to and after the administration of as needed pain medication. LPN #5 stated she assesses the resident's pain, asks the resident to rate the pain and state the location or observes the resident for non-verbal behaviors such as grimacing, guarding and reaching. LPN #5 stated she also offers non-pharmacological interventions such as positioning. LPN #5 stated after as needed pain medication administration, she re-assesses the resident's pain. LPN #5 was asked where she documents pain assessments and interventions. LPN #5 stated she documents this information on the back of the MAR or in the progress notes in the computer system. LPN #5 was asked how she assesses Resident #1's pain. LPN #5 stated she assesses the resident's mannerisms for facial grimacing and guarding. LPN #5 stated she also offloads the resident off her "backside." At this time, LPN #5 was asked to review Resident #1's December 2016 and January 2017 MARs and nurses' notes and show this surveyor documentation of her pain assessments and interventions on the dates she administered as needed pain medication to the resident. LPN #5 confirmed there was a lack of documentation.

On 2/15/17 at 2:03 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 documents titled, "Pain Practice Guide" and "Documentation" failed to document

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specific information regarding the documentation of pain assessments and non-pharmacological interventions.

No further information was presented prior to exit.

(1) Oxycodone is used to treat pain. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f3190521-f5d9-4296-b8bb-cddbe2dde654

3. The facility staff failed to document non pharmacological interventions provided, the pain assessment when administering as needed (PRN) medication to Resident #17 and failed to document follow up on the effectiveness of the medication administered on 2/14/17.

Resident #17 was admitted to the facility on 12/21/16 with a recent readmission on 1/13/17 with diagnoses that included but were not limited to: heart failure, diabetes, chronic obstructive pulmonary disease (COPD), high blood pressure, and atrial fibrillation (rapid and random contractions of the atria of the heart causing irregular beats of the ventricles (1)).

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 1/25/17, coded the resident as being cognitively intact to make daily decisions. Resident #17 was coded as requiring extensive assistance of one or more staff members for most of his activities of daily living.

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Observation was made of LPN (licensed practical nurse) #8 administering medications to Resident #17 on 2/14/17 at 4:07 p.m. LPN #8 administered a Tramadol (used to treat moderate to moderately severe pain (2)) 50 mg (milligrams) one tablet to Resident #17.

Review of the physician order dated, 2/3/17 documented, "Tramadol 50 mg 1 PO (by mouth) Q (every) 6 H (hours) PRN Dx (diagnosis) Pain."

Review of the MAR (medication administration record) for February 2017 documented, "Tramadol 50 mg 1 PO Q 6 H, PRN Dx: Pain." The nurse documented the time of 17:10 (4:10 p.m.) with her initials. The reverse side of the MAR was blank. The MAR also documented, "Pain Score every shift." The score documented for 2/14/17 at 4:00 p.m. was a "0" indicating no pain.

The nurse's notes for 2/14/17 were reviewed. There was no documentation of the administration of the Tramadol.

An interview was conducted with LPN #8 on 2/15/17 at 3:02 p.m., regarding what staff does when a resident complains of pain. LPN #8 stated, "You assess the pain. Check the intensity, the pain level, location of pain." LPN #8 was asked to review the MAR and nurse's notes for 2/14/17. When asked where she documented the assessment, administration of medication and follow up on the effectiveness, LPN #8 stated, "I didn't. He was having back pain on a scale of six out of ten. Before he goes to bed each night, I check on him. He's a very lonely man. He told me then that he was more comfortable after the pain medication." When asked if she had tried

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any non-pharmacologic interventions prior to giving the pain medication, LPN #8 stated he had just been repositioned by the aide and was still in pain." When asked where she documented everything she did for this resident, LPN #8 stated, "I didn't."

The facility policy, "Medication Administration: Medication Pass" documented in part, "Suggested Documentation: Unusual observations or complaints and subsequent interventions including communications with physician."

The administrator was made aware of the above concern on 2/15/17 at 3:28 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.
(2) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=246a45d0-0953-4f4f-8175-dab3bafac2db.

4. The facility staff filed another resident's laboratory results on Resident #5's clinical record.

Resident #5 was most recently readmitted to the facility on 8/11/15 with the diagnoses of but not limited to a brain injury, high blood pressure, stroke, obstructive pulmonary disease, neurogenic bladder, dysphagia, and a sacral ulcer. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/16/16. The

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resident was coded as being severely impaired in ability to make daily life decisions. The resident required total care for transfers, hygiene, and bathing; extensive assistance for dressing and eating; and was coded as being incontinent of bowel and as having a catheter for bladder.

A review of the clinical record revealed laboratory results for a CMP (complete metabolic panel (1)) and CBC (complete blood count (2)) dated 1/25/17. Further review revealed these laboratory tests were actually for another resident but were filed in Resident #5's clinical record.

On 2/15/17 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the unit manager. She stated that most of the filing is done on the 11pm to 7am shift, and sometimes on the 3pm to 11pm shift. She could not speak for who may have misfiled the labs.

A review of the facility policy "Filing system" did not address the accuracy of the filing.

On 2/15/17 at 2:00 p.m., the administrator (Administrative Staff Member #1) and the DON (Director of Nursing - Administrative Staff Member #2) were made aware of the above concerns. No further information was provided by the end of the survey.

(1) A comprehensive metabolic panel is a group of chemical tests performed on the blood serum (the part of blood that doesn't contain cells). These tests include total cholesterol, total protein, and various electrolytes. Electrolytes in the body include sodium, potassium, chlorine, and many others. The rest of the tests measure chemicals that reflect liver and kidney function. This test

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helps provide information about your body's metabolism. It gives your doctor information about how your kidneys and liver are working, and can be used to evaluate blood sugar, cholesterol, and calcium levels, among other things. This information was obtained from the website: <http://www.nlm.nih.gov/medlineplus/ency/article/003468.htm>

(2) According to Mosby's Medical Dictionary, sixth edition, 2002. St. Louis, MO: Mosby, Inc. Page 405, a CBC (complete blood count) is a blood test used to determine the number of red and white blood cells per cubic millimeter of blood; and is one of the most valuable screening and diagnostic techniques.