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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING ______ B. WING ______	C 05/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted on 5/17/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/15/18 tthrough 5/18/18. Four complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 150 certified bed facility was 124 at the time of survey. The survey sample consisted of 41 current Resident reviews (5, 433, 426, 62, 113, 110, 419, 69, 432, 71, 47, 61, 31, 427, 48, 103, 101, 59, 42, 65, 63, 105, 4, 19, 23, 57, 2, 94, 85, 53, 51, 32, 420, 37, 423, 44, 219, 40, 111, 97, and 50) and seven closed record reviews (199, 469, 370, 434, 120, 119, second resident #119 and 319).	F 000	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies 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 POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 6/21/18

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

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F 580	Continued From page 1 deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 580		

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F 580	Continued From page 2 Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to notify the physician of a possible need to alter treatment for two of 48 residents in the survey sample, Resident #69 and #5. 1. The facility staff failed to notify the physician that Resident #69 had missed three doses of her Aubagio (1) medication. 2. The facility staff failed to notify Resident #5's physician when a medicated gel was not available for administration on 5/9/18. The findings include: 1. Resident #69 was admitted to the facility on 7/8/17 and readmitted on 5/1/18 with diagnoses that included but were not limited to Parkinson's disease, multiple sclerosis (2), and bipolar disorder. Resident #69's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/12/18. Resident #69 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #69's most recent POS (Physician Order Summary) revealed the following medication: (1) "Aubagio 14 MG (milligram) Give 14 mg by mouth one time a day for MS (multiple sclerosis)." This order was ordered on 5/1/18 and initiated on 5/2/18. Review of Resident #69's MAR (Medication	F 580	It is the practice of the facility to notify physician of a possible need to alter treatments. 1. Resident #69, doctor was notified of missed doses of medication. No new orders obtained. Resident #5, doctor was notified of missed medication. No new orders obtained. 2. All residents have the potential to be affected. 3. Licensed nurses will be re-educated on proper notification of doctor regarding missed medications and/or treatments. 4. DON and/or designee will complete 5 random audits of resident EMAR/ETAR to make sure medications are administered as ordered. These audits will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or actions. 5. Date of compliance will be June 19, 2018.	

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F 580	Continued From page 3 Administration Record) for May 2018 revealed that Resident #69 did not receive her daily dose of Aubagio on 5/2/18, 5/3/18 and 5/4/18. The first dose of Aubagio was not administered until 5/5/18. A nursing note dated 5/3/18 documented the following: "Daughter did visit today, I did speak to daughter regarding medication Abagio (sic). The medication is sent directly to the daughters house. She is made aware that we have no medication to give at this time. Per the daughter she did verbalize that she "will call" for the medication." Further review of the nursing notes failed to evidence any prior attempts to receive the Aubagio. There was no evidence that this medication was attempted to be obtained by pharmacy. There was no evidence in the nursing notes that the physician was made aware of the three missed doses. On 5/17/18 at 1:35 p.m., an interview was conducted with LPN (licensed practical nurse) #3, Resident #69's nurse. LPN #3 was asked about the process staff follows if a medication that was due to be administered was missing from the medication cart. LPN #3 stated that she would leave the eMAR blank for that particular medication, check the STAT (immediate) box for the ordered medication, and if the medication were not in the STAT box, she would notify the physician and family. LPN #3 stated that she would also notify pharmacy to send the medication as soon as possible. When asked why Resident #69's Aubagio was not given until 5/5/18 when it was ordered on 5/1/18, LPN #3 stated that Resident #69's daughter orders the	F 580		

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F 580	Continued From page 4 Aubagio from a specialty pharmacy. LPN #3 stated that the medication was delivered to the daughter rather the facility. LPN #3 stated that now the medication is delivered right to the facility. LPN #3 stated that she was told that the facility pharmacy does not supply this medication. When asked if LPN #3 notified the daughter that they did not have the medication on 5/2/18, LPN #3 stated that she was not sure. When asked if the physician was notified of the three missed doses of the Aubagio, LPN #3 stated, "I have a bad habit of calling the MD (medical doctor) all the time." LPN #3 stated that she usually writes a note saying that the MD was made aware. LPN #3 could not provide any evidence that she notified the MD or NP (nurse practitioner) about the three missed doses of Aubagio. LPN #3 stated that it should have been documented. When asked who LPN #3 contacted regarding Resident #69's Aubagio, LPN #3 stated that she could not remember. LPN #3 stated that Aubagio was not a medication in the emergency STAT box. Review of the emergency STAT box list did not evidence Aubagio as a medication supplied in the STAT box. On 5/17/18 at 1:46 p.m., an interview was conducted with ASM (administrative staff member) #6, the Nurse Practitioner. ASM #6 stated that she knew the daughter was the one to supply Resident #69's medication. ASM #6 stated that she would expect to be notified by the nurses if the resident's medication was not available to be administered. ASM #6 stated that she or the physician would have given an order to hold the medication until it was available. ASM #6 stated that she was not aware of Resident	F 580		

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F 580	Continued From page 5	F 580		

#69's missed doses of Aubagio. ASM #6 stated that maybe the physician was notified, but that he probably would have given a hold order.

Two attempts to contact Resident #69's physician were made during the survey. He could not be reached for an interview.

On 5/17/18 at 6:05 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

No further information was presented prior to exit.

The facility policy titled "Medication and Treatment Administration Guidelines" documents in part, the following: "Medications not administered according to medical practitioner's orders are reported to the attending medical practitioner and documented in the clinical record including the name and dose of the medication and reason the medication was not administered."

(1) Aubagio (Teriflunomide) is an orally available immunomodulatory agent used to treat relapsing multiple sclerosis. This information was obtained from The National Institutes of Health at https://pubchem.ncbi.nlm.nih.gov/compound/Teriflunomide#section=Top.

(2) Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained

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F 580	Continued From page 6 from The National Institutes of Health at https://medlineplus.gov/multiplesclerosis.html. 2. The facility staff failed to notify Resident #5's physician when a medicated gel was not available for administration on 5/9/18. Resident #5 was admitted to the facility on 7/16/16. Resident #5's diagnoses included but were not limited to diabetes, muscle weakness and osteoarthritis. Resident #5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/10/18, coded the resident's cognition as moderately impaired. Section J documented Resident #5 reported no pain during the last five days. Review of Resident #5's clinical record revealed a physician's order dated 4/12/18 for Capsagel Gel (Capsaicin) (1) 0.025%- to be applied to the resident's bilateral knees one time a day for pain. Resident #5's May 2018 eMAR (electronic medication administration record) documented, "Capsagel Gel 0.025% (Capsaicin) Apply to bilat (bilateral) knees topically one time a day for pain." On 5/9/18, the eMAR documented a nurse's initials and the code "5" that indicated, "Hold/See Nurse Notes." The May 2018 eMAR location of administration report documented Capsagel was topically applied to both of Resident #5's knees every day in May 2018 except for 5/9/18. A nurse's note dated 5/9/18 documented, "Capsagel Gel 0.025% Apply to bilat knees topically one time a day for pain Pharmacy aware order placed." There was no documentation to evidence Resident #5's physician was made aware the Capsagel was held. Resident #5's comprehensive care plan dated	F 580		

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F 580	Continued From page 7	F 580		

7/16/16 documented, "Generalized pain...Administer pain medication per physician orders..."

On 5/15/18 at 12:10 p.m., an interview was conducted with Resident #5. The resident stated she has knee pain but she gets a pill and cream every day and that helps her pain.

The nurse responsible for signing the above 5/9/18 nurse's note was no longer employed at the facility.

On 5/17/18 at 8:36 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what the code "5" on the eMAR meant. LPN #1 stated, "Hold. See nurses note." LPN #1 was shown the code "5" for the Capsagel on Resident 5's eMAR for 5/9/18. LPN #1 was asked if the code meant the medication was not given. LPN #1 stated, "It could be." LPN #1 was asked to read the nurse's note dated 5/9/18. LPN #1 stated, "Sometimes if we do click and it says it's on order and you call the pharmacy and they say they will bring it on the next run then notify the MD (medical doctor)." LPN #1 was asked how nurses should evidence they notified the physician. LPN #1 stated, "By putting it in your notes."

On 5/17/18 at 9:34 a.m., an interview was conducted with LPN #4. LPN #4 was asked if the physician should be notified when a resident's medication is not available for administration. LPN #4 stated, "Yes." When asked why, LPN #4 stated, "Because they may have another alternative or may want to switch something for the time being."

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F 580	Continued From page 8 On 5/17/18 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. (1) Capsagel is used to treat osteoarthritis, a condition in which joints become swollen and stiff. This information was obtained from the website: https://ahrq-ehc-application.s3.amazonaws.com/media/pdf/osteoarthritis-pain_consumer.pdf	F 580		
F 622 SS=B	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a	F 622	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies 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 POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	

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F 622	Continued From page 9 resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)	F 622		

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F 622	Continued From page 10 (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide all required documentation to the receiving hospital and failed to ensure all required documentation in the clinical record upon transfer for nine of 48 residents in the survey sample, Residents #433, 110, 85, 113, 65, 69, 44, 105 and 97. 1. The facility staff failed to evidence that Resident #433's care plan goals were provided to the receiving provider for a facility initiated transfer on 4/27/18. 2. The facility staff failed to evidence that Resident #110's care plan goals were provided to the receiving provider for a facility initiated transfer on 4/12/18.	F 622	It is the practice of the facility to provide all required documentation to the receiving hospital and to ensure all required documentation in the clinical record is sent upon transfer. 1. Residents #433, #110, #85, #113, #65, #69, #44, #105, and #97 no longer reside in the facility. 2. All residents have the potential to be affected. 3. Licensed Nurses will be re-educated on sending resident's comprehensive care plan goals with the resident on transfers to another facility. Doctor will be educated on documenting the specific need that could not be met in facility and what the resident needs at the receiving facility.	

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F 622	Continued From page 11 3. The facility staff failed to evidence that Resident #85's care plan goals were provided to the receiving provider for a facility initiated transfer on 5/6/18. 4a. The facility staff failed to provide the receiving facility a copy of Resident # 113's care plan goals for a facility initiated transfer. 4b. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 113 for a facility initiated transfer. 5. The facility staff failed to provide Resident #65's comprehensive care plan goals to hospital staff when the resident transferred to the hospital on 4/23/18. 6. The facility staff failed to evidence that all required information was provided to the receiving provider for Resident #69's facility-initiated transfer to the hospital on 3/28/18 and 4/27/18. 7. The facility staff failed to evidence that all required information was provided to the receiving provider for Resident #44's facility-initiated transfer to the hospital on 2/1/18. 8. The facility staff failed to evidence the care plan goals were sent with Resident #105, for a facility initiated transfer to the hospital on 12/1/17.	F 622	4. DON and/or designee will do random audits of five (5) discharges to the hospital to ensure that care plan goals have been sent with the resident and that doctor documented the need that could not be met in the facility and said information was communicated to the receiving facility. These audits will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determinbe need for further audits and/or action. 5. Date of Compliance is June 19,2018	

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9. The facility staff failed to evidence the care plan goals were sent with Resident #97, for a facility initiated transfer to the hospital on 4/19/18.

The findings include:

1. Resident #433 was admitted to the facility on 4/2/18 and readmitted on 5/3/18 with diagnoses that included but were not limited to: respiratory failure, anemia, obesity and diabetes.

The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 5/10/18 coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status indicating the resident was cognitively intact to make daily decisions.

Review of the nurse's note dated 4/27/18 at 12:50 p.m. documented, "Resident alert and responsive. v/s (vital signs) this morning before therapy was 115/59 (blood pressure) 75 (pulse) 18 (respirations) 97.5 (temperature) oxygen saturation at 86% (normal 90 - 100) on Oxygen 3l/min (liters per minute) via nasal cannula (soft prongs that fit in the nose to deliver oxygen). md (medical doctor) was notified RP (responsible party) at bedside and made aware. MD (medical doctor) assessed patient and ordered to transfer resident out to ER (emergency room) for diagnosis of hypoxia (1)."

Further review of the clinical record did not evidence documentation that the care plan was sent to emergency room with the resident.

An interview was conducted on 5/17/18 at 9:33 a.m. with LPN (licensed practical nurse) #4.

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F 622	Continued From page 13 When asked about the process staff follows when a resident is transferred to the emergency room, LPN #4 stated, "I call the hospital and tell them the diagnosis or what the problem is. I give them the vital signs, level of consciousness, pain, oxygen level and what the family wants." When asked what paperwork was sent with the resident, LPN #4 stated, "The DNR (do not resuscitate), the medication list, recent labs (laboratory results), x-ray if they had a result fall and the face sheet." When asked if the care plan is sent with the resident, LPN #4 stated, "You can tell them this patient is a fall risk." When asked if the actual care plan was sent, LPN #4 stated, "Sometimes over the phone." On 5/17/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2 the director of nursing and ASM #3 the quality assurance consultant were made aware of the findings. Review of the facility's policy titled, "INTERDISCIPLINARY CARE TRANSITIONS CHECKLISTS" documented, "TRANSITION FROM SKILLED NURSING FACILITY TO ACUTE CARE....Complete Acute Care Transfer Documentation Checklist. Collect necessary documents including a Transfer/Discharge Report from (name of software) and place in envelope. Seal envelope. Remove top copy and place in patient's clinical record." Review of the facility's form titled, "POST ACUTE CARE TRANSFER DOCUMENT CHECKLIST" did not evidence documentation that the care plan was to go with the resident. No further information was provided prior to exit.	F 622		

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1. Hypoxia is defined as the reduction or lack of oxygen in organs, tissues, or cells. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3217626/

2. The facility staff failed to evidence that Resident #110's care plan goals were provided to the receiving provider for a facility initiated transfer on 4/12/18.

Resident #110 was admitted to the facility on 4/4/18 and readmitted on 4/20/18 with diagnoses that included but were not limited to: chronic heart failure, anemia, heart attack and high cholesterol.

The most recent MDS, a 14-day assessment, with an ARD of 5/3/18 coded the resident as having scored 12 out of 15 on the BIMS indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was set up.

Review of the physician's notes dated 4/12/18 at 11:52 p.m., documented, "Notified by nursing that patient very lethargic, very high BP (blood pressure), hypoxic despite NRM (non-rebreather mask) and tachycardic (fast heart rate). Ordered pt (patient) transfer to ER (emergency room) via 911."

Further review of the clinical record did not evidence documentation that the care plan had been sent to the emergency room with the resident.

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An interview was conducted on 5/17/18 at 9:33 a.m. with LPN (licensed practical nurse) #4. When asked about the process staff follows when a resident is transferred to the emergency room, LPN #4 stated, "I call the hospital and tell them the diagnosis or what the problem is. I give them the vital signs, level of consciousness, pain, oxygen level and what the family wants." When asked what paperwork was sent with the resident, LPN #4 stated, "The DNR (do not resuscitate), the medication list, recent labs (laboratory results), x-ray if they had a result fall and the face sheet." When asked if the care plan is sent with the resident, LPN #4 stated, "You can tell them this patient is a fall risk." When asked if the actual care plan was sent, LPN #4 stated, "Sometimes over the phone."

On 5/17/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2 the director of nursing and ASM #3 the quality assurance consultant were made aware of the findings.

No further information was provided prior to exit.

3. The facility staff failed to evidence that Resident #85's care plan goals were provided to the receiving provider for a facility initiated transfer on 5/6/18.

Resident #85 was admitted to the facility on 4/12/18 and readmitted on 5/9/18 with diagnoses that included but were not limited to: Parkinson's disease (1), diabetes, high blood pressure and anemia.

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F 622	Continued From page 16 The most recent MDS (minimum data set), an end of therapy assessment, with an ARD (assessment reference date) of 4/29/18 coded the resident as having scored a 14 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the nurse's notes dated 5/6/18 at 10:20 a.m., documented, "At around 0945 (9:45 a.m.), writer was alert (sic) by nursing aide that patient is unresponsive....(Name of physician) visited and assessed patient and gave order to send patient to (name of hospital) ER (emergency room) for further evaluation." Further review of the clinical record did not evidence documentation that the care plan had been sent to the emergency room with the resident. An interview was conducted on 5/17/18 at 9:33 a.m. with LPN (licensed practical nurse) #4. When asked about the process staff follows when a resident is transferred to the emergency room, LPN #4 stated, "I call the hospital and tell them the diagnosis or what the problem is. I give them the vital signs, level of consciousness, pain, oxygen level and what the family wants." When asked what paperwork was sent with the resident, LPN #4 stated, "The DNR (do not resuscitate), the medication list, recent labs (laboratory results), x-ray if they had a result fall and the face sheet." When asked if the care plan is sent with the resident, LPN #4 stated, "You can tell them this patient is a fall risk." When asked if the actual care plan was sent, LPN #4 stated, "Sometimes over the phone."	F 622		

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On 5/17/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2 the director of nursing and ASM #3 the quality assurance consultant were made aware of the findings.

1. Parkinson's disease -- Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families. This information was obtained from: https://medlineplus.gov/parkinsonsdisease.html

4a. The facility staff failed to provide the receiving facility a copy of Resident # 318's care plan goals for a facility initiated transfer.

Resident # 113 was admitted to the facility on 09/23/14 with a readmission of 03/05/18 with diagnoses that included but were not limited to cerebrovascular disease (1), anemia (2), atherosclerotic heart disease (3) and muscle weakness.

Resident # 113's most recent MDS (minimum data set), a 5 (five)-day assessment with an ARD (assessment reference date) of 03/12/18, coded Resident # 113 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 113 was coded as requiring extensive assistance of one staff member for activities of daily living.

The nurse's "Progress Notes," for Resident # 113 documented in part, "02/22/2018. Call placed to

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(Name of Physician) to inform and receive order to send to (Mane of Hospital). Call placed to Daughter (Name of Daughter) she is aware. She did call and talked with her mother/resident to inform of what to expect in her language/Romanian. Resident verbalized understanding. Call placed to (Name of Transportation Company) ETA (estimated time of arrival) is 30 minutes. Call placed to (Name of Hospital) ER (emergency room) and report given to (Name of Hospital Nurse). Paperwork is complete and resident is ready for transport."

An interview was conducted with LPN (licensed practical nurse) # 4 on 5/17/18 at 9:33 a.m. When asked about the process staff follows when a resident is transferred to the hospital, LPN #4 stated, "We call and give them report. We send them with full vital signs, diagnosis, what the change in condition is, if the resident is able to speak, what their pain level is and what their oxygen level is." When asked what she sends with the resident to the hospital, LPN #4 stated, "DNR (do not resuscitate) form, medication lists, recent x-rays, labs (laboratory reports) and a face sheet." When asked if the care plan goals are sent with the resident, LPN #4 stated, "Mostly, if they have behaviors, depends on how they are going. We tell them if they are a fall risk." When asked if they provide their care plan goals, LPN #4 stated, "Sometimes by phone, not on paper." When asked if she goes through the entire care plan on the phone, LPN #4 stated, "No, we summarize what they need for that time to stabilize the resident. We summarize but don't give them each goal.

On 05/17/18 at approximately 5:50 p.m. ASM (administrative staff member) # 1, the

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F 622	Continued From page 19 administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . (2) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . (3) A disease in which plaque builds up inside your arteries. Plaque is a sticky substance made up of fat, cholesterol, calcium, and other substances found in the blood. Over time, plaque hardens and narrows your arteries. That limits the flow of oxygen-rich blood to your body. This information was obtained from the website: https://medlineplus.gov/atherosclerosis.html. 4b. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 113 for a facility initiated transfer. The nurse's "Progress Notes," for Resident # 113	F 622		

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F 622	Continued From page 20 documented in part, "02/22/2018. Call placed to (Name of Physician) to inform and receive order to send to (Mane of Hospital). Call placed to Daughter (Name of Daughter) she is aware. She did call and talked with her mother/resident to inform of what to expect in her language/Romanian. Resident verbalized understanding. Call placed to (Name of Transportation Company) ETA (estimated time of arrival) is 30 minutes. Call placed to (Name of Hospital) ER (emergency room) and report given to (Name of Hospital Nurse). Paperwork is complete and resident is ready for transport." Review of the physician's most recent progress notes dated 01/23/18 through 05/02/18 failed to evidence documentation of the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 113. On 05/17/18 at 1:58 p.m., an interview was conducted with ASM (administrative staff member) # 6, the nurse practitioner. When asked to describe what is documented when a resident is transferred, ASM # 6 stated, "We only note why we are transferring the patient." On 05/17/18 at approximately 5:50 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. 5. The facility staff failed to provide Resident #65's comprehensive care plan goals to hospital staff when the resident transferred to the hospital on 4/23/18.	F 622		

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F 622	Continued From page 21 Resident #65 was admitted to the facility on 4/13/18. Resident #65's diagnoses included but were not limited to diabetes, asthma and anxiety disorder. Resident #65's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/20/18, coded the resident's cognitive skills for daily decision making as independent. Review of Resident #65's clinical record revealed a nurse's note dated 4/23/18 that documented, "Patient was awake most of the night and received the ordered medications without problem. She requested the trach (tracheostomy) (1) cannula to be changed and was changed without problem at 0400 (4:00 a.m.) She then complained stating it was not properly done and another stuff (sic) was called and checked and patient was agreeable that the trach cannula was in proper positioning (sic). She then stated she wanted to have inhaler like the one she takes at home but could not remember the name but the colour (sic). The MD (medical doctor) was called and the inhaler description per Md was albuterol (2) and the order was obtain (sic) at about (sic) and faxed to the pharmacy and the pharmacy was called, confirmed the reception of the faxed order and promised to deliver ASAP (as soon as possible) from their backup pharmacy. Patient wanted it to be delivered immediately and refused to have the ordered neb (nebulizer) cursing the the (sic) explanation of when the inhaler would come. She took her medication at 0645 (6:45 a.m.) and accepted her neb (nebulizer) treatment at that time. She was walking up and down to bathroom and at the door. Vs (Vital signs) ware (sic) stable then bat (sic) 0710 (7:10 a.m.) started to have upper	F 622		

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respiratory congestion and and (sic) started being anxious and stating call 911. Checked VS (blood pressure) 132/88 p (pulse) 90 R (respirations) 20 02SAT (oxygen saturation) 96 with o2 (oxygen) at 6l (liters) via trac (tracheostomy). Refused to be suction (sic). 911 was called and arrived at about 0720 (7:20 a.m.) and gave their resp (respiratory) treatment. Patient started laughing and stated she didn't want to go to the hospital and that she wanted to just be stabilized, They (sic) were able to convince her to go for more treatment and more check up (sic.) and finally agreed and left at 0730 (7:30 a.m.) Clarification: Note written prior; Patient report given to (name) RN (registered nurse) questions were encouraged and answered to her satisfaction. (Name of physician) was called again and updated of change of condition and order received to send patient to ED (emergency department) for evaluation. Daughter (name) called and msge (message) left to call facility for updates. The mother was already calling her before she left. The required patient paperwork was faxed to ED and to case manager at (name of hospital)."

Further review of Resident #65's clinical record failed to reveal a description of the verbal or documented information that was provided to hospital staff.

On 5/17/18 at 12:32 p.m., an interview was conducted with RN (registered nurse) #6 (the nurse who documented the above note dated 4/23/18). RN #6 was asked what information is provided to the hospital staff when a resident is transferred to the hospital. RN #6 stated she provides information about the resident's baseline condition and information about the immediate change that has necessitated the need for the

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transfer. RN #6 was asked to describe the information she provided to hospital staff when Resident #65 was transferred to the hospital on 4/23/18. RN #6 stated she spoke to a hospital nurse on the phone and gave information regarding Resident #65's tracheostomy and diet. RN #6 stated she also sent paperwork that included a medication report, physician's orders, the MAR (medication administration record) and information about the care staff gives the resident. RN #6 was asked if she provided Resident #65's care plan goals to the receiving hospital. RN #6 stated she provided the information needed to care for Resident #65 but did not talk about the care plan goals on the phone with hospital staff or send the resident's care plan to the hospital.

On 5/17/18 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) "A tracheostomy is surgery to create a hole in your neck that goes into your windpipe." This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000076.htm

(2) "Albuterol is used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682145.h

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F 622	Continued From page 24 tml 6. The facility staff failed to evidence that all required information was provided to the receiving provider for Resident #69's facility-initiated transfer to the hospital on 3/28/18 and 4/27/18. Resident #69 was admitted to the facility on 7/8/17 and readmitted on 5/1/18 with diagnoses that included but were not limited to Parkinson's disease, multiple sclerosis (1), and bipolar disorder. Resident #69's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/12/18. Resident #69 was coded as cognitively intact scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #69's clinical record revealed that she had first been transferred to the hospital on 3/28/18. The following was documented, "At the beginning of the shift PT (patient) refused AM care and refused to eat breakfast. We encourage the patient and finally drank 1 carton of milk and half coup (sic) of coffee. At noon pt's lips are dry and getting weak. NP (nurse practitioner) ordered to start on IVF (Intravenous fluids), D5 (Dextrose) NS (normal saline) at 75 cc/hr (cubic centimeter / hour) for 1 liter and 60 cc/hr for 2 liters for decreased po (by mouth) intake. Her daughter came at 1:39 p.m., updated on condition. Daughter initially wants to send patient to the hospital but changed her mind and said she will stay with the patient for couple of hours to observe her and will decide then. At 3:00 p.m. daughter request to transfer the pt (patient) to the hospital..."	F 622		

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F 622	Continued From page 25 Review of the acute care transfer sheet dated 3/28/18 revealed that the following information was provided with the resident at the time of transfer: 1. Contact information of the practitioner responsible for the care of the resident. 2. Resident representative information including contact information. 3. All special instructions or precautions for ongoing care, as appropriate. 4. Advance Directive information. There was no evidence that the Resident #69's care plan goals were sent with the resident at the time of transfer. Further review of Resident #69's clinical record revealed that Resident #69 went out to the the hospital for the second time on 4/27/18. The following note was documented on 4/27/18: "Resident alert and verbally responsive. Observed resident at the beginning of the shift kept calling "help me," observed resident rested in bed, head elevated with no signs of acute distress. Resident stated there was someone whom she call an airman coming to see her, reoriented stated that she had no appointment to meet anyone today and no Mr. airman. Resident frequently called out and talked to herself loudly with no sign of acute distress. Last day on Ceftin (2) on UTI (urinary tract infection). VS (Vital Signs) bp (blood pressure) - 145/80, hr (heart rate) - 67, rr (respiratory rate) -17, 02 sate (sic) (saturation) 95 % RA (room air), Temp (temperature) - 96.9 F (Fahrenheit). Resident refused to take the morning medications and her breakfast, staffs attempted x3 and educated for the risk of not taking her medication and food,	F 622		

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F 622	Continued From page 26 ensure offered, but not been taken. Family member notified, spoke to (Name of daughter) about changing status. Daughter visited and attempted many time to encourage resident to drink and eat, resident took medications with some milk, daughter at bedside...will continue to monitor." The next note dated 4/27/18 at 5 p.m., documented the following: "DCS (direct care staff) reported that resident with an order for IVF (IV fluids) due to change in mental status, refused meds (medications) and decreased p.o. intake. Resident refused IVF. Order noted to send resident to the hospital. This writer visited Resident, (sic.) fluids offered but took only 1 sip even with a lot of encouragement." The last note at 4/27/18 at 6:49 p.m., documented the following: "Resident was transferred out to (Name of Hospital) for evaluation due to Mental Status change with resident refusing her medications and not eating her food, (Name of physician) is aware and resident daughter (Name of Daughter) was here this morning with resident. Resident was picked up by (Name of transport) at 6:45 p.m. VS (vital signs): 133/65, 20 (respirations), 63 (pulse), 97.3 (temperature), and 02 sat is 97 % RA (room air)." Review of the acute care transfer sheet dated 4/27/18 revealed that the following information was provided with the resident at the time of transfer: 1. Contact information of the practitioner responsible for the care of the resident. 2. Resident representative information including contact information. 3. All special instructions or precautions for	F 622		

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ongoing care, as appropriate.
4. Advance Directive information.

There was no evidence that the Resident #69's care plan goals were sent with the resident at the time of transfer.

On 5/17/18 at 9:33 a.m., an interview was conducted with LPN #4. When asked what information was provided to the hospital at the time of transfer to the hospital, LPN #4 stated that nurses send the resident's advanced directives, medication list, recent laboratory tests, face sheet and any diagnostic tests if pertinent. LPN #4 stated the resident's representative and physician contact information was located on the face sheet. When asked if care plan goals were provided to the hospital upon transfer, LPN #4 stated that sometimes she will provide some care plan goals over the phone when giving report. LPN #4 stated that she did not go over the entire care plan. LPN #4 stated that nurses did not send the care plan with residents to the hospital.

On 5/17/18 at 6:05 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

7. The facility staff failed to evidence that all required information was provided to the receiving provider for Resident #44's facility-initiated transfer to the hospital on 2/1/18.

Resident #44 was admitted to the facility on 4/26/10 and readmitted on 2/06/18 with diagnoses that included but were not limited to generalized anxiety disorder, dementia, and

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major depressive disorder. Resident #44's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 3/31/18. Resident #44 was coded as severely impaired in cognitive function scoring 05 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #44 was coded as requiring extensive assistance from one staff member with eating, and toileting; total dependence on one staff member with dressing, personal hygiene and bathing; and extensive assistance with two plus staff members with bed mobility and transfers.

Review of Resident #44's clinical record revealed that she had been transferred to the hospital on 2/1/18. The following note was written on 2/1/18 at 8:15 p.m.: "Resident alert and in bed at this time, son visiting with her came (sic) to the nursing station to report that her (sic) Mom complain to him that she was getting sick and think she is having Flu like symptoms and he want the Mom to go to the Hospital (sic), he was encourage to let the MD (medical doctor) take care of that but he said no (Name of Doctor) (sic) was called and he said if that is what the family want than she should go to the Hospital (sic) VS (vital signs) 91/51 (blood pressure), 18 (respirations), 98 (pulse), 99.8 (temperature) and 02 (oxygen) saturation is 95 percent RA (room air), resident already have Tylenol (1). Transport is called and theywould (sic) be here in an hour."

The next note dated 2/2/18, documented the following: "Resident was picked up at 8:15 p.m. to (Name of Hospital) for evaluation for complains of coughing and weakness. The son was here and went with her to the hospital."

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Review of the acute care transfer sheet dated 2/1/18/18 revealed that the following information was provided with the resident at the time of transfer:
1. Contact information of the practitioner responsible for the care of the resident.
2. Resident representative information including contact information.
3. All special instructions or precautions for ongoing care, as appropriate.
4. Advance Directive information.

There was no evidence that the Resident #44's care plan goals were sent with the resident at the time of transfer.

Further review of Resident #44's clinical record revealed that she was admitted to the hospital with a diagnoses of the flu. Resident #44 was admitted back to the facility on 2/7/18. Review of Resident #44's immunizations record revealed that she had received the flu vaccine for that flu season on 10/20/17.

On 5/17/18 at 9:33 a.m., an interview was conducted with LPN #4. When asked what information was provided to the hospital at the time of transfer to the hospital, LPN #4 stated that nurses send the resident's advanced directives, medication list, recent laboratory tests, face sheet and any diagnostic tests if pertinent. LPN #4 stated that the resident's representative and physician contact information was located on the face sheet. When asked if care plan goals were provided to the hospital upon transfer, LPN #4 stated that sometimes she will provide some care plan goals over the phone when giving report. LPN #4 stated that she did not go over the entire care plan. LPN #4 stated that nurses did not send

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the care plan with residents to the hospital.

On 5/17/18 at 6:05 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

8. The facility staff failed to evidence the care plan goals were sent with Resident #105 for a facility initiated transfer to the hospital on 12/1/17.

Resident #105 was admitted to the facility on 8/14/15 with a recent readmission on 12/9/17, with diagnoses that included but were not limited to: end stage renal failure requiring hemodialysis (a procedure to removed toxic condition and renal failure in which wastes and impurities are removed from the blood by a special machine) (1), obesity, sleep apnea, stroke, high blood pressure, diabetes, depression and seizure disorder.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date (ARD) of 5/4/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status score) indicating he was capable of making daily cognitive decisions.

The nurse's note dated, 12/1/17 at 9:14 a.m. documented in part, "Resident had an episode of chest pain and hypotension after 0500 (5:00 a.m.) medication administration. Metoprolol (used to treat high blood pressure) (2) was given for pts (patient's) blood pressure of 150/101, pulse 100. Approximately 30 minutes later resident complained of chest pain and headache. Blood pressure checked and was 93/46, P (pulse) 71.

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F 622	Continued From page 31 MD (medical doctor) notified and ordered resident take aspirin 81 mg (milligrams) stat (immediately) and send pt (patient) to ER (emergency room). Resident was sent to (Name of hospital) ER via stretcher. Resident did not go to dialysis today." Review of the clinical record failed to evidence documentation of the information sent to the hospital with the resident on 12/1/17. An interview was conducted with LPN (licensed practical nurse) # 4 on 5/17/18 at 9:33 a.m. When asked about the process staff follows when a resident is transferred to the hospital, LPN #4 stated, "We call and give them report. We send them with full vital signs, diagnosis, what the change in condition is, if the resident is able to speak, what their pain level is and what their oxygen level is." When asked what she sends with the resident to the hospital, LPN #4 stated, "DNR (do not resuscitate) form, medication lists, recent x-rays, labs (laboratory reports) and a face sheet." When asked if the care plan goals are sent with the resident, LPN #4 stated, "Mostly, if they have behaviors, depends on how they are going. We tell them if they are a fall risk." When asked if they provide their care plan goals, LPN #4 stated, "Sometimes by phone, not on paper." When asked if she goes through the entire care plan on the phone, LPN #4 stated, "No, we summarize what they need for that time to stabilize the resident. We summarize but don't give them each goal. The administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant, were made aware of the above concern on 5/17/18 at 5:52 p.m.	F 622		

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No further information was provided prior to exit.

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

(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011186/?report=details.

9. The facility staff failed to evidence the care plan goals were sent with Resident #97, for a facility initiated transfer to the hospital on 4/19/18. Resident #97 was admitted to the facility on 4/9/18 with a readmission on 4/24/18 with diagnoses that included but were not limited to: sepsis (destruction of tissue by bacterial toxins, contamination, infection) (1), paraplegia (paralysis of the lower limbs) (2), below the knee amputation, pressure ulcer and osteoarthritis (degenerative changes in the joints) (3).

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 5/6/18, coded the resident as scoring a 12 on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions.

The nurse's note dated, 4/19/18 at 2:11 p.m. documented in part, "Pt (patient) observed in bed with son at the bedside through the afternoon. Per son and MD (medical doctor), the pt has increased confusion going on since Sunday. Upon assessment, the pt is observed taking off

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her gown repeatedly. Speech is clear however not making much since (sic). IVF's (intravenous fluids) continued per order...MD in this afternoon to assess the pt...New order received to send to (initials of hospital) ER (emergency room) for further eval (evaluation) d/t (due to) AMS (altered mental status) and possible seizure. Son is aware of the plan of care. Report called into (name of nurse at ER). Pt left the facility at 4:45 p.m."

The "Acute Care Transfer" form failed to evidence documentation of what was sent with the resident to the hospital. There were no care plan goals documented on the form.

Review of the clinical record failed to evidence documentation of what was sent to the hospital with the resident on 12/1/17.

An interview was conducted with LPN (licensed practical nurse) # 4 on 5/17/18 at 9:33 a.m. When asked about the process staff follows when a resident is transferred to the hospital, LPN #4 stated, "We call and give them report. We send them with full vital signs, diagnosis, what the change in condition is, if the resident is able to speak, what their pain level is and what their oxygen level is." When asked what she sends with the resident to the hospital, LPN #4 stated, "DNR (do not resuscitate) form, medication lists, recent x-rays, labs (laboratory reports) and a face sheet." When asked if the care plan goals are sent with the resident, LPN #4 stated, "Mostly, if they have behaviors, depends on how they are going. We tell them if they are a fall risk." When asked if they provide their care plan goals, LPN #4 stated, "Sometimes by phone, not on paper." When asked if she goes through the entire care

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F 622	Continued From page 34 plan on the phone, LPN #4 stated, "No, we summarize what they need for that time to stabilize the resident. We summarize but don't give them each goal. The administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant, were made aware of the above concern on 5/17/18 at 5:52 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 527. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 435. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 422.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in	F 623	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies 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 corrections. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	

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F 623	Continued From page 35 accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which	F 623		

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F 623	Continued From page 36 receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as	F 623		

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F 623	Continued From page 37 well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide required written notification of a facility initiated transfer to the resident's representative and/or ombudsman for seven of 48 residents in the survey sample, Residents #433, 110, 85, 113, 69, 105 and 97. 1. The facility staff failed to provide written notification to the resident representative and ombudsman for a transfer to the hospital on 4/27/18 for Resident #433. 2. The facility staff failed to provide written notification to the resident representative and ombudsman for a transfer to the hospital on 4/12/18 for Resident #110. 3. The facility staff failed to provide written notification to the resident representative and ombudsman for a transfer to the hospital on 5/6/18 for Resident #85. 4. The facility staff failed to provide written notification to the resident representative of a facility initiated transfer for Resident # 113. 5. The facility staff failed to provide written notification to the resident representative and ombudsman for a transfer to the hospital on 4/27/18 for Resident #69. 6. The facility staff failed to provide written documentation that the resident and/or resident	F 623	It is the practice of the facility to provide required written notification of a facility initiated transfer to the resident's re-presentative and/or ombudsman. 1. Residents #433, #110, #85, #113, #69, #105 and #97 no longer reside in the facility. 2. Residents who are transferred have the potential to be affected. 3. Licensed Nurses and Social Service department will be re-educated on providing written notification to responsible party (RP)/ ombudsman on all transfers out of the facility. 4. DON and/or designee will complete five (5) random audits of resident dis-charges to ensure that written notification was provided to responsible party (RP)/ ombudsman. These audits will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appro-priate. The commitee will determine need for further audits and/or action. 5. Date of compliance is June 19, 2018	

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representative and the ombudsman were notified, in writing, when he was transferred to the hospital on 12/1/17 for Resident #105.

7. The facility staff failed to provide written documentation that the resident and/or resident representative and the ombudsman were notified, in writing, when he was transferred to the hospital on 4/19/18 for Resident #97.

The findings include:

1. Resident #433 was admitted to the facility on 4/2/18 and readmitted on 5/3/18 with diagnoses that included but were not limited to: respiratory failure, anemia, obesity and diabetes.

The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 5/10/18 coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status indicating the resident was cognitively intact to make daily decisions.

Review of the nurse's note dated 4/27/18 at 12:50 p.m. documented, "Resident alert and responsive. v/s (vital signs) this morning before therapy was 115/59 (blood pressure) 75 (pulse) 18 (respirations) 97.5 (temperature) oxygen saturation at 86% (normal 90 - 100) on Oxygen 3l/min (liters per minute) via nasal cannula (soft prongs that fit in the nose to deliver oxygen). md (medical doctor) was notified RP (responsible party) at bedside and made aware. MD (medical doctor) assessed patient and ordered to transfer resident out to ER (emergency room) for diagnosis of hypoxia (1)."

Further review of the clinical record did not

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evidence documentation that the resident's representative (RR) or the ombudsman were notified in writing of the transfer.

An interview was conducted on 5/17/18 at 9:33 a.m. with LPN (licensed practical nurse) #4. When asked about the process staff follows to notify the family when a resident is transferred to the hospital, LPN #4 stated, "Sometimes they are not here and we have to phone them and give them the number of the hospital." When asked if the family received anything in writing, LPN #4 stated, "No."

On 5/17/18 at approximately 10:45 a.m., an interview was conducted with OSM (other staff member) #7, the social worker. OSM #7 stated that when a resident is transferred to the hospital, she will create an ombudsman notification form in PCC (point click care). OSM #7 stated that the ombudsman receives a copy of this notification only upon request. OSM #7 stated that the ombudsman only wants notifications for involuntary discharges. OSM #7 stated that she does not notify the ombudsman for every facility-initiated transfer.

On 5/17/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant were made aware of the findings.

Review of the facility's policy titled, "INTERDISCIPLINARY CARE TRANSITIONS CHECKLISTS" did not evidence documentation regarding providing written notification to the RR or the ombudsman.

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No further information was obtained prior to exit.

1. Hypoxia is defined as the reduction or lack of oxygen in organs, tissues, or cells. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3217626/

2. The facility staff failed to provide written notification to the resident representative and ombudsman for a transfer to the hospital on 4/12/18 for Resident #110.

Resident #110 was admitted to the facility on 4/4/18 and readmitted on 4/20/18 with diagnoses that included but were not limited to: chronic heart failure, anemia, heart attack and high cholesterol.

The most recent MDS, a 14-day assessment, with an ARD of 5/3/18 coded the resident as having scored 12 out of 15 on the BIMS indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was set up.

Review of the physician's notes dated 4/12/18 at 11:52 p.m., documented, "Notified by nursing that patient very lethargic, very high BP (blood pressure), hypoxic despite NRM (non-rebreather mask) and tachycardic (fast heart rate). Ordered pt (patient) transfer to ER (emergency room) via 911."

Further review of the clinical record did not evidence documentation that the resident's representative (RR) or the ombudsman were

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F 623	Continued From page 41 notified in writing of the transfer. An interview was conducted on 5/17/18 at 9:33 a.m. with LPN (licensed practical nurse) #4. When asked the process staff followed to notify the family when a resident is transferred to the hospital, LPN #4 stated, "Sometimes they are not here and we have to hone them and give them the number of the hospital." When asked if the family received anything in writing, LPN #4 stated, "No." On 5/17/18 at approximately 10:45 a.m., an interview was conducted with OSM (other staff member) #7, the social worker. OSM #7 stated that when a resident is transferred to the hospital, she will create an ombudsman notification form in PCC (point click care). OSM #7 stated that the ombudsman receives a copy of this notification only upon request. OSM #7 stated that the ombudsman only wants notifications for involuntary discharges. OSM #7 stated that she does not notify the ombudsman for every facility-initiated transfer. On 5/17/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant were made aware of the findings. No further information was obtained prior to exit. 3. The facility staff failed to provide written notification to the resident representative and ombudsman for a transfer to the hospital on 5/6/18 for Resident #85.	F 623		

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Resident #85 was admitted to the facility on 4/12/18 and readmitted on 5/9/18 with diagnoses that included but were not limited to: Parkinson's disease (1), diabetes, high blood pressure and anemia.

The most recent MDS (minimum data set), an end of therapy assessment, with an ARD (assessment reference date) of 4/29/18 coded the resident as having scored a 14 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the nurse's notes dated 5/6/18 at 10:20 a.m., documented, "At around 0945 (9:45 a.m.), writer was alert (sic) by nursing aide that patient is unresponsive....(Name of physician) visited and assessed patient and gave order to send patient to (name of hospital) ER (emergency room) for further evaluation."

On 5/17/18 at approximately 10:45 a.m., an interview was conducted with OSM (other staff member) #7, the social worker. OSM #7 stated that when a resident is transferred to the hospital, she will create an ombudsman notification form in PCC (point click care). OSM #7 stated that the ombudsman receives a copy of this notification only upon request. OSM #7 stated that the ombudsman only wants notifications for involuntary discharges. OSM #7 stated that she does not notify the ombudsman for every facility-initiated transfer.

Further review of the clinical record did not evidence documentation that the resident's

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representative (RR) or the ombudsman were notified in writing of the transfer.

An interview was conducted on 5/17/18 at 9:33 a.m. with LPN (licensed practical nurse) #4. When asked the process staff followed to notify the family when a resident is transferred to the hospital, LPN #4 stated, "Sometimes they are not here and we have to hone them and give them the number of the hospital." When asked if the family received anything in writing, LPN #4 stated, "No."

On 5/17/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant were made aware of the findings.

No further information was obtained prior to exit.

1. Parkinson's disease -- Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families. This information was obtained from:
https://medlineplus.gov/parkinsonsdisease.html
4. The facility staff failed to provide written notification to the responsible party (RP) and ombudsman for a facility initiated transfer for Resident # 113.

Resident # 113 was admitted to the facility on 09/23/14 with a readmission of 03/05/18 with diagnoses that included but were not limited to cerebrovascular disease (1), anemia (2), atherosclerotic heart disease (3) and muscle

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weakness.

Resident # 113's most recent MDS (minimum data set), a 5 (five)-day assessment with an ARD (assessment reference date) of 03/12/18, coded Resident # 113 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 113 was coded as requiring extensive assistance of one staff member for activities of daily living.

The nurse's "Progress Notes," for Resident # 113 documented in part, "02/22/2018. Call placed to (Name of Physician) to inform and receive order to send to (Mane of Hospital). Call placed to Daughter (Name of Daughter) she is aware. She did call and talked with her mother/resident to inform of what to expect in her language/Romanian. Resident verbalized understanding. Call placed to (Name of Transportation Company) ETA (estimated time of arrival) is 30 minutes. Call placed to (Name of Hospital) ER (emergency room) and report given to (Name of Hospital Nurse). Paperwork is complete and resident is ready for transport."

The "Social Services Progress Note" dated 03/11/2018 failed to evidence documentation of notification to the ombudsman of Resident # 113's transfer to the hospital on 02/22/18.

On 5/17/18 at 9:33 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked how the resident or responsible party was notified of hospital transfers, LPN #4 stated that if the resident were their own representative, she would verbally tell the resident the reason for transfer. LPN #4 stated

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F 623	Continued From page 45 that if the resident's representative were not present at the facility, she would have to call them and verbally tell them over the phone. LPN #4 stated that she would document in a nursing note that the resident or resident representative was made aware of the transfer. When asked if nurses provided written notification to the resident or resident representative documenting the reason for transfer, LPN #4 stated that they did not. LPN #4 stated that the nurses do not notify the ombudsman with a transfer to the hospital. On 5/17/18 at approximately 10:45 a.m., an interview was conducted with OSM (other staff member) #7, the social worker. OSM #7 stated that when a resident is transferred to the hospital, she will create an ombudsman notification form in PCC (point click care). OSM #7 stated that the ombudsman receives a copy of this notification only upon request. OSM #7 stated that the ombudsman only wants notifications for involuntary discharges. OSM #7 stated that she does not notify the ombudsman for every facility-initiated transfer. On 05/17/18 at approximately 5:50 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the	F 623		

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website:
https://medlineplus.gov/ency/article/000726.htm .

(2) Low iron. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anemia.html
.

(3) A disease in which plaque builds up inside your arteries. Plaque is a sticky substance made up of fat, cholesterol, calcium, and other substances found in the blood. Over time, plaque hardens and narrows your arteries. That limits the flow of oxygen-rich blood to your body. This information was obtained from the website:
https://medlineplus.gov/atherosclerosis.html.

5. The facility staff failed to provide written notification to the resident representative and ombudsman for a transfer to the hospital on 4/27/18 for Resident #69.

Resident #69 was admitted to the facility on 7/8/17 and readmitted on 5/1/18 with diagnoses that included but were not limited to Parkinson's disease, multiple sclerosis (1), and bipolar disorder. Resident #69's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/12/18. Resident #69 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #69's clinical record revealed that Resident #69 went out to the the hospital on 4/27/18. The following note was documented: "Resident alert and verbally responsive. Observed resident at the beginning of the shift kept calling "help me," observed resident rested

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in bed, head elevated with no signs of acute distress. Resident stated there was someone whom she call an airman coming to see her, reoriented stated that she had no appointment to meet anyone today and no Mr. airman. Resident frequently called out and talked to herself loudly with no sign of acute distress. Last day on Ceftin (2) on UTI (urinary tract infection). VS (Vital Signs) bp (blood pressure) - 145/80, hr (heart rate) - 67, rr (respiratory rate) -17, 02 sate (sic) (saturation) 95 % RA (room air), Temp (temperature) - 96.9 F (Fahrenheit). Resident refused to take the morning medications and her breakfast, staffs attempted x 3 and educated for the risk of not taking her medication and food, ensure offered, but not been taken. Family member notified, spoke to (Name of daughter) about changing status. Daughter visited and attempted many time to encourage resident to drink and eat, resident took medications with some milk, daughter at bedside...will continue to monitor."

The next note dated 4/27/18 at 5 p.m., documented the following: "DCS (direct care staff) reported that resident with an order for IVF (IV fluids) due to change in mental status, refused meds [medications] and decreased p.o. intake. Resident refused IVF. Order noted to send resident to the hospital. This writer visited Resident, fluids offered but took only 1 sip even with a lot of encouragement."

The last note at 4/27/18 at 6:49 p.m., documented the following: "Resident was transferred out to (Name of Hospital) for evaluation due to Mental Status change with resident refusing her medications and not eating her food, (Name of physician) is aware and

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	495217	A. BUILDING ______ B. WING ______	C 05/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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resident daughter (Name of Daughter) was here this morning with resident. Resident was picked up by (Name of transport) at 6:45 p.m. VS (vital signs): 133/65, 20 (respirations), 63 (pulse), 97.3 (temperature), and 02 sat is 97 % RA (room air)."

Review of Resident #69's clinical record failed to evidence that the RP (responsible party) was notified in writing for her reason for transfer and that the ombudsman received a copy of this notification.

On 5/17/18 at 9:33 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked how the resident or responsible party was notified of hospital transfers, LPN #4 stated that if the resident were their own representative, she would verbally tell the resident the reason for transfer. LPN #4 stated that if the resident's representative were not present at the facility, she would have to call them and verbally tell them over the phone. LPN #4 stated that she would document in a nursing note that the resident or resident representative was made aware of the transfer. When asked if nurses provided written notification to the resident or resident representative documenting the reason for transfer, LPN #4 stated that they did not. LPN #4 stated that the nurses do not notify the ombudsman with a transfer to the hospital.

On 5/17/18 at approximately 10:45 a.m., an interview was conducted with OSM (other staff member) #7, the social worker. OSM #7 stated that when a resident is transferred to the hospital, she will create an ombudsman notification form in PCC (point click care). OSM #7 stated that the ombudsman receives a copy of this notification only upon request. OSM #7 stated that the

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F 623	Continued From page 49 ombudsman only wants notifications for involuntary discharges. OSM #7 stated that she does not notify the ombudsman for every facility-initiated transfer. On 5/17/18 at 6:05 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility policy titled, "Ombudsman Notification of Patient Transfer/Discharge," documents in part, the following: " Within the final rule, section 483.15 (3) (i) stated that prior to transferring or discharging a patient, the facility must notify the patient and the patient's representative of the transfer of discharge and the reasons for the move in writing in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long Term-Care Ombudsman. If the discharge is not involuntary, the Ombudsman Discharge Notification in PCC (point click care can be utilized to document the transfer/discharge date, transfer destination and reason for transfer. As noted earlier, center administration should have contacted their state ombudsman office to determine how the office wants to receive this notification. Members of the IDT (interdisciplinary team) can access the Ombudsman Discharge Notification. The staff member responsible for notifying the ombudsman's office should document the completed notification in a progress note. If the notification is via fax, the fax confirmation page is to be scanned into the patient's electronic health record."	F 623		

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(1) Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from The National Institutes of Health at https://medlineplus.gov/multiplesclerosis.html.

(2) Ceftin is a cephalosporin antibiotic used to treat bacterial infections. This information was obtained from The National Institutes of Health at https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009522/?report=details.

6. The facility staff failed to provide written documentation that the resident and/or resident representative and the ombudsman were notified, in writing, when he was transferred to the hospital on 12/1/17 for Resident #105.

Resident #105 was admitted to the facility on 8/14/15 with a recent readmission on 12/9/17, with diagnoses that included but were not limited to: end stage renal failure requiring hemodialysis (a procedure to removed toxic condition and renal failure in which wastes and impurities are removed from the blood by a special machine) (1), obesity, sleep apnea, stroke, high blood pressure, diabetes, depression and seizure disorder.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/4/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status score) indicating he was capable of making daily cognitive decisions.

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F 623	Continued From page 51 Resident #105 was coded as requiring extensive assistance for most of his activities of daily living except eating in which he only required supervision after set up assistance was provided. The nurse's note dated, 12/1/17 at 9:14 a.m. documented in part, "Resident had an episode of chest pain and hypotension after 0500 (5:00 a.m.) medication administration. Metoprolol (used to treat high blood pressure) (2) was given for pts (patient's) blood pressure of 150/101, pulse 100. Approximately 30 minutes later resident complained of chest pain and headache. Blood pressure checked and was 93/46, P (pulse) 71. MD (medical doctor) notified and ordered resident take aspirin 81 mg (milligrams) stat (right away) and send pt (patient) to ER (emergency room). Resident was sent to (Name of hospital) ER via stretcher. Resident did not go to dialysis today." Review of the clinical record failed to evidence documentation that the resident and/or resident representative were provided written documentation for the resident of the transfer and documentation that the ombudsman was notified of the transfer to the hospital on 12/1/18. An interview was conducted with LPN (licensed practical nurse) # 4 on 5/17/18 at 9:33 a.m. When asked if the family or resident are given any written documentation about the transfer, LPN #4 stated, "No they are not always at the bedside, so we call them. We give them the number at the hospital." When asked if that is documented in the clinical record, LPN #4 stated, "Yes, we document it in the clinical record but we don't give them anything in writing." An interview was conducted with other staff	F 623		

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F 623	Continued From page 52 member (OSM) # 7, the social worker and OSM #13, a social worker, on 5/17/18 at 10:53 a.m. When asked if they notify the ombudsman related to hospital discharges, OSM #7 stated, "We only notify the ombudsman on unplanned discharged." When asked if they had received instructions from the ombudsman regarding discharges, OSM #7 stated, "They only want to be notified of involuntary discharges." OSM #13 stated, "Per their (the ombudsman) request they don't want to be notified." When asked if they notify the ombudsman when a resident is transferred to the hospital, OSM #13 stated, "No." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 5/17/18 at 4:16 p.m. When asked if the resident or resident representative is given anything in writing at the time of the transfer, ASM #2 stated, "No, we complete the SBAR (situation, background, assessment, recommendation) and send that with the resident." When asked if the ombudsman is notified, ASM #2 stated, "We print out an action summary, it dictates where the residents go. (Name of former social worker) would fax it to the ombudsman. It's not being done anymore. I am not clear of the process of notifying the ombudsman. I will have to check with the administrator for the process. When asked if the resident or resident representative is given written notification of the transfer, ASM #2 stated, "No, I can tell you the nurses are not notifying the ombudsman." The administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant, were made aware of the above concern on 5/17/18 at 5:52 p.m.	F 623		

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F 623	Continued From page 53	F 623		

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 266.
(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011186/?report=details.

7. The facility staff failed to provide written documentation that the resident and/or resident representative and the ombudsman were notified, in writing, when he was transferred to the hospital on 4/19/18 for Resident #97.

Resident #97 was admitted to the facility on 4/9/18 with a readmission on 4/24/18 with diagnoses that included but were not limited to: sepsis (destruction of tissue by bacterial toxins, contamination, infection) (1), paraplegia (paralysis of the lower limbs) (2), below the knee amputation, pressure ulcer and osteoarthritis (degenerative changes in the joints) (3).

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 5/6/18, coded the resident as scoring a 12 on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision

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F 623	Continued From page 54	F 623		

after set up assistance was provided.

The nurse's note dated, 4/19/18 at 2:11 p.m. documented in part, "Pt (patient) observed in bed with son at the bedside through the afternoon. Per son and MD (medical doctor), the pt has increased confusion going on since Sunday. Upon assessment the pt is observed taking off her gown repeatedly. Speech is clear however not making much since (sic). IVF's (intravenous fluids) continued per order...MD in this afternoon to assess the pt...New order received to send to (initials of hospital) ER (emergency room) for further eval (evaluation) d/t (due to) AMS (altered mental status) and possible seizure. Son is aware of the plan of care. Report called into (name of nurse at ER). Pt left the facility at 4:45 p.m."

The "Acute Care Transfer" form, dated 4/19/18, failed to evidence documentation of what was given to the resident or resident representative or documentation the ombudsman was notified of the transfer.

An interview was conducted with LPN (licensed practical nurse) # 4 on 5/17/18 at 9:33 a.m. When asked if the family or resident are given any written documentation about the transfer, LPN #4 stated, "No they are not always at the bedside, so we call them. We give them the number at the hospital." When asked if that is documented in the clinical record, LPN #4 stated, "Yes, we document it in the clinical record but we don't give them anything in writing."

An interview was conducted with other staff member (OSM) # 7, the social worker and OSM #13, a social worker, on 5/17/18 at 10:53 a.m.

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F 623	Continued From page 55	F 623		

When asked if they notify the ombudsman related to hospital discharges, OSM #7 stated, "We only notify the ombudsman on unplanned discharged." When asked if they had received instructions from the ombudsman regarding discharges, OSM #7 stated, "They only want to be notified of involuntary discharges." OSM #13 stated, "Per their (the ombudsman) request they don't want to be notified." When asked if they notify the ombudsman when a resident is transferred to the hospital, OSM #13 stated, "No."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 5/17/18 at 4:16 p.m. When asked if the resident or resident representative is given anything in writing at the time of the transfer, ASM #2 stated, "No, we complete the SBAR (situation, background, assessment, recommendation) and send that with the resident." When asked if the ombudsman is notified, ASM #2 stated, "We print out an action summary, it dictates where the residents go. (Name of former social worker) would fax it to the ombudsman. It's not being done anymore. I am not clear of the process of notifying the ombudsman. I will have to check with the administrator of the process. When asked if the resident or resident representative is given written notification of the transfer, ASM #2 stated, "No." I can tell you the nurses are not notifying the ombudsman."

The administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant, were made aware of the above concern on 5/17/18 at 5:52 p.m.

No further information was provided prior to exit.

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F 623	Continued From page 56 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 527. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 435. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 422.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing	F 625	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies 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 POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	

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F 625	Continued From page 57 facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide bed hold notification for eight of 48 residents in the survey sample, Resident #433, 110, 85, 113, 69, 44, 105 and 97. 1. The facility staff failed to provide behold notification to the resident representative for a transfer to the hospital on 4/27/18 for Resident #433. 2. The facility staff failed to provide bed hold notification to the resident representative for a transfer to the hospital on 4/12/18 for Resident #110. 3. The facility staff failed to provide bed hold notification to the resident representative for a transfer to the hospital on 5/6/18 for Resident #85. 4. The facility staff failed to provide Resident # 113's representative written notification of the bed hold policy when the resident was discharged to the hospital on 02/22/18. 5. The facility staff failed to provide written documentation of bed hold to the Resident/Responsible Representative upon transfer to hospital for Resident #69 on 3/28/18 and 4/27/18.	F 625	It is the practice of the facility to provide bed hold notification. 1. Resident #433, #110, #85, #113, #69, #44, #105, and #97 no longer reside in the facility. 2. Residents who are transferred have the potential to be affected. 3. Licensed Nurses, Admission Director, Admission Director Co-ordinator, and Business Office Manager will be re-educated on the facility bed hold policy. 4. Administrator and/or designee will complete five (5) random audits of residents who have transferred to the hospital to ensure that they were provided with written notifications of bed hold policy. These audits will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or actions. 5. Date of compliance is June 19, 2018.	

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F 625	Continued From page 58 6. The facility staff failed to provide written documentation of bed hold to the Resident/Responsible Representative upon transfer to hospital for Resident #44 on 2/1/18. 7. The facility staff failed to provide a notice of bed hold, to the resident or resident representative upon Resident #105's transfer to the hospital on 12/1/17. 8. The facility staff failed to provide a notice of bed hold, to the resident or resident representative upon Resident #97's transfer to the hospital on 4/19/18. The findings include: Resident #433 was admitted to the facility on 4/2/18 and readmitted on 5/3/18 with diagnoses that included but were not limited to: respiratory failure, anemia, obesity and diabetes. The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 5/10/18 coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status indicating the resident was cognitively intact to make daily decisions. Review of the nurse's note dated 4/27/18 at 12:50 p.m. documented, "Resident alert and responsive. v/s (vital signs) this morning before therapy was 115/59 (blood pressure) 75 (pulse) 18 (respirations) 97.5 (temperature) oxygen saturation at 86% (normal 90 - 100) on Oxygen 3l/min (liters per minute) via nasal cannula (soft prongs that fit in the nose to deliver oxygen). md (medical doctor) was notified RP (responsible	F 625		

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F 625	Continued From page 59 party) at bedside and made aware. MD (medical doctor) assessed patient and ordered to transfer resident out to ER (emergency room) for diagnosis of hypoxia (1)." Further review of the clinical record did not evidence documentation that the resident's representative (RR) was given a bed hold notice. An interview was conducted on 5/17/18 at 9:33 a.m. with LPN (licensed practical nurse) #4. When asked about the process staff follows to notify the family when a resident is transferred to the hospital, LPN #4 stated, "Sometimes they are not here and we have to hone them and give them the number of the hospital." When asked if the resident's representative was given a bed hold notice, LPN #4 stated, "If family at bedside at time of transfer the nurse has to give it to the family, if they are home we call and tell them." When asked if this was documented, LPN #4 stated, "If you give one you document if you don't give one you don't document it." On 5/17/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant were made aware of the findings. Review of the facility's policy titled, "INTERDISCIPLINARY CARE TRANSITIONS CHECKLISTS" did not evidence documentation regarding providing bedhold notice to the RR. No further information was obtained prior to exit. 1. Hypoxia is defined as the reduction or lack of oxygen in organs, tissues, or cells. This	F 625		

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information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3217626/

2. The facility staff failed to provide bed hold notification to the resident representative for a transfer to the hospital on 4/12/18 for Resident #110.

Resident #110 was admitted to the facility on 4/4/18 and readmitted on 4/20/18 with diagnoses that included but were not limited to: chronic heart failure, anemia, heart attack and high cholesterol.

The most recent MDS, a 14-day assessment, with an ARD of 5/3/18 coded the resident as having scored 12 out of 15 on the BIMS indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was set up.

Review of the physician's notes dated 4/12/18 at 11:52 p.m., documented, "Notified by nursing that patient very lethargic, very high BP (blood pressure), hypoxic despite NRM (non-rebreather mask) and tachycardic (fast heart rate). Ordered pt (patient) transfer to ER (emergency room) via 911."

Further review of the clinical record did not evidence documentation that the resident's representative (RR) was given a bed hold notice.

An interview was conducted on 5/17/18 at 9:33 a.m. with LPN (licensed practical nurse) #4. When asked about the process staff follows to

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notify the family when a resident is transferred to the hospital, LPN #4 stated, "Sometimes they are not here and we have to hone them and give them the number of the hospital." When asked if the resident's representative was given a bed hold notice, LPN #4 stated, "If family at bedside at time of transfer the nurse has to give it to the family, if they are home we call and tell them." When asked if this was documented, LPN #4 stated, "If you give one you document if you don't give one you don't document it."

On 5/17/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant were made aware of the findings.

Review of the facility's policy titled, "INTERDISCIPLINARY CARE TRANSITIONS CHECKLISTS" did not evidence documentation regarding providing bedhold notice to the RR.

No further information was obtained prior to exit.

3. The facility staff failed to provide bed hold notification to the resident representative for a transfer to the hospital on 5/6/18 for Resident #85.

Resident #85 was admitted to the facility on 4/12/18 and readmitted on 5/9/18 with diagnoses that included but were not limited to: Parkinson's disease (1), diabetes, high blood pressure and anemia.

The most recent MDS (minimum data set), an end of therapy assessment, with an ARD

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F 625	Continued From page 62 (assessment reference date) of 4/29/18 coded the resident as having scored a 14 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the nurse's notes dated 5/6/18 at 10:20 a.m., documented, "At around 0945 (9:45 a.m.), writer was alert (sic) by nursing aide that patient is unresponsive....(Name of physician) visited and assessed patient and gave order to send patient to (name of hospital) ER (emergency room) for further evaluation." Further review of the clinical record did not evidence documentation that the resident's representative (RR) was given a bed hold notice. An interview was conducted on 5/17/18 at 9:33 a.m. with LPN (licensed practical nurse) #4. When asked the process staff followed to notify the family when a resident is transferred to the hospital, LPN #4 stated, "Sometimes they are not here and we have to hone them and give them the number of the hospital." When asked if the resident's representative was given a bed hold notice, LPN #4 stated, "If family at bedside at time of transfer the nurse has to give it to the family, if they are home we call and tell them." When asked if this was documented, LPN #4 stated, "If you give one you document if you don't give one you don't document it." On 5/17/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant were made aware of the findings.	F 625		

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No further information was obtained prior to exit.

1. Parkinson's disease -- Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families. This information was obtained from: https://medlineplus.gov/parkinsonsdisease.html
4. The facility staff failed to provide Resident # 113's representative written notification of the bed hold policy when the resident was discharged to the hospital on 02/22/18.

Resident # 113 was admitted to the facility on 09/23/14 with a readmission of 03/05/18 with diagnoses that included but were not limited to cerebrovascular disease (1), anemia (2), atherosclerotic heart disease (3) and muscle weakness.

Resident # 113's most recent MDS (minimum data set), a 5 (five)-day assessment with an ARD (assessment reference date) of 03/12/18, coded Resident # 113 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 113 was coded as requiring extensive assistance of one staff member for activities of daily living.

The nurse's "Progress Notes," for Resident # 113 documented in part, "02/22/2018. Call placed to (Name of Physician) to inform and receive order to send to (Mane of Hospital). Call placed to Daughter (Name of Daughter) she is aware. She did call and talked with her mother/resident to

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inform of what to expect in her language/Romanian. Resident verbalized understanding. Call placed to (Name of Transportation Company) ETA (estimated time of arrival) is 30 minutes. Call placed to (Name of Hospital) ER (emergency room) and report given to (Name of Hospital Nurse). Paperwork is complete and resident is ready for transport."

The "Social Services Progress Note" dated 03/11/2018 failed to evidence documentation of notification to the ombudsman of Resident # 113's transfer to the hospital on 02/22/18.

Further review of Resident #113's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident # 113"s representative.

On 5/17/18 at 9:33 a.m., an interview was conducted with LPN #4. When asked if nurses provided a written bed hold policy to the resident or responsible party at the time of transfer to the hospital, LPN #4 stated that if the representative were not present, nurses would call the family and ask them about a bed hold. LPN #4 stated that the social worker should be following up after the nurse confirms that the family wants to hold the bed. LPN #4 stated that if the family were present, nurses would provide the bed hold policy at the bedside. LPN #4 stated they will document in a nursing note if the policy was offered to the family. LPN #4 stated if there is no documentation that the bed hold policy was provided, then the policy probably was not provided to the resident or representative. LPN #4 stated some long term care residents always go back to the same bed after a transfer, and are not offered a bed hold policy for that reason. LPN #4 stated that some

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long care residents are offered a bed hold policy at the time of transfer.

On 5/17/18 at approximately 10:45 a.m., an interview was conducted with OSM (other staff member) #7, the social worker. OSM #7 stated that she was told that the nurses were supposed to offer the bed hold policy at the time of transfer. OSM #7 stated, "When a resident goes out to the hospital, I do not provide a bed hold policy. I don't issue it."

On 05/17/18 at approximately 5:50 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.

(2) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(3) A disease in which plaque builds up inside your arteries. Plaque is a sticky substance made up of fat, cholesterol, calcium, and other substances found in the blood. Over time, plaque hardens and narrows your arteries. That limits the

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flow of oxygen-rich blood to your body. This information was obtained from the website: https://medlineplus.gov/atherosclerosis.html.

5. The facility staff failed to provide written documentation of bed hold to the Resident/Responsible Representative upon transfer to hospital for Resident #69 on 3/28/18 and 4/27/18.

Resident #69 was admitted to the facility on 7/8/17 and readmitted on 5/1/18 with diagnoses that included but were not limited to Parkinson's disease, multiple sclerosis (1), and bipolar disorder. Resident #69's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/12/18. Resident #69 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #69's clinical record revealed that she had been first transferred to the hospital on 3/28/18. The following was documented, "At the beginning of the shift PT (patient) refused AM care and refused to eat breakfast. We encourage the patient and finally drank 1 cartoon of milk and half coup (sic) of coffee. At noon pt's lips are dry and getting weak. NP (nurse practitioner) ordered to start on IVF (IV fluids), D5 (Dextrose) NS (normal saline) at 75 cc/hr (cubic centime/hour) for 1 liter and 60 cc/hr for 2 liters for decreased po (by mouth) intake. Her daughter came at 1:39 p.m., updated on condition. Daughter initially wants to send patient to the hospital but changed her mind and said she will stay with the patient for couple of hours to observe her and will decide then. At 3:00 p.m. daughter request to transfer

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the pt (patient) to the hospital..."

Resident #69 returned to the facility on 4/5/18 with diagnoses of MS changes and encephalopathy (2).

Further review of Resident #69's clinical record revealed that Resident #69 went out to the hospital for the second time on 4/27/18. The following note was documented: "Resident alert and verbally responsive. Observed resident at the beginning of the shift kept calling "help me," observed resident rested in bed, head elevated with no signs of acute distress. Resident stated there was someone whom she call an airman coming to see her, reoriented stated that she had no appointment to meet anyone today and no Mr. airman. Resident frequently called out and talked to herself loudly with no sign of acute distress. Last day on Ceftin (3) on UTI (urinary tract infection). VS (Vital Signs) bp (blood pressure) - 145/80, hr (heart rate) - 67, rr (respiratory rate) -17, 02 sate (sic) (saturation) 95 % RA (room air), Temp (temperature) - 96.9 F (Fahrenheit). Resident refused to take the morning medications and her breakfast, staffs attempted x 3 and educated for the risk of not taking her medication and food, ensure offered, but not been taken. Family member notified, spoke to (Name of daughter) about changing status. Daughter visited and attempted many time to encourage resident to drink and eat, resident took medications with some milk, daughter at bedside...will continue to monitor."

The next note dated 4/27/18 at 5 p.m., documented the following: "DCS (direct care staff) reported that resident with an order for IVF (IV fluids) due to change in mental status, refused

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F 625	Continued From page 68 meds (medications) and decreased p.o. intake. Resident refused IVF. Order noted to send resident to the hospital. This writer visited Resident, fluids offered but took only 1 sip even with a lot of encouragement." The last note at 4/27/18 at 6:49 p.m., documented the following: "Resident was transferred out to (Name of Hospital) for evaluation due to Mental Status change with resident refusing her medications and not eating her food, (Name of physician) is aware and resident daughter (Name of Daughter) was here this morning with resident. Resident was picked up by (Name of transport) at 6:45 p.m. VS (vital signs): 133/65, 20 (respirations), 63 (pulse), 97.3 (temperature), and 02 sat is 97 % RA (room air)." There was no evidence of written documentation of a bed hold policy to the Resident/Responsible Representative upon transfer to the hospital on 3/28/18 and 4/27/18. Review of the clinical record revealed that Resident #69 arrived back to the facility on 5/1/18 with a diagnoses of a UTI (urinary tract infection). On 5/17/18 at 9:33 a.m., an interview was conducted with LPN #4. When asked if nurses provided a written bed hold policy to the resident or responsible party at the time of transfer to the hospital, LPN #4 stated that if the representative were not present, nurses would call the family and ask them about a bed hold. LPN #4 stated that the social worker should be following up after the nurse confirms that the family wants to hold the bed. LPN #4 stated that if the family were present, nurses would provide the bed hold policy at the bedside. LPN #4 stated they will document	F 625		

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in a nursing note if the policy was offered to the family. LPN #4 stated if there is no documentation that the bed hold policy was provided, then the policy probably was not provided to the resident or representative. LPN #4 stated that some long term care residents always go back to the same bed after a transfer, and are not offered a bed hold policy for that reason. LPN #4 stated that some long care residents are offered a bed hold policy at the time of transfer.

On 5/17/18 at approximately 10:45 a.m., an interview was conducted with OSM (other staff member) #7, the social worker. OSM #7 stated that she was told that the nurses were supposed to offer the bed hold policy at the time of transfer. OSM #7 stated, "When a resident goes out to the hospital, I do not provide a bed hold policy. I don't issue it."

On 5/17/18 at 6:05 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

(1) Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from The National Institutes of Health at https://medlineplus.gov/multiplesclerosis.html.

(2) Encephalopathy is a term for any diffuse disease of the brain that alters brain function or structure. Encephalopathy may be caused by infectious agent (bacteria, virus, or prion),

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metabolic or mitochondrial dysfunction, brain tumor or increased pressure in the skull, prolonged exposure to toxic elements (including solvents, drugs, radiation, paints, industrial chemicals, and certain metals), chronic progressive trauma, poor nutrition, or lack of oxygen or blood flow to the brain. The hallmark of encephalopathy is an altered mental state. This information was obtained from The National Institutes of Health at https://www.ninds.nih.gov/Disorders/All-Disorders/Encephalopathy-Information-Page.

(3) Ceftin is a cephalosporin antibiotic used to treat bacterial infections. This information was obtained from The National Institutes of Health at https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009522/?report=details.

6. The facility staff failed to provide written documentation of bed hold to the Resident/Responsible Representative upon transfer to hospital for Resident #44 on 2/1/18.

Resident #44 was admitted to the facility on 4/26/10 and readmitted on 2/06/18 with diagnoses that included but were not limited to generalized anxiety disorder, dementia, and major depressive disorder. Resident #44's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 3/31/18. Resident #44 was coded as severely impaired in cognitive function scoring 05 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #44's clinical record revealed

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that she had been transferred to the hospital on 2/1/18. The following note was written at 8:15 p.m., on 2/1/18: "Resident alert and in bed at this time, son visiting with her came (sic) to the nursing station to repport that her (sic) Mom complain to him that she was getting sick and think she is having Flu like symptoms and he want the Mom to go to the Hospital (sic), he was encourage to let the MD (medical doctor) take care of that but he said no (Name of Doctor) (sic) was called and he said if that is what the family want than she should go to the Hospital (sic) VS (vital signs) 91/51 (blood pressure), 18 (respirations), 98 (pulse), 99.8 (temperature) and 02 (oxygen) saturation is 95 percent RA (room air), resident already have Tylenol (1). Transport is called and theywould (sic) be here in an hour."

The next note dated 2/2/18, documented the following: "Resident was picked up at 8:15 p.m. to (Name of Hospital) for evaluation for complains of coughing and weakness. The son was here and went with her to the hospital."

There was no evidence of written documentation of a bed hold policy to the Resident/Responsible Representative upon transfer to the hospital on 2/1/18.

Further review of Resident #44's clinical record revealed that she was admitted to the hospital with a diagnoses of the flu. Resident #44 was admitted back to the facility on 2/7/18. Review of Resident #44's immunizations record revealed that she had received the flu vaccine for that flu season on 10/20/17.

On 5/17/18 at 9:33 a.m., an interview was conducted with LPN #4. When asked if nurses

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 72 provided a written bed hold policy to the resident or responsible party at the time of transfer to the hospital, LPN #4 stated that if the representative were not present, nurses would call the family and ask them about a bed hold. LPN #4 stated that the social worker should be following up after the nurse confirms that the family wants to hold the bed. LPN #4 stated that if the family were present, nurses would provide the bed hold policy at the bedside. LPN #4 stated they would document in a nursing note if the policy were offered to the family. LPN #4 stated if there is no documentation that the bed hold policy was provided, then the policy probably was not provided to the resident or representative. LPN #4 stated that some long term care residents always go back to the same bed after a transfer, and are not offered a bed hold policy for that reason. LPN #4 stated that some long care residents are offered a bed hold policy at the time of transfer. On 5/17/18 at approximately 10:45 a.m., an interview was conducted with OSM (other staff member) #7, the social worker. OSM #7 stated that she was told that the nurses were supposed to offer the bed hold policy at the time of transfer. OSM #7 stated, "When a resident goes out to the hospital, I do not provide a bed hold policy. I don't issue it." On 5/17/18 at 6:05 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. 7. The facility staff failed to provide a notice of bed hold, to the resident or resident representative upon Resident #105's transfer to	F 625		

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the hospital on 12/1/17.

Resident #105 was admitted to the facility on 8/14/15 with a recent readmission on 12/9/17, with diagnoses that included but were not limited to: end stage renal failure requiring hemodialysis (a procedure to removed toxic condition and renal failure in which wastes and impurities are removed from the blood by a special machine) (1), obesity, sleep apnea, stroke, high blood pressure, diabetes, depression and seizure disorder.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/4/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status score) indicating he was capable of making daily cognitive decisions. Resident #105 was coded as requiring extensive assistance for most of his activities of daily living except eating in which he only required supervision after set up assistance was provided.

The nurse's note dated, 12/1/17 at 9:14 a.m. documented in part, "Resident had an episode of chest pain and hypotension after 0500 (5:00 a.m.) medication administration. Metoprolol (used to treat high blood pressure) (2) was given for pts (patient's) blood pressure of 150/101, pulse 100. Approximately 30 minutes later resident complained of chest pain and headache. Blood pressure checked and was 93/46, P (pulse) 71. MD (medical doctor) notified and ordered resident take aspirin 81 mg (milligrams) stat (right away) and send pt (patient) to ER (emergency room). Resident was sent to (Name of hospital) ER via stretcher. Resident did not go to dialysis today."

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F 625	Continued From page 74	F 625		

There was no evidence of written documentation of a bed hold policy to the Resident/Responsible Representative upon transfer to the hospital on 12/1/17.

An interview was conducted with LPN (licensed practical nurse) #4, on 5/17/18 at 9:33 a.m. When asked if the nurses give the resident's family a bed hold notice, LPN #4 stated, "The nurses tell the family over the phone but given them the bed hold policy if they are at the bedside." When asked if they document if you offered the resident a bed hold, LPN #4 stated, "If it's a long term patient - the long term care residents don't always get offered a bed hold. Sometimes they take the papers with the bed hold with them." When asked if a bed hold policy is provided/offered, did staff document this in the clinical record, LPN #4 stated, "If you give the bed hold policy, then you document. If you didn't give it to them, you don't document it in the progress notes."

The administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant, were made aware of the above concern on 5/17/18 at 5:52 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 266.
(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011186/?report=details.

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F 625	Continued From page 75 8. The facility staff failed to provide a notice of bed hold, to the resident or resident representative upon Resident #97's transfer to the hospital on 4/19/18. Resident #97 was admitted to the facility on 4/9/18 with a readmission on 4/24/18 with diagnoses that included but were not limited to: sepsis (destruction of tissue by bacterial toxins, contamination, infection) (1), paraplegia (paralysis of the lower limbs) (2), below the knee amputation, pressure ulcer and osteoarthritis (degenerative changes in the joints) (3). The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 5/6/18, coded the resident as scoring a 12 on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided. The nurse's note dated, 4/19/18 at 2:11 p.m. documented in part, "Pt (patient) observed in bed with son at the bedside through the afternoon. Per son and MD (medical doctor), the pt has increased confusion going on since Sunday. Upon assessment the pt is observed taking off her gown repeatedly. Speech is clear however not making much since (sic). IVF's (intravenous fluids) continued per order...MD in this afternoon to assess the pt...New order received to send to (initials of hospital) ER (emergency room) for further eval (evaluation) d/t (due to) AMS (altered mental status) and possible seizure. Son is	F 625		

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aware of the plan of care. Report called into (name of nurse at ER). Pt left the facility at 4:45 p.m."

The "Acute Care Transfer" form, dated, 4/19/18, failed to evidence documentation of the bed hold policy being provided upon transfer to the hospital on 4/19/18.

An interview was conducted with LPN (licensed practical nurse) #4, on 5/17/18 at 9:33 a.m. When asked if the nurses give the resident's family a bed hold notice, LPN #4 stated, "The nurses tell the family over the phone but given them the bed hold policy if they are at the bedside." When asked if they document if you offered the resident a bed hold, LPN #4 stated, "If it's a long term patient - the long term care residents don't always get offered a bed hold. Sometimes they take the papers with the bed hold with them." When asked if a bed hold policy is provided/offered, did staff document this in the clinical record, LPN #4 stated, "If you give the bed hold policy, then you document. If you didn't give it to them, you don't document it in the progress notes."

The administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant, were made aware of the above concern on 5/17/18 at 5:52 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 527.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and

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F 625	Continued From page 77 Chapman; page 435. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 422.	F 625		
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.	F 645	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies 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 POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicate.	

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F 645	Continued From page 78 §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, it was determined the facility staff failed to ensure a level I PASARR (Preadmission Screening and Resident Review) was completed	F 645	It is the practice of the facility to en-sure a level 1 PASARR is completed.	

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F 645	Continued From page 79 for four of 48 residents in the survey sample, Residents # 31, # 42, # 50, and # 37. 1. The facility staff failed to ensure Resident #31's level I PASARR was completed to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. 2. The facility staff failed to ensure Resident #42's level I PASARR (preadmission screening and resident review) was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. 3. The facility staff failed to ensure Resident #50's level I PASARR (preadmission screening and resident review) was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. 4. The facility staff failed to ensure Resident #37's level I PASARR (preadmission screening and resident review) was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. The findings include: 1. The facility staff failed to ensure Resident #31's level I PASARR was completed to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. Resident # 31 was admitted to the facility on	F 645	1. Resident #31, level 1 PASARR has been obtained and placed on resident's chart. Resident #42 level 1 PASARR has been completed. Resident #50 no longer resides in the facility. Resident #37 level 1 PASARR has been obtained and placed on resident's chart. 2. All residents have the potential to be affected. 3. Interdisciplinary Team (IDT) will be re-educated to ensure that resident level 1 PASARR will be obtained prior to admission or completed upon admission if not admitted with one. 4. Administrator and/or designee will complete five (5) random audits of new admissions to ensure that level 1 PASARR has been obtained or completed. These audits will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or actions. 5. Date of compliance is June 19, 2018.	

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03/10/17. Resident #31's diagnoses included but were not limited to chronic obstructive pulmonary disease (1), hypertension (2), dementia without behavioral disturbances (3), cerebrovascular disease (4) and unspecified psychosis not due to a substance or known physiological condition (5).

Resident #31's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/18/18 coded Resident # 31 as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 (nine) - being moderately impaired of cognition for making daily decisions. Resident # 31 was coded as requiring supervision with set up for activities of daily living. Section A 1500 "Preadmission Screening and Resident Review (PASARR)" documented, "Is the resident currently considered by the state level II PASARR process to have serious mental illness and/or/ intellectual disability ("mental retardation" in federal regulation) or a related condition?" Resident # 31 was coded as "No." Section I "Active Diagnoses" coded Resident # 31 as "Psychotic disorder (other than schizophrenia)."

Review of Resident #31's clinical record failed to reveal the resident's level I PASARR.

On 05/17/18 at 10:46 a.m., an interview was conducted with OSM (other staff member) # 7, social worker and OSM # 13, social worker. OSM # 7 and # 13 stated, "We just started about a month ago." When asked who was responsible for obtaining the level I PASARR, OSM # 7 and #13 stated, "It has not been covered in our training."

On 05/17/18 at approximately 3:50 p.m., an

F 645 Continued From page 81 F 645

interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked who was responsible for obtaining the PASARRs, ASM # 2 stated, "The social workers." When informed of the interview with OSM # 7 and # 13, social workers and that they stated they had not received the train regarding PASARRs, ASM # 2 stated, "To my knowledge the social worker from our sister facility who was training the new social workers at this facility were responsible for the PASARRs." ASM # 2 further stated, "I was not aware the PASARR needed to be done for everyone."

On 05/17/18 at approximately 5:50 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Blockage of the upper airway occurs when the upper breathing passages become narrowed or blocked, making it hard to breathe. Areas in the upper airway that can be affected are the windpipe (trachea), voice box (larynx) or throat (pharynx). This information was obtained from the website:
https://medlineplus.gov/ency/article/000067.htm

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

(3) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was

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obtained from the website:
https://medlineplus.gov/ency/article/000739.htm.

(4) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website:
https://medlineplus.gov/ency/article/000726.htm .

(5) Severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is not there. This information was obtained from the website:
https://medlineplus.gov/psychoticdisorders.html.

2. The facility staff failed to ensure Resident #42's level I PASARR (preadmission screening and resident review) was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs.

Resident # 42 was admitted to the facility on 03/04/16. Resident #42's diagnoses included but were not limited to dysphagia (1), hypertension (2), dementia with behavioral disturbances (3), gastroesophageal reflux disease (4) and unspecified psychosis not due to a substance or known physiological condition (5).

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Resident #42's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/29/18 coded Resident # 42 as scoring a 99 on the brief interview for mental status (BIMS) of a score of 0 - 15, 99 - indicating the staff assessment for cognitive patterns was completed. Resident # 42 was coded as being severely impaired of cognition for making daily decisions. Resident # 42 was coded as requiring limited to extensive assistance of one staff member for activities of daily living. Section A 1500 "Preadmission Screening and Resident Review (PASARR)" documented, "Is the resident currently considered by the state level II PASARR process to have serious mental illness and/or/ intellectual disability ("mental retardation" in federal regulation) or a related condition?" Resident # 42 was coded as "No." Section I "Active Diagnoses" coded Resident # 42 as "Psychotic disorder (other than schizophrenia)."

Review of Resident #42's clinical record failed to reveal the resident's level I PASARR.

On 05/17/18 at 10:46 a.m., an interview was conducted with OSM (other staff member) # 7, social worker and OSM # 13, social worker. OSM # 7 and # 13 stated, "We just started about a month ago." When asked who was responsible for obtaining the PASARR, OSM # 7 and #13 stated, "It has not been covered in our training."

On 05/17/18 at approximately 3:50 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked who was responsible for obtaining the

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F 645	Continued From page 84 PASARRs, ASM # 2 stated, "The social workers." When informed of the interview with OSM # 7 and # 13, social workers and that they stated they had not received the train regarding PASARRs, ASM # 2 stated, "To my knowledge the social worker from our sister facility who was training the new social workers at this facility were responsible for the PASARRs." ASM # 2 further stated, "I was not aware the PASARR needed to be done for everyone." On 05/17/18 at approximately 5:50 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (3) Psychological symptoms and behavioral abnormalities are common and prominent characteristics of dementia. They include symptoms such as depression, anxiety psychosis, agitation, aggression, disinhibition, and sleep disturbances. Approximately 30% to 90% of patients with dementia suffer from such behavioral disorders. There are complex interactions between cognitive deficits, psychological symptoms, and behavioral	F 645		

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abnormalities. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181717/.

(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) Severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is not there. This information was obtained from the website: https://medlineplus.gov/psychoticdisorders.html.

3. The facility staff failed to ensure Resident #50's level I PASARR (preadmission screening and resident review) was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs.

Resident # 50 was admitted to the facility on 08/25/17 with a readmission on 09/27/17. Resident #50's diagnoses included but were not limited to type 2 (two) diabetes (1), hypertension (2), dementia without behavioral disturbances (3), gastroesophageal reflux disease (4) and unspecified psychosis not due to a substance or known physiological condition (5).

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F 645	Continued From page 86 Resident #50's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/06/18 coded Resident # 50 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions. Resident # 50 was coded as requiring extensive assistance of one staff member for activities of daily living. Section A 1500 "Preadmission Screening and Resident Review (PASARR)" documented, "Is the resident currently considered by the state level II PASARR process to have serious mental illness and/or/ intellectual disability ("mental retardation" in federal regulation) or a related condition?" Resident # 50 was coded as "No." Section I "Active Diagnoses" coded Resident # 50 as "Psychotic disorder (other than schizophrenia)." Review of Resident #50's clinical record failed to reveal the resident's level I PASARR. On 05/17/18 at 10:46 a.m., an interview was conducted with OSM (other staff member) # 7, social worker and OSM # 13, social worker. OSM # 7 and # 13 stated, "We just started about a month ago." When asked who was responsible for obtaining the PASARR, OSM # 7 and #13 stated, "It has not been covered in our training." On 05/17/18 at approximately 3:50 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked who was responsible for obtaining the PASARRs, ASM # 2 stated, "The social workers." When informed of the interview with OSM # 7 and # 13, social workers and that they stated they had not received the train regarding PASARRs, ASM	F 645		

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F 645	Continued From page 87 # 2 stated, "To my knowledge the social worker from our sister facility who was training the new social workers at this facility were responsible for the PASARRs." ASM # 2 further stated, "I was not aware the PASARR needed to be done for everyone." On 05/17/18 at approximately 5:50 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (3) 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) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the	F 645		

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

(5) Severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is not there. This information was obtained from the website:
https://medlineplus.gov/psychoticdisorders.html.

4. The facility staff failed to ensure Resident #37's level I PASARR (preadmission screening and resident review) was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs.

Resident # 37 was admitted to the facility on 10/31/16. Resident #37's diagnoses included but were not limited to anxiety (1), hypertension (2), dementia with behavioral disturbances (3), gastroesophageal reflux disease (4) and unspecified psychosis not due to a substance or known physiological condition (5).

Resident #37's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/23/18 coded Resident # 37 as scoring a 99 on the brief interview for mental status (BIMS) of a score of 0 - 15, 99 - indicating the staff assessment for cognitive patterns was completed. Resident # 37 was coded as being severely impaired of cognition for making daily decisions. Resident #

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F 645	Continued From page 89 37 was coded as requiring limited assistance of one staff member for activities of daily living. Section A 1500 "Preadmission Screening and Resident Review (PASARR)" documented, "Is the resident currently considered by the state level II PASARR process to have serious mental illness and/or/ intellectual disability ("mental retardation" in federal regulation) or a related condition?" Resident # 37 was coded as "No." Section I "Active Diagnoses" coded Resident # 37 as "Psychotic disorder (other than schizophrenia)." Review of Resident #37's clinical record failed to reveal the resident's level I PASARR. On 05/17/18 at 10:46 a.m., an interview was conducted with OSM (other staff member) # 7, social worker and OSM # 13, social worker. OSM # 7 and # 13 stated, "We just started about a month ago." When asked who was responsible for obtaining the PASARR, OSM # 7 and #13 stated, "It has not been covered in our training." On 05/17/18 at approximately 3:50 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked who was responsible for obtaining the PASARRs, ASM # 2 stated, "The social workers." When informed of the interview with OSM # 7 and # 13, social workers and that they stated they had not received the train regarding PASARRs, ASM # 2 stated, "To my knowledge the social worker from our sister facility who was training the new social workers at this facility were responsible for the PASARRs." ASM # 2 further stated, "I was not aware the PASARR needed to be done for everyone."	F 645		

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F 645	Continued From page 90 On 05/17/18 at approximately 5:50 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr essure.html. (3) Psychological symptoms and behavioral abnormalities are common and prominent characteristics of dementia. They include symptoms such as depression, anxiety psychosis, agitation, aggression, disinhibition, and sleep disturbances. Approximately 30% to 90% of patients with dementia suffer from such behavioral disorders. There are complex interactions between cognitive deficits, psychological symptoms, and behavioral abnormalities. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC31 81717/. (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) Severe mental disorders that cause abnormal	F 645		

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F 645	Continued From page 91 thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is not there. This information was obtained from the website: https://medlineplus.gov/psychoticdisorders.html.	F 645		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized 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	F 656	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies 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 POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	

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F 656	Continued From page 92 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop and/or implement the comprehensive person-centered care plan for eight of 48 residents in the survey sample, Residents #5, #19, #40, #427, #37, #47, #109 and #423. 1. The facility staff failed to implement Resident #5's comprehensive care plan for pain medication administration. 2. The facility staff failed to implement Resident #19's comprehensive care plan for oxygen administration. 3. The facility staff failed to implement Resident #40's comprehensive care plan for laboratory tests. 4. The facility staff failed to develop a care plan to	F 656	It is the practice of the facility to develop and/or implement comprehensive person-centered care plans. 1. Resident #5 pain medication care plan has been obtained and pain medication has been administered as ordered. Resident #19, oxygen has been clarified and administered at the prescribed rate. Resident #40, lab order has been clarified and lab to be drawn per ordered. Resident #427 care plan was immediately revised. Resident #37, doctor was notified and parameters for medication was clarified. Resident #47 care plan has been revised to reflect the use of splint/helmet. Resident #109, doctor was immediately notified of resident not receiving medication. No new orders were obtained.Resident#423 order was clarified and administered per doctor order.	

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F 656	Continued From page 93 address Resident #427's self-administration of medications. 5. The facility staff failed to implement Resident # 37's comprehensive care plan for the use of metoprolol (1). 6. The facility staff failed to develop a care plan to address the use of a hand splint and helmet for Resident #47. 7. The facility staff failed to implement /follow Resident #109's comprehensive care plan for the administration of Baclofen. 8. The facility staff failed to implement /follow Resident #423's comprehensive care plan for the administration of the Lidocaine patch. The findings include: 1. The facility staff failed to implement Resident #5's comprehensive care plan for pain medication administration. Resident #5 was admitted to the facility on 7/16/16. Resident #5's diagnoses included but were not limited to diabetes, muscle weakness and osteoarthritis. Resident #5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/10/18, coded the resident's cognition as moderately impaired. Section J documented Resident #5 reported no pain during the last five days. Review of Resident #5's clinical record revealed a physician's order dated 4/12/18 for Capsagel Gel (Capsaicin) (1) 0.025%- to be applied to the	F 656	2. All residents have the potential to be affected. 3. Interdisciplinary Team (IDT) will be re-educated to develop and/or implement comprehensive care plan for all residents. 4. DON and/or designee will complete five (5) random audits of residents to ensure that comprehensive care plan has been implemented. These audits will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or action. 5. Date of compliance is June 19, 2018	

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resident's bilateral knees one time a day for pain. Resident #5's May 2018 eMAR (electronic medication administration record) documented, "Capsagel Gel 0.025% (Capsaicin) Apply to bilat (bilateral) knees topically one time a day for pain." On 5/9/18, the eMAR documented a nurse's initials and the code "5" that indicated, "Hold/See Nurse Notes." The May 2018 eMAR location of administration report documented Capsagel was topically applied to both of Resident #5's knees every day in May 2018 except for 5/9/18. A nurse's note dated 5/9/18 documented, "Capsagel Gel 0.025% Apply to bilat knees topically one time a day for pain Pharmacy aware order placed."

Resident #5's comprehensive care plan dated 7/16/16 documented, "Generalized pain...Administer pain medication per physician orders..."

On 5/15/18 at 12:10 p.m., an interview was conducted with Resident #5. The resident stated she has knee pain but she gets a pill and cream every day and that helps her pain.

The nurse responsible for signing the above 5/9/18 nurse's note was no longer employed at the facility.

On 5/17/18 at 8:36 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what the code "5" on the eMAR meant. LPN #1 stated, "Hold. See nurses note." LPN #1 was shown the code "5" for the Capsagel on Resident 5's eMAR for 5/9/18. LPN #1 was asked if the code meant the medication was not given. LPN #1 stated, "It could be." LPN #1 was asked to read the nurse's note dated

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5/9/18. LPN #1 stated, "Sometimes if we do click and it says it's on order and you call the pharmacy and they say they will bring it on the next run then notify the MD (medical doctor)." LPN #1 was asked the purpose of a resident's care plan. LPN #1 stated, "We do care plan for continuity of care and also if there is anything that needs to be updated on a patient's care." LPN #1 was asked the process for ensuring a resident's care plan is followed. LPN #1 stated, "So we do have the care plan in place on the patient's profile. If you are not sure of something you can always go and read it."

On 5/17/18 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility document titled, "INTERDISCIPLINARY CARE PLANNING" documented, "The facility must develop and implement a comprehensive person-centered care plan for each patient that includes measurable objectives and timeframes to meet a patient's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment..."

No further information was provided prior to exit.

(1) Capsagel is used to treat osteoarthritis, a condition in which joints become swollen and stiff. This information was obtained from the website: https://ahrq-ehc-application.s3.amazonaws.com/media/pdf/osteoarthritis-pain_consumer.pdf

2. The facility staff failed to implement Resident #19's comprehensive care plan for oxygen

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administration.

Resident #19 was admitted to the facility on 8/26/17. Resident #19's diagnoses included but were not limited to heart failure, high cholesterol and high blood pressure. Resident #19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/4/18, coded the resident as being cognitively intact. Section O documented Resident #19 received oxygen therapy.

Review of Resident #19's clinical record revealed a physician's order dated 4/24/18 for oxygen at three liters via nasal cannula every shift for shortness of breath. Resident #19's comprehensive care plan dated 12/5/17 documented, "Cardiac disease related to hyperlipidemia (high cholesterol), Hypertension (high blood pressure)...Administer oxygen as ordered..."

On 5/15/18 at 12:28 p.m., observation of Resident #19 was conducted. The resident was lying in bed with a nasal cannula in her nose. The nasal cannula was attached to an oxygen concentrator. The oxygen was being administered to Resident #19 at a rate in between three and three and a half liters as evidenced by the middle of the ball in the concentrator flow meter positioned between the three-liter line and the three and a half liter line. The top of the ball was positioned at the three and a half liter line and the bottom of the ball was positioned at the three-liter line. At this time, Resident #19 asked how much oxygen she was receiving and was made aware of this surveyor's observation. Resident #19 voiced concern because she thought she was supposed to receive between

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one and two liters. Resident #19 was made aware this surveyor would get a nurse.

On 5/15/18 at 12:29 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 was asked for the rate of oxygen Resident #19 was supposed to receive. LPN #8 stated Resident #19's oxygen was supposed to be set at a rate of three liters. LPN #8 was asked to observe Resident #19's oxygen concentrator. LPN #8 observed the concentrator and turned the knob on the flow meter. LPN #8 stated the middle of the ball in the flow meter should be on the three-liter line. When asked if the middle of the ball was on the three liter line, LPN #8 stated the middle of the ball was a little above the three liter line.

On 5/17/18 at 8:36 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the purpose of a resident's care plan. LPN #1 stated, "We do care plan for continuity of care and also if there is anything that needs to be updated on a patient's care." LPN #1 was asked the process for ensuring a resident's care plan is followed. LPN #1 stated, "So we do have the care plan in place on the patient's profile. If you are not sure of something you can always go and read it."

On 5/17/18 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

3. The facility staff failed to implement Resident #40's comprehensive care plan for laboratory

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tests.

Resident #40 was admitted to the facility on 10/1/16. Resident #40's diagnoses included but were not limited to high blood pressure, generalized anxiety disorder and diabetes. Resident #40's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/26/18, coded the resident's cognition as severely impaired.

Review of Resident #40's clinical record revealed a physician's order signed by the nurse practitioner on 4/17/18 that documented, "4. Decrease the frequency of INR (1) testing to every other Monday. Next one is 4/30/18..." Resident #40's May 2018 eTAR (electronic treatment administration record) documented, "PT/INR every other Monday in the morning every 14 day(s)." Further review of Resident #40's clinical record revealed multiple results of PT/INR labs dated 4/30/18, 5/7/18 and 5/14/18 (obtained every week instead of every other week).

Resident #40's comprehensive care plan dated 11/28/17 documented, "Hematological condition r/t (related to) anemia...Obtain Lab results as ordered and notify physician of results..."

On 5/17/18 at 8:36 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the purpose of a resident's care plan. LPN #1 stated, "We do care plan for continuity of care and also if there is anything that needs to be updated on a patient's care." LPN #1 was asked the process for ensuring a resident's care plan is followed. LPN #1 stated, "So we do have the care plan in place on the patient's profile. If you are not sure of something you can

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F 656	Continued From page 99 always go and read it." On 5/17/18 at 12:12 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 was asked to review Resident #40's physician order for PT/INRs. RN #5 was made aware a PT/INR was obtained on 4/30/18 and asked when the next PT/INR should have been done. RN #5 stated the next PT/INR should have been done on 5/14/18. RN #5 was asked if there was a reason, a PT/INR was obtained on 5/7/18. RN #5 stated he needed to check the chart and progress notes. On 5/17/18 at 1:35 p.m., an interview was conducted with RN #5 and ASM (administrative staff member) #2 (the director of nursing). RN #5 stated, "According to the policy, there is always an opportunity to update labs based on the physician's discretion." RN #5 was asked to clarify his statement. ASM #2 stated the physician's order was supposed to read for the PT/INR to be obtained every 14 days and she saw a weekly trend of labs when she looked through the chart. ASM #2 stated she did not see a physician's order for weekly PT/INRs. ASM #2 stated the nurses are calling the doctor and the doctor is addressing the labs as noted by the signature written on the lab results. ASM #2 confirmed Resident #40's PT/INRs were not obtained as ordered and stated there was an opportunity to improve the lab process. No further information was presented prior to exit. (1) "A prothrombin time (PT) is a test used to help detect and diagnose a bleeding disorder or excessive clotting disorder; the international normalized ratio (INR) is calculated from a PT	F 656		

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F 656	Continued From page 100 result and is used to monitor how well the blood-thinning medication (anticoagulant) warfarin (Coumadin®) is working to prevent blood clots." This information was obtained from the website: https://labtestsonline.org/tests/prothrombin-time-and-international-normalized-ratio-ptinr 4. The facility staff failed to develop a care plan to address Resident #427's self-administration of medications. Resident #427 was admitted to the facility on 5/3/18 with diagnoses that included but were not limited to: HIV, right knee replacement, bipolar disorder (1) and muscle weakness. Review of the most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 5/10/18 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the May 2018 physician's orders documented, "Complera Tablet (2) 200-25-300 MG (milligrams) Give 1 tablet by mouth one time a day for Antiviral unsupervised self-administration. Patient's own stock from home." Review of the May 2018 medication administration record documented, "Complera Tablet 200-25-300 MG (milligrams) Give 1 tablet	F 656		

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by mouth one time a day for Antiviral unsupervised self-administration. Patient's own stock from home." It was documented on the MAR that the medication had been self-administered each day.

Review of the 5/4/18 self-administration assessment documented that the resident was safe to administer medications to self.

Review of the care plan initiated on 5/3/18 did not evidence a plan of care for the resident to self-administer the medications.

An interview was conducted on 5/16/18 at 3:44 p.m. with LPN (licensed practical nurse) #10. the resident's nurse. When asked why residents had care plans, LPN #10 stated, "The care plan tells us what the resident needs for their health." When asked who used the care plans, LPN #10 stated, "We use them. We review that with them and we get their signature and we work towards the patient's care plan." When asked what type of information was added to the care plan, LPN #10 stated, "After we do the assessment, can look at their ADL (activities of daily living) care, medications, and skin problems." When asked if a resident would have a care plan if they were self-administering their own medications, LPN #10 stated, "Yes."

An interview was conducted on 5/17/18 at 10:41 a.m. with LPN #2. When asked why residents had care plans, LPN #2 stated, "We have to have a plan of care in place so everyone can follow the same treatment." When asked who used the care plan, LPN #2 stated, "All the nurses, MDS, unit managers, even the CNAs (certified nursing assistants)." When asked what information was

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put in the care plan, LPN #2 stated, "We put almost everything that pertains to the patient." When asked if a care plan would be developed for a resident who was self-administering their medication, LPN #2 stated, "Yes."

An interview was conducted on 5/17/18 at 1:56 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked why residents had care plans, ASM #2 stated, "To direct the plan of care from the beginning to end." When asked who used the care plan, ASM #2 stated, "Everyone, if something changes, they update the care plan to reflect it." When asked if a care plan would be developed for a resident who was self-administering medication, ASM #2 stated, "Of course."

On 5/17/18 at 5:45 p.m. ASM #1, the administrator, ASM #2, the director of nursing, ASM #3 the quality assurance consultant were made aware of the findings.

Review of the facility's policy titled, "INTERDISCIPLINARY CARE PLANNING" documented, "COMPREHENSIVE CARE PLANNING REQUIREMENTS: the facility must develop and implement a comprehensive person-centered care plan for each patient that includes measurable objectives and timeframes to meet a patient's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:...the services that are to be furnished to maintain the patient's highest practicable physical, mental, and psychosocial well-being."

No further information was obtained prior to exit.

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1.: Bipolar disorder -- Bipolar disorder is a mental health condition that causes extreme shifts in mood, energy, and behavior. This disorder most often appears in late adolescence or early adulthood, although symptoms can begin at any time of life. This information was obtained from: https://ghr.nlm.nih.gov/condition/bipolar-disorder

2. Complear -- Complera is a prescription medicine approved by the U.S. Food and Drug Administration (FDA) for the treatment of HIV infection in adults and children 12 years of age and older who have never taken HIV medicines before and who have a viral load (number of HIV RNA copies per mL of blood) of 100,000 copies/mL or less. This information was obtained from:
https://aidsinfo.nih.gov/drugs/441/complera/0/pati ent
5. The facility staff failed to implement Resident # 37's comprehensive care plan for the use of metoprolol (1).

Resident # 37 was admitted to the facility on 10/31/16. Resident #37's diagnoses included but were not limited to anxiety (2), hypertension (3), dementia with behavioral disturbances (4), gastroesophageal reflux disease (5) and unspecified psychosis not due to a substance or known physiological condition (6).

Resident #37's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/23/18 coded Resident # 37 as scoring a 99 on the brief interview for mental status (BIMS) of a score of 0 - 15, 99 - indicating the staff assessment for cognitive patterns was completed. Resident # 37

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was coded as being severely impaired of cognition for making daily decisions. Resident # 37 was coded as requiring limited assistance of one staff member for activities of daily living.

The POS (physician's order sheet) dated May 2018 and signed by the physician On 05/13/18 documented, "Metopolol Tablet 25 MG (milligram). Give 0.5 tablet by mouth one time a day for HTN (hypertension). 0.5 tablet=12.5 mg. Hold for SBP(systolic blood pressure [blood pressure is given as 2 numbers. The first number represents the pressure in your blood vessels as the heart beats called systolic pressure] (7)) < (less than) 120 and HR (heart rate) < (less than) 60."

The eMARs (electronic medication administration records) dated March 2018, April 2018 and May 2018 documented, "Metopolol Tablet 25 MG (milligram). Give 0.5 tablet by mouth one time a day for HTN (hypertension). 0.5 tablet=12.5 mg. Hold for SBP (systolic blood pressure) < (less than) 120 and HR (heart rate) < (less than) 60."

Review of the eMAR dated March 2018 documented:
03/05/18 - SBP 112 and HR 79 coded 5 (five).
03/09/18 - SBP 107 and HR 84 coded 5.
03/14/18 - SBP 118 and HR 83 coded 5.
03/19/18 - SBP 106 and HR 84 coded 5.
03/21/18 - SBP 119 and HR 72 coded 5.
03/28/18 - SBP 103 and HR 61 coded 5.
Further review of the eMAR dated March 2018 documented, "Chart Codes. 5=Hold."

Review of the eMAR dated April 2018 documented:

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F 656	Continued From page 105 04/13/18 - SBP 115 and HR 88 coded 5. 04/22/18 - SBP 111 and HR 70 coded 5. 04/23/18 - SBP 118 and HR 73 coded 5. Review of the eMAR dated May 2018 documented: 05/06/18 - SBP 117 and HR 77 coded 5. 05/16/18 - SBP 115 and HR 80 coded 5. The care plan for Resident # 37 with a target date of 07/21/2018 documented, "Focus. Cardiac disease related to Hyperlipidemia, Hypertension." Under "Interventions" it documented, "Administer medication per physician orders. Date initiated: 11/01/2016." On 05/17/18 at 8:56 a.m., an interview was conducted with LPN (licensed practical nurse) # 1. LPN # 1 was asked to review the eMARs for resident # 37 dated March and April and May 2018. When asked about the parameters of Hold for SBP (systolic blood pressure) < (less than) 120 and HR (heart rate) < (less than) 60" for the medication metoprolol, LPN # 1 stated that both parameters needed to be met to hold the medication. When asked if it was correct to hold the medication when only one parameter was met, LPN # 1 stated "No." After reviewing the eMARs dated 03/05/18, 03/09/18, 03/14/18, 03/19/18, 03/21/18, 03/28/18, 04/13/18, 04/22/18, 04/23/18, 05/06/18 and 05/16/18, LPN # 1 stated, "The medication should have been given." After reviewing the cardiac care plan for Resident # 37, LPN # 1 was asked if the medication of metoprolol was to treat Resident # 37's cardiac issues. LPN # 1 stated, "Yes." When asked if the care plan was being followed if the medication was held on the dates documented above, LPN # 1 stated, "No."	F 656		

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On 05/17/18 at 3:50 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing regarding the procedure for implementing and following the care plan. When asked to describe the purpose of the care plan ASM # 2 stated, "To reflect the care given to the resident." After reviewing the cardiac care plan for Resident # 37, ASM # 2 was asked if the medication of metoprolol was to treat Resident # 37's cardiac issues. ASM # 2 stated, "Yes." When asked if the care plan was being followed if the medication was held on 03/05/18, 03/09/18, 03/14/18, 03/19/18, 03/21/18, 03/28/18, 04/13/18, 04/22/18, 04/23/18, 05/06/18 and 05/16/18, ASM # 2 stated, "No."

On 05/17/18 at approximately 5:50 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Used alone or in combination with other medications to treat high blood pressure. It also is used to prevent angina (chest pain) and to improve survival after a heart attack. Metoprolol also is used in combination with other medications to treat heart failure. Metoprolol is in a class of medications called beta blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure. This information was obtained from the website: https:
https://medlineplus.gov/druginfo/meds/a682864.html

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F 656	Continued From page 107 (2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) Psychological symptoms and behavioral abnormalities are common and prominent characteristics of dementia. They include symptoms such as depression, anxiety psychosis, agitation, aggression, disinhibition, and sleep disturbances. Approximately 30% to 90% of patients with dementia suffer from such behavioral disorders. There are complex interactions between cognitive deficits, psychological symptoms, and behavioral abnormalities. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181717/. (5) 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. (6) Severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is not there. This information was	F 656		

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F 656	Continued From page 108 obtained from the website: https://medlineplus.gov/psychoticdisorders.html. (7) This information was obtained from the website: https://newsinhealth.nih.gov/2016/01/blood-pressure-matters 6. The facility staff failed to develop a care plan to address the use of a hand splint and helmet for Resident #47. Resident #47 was admitted to the facility on 4/3/18 with diagnoses that included but were not limited to: subdural hematoma (a collection of blood beneath the dura mater and above the arachnoid membrane of the meninges in the brain) (1), status post brain surgery, hemiplegia (paralysis on one side) (2), depression, bipolar disorder) a mental disorder characterized by episodes of mania and depression) (3), seizures, and high blood pressure. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 4/10/18, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members to being totally dependent upon one or more staff members for all of his activities of daily living. In Section J - Health Conditions, the resident was coded as having had one fall, without injury, since admission to the facility on 4/3/18. Observation was made of Resident #47 during the initial tour of the facility on 5/15/18, at	F 656		

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approximately 11:30 a.m., he was in his bed being assisted by a staff member with his helmet on and his hand splint on his left hand. Observation was again made of Resident #47 on 5/16/18 at 8:23 a.m. The resident was in the dining room in a Geri-chair. He had a helmet on and a splint on his left hand.

Review of the comprehensive care plan, dated 4/4/18, failed to evidence documentation related to the use of a hand splint and the use of a helmet. The care plan dated 4/4/18 documented in part, "Focus: Surgical site to parietal area at head due to craniotomy." The "Interventions" documented, "Administer treatments per physician orders. Report evidence of infection such as purulent drainage, swelling, localized heat, increased pain, etc. Notify physician prn (as needed)."

Review of the clinical record, failed to evidence a physician order for the helmet or the splint.

An interview was conducted with LPN (licensed practical nurse) #1 on 5/16/18 at 1:59 p.m. LPN #1 was asked if a resident with a hand splint would have a care plan addressing the use of the splint. LPN #1 stated, "Yes." When asked if the use of a helmet would be care planned, LPN #1 stated, "Yes." When asked who completed the care plans, LPN #1 stated, "The nurses and the unit managers."

An interview was conducted with RN (registered nurse) #5 on 5/16/18 at 2:07 p.m. When asked if use of a splint, would be care planned, RN #5 stated, "Yes." When asked use of a helmet, would be care planned, RN #5 stated, "Yes." RN #5 reviewed Resident #47's care plan. When asked

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if he saw the use of a helmet or splint on the care plan, RN #5 stated, "No, he did not."

An interview was conducted with LPN #3 on 5/17/18 at 12:22 p.m. When asked the purpose of the care plan, LPN #3 stated it was how they would care for the resident. When asked who uses the care plan, LPN #3 stated, "Anyone who provides care to the resident."

The administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant, were made aware of the above concern on 5/17/18 at 5:52 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; pages 265 and 549.

7. The facility staff failed to implement /follow Resident #109's comprehensive care plan for the administration of Baclofen.

Resident #109 was admitted to the facility on 4/30/18 with the diagnoses of but not limited to multiple sclerosis and a displaced avulsion fracture of the left ankle. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 5/7/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, toileting, and transfers; extensive assistance for bed mobility, dressing and eating; and as incontinent

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F 656	Continued From page 111 of bowel and bladder. On 5/16/18 at 9:26 a.m., RN (registered nurse) #1 was observed preparing the following medications for Resident #109: Baclofen [1] 10 mg (milligrams) tab (tablet). Each bubble on the medication card contained a half tablet (5 mg), and the pharmacy label directions were to give 15 mg (3 halves). RN #1 removed a single half tab and put it in the medication cup. Pepcid [2] 20 mg, one tab Zoloft [3] 25 mg, one tab Multivitamin [4], one tab Vitamin D3 [5], 1000 units, one tab Zoloft 50 mg, one tab. At this time, RN #1 was observed noting that there were two different orders for the Zoloft. She reviewed the orders and noted that the 25 mg dose she had previously pulled was discontinued and that the resident was to get the 50 mg. RN #1 was then observed removing the half tab of Baclofen from the cup and discarding it. RN #1 did not remove the 25 mg of zoloft and was then observed dispensing a 50 mg zoloft tablet into the cup. The cup now contained 75 mg of Zoloft and no Baclofen. RN #1 then administered the medications to the resident. Resident #109 received 75 mg of Zoloft (instead of the ordered 50 mg) and no Baclofen. A review of the clinical record revealed the physician's order sheet (POS) for May 2018. This review revealed an order dated 5/4/18 for the Baclofen for 15 mg, three times a day. On 5/16/18 at 11:43 a.m., in an interview with RN #1, when asked about the resident not receiving Baclofen, RN #1 stated that he did not get the	F 656		

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right dose of medication as ordered.

A review of the care plan revealed one dated 5/2/18 for "At risk for complications due to musculoskeletal problems r/ (related to) muscle spasm secondary to MS (multiple sclerosis)." This care plan included an intervention for "Administer medication per physician order." This intervention was dated 5/2/18.

On 5/17/18 at 12:20 p.m., in an interview with LPN #3 (Licensed Practical Nurse) she stated that the care plan was not followed for the Baclofen.

No further information was provided.

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

[2] Pepcid (Prescription) is used to treat ulcers (sores on the lining of the stomach or small intestine); gastroesophageal reflux disease (GERD, a condition in which backward flow of acid from the stomach causes heartburn and injury of the esophagus [tube that connects the mouth and stomach]); and conditions where the stomach produces too much acid....Over-the-counter famotidine (Pepcid) is used to prevent and treat heartburn due to acid indigestion and sour stomach caused by eating or drinking certain foods or drinks.

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Information obtained from
https://medlineplus.gov/druginfo/meds/a687011.html

[3] Zoloft is used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks), posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). It is also used to relieve the symptoms of premenstrual dysphoric disorder, including mood swings, irritability, bloating, and breast tenderness.
Information obtained from
https://medlineplus.gov/druginfo/meds/a697048.html

[4] Multivitamin/mineral supplements contain a combination of vitamins and minerals. They sometimes have other ingredients, such as herbs. They are also called multis, multiples, or simply vitamins. Multis help people get the recommended amounts of vitamins and minerals when they cannot or do not get enough of these nutrients from food.
Information obtained from
https://medlineplus.gov/definitions/vitaminsdefinitions.html

[5] Vitamin D3 helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin

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D also has a role in your nerve, muscle, and immune systems.
Information obtained from
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=vitamin+d&_ga=2.192500842.1377447934.1502114951-734861906.1502114951

8. The facility staff failed to implement /follow Resident #423's comprehensive care plan for the administration of the Lidocaine patch.

Resident #423 was admitted to the facility on 5/2/18 with the diagnoses of but not limited to stroke, high cholesterol, diabetes, Parkinson's Disease, chronic pain, and choric embolism. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 5/9/18. The resident was coded as cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive care for all areas of activities of daily living and as incontinent of bowel and bladder.

On 5/16/18 at 9:46 AM, RN (Registered Nurse) #1 was observed preparing the following medications for Resident #423:

Senokot [1] 8.6/50 mg (milligrams), one tab (tablet)
Lidocaine [2] patch 5%, applied to left shoulder
Plavix [3] 75 mg, one tab
Aspirin [4] 81 mg, one tab
Lantus[5] 20 units, injection

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A review of the May 2018 Physician's Order Sheet (POS) revealed that there were orders for the Lidocaine patch as follows: An order dated 5/4/18 for Lidocaine patch "Apply to left shoulder topically every 12 hours for pain management and remove per schedule." An order dated 5/2/18 for Lidocaine patch "Apply to right shoulder topically at bedtime, for Pain Remove patch for 12 hours." An order dated 5/2/18 for Lidocaine patch "Apply to right shoulder topically one time a day for pain On (sic) for 12 hours, off for 12 hours."

The resident was not offered a patch for the right shoulder.

On 5/16/18 at 11:34 a.m., in an interview with RN #2, when asked about the patch for the right shoulder, she stated the order was discontinued. When informed that the order for the patch for the right shoulder was still appearing as a current order, RN #2 checked the computer and stated that it was still listed as a current order. There was no evidence provided that the order had been discontinued. RN #2 did not offer the resident a patch for the right shoulder.

A review of the care plan revealed one dated 5/4/18 for "Chronic pain r/t disease process" and included the intervention, "Administer pain medication per physician orders." This intervention was dated 5/4/18.

On 5/17/18 at 12:20 PM, in an interview with LPN #3 (Licensed Practical Nurse) she stated that the care plan was not followed for pain management, in regards to the administration of the pain patch as ordered.

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No further information was provided.

[1] Senokot is used on a short-term basis to treat constipation.
Information obtained from https://medlineplus.gov/druginfo/meds/a601112.html

[2] Lidocaine patches are used for pain.
Information obtained from https://medlineplus.gov/druginfo/meds/a603026.html

[3] Plavix is used alone or with aspirin to prevent serious or life-threatening problems with the heart and blood vessels in people who have had a stroke, heart attack, or severe chest pain....is also used to prevent serious or life-threatening problems with the heart and blood vessels in people who have peripheral arterial disease (poor circulation in the blood vessels that supply blood to the legs).
Information obtained from https://medlineplus.gov/druginfo/meds/a601040.html

[4] Aspirin used to relieve the symptoms of rheumatoid arthritis (arthritis caused by swelling of the lining of the joints), osteoarthritis (arthritis caused by breakdown of the lining of the joints), systemic lupus erythematosus (condition in which the immune system attacks the joints and organs and causes pain and swelling) and certain other rheumatologic conditions (conditions in which the immune system attacks parts of the body). Nonprescription aspirin is used to reduce fever and to relieve mild to moderate pain from headaches, menstrual periods, arthritis, colds,

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F 656	Continued From page 117 toothaches, and muscle aches....to prevent heart attacks in people who have had a heart attack in the past or who have angina (chest pain that occurs when the heart does not get enough oxygen)....to reduce the risk of death in people who are experiencing or who have recently experienced a heart attack.....to prevent ischemic strokes (strokes that occur when a blood clot blocks the flow of blood to the brain) or mini-strokes (strokes that occur when the flow of blood to the brain is blocked for a short time) in people who have had this type of stroke or mini-stroke in the past... Information obtained from https://medlineplus.gov/druginfo/meds/a682878.html [5] Lantus is used to treat diabetes Information obtained from https://medlineplus.gov/druginfo/meds/a600027.html (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 266. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 73.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken and or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of	

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F 657	Continued From page 118 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review it was determined that the facility staff failed to review and/or revise the care plan for four of 48 residents in the survey sample, Resident #53, 40, 419 and 105. 1. The facility staff failed to revise Resident #53's comprehensive care plan when she was placed on an anti-anxiety medication. 2. The facility staff failed to review and revise Resident #40's comprehensive care plan when the physician prescribed an anti-anxiety medication on 5/10/18.	F 657	compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to review and/or revise care plans.	

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F 657	Continued From page 119 3. The facility staff failed to review and revise the comprehensive care plan for the use of continuous positive airway pressure (CPAP) for Resident #419. 4. The facility staff failed to review and revise the comprehensive care plan for the use of a CPAP* machine for Resident #105. The findings include: 1. Resident #53 was admitted to the facility on 3/23/18 with diagnoses that included but were not limited to Alzheimer's disease, anxiety disorder, and muscle weakness. Resident #53's most recent comprehensive MDS (minimum data set) assessment was an admission assessment with an ARD (assessment referenced date) of 3/30/18. Resident #53 was coded as being severely impaired in cognitive function scoring 99 out of possible 15 on the BIMS (Brief Interview for Mental Status exam). Resident #53 was coded as requiring extensive assistance from one staff member with meals. Review of Resident #53's clinical record revealed a note from the NP (Nurse practitioner) that documented the following: "Chief Complaint- Insomnia, agitation. 81 y.o (sic) (year old) female with alzheimer's (sic) dementia, off Xanax last week...Night staff informed me that patient is not sleeping. Appears sleepy this morning. Staff also noticed and reported patient to be getting agitated again, was physically aggressive towards the staff this morning...Will reorder Xanax 0.25 mg q 12 (every twelve) hours prn (as needed) for 30 days." The following nursing note was documented on	F 657	1. Resident #53 care plan was revised to reflect the use of anti-anxiety. Resident #40 care plan was reviewed and revised to reflect the use of anti-anxiety. Resident #419 care plan was revised to reflect the home use of CPAP. Resident #105 care plan was reviewed and revised to reflect the non use of the CPAP. 2. All residents have the potential to be affected. 3. Interdisciplinary team (IDT) was re-educated on reviewing and revising resident care plans to reflect resident's current status. 4. DON and/or designee will complete five (5) random audits of care plans of residents with new orders/change of condition to ensure that care plan has been reviewed/revised as appropriate. These audits will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or action.	

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F 657	Continued From page 120 5/2/18: "Resident was seen today the NP (Nurse Practitioner) today with (sic) complaints of resident being anxious and not sleeping at night, new orders given for resident to restart Xanax 0.25 mg q (every) 12 hours for 30 days...to see effectiveness and it would be re-evaluated after the 30 days, Resident POA (power of attorney) notified of new orders." Review of Resident #53's most recent POS (physician order summary) dated 5/1/18 documented the following order: "Xanax Tablet (1) 0.25 MG (milligrams) Give 0.25 mg every 12 hours as needed for Anxiety for 30 days." This order was initiated on 5/2/18 and discontinued on 5/3/18. This order was changed to the following on 5/3/18: "Xanax Tablet 0.25 MG (milligrams) Give 0.25 mg every 12 hours as needed for Anxiety for 14 days." Review of Resident #53's May 2018 MAR (medication administration record) revealed that Resident #53 received Xanax on the following dates and times: 5/14/18 at 8:15 a.m. and 8/16/18 at 8:51 a.m. Review of Resident #53's comprehensive care plan dated 3/24/18 and updated 4/30/18, failed to evidence a care plan addressing that Resident #53 was on anti-anxiety medication. The following care plan focus was documented on 4/4/18: "Verbal/physical agitation/aggression related to: Cognitive impairment, Alzheimer's diagnoses. Goal: Will not strike others. Interventions: Approach slowly and slightly to bedside. Remove from public area when behavior is disruptive/unacceptable." On 5/17/18 at 1:58 p.m., an interview was	F 657	5. Date of Compliance is June 19,2018	

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F 657	Continued From page 121 conducted with LPN (licensed practical nurse) #3. When asked if it was important for the care plan to be accurate, LPN #3 stated that it was. LPN #3 stated that the care plan was updated with any new orders or change in the resident's condition. LPN #3 stated that any nurse could update the care plan. When asked if she would expect to see anti-anxiety medications on the residents care plan, LPN #3 stated that she would. When asked what is monitored for a resident on anti-anxiety medication, LPN #3 stated that she would monitor for any changes in behavior and side effects of the medication. LPN #3 stated that these interventions should be on the care plan for residents on anti-anxiety medication. On 5/17/18 at 6:05 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility policy titled, "Interdisciplinary Care Planning," documents in part, the following: "As the care plan is implemented, members of the interdisciplinary team need to evaluate whether the interventions are effective or whether the care plan needs to be revised." No further information was presented prior to exit. According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient	F 657		

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F 657	Continued From page 122	F 657		

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) Xanax is used to relief symptoms of anxiety and panic disorder. Xanax is a benzodiazepine that depresses the central nervous system. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008896/?report=details

2. The facility staff failed to review and revise Resident #40's comprehensive care plan when the physician prescribed an anti-anxiety medication on 5/10/18.

Resident #40 was admitted to the facility on 10/1/16. Resident #40's diagnoses included but were not limited to high blood pressure, generalized anxiety disorder and diabetes. Resident #40's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/26/18, coded the resident's cognition as severely impaired.

Review of Resident #40's clinical record revealed a physician's order dated 5/10/18 for Xanax (1) 0.5 milligrams by mouth at bedtime for anxiety for 30 days. Review of Resident #40's May 2018 eMAR (electronic medication administration record) revealed the resident was administered Xanax each night from 5/10/18 through 5/15/18. Review of Resident #40's comprehensive care plan dated 10/3/16 failed to document information regarding anti-anxiety medication.

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F 657	Continued From page 123 On 5/16/18 at 4:34 p.m., an interview was conducted with RN (registered nurse) #7 (MDS coordinator) and RN #8 (MDS coordinator). RN #7 and RN #8 were asked about the process staff follows for reviewing and revising care plans. RN #7 stated the nurses and MDS department create care plans within 48 hours of a resident's admission. RN #7 stated the nurses and MDS department are also responsible for updating the care plans. RN #7 was asked if a care plan should be updated when a resident receives a new physician's order for an anti-anxiety medication. RN #7 stated the MDS department updates the care plan if they are made aware of the new order but the nurse managers can update the care plan too. RN #7 was asked to show this surveyor where Resident #40's use of anti-anxiety medication was addressed on the resident's care plan. RN #7 reviewed the care plan and confirmed the use of anti-anxiety medication was not addressed on the care plan. RN #7 stated the use of anti-anxiety medication was previously addressed on the care plan because the resident had previously received the medication but the use was resolved from the care plan when the medication was previously discontinued. RN #7 was asked how long it should take to review and revise the care plan when an anti-anxiety medication is restarted. RN #7 stated the nurse who received the new order should have updated the care plan when the new order was received or the care plan should have been updated the following morning. When asked if the care plan should have been updated by todays date (5/16/18), RN #7 stated yes. RN #7 was asked the purpose of the care plan and stated, "It should be a patient centered care plan so that everybody is aware of what we are doing for the patient."	F 657		

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F 657	Continued From page 124	F 657		

On 5/17/18 at 8:36 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if a resident's care plan should be updated when an anti-anxiety medication is prescribed, LPN #1 stated, "Yes." When asked who is responsible for updating the care plan, LPN #1 stated, "The nurse who took the order, the unit manager and I believe MDS." When asked when the care plan should be updated, LPN #1 stated, "As soon as you take the order."

On 5/17/18 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) Xanax is used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684001.html

3. The facility staff failed to review and revise the comprehensive care plan for the use of continuous positive airway pressure (CPAP) for Resident #419.

Resident #419 was admitted to the facility on 5/3/18 with diagnoses that included but were not limited to: heart disease, muscular dystrophy (1), diabetes, sleep apnea and high blood pressure.

The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 5/10/18, coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status)

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F 657	Continued From page 125 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. During an interview conducted on 5/16/18 at 9:22 a.m. with Resident #419, the resident stated, "And I don't have to use the CPAP (2) anymore." Review of Resident #419's comprehensive care plan initiated on 5/4/18 documented, "Focus. Has/At risk for respiratory impairment related to sleep apnea. Interventions. CPAP use per physician orders." Review of the May 2018 physician's orders did not evidence documentation of an order for CPAP. An interview was conducted on 5/17/18 at 12:14 p.m. with LPN #3. When asked why residents had care plans, LPN #3 stated, "Basically so we know what to do. It paints a picture for everybody who is taking care of the resident." When asked when a care plan would be revised, LPN #3 stated, "If something changes." When asked about a resident who was care planned for the use of CPAP but did not have any physicians orders for CPAP, LPN #3 stated, "Okay that care plan needs to be updated," An interview was conducted on 5/17/18 at 1:56 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked if a care plan would be revised for a resident who did not have physicians orders for a CPAP but was care planned for the use of one, ASM #2 stated, "Yes." Review of the facility's policy titled,	F 657		

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F 657	Continued From page 126 "INTERDISCIPLINARY CARE PLANNING" documented, "A comprehensive care plan must be -- reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive, quarterly, and significant change review assessments." No further information was provided prior to exit. 1. Muscular dystrophy -- Muscular dystrophy (MD) refers to a group of more than 30 genetic diseases characterized by muscle weakness and muscle loss that progress over time. Some forms of MD appear in infancy or childhood, while others may not appear until adulthood or middle age. This information was obtained from: https://www.nichd.nih.gov/health/topics/muscular dys 2. CPAP -- It involves using a CPAP machine that includes a mask or other device that fits over your nose or your nose and mouth, straps to position the mask, a tube that connects the mask to the machine's motor, and a motor that blows air into the tube. CPAP is used to treat sleep-related breathing disorders including sleep apnea. It also may be used to treat preterm infants who have underdeveloped lungs. This information was obtained from: https://www.nhlbi.nih.gov/health-topics/cpap 4. The facility staff failed to review and revise the comprehensive care plan for the use of a CPAP* machine for Resident #105. *CPAP (continuous positive airways pressure), a non-ventilator technique that recruits lung volume and often improves the Pao2/Flo2 ratio, is most likely to help patients with modest ventilatory requirements and acute atelectasis or lung	F 657		

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edema. (1)

Resident #105 was admitted to the facility on 8/14/15 with a recent readmission on 12/9/17, with diagnoses that included but were not limited to: end stage renal failure requiring hemodialysis (a procedure to removed toxic condition and renal failure in which wastes and impurities are removed from the blood by a special machine) (2), obesity, sleep apnea, stroke, high blood pressure, diabetes, depression and seizure disorder.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/4/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status score) indicating he was capable of making daily cognitive decisions. Resident #105 was coded as requiring extensive assistance for most of his activities of daily living except eating in which he only required supervision after set up assistance was provided.

The comprehensive care plan dated, 11/12/15 with a revision on 4/4/17, documented in part, "Focus: Has/At risk for respiratory impairment related to sleep apnea (a condition in which the patient has transient periods of apnea [not breathing] during sleep) (3), cough, allergy and sore throat." The "Interventions" documented in part, "C-PAP use per physician orders."

A CPAP machine was observed in Resident #105's room on 5/15/18 at 3:14 p.m. An interview was conducted with Resident #105 on 5/15/18 at 3:14 p.m. When asked if he uses the CPAP machine, Resident #105 stated he hasn't used it

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F 657	Continued From page 128 in over a year. An interview was conducted with LPN (licensed practical nurse) #3 on 5/17/18 at 12:22 p.m. When asked why a resident has a care plan, LPN #3 stated, "It's how we care for the resident." When asked who uses the care plan, LPN #3 stated, "Anyone who cares for the resident." When asked who updates the care plans, LPN #3 stated, "I would revise it if something changed. The MDS people update them and look at them." LPN #3 was asked if the care plan would be revised if a resident were not using the C-PAP, LPN #3 stated, "Yes." When asked why, LPN #3 stated, "We have to paint an accurate picture of how to care for the resident." On 5/17/18 at 12:45 p.m., an interview was conducted with LPN #1. When asked if Resident #105 had a physician order for the use of a C-PAP, LPN #1 reviewed the physician orders and stated there was no order for a C-PAP. LPN #1 was asked to review the care plan for Resident #105. Once completed, LPN #1 stated, "The care plan should be updated since he doesn't have an order for it." An interview was conducted with RN (registered nurse) #5, the unit manager on 5/17/18 at 3:58 p.m. RN #5 was asked to review the orders for Resident #105. When asked if the resident has an order for a C-PAP machine, RN #5 stated he could not find one. When asked if there is no order for a C-PAP machine, should the C-PAP machine be on the care plan, RN #5 stated, "It's something I have to investigate." When asked why residents have care plans, RN #5 stated, "The care plan is the engine of nursing profession. Without a care plan, we can't do	F 657		

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F 657	Continued From page 129 anything for the resident. It guides us to care for the resident." When asked who uses the care plan, RN #5 stated, "The nurses use the care plan." On 5/17/18 at 5:08 p.m., RN #5 returned to this writer and stated the C-PAP was discontinued. Since it was discontinued, the care plan should have been updated. The administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant, were made aware of the above concern on 5/17/18 at 5:52 p.m. No further information was provided prior to exit. (1) The Merck Manual, 16th Edition, 1992 page 639. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 266. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 534.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 658	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies 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 POC constitutes the center's allegation of compliance such that all alleged deficiencies have been or will be corrected by the date indicated.	

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F 658	Continued From page 130 document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to follow professional standards of practice for seven of 48 residents in the survey sample, Residents #370, #37, #110 #427, #47, #105, and #97. 1. The facility staff failed to transcribe a physician's order for bacitracin to Resident #370's treatment administration record. 2. The facility staff failed to clarify Resident # 37's medication orders for metoprolol (1). 3. The facility staff failed to ensure the physician's order for a fluid restriction was documented for Resident #110. 4. Facility staff failed to store Resident #427's medication in a properly labeled container and to ensure the resident was self- administering the medication. 5. The facility staff failed to obtain a physician order for the use of a hand splint and a helmet for Resident #47. 6. The facility staff documented a medication was administered to Resident #105 when the resident was out of the facility for dialysis. 7. The facility staff failed to clarify two different pain medication's instructions for administration for Resident #97. The findings include:	F 658	It is the practice of the facility to follow professional standards. 1. Resident #370 no longer resides in facility. Resident #37, medication order was clarified. Resident #110 documentation of fluid restriction was completed. Resident #427, medication was stored safely and returned to resident upon discharge. Resident #47, doctor was notified and order obtained for splint/ helmet. Resident #105, nurse was re-educated on not signing medications out for unavailable residents. Resident #97, doctor clarified medication. 2. All residents have the potential to be affected. 3. Licensed Nurses will be educated on transcribing medications correctly, clarifying instructions before administering medications and not signing out medications for residents who are not available. 4. DON and/or designee will complete five (5) random audits of residents EMAR to ensure that orders are transcribed correctly, instructions clarified, and documentation of resident when not available. These audits will be done weekly x four (4) and then monthly x two (2).	

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F 658	Continued From page 131 1. The facility staff failed to transcribe a physician's order for bacitracin (1) to Resident #370's treatment administration record. Resident #370 was admitted to the facility on 4/19/17. Resident #370's diagnoses included but were not limited to diabetes, high blood pressure and low back pain. Resident #370's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 4/24/17, coded the resident's cognitive skills for daily decision making as modified independence (some difficulty in new situations only). A nurse's note dated 4/21/17 documented, "Patient assessed by MD (medical doctor) and new orders given. D/C (Discontinue) Flomax (2). Bacitracin Ointment to Left Arm open area BED (sic) till (sic) healed. bactrim (sic) DS (double strength) (3), 1 tablet PO (by mouth) now and every 12 hours X (times) 6 doses total. Patient and RP (responsible party) aware." A physician's order dated 4/21/17 documented in part, "Bacitracin ointment L (left) arm open area Bid (twice a day) till (sic) healed..." Review of Resident #370's April 2017 eMAR (electronic medication administration record) and eTAR (electronic treatment administration record) failed to reveal the physician order for bacitracin was transcribed to the eMAR or eTAR (however, nurses' notes from 4/21/17 through 4/24/17 revealed documentation that all scheduled medications were administered per physician's order). Resident #370's care plan dated 4/20/17 failed to	F 658	These audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or actions. 5. Date of compliance is June 19, 2018	

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F 658	Continued From page 132 document information regarding the open area on the resident's left arm. On 5/17/18 at 1:13 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked how staff ensures a physician's order for bacitracin is performed. RN #1 stated the physician's order should be entered into the computer system. When asked if the order should be on the MAR or TAR, RN #1 stated the order should "pop up" on the electronic TAR when it is scheduled. RN #1 confirmed the physician's order for Resident #370's bacitracin was not transcribed onto the eMAR or eTAR. On 5/17/18 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The facility document titled, "MEDICATION AND TREATMENT ADMINISTRATION GUIDELINES" documented, "Orders are transcribed or electronically entered then noted by the licensed nurse. The licensed nurse noting an order is responsible for accurate transcription and initiation of orders..." No further information was provided prior to exit. (1) Bacitracin is used to prevent minor skin injuries from becoming infected. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601098.html (2) Flomax is used to treat the symptoms of an enlarged prostate. This information was obtained from the website:	F 658		

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Continued From page 133
https://medlineplus.gov/druginfo/meds/a698012.html

(3) Bactrim DS (double strength) is used to treat certain bacterial infections. This information was obtained from the website:
https://medlineplus.gov/druginfo/meds/a684026.html
2. The facility staff failed to clarify Resident # 37's medication orders for metoprolol (1).

Resident # 37 was admitted to the facility on 10/31/16. Resident #37's diagnoses included but were not limited to anxiety (2), hypertension (3), dementia with behavioral disturbances (4), gastroesophageal reflux disease (5) and unspecified psychosis not due to a substance or known physiological condition (6).

Resident #37's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/23/18 coded Resident # 37 as scoring a 99 on the brief interview for mental status (BIMS) of a score of 0 - 15, 99 - indicating the staff assessment for cognitive patterns was completed. Resident # 37 was coded as severely impaired of cognition for making daily decisions. Resident # 37 was coded as requiring limited assistance of one staff member for activities of daily living.

The POS (physician's order sheet) dated May 2018 and signed by the physician on 05/13/18 documented, "Metopolol Tablet 25 MG (milligram). Give 0.5 tablet by mouth one time a day for HTN (hypertension). 0.5 tablet=12.5 mg. Hold for SBP (systolic blood pressure [blood pressure is given as 2 numbers. The first number represents the pressure in your blood vessels as

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F 658	Continued From page 134 the heart beats called systolic pressure] (7)) < (less than) 120 and HR (heart rate) < (less than) 60." The eMARs (electronic medication administration records) dated March 2018, April 2018 and May 2018 documented, "Metopolol Tablet 25 MG (milligram). Give 0.5 tablet by mouth one time a day for HTN (hypertension). 0.5 tablet=12.5 mg. Hold for SBP 120 and HR (heart rate) < (less than) 60." Review of the eMAR dated March 2018 documented: 03/05/18 - SBP 112 and HR 79 coded 5 (five). 03/09/18 - SBP 107 and HR 84 coded 5. 03/14/18 - SBP 118 and HR 83 coded 5. 03/19/18 - SBP 106 and HR 84 coded 5. 03/21/18 - SBP 119 and HR 72 coded 5. 03/28/18 - SBP 103 and HR 61 coded 5. Further review of the eMAR dated March 2018 documented, "Chart Codes. 5=Hold." Review of the eMAR dated April 2018 documented: 04/13/18 - SBP 115 and HR 88 coded 5. 04/22/18 - SBP 111 and HR 70 coded 5. 04/23/18 - SBP 118 and HR 73 coded 5. Review of the eMAR dated May 2018 documented: 05/06/18 - SBP 117 and HR 77 coded 5. 05/16/18 - SBP 115 and HR 80 coded 5. On 05/17/18 at 8:56 a.m., an interview was conducted with LPN (licensed practical nurse) # 1. LPN # 1 was asked to review the eMARs for resident # 37 dated March and April and May 2018. When asked about the parameters of Hold for SBP (systolic blood pressure) < (less than)	F 658		

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F 658	Continued From page 135 120 and HR (heart rate) < (less than) 60" for the medication metoprolol, LPN # 1 stated that both parameters needed to be met to hold the medication. When asked if it was correct to hold the medication when only one parameter was met, LPN # 1 stated "No." After reviewing the eMARs dated 03/05/18, 03/09/18, 03/14/18, 03/19/18, 03/21/18, 03/28/18, 04/13/18, 04/22/18, 04/23/18, 05/06/18 and 05/16/18, LPN # 1 stated, "The medication should have been given." LPN # 1 did not say anything about the physician's order being clarified. On 05/17/18 at 10:50 a.m., an interview with ASM (administrative staff member) # 6, nurse practitioner. After reviewing the physician's order for metoprolol and the eMARs dated 03/05/18, 03/09/18, 03/14/18, 03/19/18, 03/21/18, 03/28/18, 04/13/18, 04/22/18, 04/23/18, 05/06/18 and 05/16/18 for Resident # 37, ASM # 6 stated, "The parameter should read hold for SBP (systolic blood pressure) < (less than) 120 and/or HR (heart rate) < (less than) 60, nursing should have clarified the order. I'll clarify it now." On 05/17/18 at 3:50 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing regarding the procedure for clarifying a physician's order. ASM # 2 stated, "If the nurse has a question about the order the nurse would call the physician and get clarification of the order." After reviewing the physician's order for metoprolol and the eMARs dated 03/05/18, 03/09/18, 03/14/18, 03/19/18, 03/21/18, 03/28/18, 04/13/18, 04/22/18, 04/23/18, 05/06/18 and 05/16/18 for Resident # 37, ASM # 2 stated, "The order should have been clarified." On 05/17/18 at approximately 5:50 p.m. ASM	F 658		

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F 658	Continued From page 136 (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) Used alone or in combination with other medications to treat high blood pressure. It also is used to prevent angina (chest pain) and to improve survival after a heart attack. Metoprolol also is used in combination with other medications to treat heart failure. Metoprolol is in a class of medications called beta blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a682864.html (2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) Psychological symptoms and behavioral abnormalities are common and prominent characteristics of dementia. They include symptoms such as depression, anxiety psychosis, agitation, aggression, disinhibition, and sleep disturbances. Approximately 30% to 90% of patients with dementia suffer from such behavioral disorders. There are complex	F 658		

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F 658	Continued From page 137 interactions between cognitive deficits, psychological symptoms, and behavioral abnormalities. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181717/. (5) 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. (6) Severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is not there. This information was obtained from the website: https://medlineplus.gov/psychoticdisorders.html. (7) This information was obtained from the website: https://newsinhealth.nih.gov/2016/01/blood-pressure-matters 3. The facility staff failed to document the amount of fluids Resident #110 consumed to ensure the amount of fluids consumed was within the fluid restrictions ordered by the physician. Resident #110 was admitted to the facility on 4/4/18 and readmitted on 4/20/18 with diagnoses that included but were not limited to: chronic heart failure, anemia, heart attack and high cholesterol.	F 658		

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F 658	Continued From page 138 The most recent MDS, a 14 day assessment, with an ARD of 5/3/18 coded the resident as having scored a 12 out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was set up. Review of the May 2018 physician's orders documented, "Fluid Restriction -- Total: 1200 mLs (milliliters)/24 hours every shift..." Review of the May 2018 medication and treatment administration records (MAR and TAR) did not evidence documentation regarding the fluid restriction. Further review of the clinical record did not evidence documentation regarding the resident's fluid restriction. An interview was conducted on 5/18/18 at 8:43 a.m. with LPN #8, the resident's nurse. When asked what about the process staff follows for a resident on a fluid restriction, LPN #8 stated, "Fluid restriction. They get a certain amount from nursing and certain amount from dietary. The nurse monitors how much the patient is given." When asked if the amount the resident consumes is documented, LPN #8 stated, "Yes it pops up in (name of software)." LPN #8 was asked to review Resident #110's MAR and TAR for May 2018. LPN #8 stated, "They clicked other so it's not showing up on her MAR." When asked how staff would know if the resident was within the fluid restriction, LPN #8 stated, "We don't."	F 658		

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An interview was conducted on 5/18/18 at 9:12 a.m. with RN (registered nurse) #2, the unit manager. When asked what about the process staff follows for a resident on a fluid restriction, RN #2 stated, "The nurses keep track of it and enter it into the computer for them to see and document accurately what they are supposed to get." RN #2 was asked to review Resident #110's MAR and TAR for May 2018. RN #2 stated, "It's supposed to be showing here." When asked if staff would know if the resident was within the fluid restriction, LPN #8 stated, "No."

On 5/18/18 at 10:15 a.m. ASM (administrative staff member) #2, the director of nursing was made aware of the findings.

Review of the facility's policy titled, "FLUID RESTRICTIONS" did not specifically address documenting the resident's intake of fluids.

No further information was obtained prior to exit.

4. The facility staff failed to store Resident #427's medication in a properly labeled container and failed to ensure the resident was self-administering the medication.

Resident #427 was admitted to the facility on 5/3/18 with diagnoses that included but were not limited to: HIV, right knee replacement, bipolar disorder (1) and muscle weakness.

Review of the most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 5/10/18 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status)

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indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the May 2018 physician's orders documented, "Complera Tablet (2) 200-25-300 MG (milligrams) Give 1 tablet by mouth one time a day for Antiviral unsupervised self-administration. Patient's own stock from home."

Review of the May 2018 medication administration record documented, "Complera Tablet 200-25-300 MG (milligrams) Give 1 tablet by mouth one time a day for Antiviral unsupervised self-administration. Patient's own stock from home." It was documented that the medication had been self-administered each day.

An interview was conducted on 5/16/18 at 3:44 p.m., with RN (registered nurse) #10, the resident's day shift nurse. When asked about the process staff follows for a resident that is self-administering their medication, RN #10 stated, "We get a doctor's order." When asked how staff knew if the resident was taking the medication, RN #10 did not answer. When asked if Resident #427 was taking the medication as ordered, RN #10 stated, "I'm not sure, I believe he was, but now we have the medication in the cart and we're giving it to him." When asked why the resident's MAR documented that the resident was self-administering the medication when the staff were giving the resident the medication, RN #10 stated, "We have to change it. My unit manager was trying to help me."

An interview was conducted on 5/17/18 at 10:41

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a.m. with RN #2, the unit manager, regarding the process staff follows when a resident self-administered their medication. RN #2 stated, "We assess to make sure they can take the medication safely." When asked if staff ensured the medication was taken, RN #2 stated yes. RN #2 stated, "He (Resident #427) had his medication with him and didn't want to give it to us. We don't usually allow them (residents) to bring in their medication." When asked who verified the medication was correct, RN #2 stated, "I did. I googled it. We give it to him now so I have his medication locked up."

On 5/18/18 at 8:40 a.m., a request was made to see the resident's medication. RN #2 brought a medication bottle with the label torn off most of the way. RN #2 stated, "The resident tore it off when I told him I was going to lock it up." In the right upper corner written in pencil was the resident's name. At the bottom of the label was, "Aripiprazole (3) 5 mg (milligrams)." This was not the name of the medication the resident was self-administering. The tablets inside the bottle were peach colored and oblong with a "GSI" imprinted on it. An Internet look up on "Pill finder" was done by one of the surveyors and the medication was determined to be Complear. RN #2 was asked how staff would know that the medication in the bottle was the correct medication. RN #2 did not have a reply.

An interview was conducted on 5/18/18 at 8:43 a.m. with LPN #8, the resident's nurse. When asked how she knew that the medication the resident had was Complear. LPN #8 stated, "I was told." When asked who told her, LPN #8 stated, "The resident told me." When asked if she had looked at the medication, LPN #8 stated, "He

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would not give it to me. I didn't want to argue with him, I believe he had some bi-polar." When asked what she did if she was not sure the medication was the correct one, LPN #8 stated, "If I'm uncomfortable I always contact my unit manager."

On 5/18/18 at 9:12 a.m. RN #2 came to this writer and stated, "Come to think about it we should have gotten a correct label (on the bottle)."

On 5/18/18 at 11:15 a.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 worksheet titled, "SELF-ADMINISTRATION OF MEDICATION" documented, "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."

No further information was provided prior to exit.

Safe medication administration -- The causes of these deaths were categorized as oral and written miscommunication, name confusion (e.g., names that look or sound alike), similar or misleading container labeling, performance or knowledge deficits, and inappropriate packaging or device design. This information was obtained from: https://www.ncbi.nlm.nih.gov/books/NBK2656/

1. Bipolar disorder -- Bipolar disorder is a mental health condition that causes extreme shifts in mood, energy, and behavior. This disorder most often appears in late adolescence or early adulthood, although symptoms can begin at any

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F 658	Continued From page 143 time of life. This information was obtained from: https://ghr.nlm.nih.gov/condition/bipolar-disorder 2. Complear -- Complera is a prescription medicine approved by the U.S. Food and Drug Administration (FDA) for the treatment of HIV infection in adults and children 12 years of age and older who have never taken HIV medicines before and who have a viral load (number of HIV RNA copies per mL of blood) of 100,000 copies/mL or less. This information was obtained from: https://aidsinfo.nih.gov/drugs/441/complera/0/patient 3. Aripiprazole -- Aripiprazole is used alone or together with other medicines to treat mental conditions such as, bipolar I disorder (manic-depressive) This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0000157/ 5. The facility staff failed to obtain a physician order for the use of a hand splint and a helmet for Resident #47. Resident #47 was admitted to the facility on 4/3/18 with diagnoses that included but were not limited to: subdural hematoma (a collection of blood beneath the dura mater and above the arachnoid membrane of the meninges in the brain) (1), status post brain surgery, hemiplegia (paralysis on one side) (2), depression, bipolar disorder) a mental disorder characterized by episodes of mania and depression) (3), seizures, and high blood pressure.	F 658		

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F 658	Continued From page 144 The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 4/10/18, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members to being totally dependent upon one or more staff members for all of his activities of daily living. In Section J - Health Conditions, the resident was coded as having had one fall, without injury, since admission to the facility on 4/3/18. Observation was made of Resident #47 during the initial tour of the facility on 5/15/18, at approximately 11:30 a.m., he was in his bed being assisted by a staff member with helmet on and hand splint on the left hand. Observation was again made of Resident #47 on 5/16/18 at 8:23 a.m. The resident was in the dining room in a Geri-chair. He had a helmet on and a splint on his left hand. Review of the clinical record, failed to evidence a physician order for the helmet or the splint. Review of the comprehensive care plan, dated 4/4/18, failed to evidence documentation related to the use of a hand splint and the use of a helmet. The care plan dated 4/4/18 documented in part, "Focus: Surgical site to parietal area at head due to craniotomy." The "Interventions" documented, "Administer treatments per physician orders. Report evidence of infection such as purulent drainage, swelling, localized hear, increased pain, etc. Notify physician prn (as needed)."	F 658		

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The "Care Kardex" documented, "Special Needs: Helmet at all times (FYI)."

An interview was conducted with other staff member (OSM) #11, the occupational therapist, on 5/16/18 at 1:23 p.m. When asked if there should be a physician for a resident wearing a splint, OSM #11 stated, "It should have an order to say how many hours on and how many hours off, daytime or nighttime use."

An interview was conducted with OSM #12, the physical therapist, on 5/16/18 at 1:26 p.m. When asked if there should be an order for the use of a helmet, OSM #12 stated that nursing should do the orders for that.

An interview was conducted with CNA (certified nursing assistant) #10, on 5/16/18 at 1:30 p.m. When asked how he knows what type of assistive devices a resident needs, CNA #10 stated, "Splints, they either come here with it or therapy orders it." When asked about the use of a helmet, CNA #10 stated, "There should be an order if the resident needs it for a purpose. I was told to apply it at all times, in chair, in bed." When asked how he knows this, CNA #10 stated, "The nurses have to tell us and there is a kardex in the system." When asked when the splint is supposed to be used, CNA #10 stated, "I was told it should be on at all times."

An interview was conducted with LPN (licensed practical nurse) #1, on 5/16/18 at 1:59 p.m., LPN #1 was asked if there a physician's order was needed for splints. LPN #1 stated, "Yes, it should say why, the frequency and how long it should be on and how long it should be off." LPN #1 was

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MANORCARE HEALTH SERVICES-FAIR OAKS	**12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033**

(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 658	Continued From page 146 asked if there should be a physician order for the use of a helmet. LPN #1 stated, "Yes." When asked what the orders should include, LPN #1 stated, "It should have why he has it, and when the helmet should be on and off." LPN #1 was asked to pull up Resident #47's physician orders on her computer. When asked if she saw an order for a helmet or splint, LPN #1 stated, "We have it on the kardex under the tasks, the CNA and nurses see that." When asked why it is important for Resident #47 to have his helmet. LPN #1 stated, "The helmet is because he has frequent falls. It's to prevent him from hitting his head." When asked how often the skin under the helmet is checked, LPN #1 stated, "Frequently, every shift and PRN (as needed)." LPN #1 was asked if there should be an order for Resident #47's splint. LPN #1 stated yes, there should be an order. An interview was conducted with RN (registered nurse) #5, the unit manager, on 5/16/18 at 2:07 p.m. When asked if a physician order is needed for the use of a helmet, RN #5 stated, "Yes." When asked why Resident #47 has to wear a helmet, RN #5 stated, "He has a history of falls. He had surgery on his head." When asked when Resident #47 should wear the helmet, RN #5 stated, "Anytime he is out of bed he has to have it on." When asked if a resident has a splint, should there be an order, RN #5 stated, "Yes." When asked what the order should say, RN #5 stated, "To be applied at all times." The administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant, were made aware of the above concern on 5/17/18 at 5:52 p.m.	F 658		

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F 658	Continued From page 147	F 658		

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; pages 265 and 549.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 266.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 73.

6. The facility staff documented a medication was administered to Resident #105 when the resident was out of the facility for dialysis.

Resident #105 was admitted to the facility on 8/14/15 with a recent readmission on 12/9/17, with diagnoses that included but were not limited to: end stage renal failure requiring hemodialysis (a procedure to removed toxic condition and renal failure in which wastes and impurities are removed from the blood by a special machine) (1), obesity, sleep apnea, stroke, high blood pressure, diabetes, depression and seizure disorder.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/4/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status score) indicating he was capable of making daily cognitive decisions. Resident #105 was coded as requiring extensive assistance for most of his activities of daily living except eating in which he only required

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supervision after set up assistance was provided.

The physician order dated, 4/12/18 documented, "Renvela* Tablet 800 MG (milligrams); Give 2 tablet by mouth three times a day for CKD (chronic kidney disease), Hold during dialysis Monday, Wednesday and Friday."

*Renvela® (sevelamer carbonate) is indicated for the control of serum phosphorus in patients with chronic kidney disease (CKD) on dialysis. (2)

Review of the May 2018 MAR (medication administration record) documented, "Renvela* Tablet 800 MG; Give 2 tablet by mouth three times a day for CKD, Hold during dialysis Monday, Wednesday and Friday." The medication was documented as having been administered on 5/16/18 at 9:00 a.m.

The comprehensive care plan dated, 4/27/17, documented in part, "Focus: Renal insufficiencies related to: ESRD (end stage renal disease)." The "Interventions" documented in part, "Administer medications per physician orders."

It was reported to this writer by LPN (licensed practical nurse) #1, that Resident #105 went to dialysis on 5/16/18 at approximately 6:00 a.m. He was observed returning to the facility on 5/16/18 at 11:00 a.m.

An interview was conducted with LPN (licensed practical nurse) #1 on 5/17/18 at 8:48 a.m. When asked when Resident #105 goes to dialysis, LPN #1 stated the resident went to dialysis on Monday, Wednesday and Friday. LPN #1 stated, "I believe he goes very early." When asked what time he returns, LPN #1 stated he returned yesterday

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around 11:00 a.m. LPN #1 was asked to read Resident #105's Renvela order. LPN #1 was then asked to review the MAR for 5/16/18 for the Renvela. When asked if she gave the Renvela on 5/16/18 at 9:00 a.m. LPN #1 stated, "No, I did not give that medication." When informed the medication was signed off as administered, LPN #1 stated, "That's a problem."

The facility policy, "Medication and Treatment Administration Guidelines" documented in part, "Medications and treatments administered are documented immediately following administration or per state specified standards. The licensed nurse is responsible for validating documentation is completed for any medication administered during the shift."

According to "Fundamentals of Nursing", Seventh 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."

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

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made aware of the above concern on 5/17/18 at 5:52 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 266.
(2) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=6178c669-a2e5-4a82-9ca2-7dfef56b63b9

7. The facility staff failed to clarify two different pain medication's instructions for administration for Resident #97.

Resident #97 was admitted to the facility on 4/9/18 with a readmission on 4/24/18 with diagnoses that included but were not limited to: sepsis (destruction of tissue by bacterial toxins, contamination, infection) (1), paraplegia (paralysis of the lower limbs) (2), below the knee amputation, pressure ulcer and osteoarthritis (degenerative changes in the joints) (3).

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 5/6/18, coded the resident as scoring a 12 on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision

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F 658	Continued From page 151 after set up assistance was provided. The physician order dated, 5/9/18, documented, "Tramadol (used to treat moderate to moderately severe pain) (4) 50 MG (milligrams), Give 1 tablet by mouth every 6 hours as needed for pain. Give one to two tabs (tablets) for moderate to severe pain." The physician order dated, 4/25/18, documented, "Tylenol Tablet 325 MG; give 2 tablet by mouth every 6 hours as needed for PAIN." The May 2018 medication administration record (MAR), documented, "Tramadol 50 MG, Give 1 tablet by mouth every 6 hours as needed for pain. Give one to two tabs for moderate to severe pain." The Tramadol was administered on the following dates, times and pain level: 5/9/18 at 5:22 p.m. pain level - 6 5/10/18 at 11:45 a.m. - pain level - 4, 6:00 p.m. pain level - 5 5/12/18 at 2:51 p.m. - pain level - 4 5/16/18 at 9:56 p.m. - pain level - 2 5/17/18 at 1:51 p.m. - pain level - 4. There was no documentation indicating if the resident received one or two tablets. The May 2018 MAR documented, "Tylenol Tablet 325 MG; give 2 tablet by mouth every 6 hours as needed for PAIN." The Tylenol was administered on the following dates, times and pain level: 5/3/18 at 4:38 p.m. - pain level - 3 5/5/18 at 4:41 p.m. - pain level - 3 5/7/18 at 9:22 a.m. - pain level - 3; 4:51 p.m. - pain level - 3 5/8/18 at 1:35 p.m. - pain level - 3 5/9/18 at 1:31 p.m. - pain level - 4 5/10/18 at 7:01 a.m. - pain level - 3	F 658		

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5/14/18 at 2:07 p.m. - pain level - 3
5/17/18 at 4:39 p.m. - pain level - 3

An interview was conducted with RN (registered nurse) #13 on 5/18/18 at 8:45 a.m. RN #13 was asked to read both the Tramadol order and the Tylenol orders. When asked which medication should be given, RN #13 stated, "First you ask the resident their pain level. Then review the medications. Both of these orders need to be clarified. They are not clear as to what to give for what level of pain."

On 5/18/18 at 8:55 a.m., an interview was conducted with administrative staff member (ASM) #2, the director of nursing. ASM #2 was asked to review the Tramadol and Tylenol orders. ASM #2 read the orders and stated, "These orders need to be clarified." When asked if it is in the nurse's scope of practice to decide which one to give unless the physician has specific parameters, ASM #2 stated, "You are correct."

ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the quality assurance consultant, and ASM #8, an administrator from another facility in the corporation, were made aware of the above findings on 5/18/18 at 1:06 p.m.

No further information was provide prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 527.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 435.
(3) Barron's Dictionary of Medical Terms for the

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F 658	Continued From page 153 Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 422. (4) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012486/?report=details	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure residents received treatment and services in accordance with professional standards of practice and the comprehensive care plan for one of 48 residents in the survey sample, Resident #37. The facility staff failed to administer Resident # 37's metoprolol (1) per the physician order. The findings include: Resident # 37 was admitted to the facility on 10/31/16. Resident #37's diagnoses included but were not limited to anxiety (2), hypertension (3), dementia with behavioral disturbances (4), gastroesophageal reflux disease (5) and	F 684	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged dficiencies 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 POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to ensure residents receive treatment and services in accordance with professional standards of practice and comprehensive care plans.	

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F 684	Continued From page 154 unspecified psychosis not due to a substance or known physiological condition (6). Resident #37's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/23/18 coded Resident # 37 as scoring a 99 on the brief interview for mental status (BIMS) of a score of 0 - 15, 99 - indicating the staff assessment for cognitive patterns was completed. Resident # 37 was coded as being severely impaired of cognition for making daily decisions. Resident # 37 was coded as requiring limited assistance of one staff member for activities of daily living. The POS (physician's order sheet) dated May 2018 and signed by the physician on 05/13/18 documented, "Metopolol Tablet 25 MG (milligram). Give 0.5 tablet by mouth one time a day for HTN (hypertension). 0.5 tablet=12.5 mg. Hold for SBP (systolic blood pressure [blood pressure is given as 2 numbers. The first number represents the pressure in your blood vessels as the heart beats called systolic pressure] (7)) < (less than) 120 and HR (heart rate) < (less than) 60." The eMARs (electronic medication administration records) dated March 2018, April 2018 and May 2018 documented, "Metopolol Tablet 25 MG (milligram). Give 0.5 tablet by mouth one time a day for HTN (hypertension). 0.5 tablet=12.5 mg. Hold for SBP (systolic blood pressure) < (less than) 120 and HR (heart rate) < (less than) 60." Review of the eMAR dated March 2018 documented: 03/05/18 - SBP 112 and HR 79 coded 5 (five). 03/09/18 - SBP 107 and HR 84 coded 5.	F 684	1. Resident #37, doctor was notified and order was clarified. 2. All residents have the potential to be affected. 3. Licensed nurses will be re-educated to administer medications per doctor order. 4. DON and/or designee will complete 5 random audits of EMAR/ETAR to ensure medications are administered per doctor orders. These audits will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or action. 5. Date of compliance is June 19, 2018.	

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03/14/18 - SBP 118 and HR 83 coded 5.
03/19/18 - SBP 106 and HR 84 coded 5.
03/21/18 - SBP 119 and HR 72 coded 5.
03/28/18 - SBP 103 and HR 61 coded 5.
Further review of the eMAR dated March 2018 documented, "Chart Codes. 5=Hold."

Review of the eMAR dated April 2018 documented:
04/13/18 - SBP 115 and HR 88 coded 5.
04/22/18 - SBP 111 and HR 70 coded 5.
04/23/18 - SBP 118 and HR 73 coded 5.

Review of the eMAR dated May 2018 documented:
05/06/18 - SBP 117 and HR 77 coded 5.
05/16/18 - SBP 115 and HR 80 coded 5.

The care plan for Resident # 37 with a target date of 07/21/2018 documented, "Focus. Cardiac disease related to Hyperlipidemia, Hypertension." Under "Interventions" it documented, "Administer medication per physician orders. Date initiated: 11/01/2016."

On 05/17/18 at 8:56 a.m., an interview was conducted with LPN (licensed practical nurse) # 1. LPN # 1 was asked to review the eMARs for resident # 37 dated March and April and May 2018. When asked about the parameters of Hold for SBP (systolic blood pressure) < (less than) 120 and HR (heart rate) < (less than) 60" for the medication metoprolol, LPN # 1 stated that both parameters needed to be met to hold the medication. When asked if it was correct to hold the medication when only one parameter was met LPN # 1 stated "No." After reviewing the eMARs dated 03/05/18, 03/09/18, 03/14/18, 03/19/18,

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F 684	Continued From page 156 03/21/18, 03/28/18, 04/13/18, 04/22/18, 04/23/18, 05/06/18 and 05/16/18, LPN # 1 stated, "The medication should have been given." When asked if the physician's order was followed, LPN # 1 stated, "No." On 05/17/18 at 3:50 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing regarding the procedure for following the physician's orders. ASM # 2 was asked to review the eMARs for resident # 37 dated March and April and May 2018. When asked about the parameters of Hold for SBP (systolic blood pressure) < (less than) 120 and HR (heart rate) < (less than) 60" for the medication metoprolol, ASM # 2 agreed that both parameters needed to be met to hold the medication. When asked if it was correct to hold the medication when only one parameter was met, ASM # 2 stated "No." After reviewing the eMARs dated 03/05/18, 03/09/18, 03/14/18, 03/19/18, 03/21/18, 03/28/18, 04/13/18, 04/22/18, 04/23/18, 05/06/18 and 05/16/18, ASM # 2 stated, "The medication should have been given." When asked if the physician's order was followed ASM # 2 stated, "No." The facility document titled, "MEDICATION AND TREATMENT ADMINISTRATION GUIDELINES" documented, "Medications are administered in accordance with standards of practice and state specific and federal guidelines." On 05/17/18 at approximately 5:50 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	F 684		

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F 684	Continued From page 157 References: (1) Used alone or in combination with other medications to treat high blood pressure. It also is used to prevent angina (chest pain) and to improve survival after a heart attack. Metoprolol also is used in combination with other medications to treat heart failure. Metoprolol is in a class of medications called beta blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a682864.html (2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) Psychological symptoms and behavioral abnormalities are common and prominent characteristics of dementia. They include symptoms such as depression, anxiety psychosis, agitation, aggression, disinhibition, and sleep disturbances. Approximately 30% to 90% of patients with dementia suffer from such behavioral disorders. There are complex interactions between cognitive deficits, psychological symptoms, and behavioral abnormalities. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC31	F 684		

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F 684	Continued From page 158 81717/. (5) 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. (6) Severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is not there. This information was obtained from the website: https://medlineplus.gov/psychoticdisorders.html.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 686	The statement made of this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies 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 POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	

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F 686	Continued From page 159 document review, and clinical record review it was determined that facility staff failed to provide treatment and services in a manner to prevent infection and promote healing of a pressure ulcer for two of 48 residents in the survey sample, Resident #57 and #101. 1. The facility staff did not wash hands prior to Resident #57's dressing change, did not clean the scissors removed from a staffs uniform pocket and used them to cut the dressing that was put directly into Resident #57's wound. The facility staff also used gloves, which were stored in the uniform pocket to perform wound care. 2. The facility staff failed to wash hands after removing Resident #101's pressure wound dressing, prior to donning new gloves, worn to perform wound care. The facility staff also used gloves, which were stored in the uniform pocket to perform wound care. The findings include: 1. Resident #57 was admitted to the facility on 12/9/09 and readmitted on 6/7/12 with diagnoses that included but were not limited to stroke, dementia, high cholesterol, and high blood pressure. Resident #57's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 4/8/18. Resident #57 was coded as severely impaired for cognitive function, on the Staff Interview for Mental Status exam. Resident #57 was coded as requiring extensive assistance from two staff members with bed mobility, transfers and toileting; extensive assistance from one staff member with eating, and personal	F 686	It is the practice of the facility to provide treatment and services in a manner to prevent infection and promote healing of a pressure ulcer.	

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F 686	Continued From page 160 hygiene; and total dependence on staff with dressing and bathing. Resident #57 was coded in section M (Skin Conditions) as having an unhealed stage three or four pressure ulcer (1) measuring 4.4 x 3.6 x 1.0 cm (centimeters). Review of Resident #57's POS (physician order summary) dated 5/1/18, revealed the following order: "SKIN every day shift for wound care clean sacrum wound with NS (normal saline), pat dry, apply zinc ointment to surrounding tissue pack wound with calcium alginate (2) and cover with foam dressing. This order was initiated on 5/11/18. Review of Resident #57's skin integrity care plan dated 6/8/2012 and revised 11/15/17, documented the following: "At risk for alteration in skin integrity related to fragile skin and resident being incontinent of bowl and bladder, Pressure ulcer to sacrum. Goal: Skin will remain intact, free from erythema, breakdown, excoriation or bruising until next review. Interventions: Gentle handling while transferring/repositioning, Observe skin condition with ADL (activities of daily living) care daily; report abnormalities, pressure redistributing device on bed and chair, weekly skin audit, administer treatments per order, diet and supplements per physician's orders, Encourage and assist as needed to turn and reposition; use assistive devices as needed." On 5/16/18 at 9:06 a.m., wound care observation was conducted with LPN (licensed practical nurse) #6 and LPN (licensed practical nurse) #3. LPN #6 was observed at the treatment cart gathering supplies. LPN #6 took a handful of gloves and placed them into her scrub pocket. LPN #6 then wiped down the resident's beside	F 686	1. Resident #57, doctor was notified of identified risk of infection for area during wound rounds. No new orders written. Resident #101, doctor was notified of poor infection practices while resident was receiving wound care. No new orders written. 2. All residents with wound care have the potential to be affected. 3. Licensed nurses will be re-educated on correct infection control practices (handwashing before, during, and after wound care, cleaning of reusable supplies and not storing any supplies used for wound care in pockets. 4. DON and/or designee will visually observe 2 nurses during wound care for proper infection control practices. These audits will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need audits and/or actions. 5. Date of compliance will be June 19, 2018.	

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F 686	Continued From page 161 table with an antiseptic wipe. LPN #6 placed a drape on the table and set her supplies down. LPN #6 then put on a pair of gloves that were removed from her scrub pocket. LPN #6 was not observed washing her hands prior to Resident #57's dressing change. LPN #6 stated that she could not find her scissors. LPN #6 placed her hand into LPN #3's pocket, and grabbed a pair of scissors. LPN #6 then used the scissors to cut the calcium alginate. LPN #6 did not sanitize the scissors prior to use. LPN #6 then put the calcium alginate back on the drape. LPN #6 pulled a sharpie out of her pocket and signed the foam dressing. The foam dressing was then placed back on the drape. LPN#6 then removed her gloves and donned a new pair of gloves from her scrub pocket. LPN#6 stated, "My pockets are full of gloves." LPN #6 then assisted LPN #3 with turning Resident #57. LPN #6 placed a blue drape under Resident #57 and began removing the old dressing to her sacrum. Resident #57 had a stage four (3) pressure ulcer. LPN #6 removed her gloves and then donned a new pair of gloves from her scrub pocket. LPN #6 took a saline bottle, cleaned the wound and then used gauze to wipe around the wound. LPN #6 then grabbed the calcium alginate and placed it directly into the wound bed. LPN #6 applied the zinc protectant around Resident #57's wound; skin prepped the area and placed the foam dressing over the wound. LPN #6 then used the same gloves that were used for the dressing change to place Resident #57's pillows underneath the resident for repositioning. The same gloves were also used to apply Resident #57's heel boots. LPN #6 then threw away the trash, washed her hands and washed the scissors. LPN #6 then used bleach wipes to wipe down the scissors.	F 686		

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F 686	Continued From page 162 On 5/17/18 at 1:58 p.m., an interview was conducted with LPN #6. When asked when she would wash her hands during a dressing change, LPN #6 stated that if a resident only has one wound, she would wash her hands prior to the dressing change and after completion of the dressing. LPN #6 stated that if a resident had two wounds, she would wash her hands between each wound dressing. LPN #6 stated that she would just change her gloves when going from dirty to clean. When asked how she would transport supplies such as gloves for a dressing change, LPN #6 stated that she would put them in her scrub pocket. When asked what was in her pocket with the gloves while she was doing the dressing change on Resident #57, LPN #6 stated, "I don't recall what was in my pocket then." When asked what was in her pocket at that current time, LPN #6 stated that she had her pen and cell phone in her pocket. LPN #6 stated that she washed her uniform every day and that her scrub top was clean that day. When asked if her pen and cell phone were clean, LPN #6 stated, "Everything I put in it is clean, yes." When asked if she knew if LPN #3's scrub top was clean when she used the scissors from her scrub pocket, LPN #6 stated that she wasn't sure. When asked if the scissors she used were clean, LPN #6 stated, "We always clean the scissors. I didn't cut anything that went into the wound bed." When LPN #6 was informed of the observations made on 5/16/18, LPN #6 did not say anything. When asked what was in LPN #3's pocket with the scissors that were used to cut the alginate, LPN #6 stated that did not know. When asked why the above observations were a concern, LPN #6 stated that it was an infection control issue.	F 686		

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F 686	Continued From page 163 On 5/17/18 at 6:05 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility document titled, "SKIN PRACTICE GUIDE" documented, "Dressing changes are performed using non-sterile, clean techniques unless otherwise ordered by the attending physician. In general, the following guidelines are considered when performing treatments: -adhere to principles of infection control- separate clean and dirty, provide barrier field for treatment supplies, appropriate use and changing of gloves, maintain appropriate precautions, appropriate cleaning of wound bed (center of wound to outside perimeter), cleansing of scissors, hand washing, disposal of soiled dressings..." (1) A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155. (2) Calcium Alginate- wound dressing that partly dissolve on contact with wound fluid to form a hydrophilic gel as a result of the exchange of sodium ions in wound fluid for calcium ions in the dressing. This information was obtained from The National Institutes of Health at	F 686		

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F 686	Continued From page 164	F 686		

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1420733/.

(3) Stage Four Pressure Ulcer- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. This information was obtained from The National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

2. The facility staff failed to wash hands after removing Resident #101's pressure wound dressing and prior to donning new gloves, worn to perform wound care. The facility staff also used gloves, which were stored in the uniform pocket to perform wound care.

Resident #101 was admitted to the facility on 3/22/18 and readmitted on 4/17/18 with diagnoses that included but were not limited to: depression, diabetes, high blood pressure and irregular heart beat.

The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 6/1/18 coded the resident as having scored a 15 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions.

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F 686	Continued From page 165 The resident was coded as requiring assistance for all activities of daily living. Review of the resident's care plan initiated on 4/17/18 documented, "Focus. Resident has pressure ulcer to the sacrum related to impaired mobility. Interventions. Administer treatment per physician orders." Review of the May 2018 physician's orders documented, "Cleanse open area to sacrum with normal saline, pat dry, apply Xeroform (1) and cover with foam dressing." Review of the May 2018 medication administration record documented, "Cleanse open area to sacrum with normal saline, pat dry, apply Xeroform and cover with foam dressing." A wound care observation was conducted on 5/17/18 at 11:07 a.m. with LPN (licensed practical nurse) #6, the wound care nurse and RN (registered nurse) #1. LPN #6 washed her hands and took a pair of gloves out of her pocket. RN #1 washed her hands and put on a pair of gloves from the box in the bathroom. LPN #1 then rolled the resident over onto the right side, opened up the brief. LPN #6 removed her gloves and took a pair of gloves out of her pocket and put them on. LPN #6 did not wash or sanitize her hands. LPN #6 removed the resident's brief and removed the dressing. LPN #6 removed her gloves, took another pair of gloves out of her pocket and put them on without washing her hands. LPN #6 cleaned the wound and applied the dressing. LPN #6 removed the gloves and washed her hands. RN #1 picked up a piece of trash off the floor, threw it in the trashcan, removed her gloves and put on a new pair of gloves. RN #1 did not wash	F 686		

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F 686	Continued From page 166	F 686		

or sanitize her hands. The resident was positioned and covered.

An interview was conducted on 5/17/18 at 1:56 p.m. with ASM (administrative staff member) #2, the director of nurses. When asked when staff should wash their hands, ASM #2 stated, "After each patient care, when they go into the patient's room." When asked when staff washed their hands during wound care, ASM #2 stated, "After each time you remove the dirty wound dressing." When asked where the gloves should be kept that were to be used for the wound care, ASM #2 stated, "They should be on the side of the field." When asked if uniform pockets were clean, ASM #2 stated they were not.

An interview was conducted on 5/17/18 at 1:59 p.m. with LPN #6, the wound care nurse. When asked when staff washed their hands during wound care, LPN #6 stated, "Handwashing is number one. We wash our hands between different wounds." When asked if the uniform pockets were considered clean, LPN #6 stated, "Well I wash my uniform every night." When asked what else was kept in her uniform pocket that the gloves were kept in, LPN #6 did not reply.

An interview was conducted on 5/17/18 at 3:20 p.m. with RN #1. When asked when staff should wash their hands, RN #1 stated, "After taking care of a resident, after taking off gloves." When made aware of the observation made that day during wound care, RN #1 stated, "I thought I did but I didn't (wash her hands after removing her gloves)."

On 5/17/18 at 5:45 p.m. ASM #1, the administrator, ASM #2, the director of nursing and

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F 686	Continued From page 167 ASM #3, the quality assurance consultant were made aware of the findings. No further information was obtained prior to exit. 1. Xeroform -- a medicinal preparation of bismuth subtribromo-phenolate and bismuth trioxide that has an astringent, desicca-tive, and antiseptic effect. Xeroform is used externally in powders and salves for the treatment of intertrigoes and of ulcers and inflammations of the mucosa. This information was obtained from: https://encyclopedia2.thefreedictionary.com/Xeroform	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure adequate supervision and services to prevent accidents and hazards for one of 48 residents in the survey sample, Resident #427. The facility staff failed to complete a smoking safety assessment to ensure safety with smoking	F 689	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies 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 such that all alleged deficiences cited have been or will be corrected by the date indicated.	

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F 689	Continued From page 168 for Resident # 427 who was observed outside the facility smoking without supervision. The staff also failed to ensure Resident #427's cigarettes were not kept on his person. The findings include: Resident #427 was admitted to the facility on 5/3/18 with diagnoses that included but were not limited to: HIV, right knee replacement, bipolar disorder (1) and muscle weakness. Review of the most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 5/10/18 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. On 5/15/18 at 11:00 a.m., a request was made for a list of any residents who smoked. A paper was received documenting, "No known smokers are in the facility." An observation was made on 5/15/18 at 5:05 p.m. of Resident #427. The resident was sitting outside the facility under the administrator's and director of nurse's windows. The resident was smoking a cigarette. An interview was conducted on 5/16/18 at 3:06 p.m. with Resident #427. When asked if he was smoking yesterday outside the facility, Resident #427 stated, "Yes I was out there. I usually go out to the gazebo." When asked if the staff were aware that he smoked, Resident #427 stated,	F 689	It is the practice of the facility to ensure adequate supervision and services to prevent accidents and hazards. 1. Resident #427, smoking assessment was completed immediately and smoking materials were collected from resident and secured at nurses' station. Resident #427 was re-educated on facility smoking policy. An audit was completed on all residents to ensure that there were no more un-identified smokers. 2. Any resident that smokes has the potential to be affected. 3. Staff has been re-educated on the facility policy on smoking. 4. DON and/or designee will audit all new admissions to ensure that there are no new smokers. These audits will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The Committee will determine need for further audits and/or actions. 5. Date of compliance will be June 19, 2018	

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F 689	Continued From page 169 "Yes. They have seen me out there." When asked if he was allowed to keep his cigarettes and lighter, Resident #427 stated he was. A review of the resident's care plan initiated on 5/3/18 did not evidence documentation regarding the resident smoking. A review of the 5/3/18 nursing admission assessment documented that the resident was a "non-smoker." A review of the 5/6/18 physician's history and physical documented, "Tobacco. 1/2 PPD (pack per day)." Further review of the clinical record did not evidence documentation regarding a smoking safety assessment. An interview was conducted on 5/16/18 at 3:44 p.m. with LPN (licensed practical nurse) #10, the resident's nurse. When asked what process staff followed if a resident smoked, LPN #10 stated, "As far as I know we're smoke-free. If we notice if somebody is smoking we check to see if they have any cigarettes in their room and report it to the unit manager." When asked if any of her residents smoked, LPN #10 stated, "No, not as far as I know but if you step outside to the courtyard you can catch them." An interview was conducted on 5/17/18 at 10:41 a.m. with RN (registered nurse) #2, the unit manager. When asked the process staff follow if a resident smoked, RN #2 stated, "During admission we ask if they are a smoker or non-smoker. This is a non-smoking facility. If they smoke we talk to them about calling the doctor	F 689		

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F 689	Continued From page 170	F 689		

and getting a nicotine patch. We just learned we had a smoker that we were not aware of (name of Resident #427)."

An interview was conducted on 5/17/18 at 3:46 p.m. with RN #12, the nursing supervisor. When asked if she was aware of any resident who smoked, RN #12 stated Resident #427 smoked. When asked when that was discovered, RN #12 stated, "Probably four or five days after he got here. He told me he had a family member buy him a pack of cigarettes and I told him him could not smoke in the room and that he needed to be far away from the facility because by Virginia law this is a non-smoking facility. I took his lighter." When asked if she passed this information on to other staff, RN #12 stated, "Everybody must have known that he smoked because he smelled very strongly of smoke." When asked if she had completed a smoking safety assessment, RN #12 stated, "No, I didn't think about it." When asked if one should have been completed, RN #12 stated yes.

On 5/17/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nurses and ASM #3, the quality assurance consultant were made aware of the findings.

Review of the facility's policy titled, "SMOKING GUIDELINES" documented, "PURPOSE: To determine if a patient is an independent Smoker or an At Risk Smoker before the patient exercises the privilege to smoke while residing within the center and to establish guidelines for all patient that desire to smoke, as well an non-smokers. GUIDELINES: Evaluate patients that smoke utilizing the Smoking Evaluation tool either: (a)

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F 689	Continued From page 171 upon admission; (b) when a previous non-smoking patient takes up smoking: (c) if unsafe smoking practices are observed in a current smoker; or, (d) when a patient that smokes has a significant change in medical condition....Upon completion of the evaluation, the interdisciplinary team, including the attending physician will make a decision whether the patient is an Independent or At Risk Smoker. - if the patient is determined to be an Independent Smoker, the patient may smoke without assistance at center designated times. Independent Smokers must still follow smoking guidelines including, but not limited to, keeping smoking accessories in control of center staff when not in use and smoking only in designated areas at designated times." No further information was obtained prior to exit. 1. Bipolar disorder -- Bipolar disorder is a mental health condition that causes extreme shifts in mood, energy, and behavior. This disorder most often appears in late adolescence or early adulthood, although symptoms can begin at any time of life. This infomation was obtained from: https://ghr.nlm.nih.gov/condition/bipolar-disorder	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions ser forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be ~~corrected by the date indicated.~~	

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F 695	Continued From page 172 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide respiratory care and services for two of 48 residents in the survey sample, Residents #19 and #71. 1. The facility staff failed to administer oxygen to Resident #19 at the physician prescribed rate of three liters. 2. The facility staff failed to store Resident #71's respiratory equipment in a sanitary manner. The findings include: 1. The facility staff failed to administer oxygen to Resident #19 at the physician prescribed rate of three liters. Resident #19 was admitted to the facility on 8/26/17. Resident #19's diagnoses included but were not limited to heart failure, high cholesterol and high blood pressure. Resident #19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/4/18, coded the resident as being cognitively intact. Section O documented Resident #19 received oxygen therapy. Review of Resident #19's clinical record revealed a physician's order dated 4/24/18 for oxygen at three liters via nasal cannula every shift for shortness of breath. Resident #19's comprehensive care plan dated 12/5/17 documented, "Cardiac disease related to	F 695	It is the practice of the facility to provide respiratory care and services. 1. The facility immediately completed audit of oxygen order of resident #19 and doctor notified and oxygen applied at prescribed rate. Resident #71 respiratory mask was sanitized and tubing was replaced and stored in a plastic bag. 2. Residents who are receiving respiratory care have the potential to be affected. 3. Nursing staff has been re-educated on proper storing of respiratory equipment in a sanitary manner and licensed staff has been re-educated on administration of oxygen at the prescribed rate. 4. DON and/or designee will audit five (5) residents receiving respiratory care to ensure that oxygen is being administered at prescribed rate and equipment stored in a sanitary manner weekly x four and then monthly x two. The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or actions. 5. Date of compliance will be June 19, 2018.	

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F 695	Continued From page 173 hyperlipidemia (high cholesterol), Hypertension (high blood pressure)...Administer oxygen as ordered..." On 5/15/18 at 12:28 p.m., observation of Resident #19 was conducted. The resident was lying in bed with a nasal cannula in her nose. The nasal cannula was attached to an oxygen concentrator. The oxygen was administered to Resident #19 at a rate in between three and three and a half liters as evidenced by the middle of the ball in the concentrator flow meter positioned between the three-liter line and the three and a half liter line. At this time, Resident #19 asked this surveyor how much oxygen was she receiving and was made aware of this surveyor's observation. Resident #19 voiced concern because she thought she was supposed to receive between one and two liters. Resident #19 was made aware this surveyor would get a nurse. On 5/15/18 at 12:29 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 was asked for the rate of oxygen Resident #19 was supposed to receive. LPN #8 stated Resident #19's oxygen was supposed to be set at a rate of three liters. LPN #8 was asked to observe Resident #19's oxygen concentrator. LPN #8 observed the concentrator and turned the knob on the flow meter. LPN #8 stated the middle of the ball in the flow meter should be on the three-liter line. When asked if the middle of the ball was on the three liter line, LPN #8 stated the middle of the ball was a little above the three liter line. On 5/17/18 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the	F 695		

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F 695	Continued From page 174	F 695		

above concern.

The facility document titled, "OXYGEN ADMINISTRATION" documented, "PREPARATION OF EQUIPMENT...3. For oxygen concentrator, plug in power cord, turn unit on and set flow meter to correct flow rate..."

No further information was presented prior to exit.

2. The facility staff failed to store Resident #71's respiratory equipment in a sanitary manner.

Resident #71 was admitted to the facility on 4/16/18. Resident #71's diagnoses included but were not limited to amyotrophic lateral sclerosis (1), muscle weakness and difficulty swallowing. Resident #71's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/23/18, coded the resident as being cognitively intact. Section G coded Resident #71 as totally dependent on two or more staff with bed mobility/transfers and required extensive assistance of one staff with dressing and eating. Section O documented Resident #71 utilized BIPAP/CPAP (2).

Review of Resident #71's clinical record revealed a physician's order dated 4/16/18 for a ventilatory respiratory machine.

On 5/15/18 at 12:49 p.m. and 5/15/18 at 2:48 p.m., the mask attached to Resident #71's respiratory machine was observed lying on a table in the resident's room. The mask was not covered. Resident #71 was out of the room. On 5/16/18 at 10:32 a.m., the mask was observed in a plastic bag. Resident #71 was out of the room.

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F 695	Continued From page 175	F 695		

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On 5/17/18 at 8:36 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked how a mask attached to respiratory equipment should be stored. LPN #1 stated, "So we have a bag. The mask, you put it in the bag and we date everything." When asked why the mask should be stored in a bag, LPN #1 stated, "For infection control." When asked if the mask should be out on the table when not in use, LPN #1 stated, "No. If not used, it should always be in a bag."

Resident #71's comprehensive care plan dated 5/16/18 failed to document information regarding the storage of respiratory equipment.

On 5/17/18 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "OXYGEN ADMINISTRATION" documented, "2. When not in use, store oxygen tubing and nasal cannula or mask in separate, labeled plastic bag..."

No further information was presented prior to exit.

(1) "Amyotrophic lateral sclerosis (ALS) is a nervous system disease that attacks nerve cells called neurons in your brain and spinal cord. These neurons transmit messages from your brain and spinal cord to your voluntary muscles - the ones you can control, like in your arms and legs..." This information was obtained from the website:
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=

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F 695	Continued From page 176 medlineplus-bundle&query=amyotrophic+lateral+ sclerosis (2) "Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems... Your health care provider will prescribe the type of PAP machine that targets your problem: Continuous positive airway pressure (CPAP) provides a gentle and steady pressure of air in your airway to keep it open. Autotitrating (adjustable) positive airway pressure (APAP) changes pressure throughout the night, based on your breathing patterns. Bilevel positive airway pressure (BiPAP or BIPAP) has a higher pressure when you breathe in and lower pressure when you breathe out..." This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to	F 697	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies 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 POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	

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F 697	Continued From page 177 provide a comprehensive pain management program and services for one of 48 residents in the survey sample, Resident #5. The facility staff failed to administer Resident #5's pain medication gel on 5/9/18. The findings include: Resident #5 was admitted to the facility on 7/16/16. Resident #5's diagnoses included but were not limited to diabetes, muscle weakness and osteoarthritis. Resident #5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/10/18, coded the resident's cognition as moderately impaired. Section J documented Resident #5 reported no pain during the last five days. Review of Resident #5's clinical record revealed a physician's order dated 4/12/18 for Capsagel Gel (Capsaicin) (1) 0.025%- to be applied to the resident's bilateral knees one time a day for pain. Resident #5's May 2018 eMAR (electronic medication administration record) documented, "Capsagel Gel 0.025% (Capsaicin) Apply to bilat (bilateral) knees topically one time a day for pain." On 5/9/18, the eMAR documented a nurse's initials and the code "5" that indicated, "Hold/See Nurse Notes." The May 2018 eMAR location of administration report documented Capsagel was topically applied to both of Resident #5's knees every day in May 2018 except for 5/9/18. The eMAR documented a pain evaluation was completed on 5/9/18 but failed to document any further information regarding the evaluation. A nurse's note dated 5/9/18 documented, "Capsagel Gel 0.025% Apply to bilat knees	F 697	It is the practice of the facility to provide a comprehensive pain management program and services. 1. The facility immediately completed pain assessment on resident #5 and notified doctor of missed dose. No new order was obtained by doctor. 2. Residents who have pain medication prescribed have the potential to be affected. 3.Licensed nurses have been re-educated to follow doctor's orders and administer pain gel as prescribed. 4. DON and/or designee will complete random audits of five (5) residents EMAR/ETAR to ensure that pain medications are being administered as prescribed. These audits will be done weekly x four (4) and monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or actions. 5. Date of compliance will be June 19, 2018	

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F 697	Continued From page 178	F 697		

topically one time a day for pain Pharmacy aware order placed."

Resident #5's comprehensive care plan dated 7/16/16 documented, "Generalized pain...Administer pain medication per physician orders..."

On 5/15/18 at 12:10 p.m., an interview was conducted with Resident #5. The resident stated she has knee pain but she gets a pill and cream every day and that helps her pain.

The nurse responsible for signing the above 5/9/18 nurse's note was no longer employed at the facility.

On 5/17/18 at 8:36 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what the code "5" on the eMAR meant. LPN #1 stated, "Hold. See nurses note." LPN #1 was shown the code "5" for the Capsagel on Resident 5's eMAR for 5/9/18. LPN #1 was asked if the code meant the medication was not given. LPN #1 stated, "It could be." LPN #1 was asked to read the nurse's note dated 5/9/18. LPN #1 stated, "Sometimes if we do click and it says it's on order and you call the pharmacy and they say they will bring it on the next run then notify the MD (medical doctor)." LPN #1 was asked the process to ensure nurses did not run out of physician ordered medicated gels. LPN #1 stated, "When you are giving and see that it's running low, you send for a refill."

On 5/17/18 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

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F 697	Continued From page 179	F 697		

The facility document titled, "PAIN PRACTICE GUIDE" documented, "Topical agents are used to treat musculoskeletal and neuropathic pain."

The facility document titled, "MEDICATION AND TREATMENT ADMINISTRATION GUIDELINES" documented, "Medications are administered in accordance with standards of practice and state specific and federal guidelines."

No further information was provided prior to exit.

(1) Capsagel is used to treat osteoarthritis, a condition in which joints become swollen and stiff. This information was obtained from the website: https://ahrq-ehc-application.s3.amazonaws.com/media/pdf/osteoarthritis-pain_consumer.pdf

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		

§483.45 Pharmacy Services
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed

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F 755	Continued From page 180 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure physician prescribed medications were available for administration for two of 48 residents in the survey sample, Resident #5 and Resident #69. 1. The facility staff failed to acquire Resident #5's pain medication gel from the pharmacy in a timely manner, resulting in a missed dose on 5/9/18. 2. The facility staff failed to ensure Resident #69 Aubagio (1) was available for administration as ordered by the physician. Resident #69 missed three doses of her medication. The findings include: 1. Resident #5 was admitted to the facility on 7/16/16. Resident #5's diagnoses included but were not limited to diabetes, muscle weakness and osteoarthritis. Resident #5's most recent	F 755	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies 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 POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to ensure physician prescribed medications are available.	

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F 755	Continued From page 181 MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/10/18, coded the resident's cognition as moderately impaired. Section J documented Resident #5 reported no pain during the last five days. Review of Resident #5's clinical record revealed a physician's order dated 4/12/18 for Capsagel Gel (Capsaicin) (1) 0.025%- to be applied to the resident's bilateral knees one time a day for pain. Resident #5's May 2018 eMAR (electronic medication administration record) documented, "Capsagel Gel 0.025% (Capsaicin) Apply to bilat (bilateral) knees topically one time a day for pain." On 5/9/18, the eMAR documented a nurse's initials and the code "5" that indicated, "Hold/See Nurse Notes." The May 2018 eMAR location of administration report documented Capsagel was topically applied to both of Resident #5's knees every day in May 2018 except for 5/9/18. A nurse's note dated 5/9/18 documented, "Capsagel Gel 0.025% Apply to bilat knees topically one time a day for pain Pharmacy aware order placed." Resident #5's comprehensive care plan dated 7/16/16 documented, "Generalized pain...Administer pain medication per physician orders..." On 5/15/18 at 12:10 p.m., an interview was conducted with Resident #5. The resident stated she has knee pain but she gets a pill and cream every day and that helps her pain. The nurse responsible for signing the above 5/9/18 nurse's note was no longer employed at the facility.	F 755	1. Resident #5 pain gel is available in the facility. Resident # 69 medication is now available in the facility. 2. All residents have the potential to be affected. 3. Licensed nurses will be re-educated on the process of obtaining medications and notifying doctor when medications are unavailable for further orders as needed. 4. DON and/or designee will complete random audits of five (5) resident EMAR/ETAR to ensure that medications are available and administered per doctor order. These audits will be done weekly x four (4) and monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or actions. 5. Date of compliance will be June 19, 2018	

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F 755	Continued From page 182	F 755		

On 5/17/18 at 8:36 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what the code "5" on the eMAR meant. LPN #1 stated, "Hold. See nurses note." LPN #1 was shown the code "5" for the Capsagel on Resident 5's eMAR for 5/9/18. LPN #1 was asked if the code meant the medication was not given. LPN #1 stated, "It could be." LPN #1 was asked to read the nurse's note dated 5/9/18. LPN #1 stated, "Sometimes if we do click and it says it's on order and you call the pharmacy and they say they will bring it on the next run then notify the MD (medical doctor)." LPN #1 was asked the process to ensure nurses did not run out of physician ordered medicated gels. LPN #1 stated, "When you are giving and see that it's running low, you send for a refill."

On 5/17/18 at 1:52 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated that although Capsagel can be an over the counter medication, the facility staff obtains the medication from the pharmacy. ASM #2 stated Capsagel is not located in the facility STAT (immediate) box (a box containing various medications that can be accessed if a resident's medication is not available).

On 5/17/18 at 5:09 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility/pharmacy document titled, "5.1 Delivery and Receipt of Routine Deliveries" failed to document information regarding the above concern.

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F 755	Continued From page 183	F 755		

The facility document titled, "MEDICATION AND TREATMENT ADMINISTRATION GUIDELINES" documented, "Medications are administered in accordance with standards of practice and state specific and federal guidelines."

No further information was provided prior to exit.

(1) Capsagel is used to treat osteoarthritis, a condition in which joints become swollen and stiff. This information was obtained from the website: https://ahrq-ehc-application.s3.amazonaws.com/media/pdf/osteoarthritis-pain_consumer.pdf

2. The facility staff failed to ensure Resident #69 Aubagio (1) was available for administration as ordered by the physician. Resident #69 missed three doses of her medication.

Resident #69 was admitted to the facility on 7/8/17 and readmitted on 5/1/18 with diagnoses that included but were not limited to Parkinson's disease, multiple sclerosis (2), and bipolar disorder. Resident #69's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/12/18. Resident #69 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #69 was coded as requiring extensive assistance from two or more staff members with bed mobility, transfers, and toileting, extensive assistance from one staff member with locomotion, dressing, eating, and personal hygiene and total dependence on staff with bathing.

Review of Resident #69's most recent POS (Physician Order Summary) revealed the

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F 755	Continued From page 184	F 755		

following medication:

(1) "Aubagio 14 MG (milligram) Give 14 mg by mouth one time a day for MS (multiple sclerosis)." This order was ordered on 5/1/18 and initiated on 5/2/18.

Review of the May 2018 MAR (Medication Administration Record) for Resident #69's revealed that Resident #69 did not receive her daily dose of Aubagio on 5/2/18, 5/3/18 and 5/4/18. The first dose of Aubagio was not administered until 5/5/18.

A nursing note dated 5/3/18 documented the following: "Daughter did visit today; I did speak to daughter regarding medication Abagio (sic). The medication is sent directly to the daughters house. She is made aware that we have no medication to give at this time. Per the daughter she did verbalize that she "will call" for the medication."

Further review of the nursing notes failed to evidence any prior attempts to receive the Aubagio. There was no documented evidence of attempts to obtain this medication from the pharmacy. There was no evidence in the nursing notes that the physician was made aware of the three missed doses.

On 5/17/18 at 1:35 p.m., an interview was conducted with LPN (licensed practical nurse) #3, Resident #69's nurse. LPN #3 was asked about the process staff follows if a medication that was due to be administered is missing from the medication cart. LPN #3 stated that she would leave the eMAR blank for that particular medication, check the STAT (immediate) box for

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F 755	Continued From page 185 the ordered medication, and if the medication were not in the STAT box, she would notify the physician and family. LPN #3 stated that she would also notify pharmacy to send the medication as soon as possible. When asked why Resident #69's Aubagio was not given until 5/5/18 when it was ordered on 5/1/18, LPN #3 stated that Resident #69's daughter orders the Aubagio from a specialty pharmacy. LPN #3 stated that the medication was delivered to the daughter rather the facility. LPN #3 stated that now the medication is delivered right to the facility. LPN #3 stated that she was told that the facility pharmacy does not supply this medication. When LPN #3 was asked if she notified the daughter that they did not have the medication on 5/2/18, LPN #3 stated that she was not sure. When asked if the physician was notified of the three missed doses of the Aubagio, LPN #3 stated, "I have a bad habit of calling the MD (medical doctor) all the time." LPN #3 stated she usually writes a note saying that the MD was made aware. LPN #3 could not provide any evidence that she notified the MD or NP (nurse practitioner) about the three missed doses of Aubagio. LPN #3 stated that it should have been documented. When asked if the physician usually gives an order to hold the medication until it arrives, LPN #3 stated, "No, they did not give any order." When asked who LPN #3 contacted regarding Resident #69's Aubagio, LPN #3 stated that she could not remember. LPN #3 stated that Aubagio was not a medication in the emergency STAT box. Review of the emergency STAT box list did not evidence Aubagio as a medication supplied in the STAT box.	F 755		

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F 755	Continued From page 186 On 5/17/18 at 2:13 p.m., an interview was conducted with OSM (other staff member) #5, the pharmacy technician. When asked if the pharmacy carried the medication Aubagio, OSM #5 stated that the pharmacy did not carry the medication but that the facility could have requested that the pharmacist order the medication from a specialty pharmacy. OSM #5 stated that they had received the order for the medication, but that there was no hard script for the medication that was required to fill the medication. On 5/17/18 at 6:05 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility policy titled "Medication and Treatment Administration Guidelines" documents in part, the following: "New medications orders are to be initiated by the time of the next scheduled routine dose unless otherwise indicated in the medical practitioner's order." (1) Aubagio (Teriflunomide) is an orally available immunomodulatory agent used to treat relapsing multiple sclerosis. This information was obtained from The National Institutes of Health at https://pubchem.ncbi.nlm.nih.gov/compound/Teriflunomide#section=Top. (2) Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained	F 755		

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F 755	Continued From page 187 from The National Institutes of Health at https://medlineplus.gov/multiplesclerosis.html.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		

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are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a resident was free of unnecessary psychotropic medication for one of 48 residents in the survey sample, Resident #420.

The facility staff failed to clarify the physician's order to give Seroquel, an antipsychotic medication, on an as needed basis.

The findings include:

Resident #420 was admitted to the facility on 5/11/18 with diagnoses that included but were not limited to: heart disease, high blood pressure, pneumonia and dementia.

There was no completed minimum data set (MDS) at the time of the survey.

Review of the 5/11/18 nursing admission assessment documented that the resident could sometimes make self understood. The resident

The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies 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 POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.

It is the practice of the facility to ensure a resident is free of unnecessary psychotropic medication.

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F 758	Continued From page 189 was documented as being oriented to self only. Review of the care plan initiated on 5/15/18 documented, "Focus. At risk for adverse effects related to: use of antidepression (sic) and antipsychotic medications. Interventions. Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs." Review of the May 2018 physician's orders documented, "SEROquel (1) Tablet 25 MG (milligrams) Give 0.5 tablet by mouth every 24 hours as needed for agitation. Start Date: 5/16/18." Review of the May 2018 medication administration guide documented, "SEROquel Tablet 25 MG (milligrams) Give 0.5 tablet by mouth every 24 hours as needed for agitation." It was documented that the medication had been given on 5/12/18 at 9:14 p.m. An interview was conducted on 5/17/18 at 1:56 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked what Seroquel was used for, ASM #2 stated, "Seroquel Seroquel is to be ordered for specific disorders, bipolar schizophrenia and I've seen doctors use it for dementia with a lot of behaviors." When asked if Seroquel could be given on an as needed basis, ASM #2 stated, "No. The nurses should be talking to the doctor. At the end of the day we need to engage a psych (psychiatric) consult." An interview was conducted on 5/17/18 at 3:46 p.m. with RN (registered nurse) #12, the nursing supervisor. When asked what Seroquel was used for, RN #12 stated, "It's used for agitation it's also	F 758	1. Resident #420 doctor was called and order clarified to discontinue prn anti-psychotic medication as resident was not using medication. An audit of all residents was completed. There were no other residents who were on prn anti-psychotic medications. 2. Residents who have prn anti-psychotic medications orderdhave the potential to be affected. 3. Licensed nurses were re-educated to follow-up with doctors on discontinuing prn anti-psychotic medications when appropriate. 4. DON and/or designee will complete audit of all new admissions via the EAGLE Room for prn anti-psychotic medications and clarify orders with doctors weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or actions. 5. Date of compliance will be June 19,2018.	

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F 758	Continued From page 190 used for antipsychotic behavior. I've seen a lot of prescribing for short term agitation." When asked what that meant, RN #12 stated, "As needed. In my previous experience it was something they took every day." When asked what staff should do if they had an order for as needed Seroquel, RN #12 stated, "I like to suggest to the doctor that it needs to be scheduled or give something that is more faster acting like an anti-anxiety medication." On 5/17/18 at 5:45 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant were made aware of the findings. An interview was conducted on 5/18/18 at 8:43 a.m. with LPN (licensed practical nurse) #8, the resident's nurse. When asked what Seroquel was used for, LPN #8 stated, "It's an antipsychotropic its used for BPSD (behavioral psychological symptoms of dementia). It has to be scheduled (not on an as needed basis) and there should be gradual dose reduction." Review of the facility's policy titled, "MEDICATION AND TREATMENT ADMINISTRATION GUIDELINES" documented, "GENERAL: Medications are administered in accordance with standards of practice and state specific and federal guidelines." No further information was obtained prior to exit. 1. Seroquel -- SEROQUEL is an atypical antipsychotic indicated for the treatment of: Schizophrenia (1.1) Bipolar I disorder manic episodes (1.2) Bipolar disorder, depressive episodes. This information was obtained from:	F 758		

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F 758	Continued From page 191 https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=0584dda8-bc3c-48fe-1a90-79608f78e8a0	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure the facility was free of a less than 5% (five percent) medication error rate. Of 30 opportunities for error, 4 medication errors were observed involving 2 of 5 residents involved in the medication administration observation; Residents #109 and #423. This resulted in a medication error rate of 13.33%. 1. The facility staff failed to follow physician's orders for the administration of Zoloft and Baclofen to Resident #109. 2. The facility staff failed to follow physician's orders for the administration of Senokot and a Lidocaine patch to Resident #423. The findings include: 1. Resident #109 was admitted to the facility on 4/30/18 with the diagnoses of but not limited to multiple sclerosis and a displaced avulsion fracture of the left ankle. The most recent MDS	F 759	The statement made on this plan of correction are an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the action set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies have been or will be corrected by the date indicated. It is the practice of the facility to ensure that the facility is free of a less than 5% (five percent) medication error rate.	

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	495217	A. BUILDING ______ B. WING ______	C 05/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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(Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 5/7/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, toileting, and transfers; extensive assistance for bed mobility, dressing and eating; and as incontinent of bowel and bladder.

On 5/16/18 at 9:26 a.m., RN (registered nurse) #1 was observed preparing the following medications for Resident #109:

Baclofen [1] 10 mg (milligrams) tab (tablet). Each bubble on the medication card contained a half tablet (5 mg), and the pharmacy label directions were to give 15 mg (3 halves). RN #1 removed a single half tablet and put it in the medication cup.
Pepcid [2] 20 mg, one tab
Zoloft [3] 25 mg, one tab
Multivitamin [4], one tab
Vitamin D3]5], 1000 units, one tab
Zoloft 50 mg, one tab. At this time, RN #1 was observed noting that there were two different orders for the Zoloft. She reviewed the orders and noted that the 25 mg dose she had previously pulled was discontinued and that the resident was to get the 50 mg. RN #1 was then observed removing the half tab of Baclofen from the cup and discarding it. RN #1 did not remove the 25 mg of zoloft and was then observed dispensing a 50 mg zoloft tablet into the cup. The cup now contained 75 mg of Zoloft and no Baclofen. RN #1 then administered the medications to the resident. Resident #109 received 75 mg of Zoloft (instead of the ordered 50 mg) and no Baclofen.

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F 759	Continued From page 193 A review of the clinical record revealed the physician's order sheet (POS) for May 2018. This review revealed an order dated 5/4/18 for the Baclofen for 15 mg, three times a day; and an order dated 5/8/18 for Zoloft, 25 mg daily for one week, then increase to 50 mg daily. The start date for the 50 mg dose was 5/16/18. On 5/16/18 at 11:43 a.m., in an interview with RN #1, when asked about the resident getting 75 mg of Zoloft and no Baclofen, RN #1 stated that he did not get the right dose of either medication as ordered. A review of the care plan revealed one dated 5/2/18 for "At risk for complications due to musculoskeletal problems r/t (related to) muscle spasm secondary to MS (multiple sclerosis)." This care plan included an intervention for "Administer medication per physician order." This intervention was dated 5/2/18. A review of the care plan also revealed one dated 5/15/18 for "At risk for adverse effects related to: use of antidepression medication." This care plan did not specify to administer medications per order. On 5/16/18 at 11:58 a.m., RN #2, the unit manager was notified of the concern. 5/16/18 at 3:25 p.m., ASM #2 (administrative staff member, [the Director of Nursing]) stated the facility standard of practice was the company's "Nursing Procedures" manual which was online for staff access. Policies provided were from this manual. A review of the facility policy, "Medication and	F 759	1. Resident #109, doctor was notified of medication error and order given to monitor resident for any side effects. No side effects were noted. Resident #423, doctor was notified and order was given to monitor resident for any side effects. No side effects were noted. 2. All residents have the potential to be affected. 3. Licensed nurses will be re-educated on medication administration management guide-lines to ensure that residents are free of medication errors. 4. DON and/or designee wil randomly observe one (1) nurse a week xfour (4) weeks and then monthly x two (2)to ensure medication admin-istration is accurate and follows the Medication Administration policy. The results of these audits will be for-warded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or action. 5. Date of compliance will be June 19, 2018.	

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Treatment Administration Guidelines" documented, "....Medications are administered in accordance with standards of practice and state specific and federal guidelines....Medications are administered in accordance with the following "rights" of medication administration: right patient, right medication, right dose, right route, right time, right documentation, right of patient to refuse, right clinical indication.....Medications not administered according to medical practitioner's orders are reported to the attending medical practitioner and documented in the clinical record including the name and dose of the medication and the reason it was not administered...."

On 5/16/18 at 3:57 p.m., ASM #1 (the administrator) and ASM #2 were notified of the findings. ASM #2 stated that RN #1 just froze up, that she had done ok on med pass observations conducted by the facility and an independent individual, in order to be checked off on the task as a new nurse.

No further information was provided.

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

[2] Pepcid (Prescription) is used to treat ulcers (sores on the lining of the stomach or small intestine); gastroesophageal reflux disease (GERD, a condition in which backward flow of acid from the stomach causes heartburn and

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injury of the esophagus [tube that connects the mouth and stomach]); and conditions where the stomach produces too much acid....Over-the-counter famotidine (Pepcid) is used to prevent and treat heartburn due to acid indigestion and sour stomach caused by eating or drinking certain foods or drinks. Information obtained from https://medlineplus.gov/druginfo/meds/a687011.html

[3] Zoloft is used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks), posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). It is also used to relieve the symptoms of premenstrual dysphoric disorder, including mood swings, irritability, bloating, and breast tenderness.
Information obtained from
https://medlineplus.gov/druginfo/meds/a697048.html

[4] Multivitamin/mineral supplements contain a combination of vitamins and minerals. They sometimes have other ingredients, such as herbs. They are also called multis, multiples, or simply vitamins. Multis help people get the recommended amounts of vitamins and minerals when they cannot or do not get enough of these nutrients from food.
Information obtained from

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F 759	Continued From page 196 https://medlineplus.gov/definitions/vitaminsdefinitions.html [5] Vitamin D3 helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems. Information obtained from https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=vitamin+d&_ga=2.192500842.1377447934.1502114951-734861906.1502114951 2. The facility staff failed to follow physician's orders for the administration of Senokot and a Lidocaine patch to Resident #423. Resident #423 was admitted to the facility on 5/2/18 with the diagnoses of but not limited to stroke, high cholesterol, diabetes, Parkinson's disease, chronic pain, and choric embolism. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 5/9/18. The resident was coded as cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive care for all areas of activities of daily living and as incontinent of bowel and bladder. On 5/16/18 at 9:46 a.m., RN (registered nurse) #1 was observed preparing the following medications for Resident #423: Senokot [1] 8.6/50 mg (milligrams), one tab	F 759		

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(tablet)
Lidocaine [2] patch 5%, applied to left shoulder
Plavix [3] 75 mg, one tab
Aspirin [4] 81 mg, one tab
Lantus[5] 20 units, injection

A review of the clinical record revealed the May 2018 Physician's Order Sheet (POS). The POS documented an order dated 5/3/18 for Senokot to be given twice daily. A review of the MAR (Medication Administration Record) for May 2018 revealed the scheduled dose times were at 8:00 AM and at 5:00 PM. The resident was administered the medication at 9:54 a.m., almost 2 hours past the scheduled time.

Further review of the POS revealed that there were orders for the Lidocaine patch as follows:

An order dated 5/4/18 for Lidocaine patch "Apply to left shoulder topically every 12 hours for pain management and remove per schedule."

An order dated 5/2/18 for Lidocaine patch "Apply to right shoulder topically at bedtime, for Pain Remove patch for 12 hours."

An order dated 5/2/18 for Lidocaine patch "Apply to right shoulder topically one time a day for pain On (sic) for 12 hours, off for 12 hours."

The resident was not offered a patch for the right shoulder.

On 5/16/18 at 11:34 a.m., in an interview with RN #1, she stated that the patch for the right shoulder, was discontinued. When informed the order for the patch to the right shoulder was still

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appearing as a current order, RN #1 checked the computer and stated, that it was still being listed as a current order. There was no evidence provided that the order had been discontinued. RN #1 did not offer the resident a patch for the right shoulder, and RN #1 signed off on the MAR that it had been applied.

A review of the care plan revealed one dated 5/4/18 for "Chronic pain r/t disease process" and included the intervention, "Administer pain medication per physician orders." This intervention was dated 5/4/18.

On 5/16/18 at 11:58 AM, RN #2, the unit manager was notified of the concern.

On 5/16/18 at 3:57 PM, the ASM #1 (the Administrator) and ASM #2 were notified of the findings. ASM #2 stated that RN #1 just froze up, that she had done ok on med pass observations conducted by the facility and an independent individual, in order to be checked off on the task as a new nurse.

No further information was provided.

[1] Senokot is used on a short-term basis to treat constipation.
Information obtained from
https://medlineplus.gov/druginfo/meds/a601112.html

[2] Lidocaine patches are used for pain.
Information obtained from
https://medlineplus.gov/druginfo/meds/a603026.html

[3] Plavix is used alone or with aspirin to prevent

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F 759	Continued From page 199 serious or life-threatening problems with the heart and blood vessels in people who have had a stroke, heart attack, or severe chest pain....is also used to prevent serious or life-threatening problems with the heart and blood vessels in people who have peripheral arterial disease (poor circulation in the blood vessels that supply blood to the legs). Information obtained from https://medlineplus.gov/druginfo/meds/a601040.html [4] Aspirin used to relieve the symptoms of rheumatoid arthritis (arthritis caused by swelling of the lining of the joints), osteoarthritis (arthritis caused by breakdown of the lining of the joints), systemic lupus erythematosus (condition in which the immune system attacks the joints and organs and causes pain and swelling) and certain other rheumatologic conditions (conditions in which the immune system attacks parts of the body). Nonprescription aspirin is used to reduce fever and to relieve mild to moderate pain from headaches, menstrual periods, arthritis, colds, toothaches, and muscle aches....to prevent heart attacks in people who have had a heart attack in the past or who have angina (chest pain that occurs when the heart does not get enough oxygen)....to reduce the risk of death in people who are experiencing or who have recently experienced a heart attack.....to prevent ischemic strokes (strokes that occur when a blood clot blocks the flow of blood to the brain) or mini-strokes (strokes that occur when the flow of blood to the brain is blocked for a short time) in people who have had this type of stroke or mini-stroke in the past... Information obtained from https://medlineplus.gov/druginfo/meds/a682878.h	F 759		

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F 759	Continued From page 200 tml [5] Lantus is used to treat diabetes Information obtained from https://medlineplus.gov/druginfo/meds/a600027.html	F 759		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to obtain laboratory services per nurse practitioner's order for one of 48 residents in the survey sample, Resident #40. The facility staff failed to obtain Resident #40's PT/INR (prothrombin time/international normalized ratio (1)) laboratory (lab) tests every other week per the nurse practitioner's order dated 4/17/18. The staff obtained the labs every week (4/30/18, 5/7/18 and 5/14/18). The findings include:	F 773	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies 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 POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to obtain laboratory services per nurse practitioner's order.	

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F 773	Continued From page 201 Resident #40 was admitted to the facility on 10/1/16. Resident #40's diagnoses included but were not limited to high blood pressure, generalized anxiety disorder and diabetes. Resident #40's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/26/18, coded the resident's cognition as severely impaired. Review of Resident #40's clinical record revealed a physician's order signed by the nurse practitioner on 4/17/18 that documented, "4. Decrease the frequency of INR testing to every other Monday. Next one is 4/30/18... "Resident #40's May 2018 eTAR (electronic treatment administration record) documented, "PT/INR every other Monday in the morning every 14 day(s)." Further review of Resident #40's clinical record revealed multiple results of PT/INR labs dated 4/30/18, 5/7/18 and 5/14/18 (obtained every week instead of every other week). Resident #40's comprehensive care plan dated 11/28/17 documented, "Hematological condition r/t (related to) anemia...Obtain Lab results as ordered and notify physician of results..." On 5/17/18 at 12:12 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 was asked to review Resident #40's physician order for PT/INRs. RN #5 was made aware a PT/INR was obtained on 4/30/18, and was asked when the next PT/INR should have been done. RN #5 stated the next PT/INR should have been done on 5/14/18. RN #5 was asked if there was a reason a PT/INR was obtained on 5/7/18 and stated he needed to check the chart and progress notes.	F 773	1. Resident #40, lab schedule was immediately clarified by doctor. 2. All residents who have PT/INR labs scheduled have the potential to be affected. 3. Licensed nurses will be re-educated on following doctor order and obtain labs (PT/INR) as ordered. 4. DON and/or designee will complete random audits of five (5) resident lab orders to ensure that PT/INR labs were obtained as ordered. These audits will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or actions. 5. Date of compliance will be June 19, 2018.	

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F 773	Continued From page 202 On 5/17/18 at 1:35 p.m., an interview was conducted with RN #5 and ASM (administrative staff member) #2 (the director of nursing). RN #5 stated, "According to the policy, there is always an opportunity to update labs based on the physician's discretion." RN #5 was asked to clarify his statement. ASM #2 stated the physician's order was supposed to read for the PT/INR to be obtained every 14 days and she saw a weekly trend of labs when she looked through the chart. ASM #2 stated she did not see a physician's order for weekly PT/INRs. ASM #2 stated the nurses are calling the doctor and the doctor is addressing the labs as noted by the signature written on the lab results. ASM #2 confirmed Resident #40's PT/INRs were not obtained as ordered and stated there was an opportunity to improve the lab process. On 5/17/18 at 2:22 p.m., an interview was conducted with ASM #6 (the nurse practitioner who signed Resident #40's PT/INR lab results). ASM #6 was made aware of this surveyor's concern. ASM #6 stated she realized Resident #40's PT/INRs were being obtained more than ordered on 5/14/18 when she reviewed the lab results and asked the unit manager to change the order in the computer. On 5/17/18 at 5:09 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above findings. The facility document titled, "LABORATORY TRACKING GUIDELINES" documented, "Lab tests and, or services are provided: in accordance, with a signed contract for services that specifies what services are provided by the	F 773		

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F 773	Continued From page 203 center staff and what services are provided by the laboratory staff; and within what timeframe those services are provided including the draw completion and reporting of STAT (immediate), routine critical or panic value lab results; the provision of requisitions and, or lab draw supplies; when specifically ordered by the attending physician or physician extender." No further information was presented prior to exit. (1) "A prothrombin time (PT) is a test used to help detect and diagnose a bleeding disorder or excessive clotting disorder; the international normalized ratio (INR) is calculated from a PT result and is used to monitor how well the blood-thinning medication (anticoagulant) warfarin (Coumadin®) is working to prevent blood clots." This information was obtained from the website: https://labtestsonline.org/tests/prothrombin-time-and-international-normalized-ratio-ptinr	F 773		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		

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F 812	Continued From page 204 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. 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 prepare food in a sanitary manner in the kitchen. The facility staff failed to prepare food in a sanitary manner on 5/15/15. OSM (other staff member) #2 (the cook) dropped a potholder on the floor then used the potholder to remove broccoli from the steamer and mashed potatoes from the tilt skillet. The findings include: The facility staff failed to prepare food in a sanitary manner on 5/15/15. OSM (other staff member) #2 (the cook) dropped a potholder on the floor then used the potholder to remove broccoli from the steamer and mashed potatoes from the tilt skillet. On 5/15/18 at 11:33 a.m., OSM #2 was preparing food for the lunch meal service. OSM #2 dropped a potholder on the floor then picked the potholder up and placed it on top of the tilt skillet along with another potholder. OSM #2 picked up the potholder that he dropped on the floor and used it to remove a pan of broccoli from the steamer. OSM #2 then placed the potholder on	F 812	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies 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 POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to prepare food in a sanitary manner in the kitchen.	

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F 812	Continued From page 205 the steam table. A few minutes later, OSM #2 used the potholder to remove a pan of mashed potatoes from the tilt skillet. On 5/15/18 at 11:45 a.m., an interview was conducted with OSM #2. OSM #2 was asked what should be done if he drops a potholder on the floor. OSM #2 stated he usually takes the potholder to the dirty clothes. OSM #2 was asked if he remembered dropping a potholder on the floor. OSM #2 stated he remembered and he put the potholder on the counter. OSM #2 stated he did not want to use the potholder because it was contaminated. At this time, OSM #2 was made aware this surveyor observed him drop the potholder on the floor then use it to remove food from the steamer and tilt skillet. OSM #2 stated, "Ah. Did I? I'm not sure if I used that one." On 5/17/18 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility document titled, "INTRODUCTION TO SAFE FOOD HANDLING" documented, "2. The elderly, infants, pre-school age children, pregnant women and those who are ill are most at risk from contracting foodborne illnesses and serious consequences from the illness due to immature or compromised immune systems. 3. Foods become unsafe by time-temperature abuse, cross-contamination and poor personal hygiene..." No further information was presented prior to exit.	F 812	1. OSM #2 was immediately re-educated on preparing food in a sanitary manner. 2. All residents have the potential to be affect. 3. Dietary staff will be re-educated on preparing food in a sanitary manner. 4. Food Service Director and/or designee will observe food preparation to ensure food is prepared in sanitary manner weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine the need for further audits and/or actions. 5. Date of compliance will be June 19, 2018.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 206 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 207 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to maintain infection control practices for five of 48 residents in the survey sample, Resident #2, #57, #101, #71, and #423. 1. The facility staff failed to provide feeding assistance in a sanitary manner to Resident #2 in the Arcadia dining room.	F 880	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions ser forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to maintain infection control practices.	

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F 880	Continued From page 208 2. The facility staff failed to follow infection control practices during wound care for Resident #57. 3. The facility staff failed to follow infection control practices during the 5/17/18 wound care observation of Resident #101. 4. The facility staff failed to store Resident #71's respiratory equipment in a sanitary manner. 5. The facility staff performed a blood glucose check without cleaning the glucometer before obtaining Resident #423 blood sugar reading and after use. The findings include: 1. Resident #2 was admitted to the facility on 12/14/11 and readmitted on 7/25/16 with diagnoses that included but were not limited to dementia, type two diabetes, and arthritis. Resident #2's most recent MDS (minimum data set) was quarterly assessment with an ARD (assessment reference date) of 5/5/18. Resident #2 was coded as being severely impaired in cognitive function scoring three out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #2 was coded as requiring limited assistance from staff member with meals. On 5/15/18 at 1:24 p.m., observation of the Arcadia dining room was conducted. At 1:28 p.m., RN (registered nurse) #9 was observed talking to a male resident. RN #9 touched his arm and then proceeded to the food cart and picked up a tray. RN #9 did not wash her hands prior to picking up the food tray. At 1:29 p.m., RN #9 served this tray to Resident	F 880	1. RN #9 was immediately re-educated on feeding assistance to a resident in a sanitary manner. Resident #57 and#101, LPN #3 and #6 were re-educated on following infection control practices during wound care. Resident #71 respiratory equipment was sanitized and stored in a sanitary manner. RN#1 was re-educated on proper cleaning of reusuable equipment before, in between, and after use. 2. All residents have the potential to be affected. 3. Nursing staff will be re-educated on following proper infection control practices during respiratory care and proper infection control practices of cleaning of reusuable equipment. 4. DON and/or designee will complete 5 random audits to ensure wound care is being done following infection control practices, respiratory equipment is being stored in sanitary manner and glucometers are being cleaned properly according to infection control practices. These audits will be done weekly x four (4) and then monthly x two (2) These audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or actions. 5. Date of compliance is June 19, 2018	

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F 880	Continued From page 209	F 880		

#2. RN #9 sat down next to Resident #2 and opened her milk carton. RN #9 opened Resident #2's straw with her bare hands touching the mouthpiece of the straw. RN #9 then gave Resident #2 a sip of milk using the straw. RN #9 then proceeded to feed Resident #2 the rest of her meal.

On 5/17/18 at 2:37 p.m., an interview was conducted with RN #9. When asked how to maintain infection control while assisting residents with their meals, RN #9 stated that she would wash her hands before and after serving a meal tray and feeding a resident. When asked why it is important to wash hands before and after feeding a resident, RN # stated it was to maintain infection control. RN #9 could not recall touching the male resident's arm prior to feeding Resident #2. RN #9 stated that she should have washed her hands. RN #9 also stated that her bare hands should not have touched the mouthpiece of Resident #2's straw because it was unsanitary.

On 5/17/18 at 6:05 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Hand Hygiene," documents in part the following: "Hand hygiene is defined as any action of hand cleansing which may include either washing hands using an antiseptic agent, plain soap and water or an antiseptic alcohol based hand hygiene product. Hand hygiene will be performed using an alcohol-based hand rub when the hands are not visibly soiled or with antimicrobial soap and water: ...after contact with intact skin. Hand hygiene should also be performed before contact with or

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F 880	Continued From page 210 preparing food items and beverages." No further information was presented prior to exit. 2. The facility staff failed to follow infection control practices during wound care for Resident #57. Resident #57 was admitted to the facility on 12/9/09 and readmitted on 6/7/12 with diagnoses that included but were not limited to stroke, dementia, high cholesterol, and high blood pressure. Resident #57's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 4/8/18. Resident #57 was coded as severely impaired for cognitive function, on the Staff Interview for Mental Status exam. Resident #57 was coded as requiring extensive assistance from two staff members with bed mobility, transfers and toileting; extensive assistance from one staff member with eating, and personal hygiene; and total dependence on staff with dressing and bathing. Resident #57 was coded in section M (Skin Conditions) as having an unhealed stage three or four pressure ulcer (1) measuring 4.4 x 3.6 x 1.0 cm (centimeters). Review of Resident #57's POS (physician order summary) dated 5/1/18, revealed the following order: "SKIN every day shift for wound care clean sacrum wound with NS (normal saline), pat dry, apply zinc ointment to surrounding tissue pack wound with calcium alginate (2) and cover with foam dressing. This order was initiated on 5/11/18. Review of Resident #57's skin integrity care plan dated 6/8/2012 and revised 11/15/17,	F 880		

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F 880	Continued From page 211 documented the following: "At risk for alteration in skin integrity related to fragile skin and resident being incontinent of bowl and bladder, Pressure ulcer to sacrum. Goal: Skin will remain intact, free from erythema, breakdown, excoriation or bruising until next review. Interventions: Gentle handling while transferring/repositioning, Observe skin condition with ADL (activities of daily living) care daily; report abnormalities, pressure redistributing device on bed and chair, weekly skin audit, administer treatments per order, diet and supplements per physician's orders, Encourage and assist as needed to turn and reposition; use assistive devices as needed." On 5/16/18 at 9:06 a.m., wound care observation was conducted with LPN (licensed practical nurse) #6 and LPN (licensed practical nurse) #3. LPN #6 was observed at the treatment cart gathering supplies. LPN #6 took a handful of gloves and placed them into her scrub pocket. LPN #6 then wiped down the resident's beside table with an antiseptic wipe. LPN #6 placed a drape on the table and set her supplies down. LPN #6 then put on a pair of gloves that were removed from her scrub pocket. LPN #6 was not observed washing her hands prior to Resident #57's dressing change. LPN #6 stated that she could not find her scissors. LPN #6 placed her hand into LPN #3's pocket, and grabbed a pair of scissors. LPN #6 then used the scissors to cut the calcium alginate. LPN #6 did not sanitize the scissors prior to use. LPN #6 then put the calcium alginate back on the drape. LPN #6 pulled a sharpie out of her pocket and signed the foam dressing. The foam dressing was then placed back on the drape. LPN#6 then removed her gloves and donned a new pair of gloves from her scrub pocket. LPN#6 stated, "My pockets are	F 880		

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F 880	Continued From page 212 full of gloves." LPN #6 then assisted LPN #3 with turning Resident #57. LPN #6 placed a blue drape under Resident #57 and began removing the old dressing to her sacrum. Resident #57 had a stage four (3) pressure ulcer. LPN #6 removed her gloves and then donned a new pair of gloves from her scrub pocket. LPN #6 took a saline bottle, cleaned the wound and then used gauze to wipe around the wound. LPN #6 then grabbed the calcium alginate and placed it directly into the wound bed. LPN #6 applied the zinc protectant around Resident #57's wound; skin prepped the area and placed the foam dressing over the wound. LPN #6 then used the same gloves that were used for the dressing change to place Resident #57's pillows underneath the resident for repositioning. The same gloves were also used to apply Resident #57's heel boots. LPN #6 then threw away the trash, washed her hands and washed the scissors. LPN #6 then used bleach wipes to wipe down the scissors. On 5/17/18 at 1:58 p.m., an interview was conducted with LPN #6. When asked when she would wash her hands during a dressing change, LPN #6 stated that if a resident only has one wound, she would wash her hands prior to the dressing change and after completion of the dressing. LPN #6 stated that if a resident had two wounds, she would wash her hands between each wound dressing. LPN #6 stated that she would just change her gloves when going from dirty to clean. When asked how she would transport supplies such as gloves for a dressing change, LPN #6 stated that she would put them in her scrub pocket. When asked what was in her pocket with the gloves while she was doing the dressing change on Resident #57, LPN #6 stated,	F 880		

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F 880	Continued From page 213 "I don't recall what was in my pocket then." When asked what was in her pocket at that current time, LPN #6 stated that she had her pen and cell phone in her pocket. LPN #6 stated that she washed her uniform every day and that her scrub top was clean that day. When asked if her pen and cell phone were clean, LPN #6 stated, "Everything I put in it is clean, yes." When asked if she knew if LPN #3's scrub top was clean when she used the scissors from her scrub pocket, LPN #6 stated that she wasn't sure. When asked if the scissors she used were clean, LPN #6 stated, "We always clean the scissors. I didn't cut anything that went into the wound bed." When LPN #6 was informed of the observations made on 5/16/18, LPN #6 did not say anything. When asked what was in LPN #3's pocket with the scissors that were used to cut the alginate, LPN #6 stated that did not know. When asked why the above observations were a concern, LPN #6 stated that it was an infection control issue. On 5/17/18 at 6:05 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility document titled, "SKIN PRACTICE GUIDE" documented, "Dressing changes are performed using non-sterile, clean techniques unless otherwise ordered by the attending physician. In general, the following guidelines are considered when performing treatments: -adhere to principles of infection control- separate clean and dirty, provide barrier field for treatment supplies, appropriate use and changing of gloves, maintain appropriate precautions, appropriate cleaning of wound bed (center of wound to outside perimeter), cleansing of scissors, hand	F 880		

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washing, disposal of soiled dressings..."

(1) A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155.

(2) Calcium Alginate- wound dressing that partly dissolve on contact with wound fluid to form a hydrophilic gel as a result of the exchange of sodium ions in wound fluid for calcium ions in the dressing. This information was obtained from The National Institutes of Health at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1420733/.

(3) Stage Four Pressure Ulcer- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. This information was obtained from The National Pressure Ulcer

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Advisory Panel website at http://www.npuap.org/pr2.htm.

3. The facility staff failed to follow infection control practices during the 5/17/18 wound care observation of Resident #101.

Resident #101 was admitted to the facility on 3/22/18 and readmitted on 4/17/18 with diagnoses that included but were not limited to: depression, diabetes, high blood pressure and irregular heart beat.

The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 6/1/18 coded the resident as having scored a 15 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance for all activities of daily living.

Review of the resident's care plan initiated on 4/17/18 documented "Focus. Resident has pressure ulcer to the sacrum related to impaired mobility. Interventions. Administer treatment per physician orders."

Review of the May 2018 physician's orders documented, "Cleanse open area to sacrum with normal saline, pat dry, apply Xeroform (1) and cover with foam dressing."

Review of the May 2018 medication administration record documented, "Cleanse open area to sacrum with normal saline, pat dry, apply Xeroform and cover with foam dressing."

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 880	Continued From page 216 A wound care observation was conducted on 5/17/18 at 11:07 a.m. with LPN (licensed practical nurse) #6, the wound care nurse and RN (registered nurse) #1. LPN #6 washed her hands and took a pair of gloves out of her pocket. RN #1 washed her hands and put on a pair of gloves from the box in the bathroom. LPN #1 then rolled the resident over onto the right side, opened up the brief. LPN #6 removed her gloves, and took a pair of gloves out of her pocket and put them on. LPN #6 did not wash or sanitize her hands. LPN #6 removed the resident's brief and removed the dressing. LPN #6 removed her gloves, took another pair of gloves out of her pocket and put them on without sanitizing or washing her hands. LPN #6 cleaned the wound and applied the dressing. LPN #6 removed the gloves and washed her hands. RN #1 picked up a piece of trash off the floor, threw it in the trashcan, removed her gloves and put on a new pair of gloves. RN #1 did not wash or sanitize her hands. The resident was positioned and covered. An interview was conducted on 5/17/18 at 1:56 p.m. with ASM (administrative staff member) #2, the director of nurses. When asked when staff should wash their hands, ASM #2 stated, "After each patient care, when they go into the patient's room." When asked when staff washed their hands during wound care, ASM #2 stated, "After each time you remove the dirty wound dressing." When asked where the gloves should be kept that were to be used for the wound care, ASM #2 stated, "They should be on the side of the field." When asked if uniform pockets were clean, ASM #2 stated they were not. An interview was conducted on 5/17/18 at 1:59 p.m. with LPN #6, the wound care nurse. When	F 880		

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asked when staff washed their hands during wound care, LPN #6 stated, "Handwashing is number one. We wash our hands between different wounds." When asked if the uniform pockets were considered clean, LPN #6 stated, "Well I wash my uniform every night." When asked what else was kept in her pocket the gloves were kept in, LPN #6 did not reply.

An interview was conducted on 5/17/18 at 3:20 p.m. with RN #1. When asked when staff should wash their hands, RN #1 stated, "After taking care of a resident, after taking off gloves." When made aware of the observation made that day during wound care, RN #1 stated, "I thought I did but I didn't (wash her hands after removing her gloves)." When asked why they wash their hands, RN #1 stated, "Infection control."

On 5/17/18 at 5:45 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality assurance consultant were made aware of the findings.

No further information was obtained prior to exit.

1. Xeroform – a medicinal preparation of bismuth subtribromo-phenolate and bismuth trioxide that has an astringent, desicca-tive, and antiseptic effect. Xeroform is used externally in powders and salves for the treatment of intertrigoes and of ulcers and inflammations of the mucosa. This information was obtained from: https://encyclopedia2.thefreedictionary.com/Xeroform
4. The facility staff failed to store Resident #71's respiratory equipment in a sanitary manner.

Resident #71 was admitted to the facility on

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4/16/18. Resident #71's diagnoses included but were not limited to amyotrophic lateral sclerosis (1), muscle weakness and difficulty swallowing. Resident #71's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/23/18, coded the resident as being cognitively intact. Section G documented Resident #71 was totally dependent on two or more staff with bed mobility/transfers and required extensive assistance of one staff with dressing and eating. Section O documented Resident #71 utilized BIPAP/CPAP (2).

Review of Resident #71's clinical record revealed a physician's order dated 4/16/18 for a ventilatory respiratory machine.

On 5/15/18 at 12:49 p.m. and 5/15/18 at 2:48 p.m., the mask attached to Resident #71's respiratory machine was observed lying on a table in the resident's room. The mask was not covered. Resident #71 was out of the room. On 5/16/18 at 10:32 a.m., the mask was observed in a plastic bag. Resident #71 was out of the room.

On 5/17/18 at 8:36 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked how a mask attached to respiratory equipment should be stored. LPN #1 stated, "So we have a bag. The mask, you put it in the bag and we date everything." When asked why the mask should be stored in a bag, LPN #1 stated, "For infection control." When asked if the mask should be out on the table when not in use, LPN #1 stated, "No. If not used, it should always be in a bag."

Resident #71's comprehensive care plan dated 5/16/18 failed to document information regarding

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the storage of respiratory equipment.

On 5/17/18 at 5:09 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "OXYGEN ADMINISTRATION" documented, "2. When not in use, store oxygen tubing and nasal cannula or mask in separate, labeled plastic bag..."

No further information was presented prior to exit.

(1) "Amyotrophic lateral sclerosis (ALS) is a nervous system disease that attacks nerve cells called neurons in your brain and spinal cord. These neurons transmit messages from your brain and spinal cord to your voluntary muscles - the ones you can control, like in your arms and legs..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=amyotrophic+lateral+sclerosis

(2) "Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems...
Your health care provider will prescribe the type of PAP machine that targets your problem:
Continuous positive airway pressure (CPAP) provides a gentle and steady pressure of air in

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your airway to keep it open.
Autotitrating (adjustable) positive airway pressure (APAP) changes pressure throughout the night, based on your breathing patterns.
Bilevel positive airway pressure (BiPAP or BIPAP) has a higher pressure when you breathe in and lower pressure when you breathe out..." This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm

5. The facility staff performed a blood glucose check without cleaning the glucometer before obtaining Resident #423 blood sugar reading and after use.

Resident #423 was admitted to the facility on 5/2/18 with the diagnoses of but not limited to stroke, high cholesterol, diabetes, Parkinson's disease, chronic pain, and choric embolism. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (assessment reference date) of 5/9/18. The resident was coded as cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive care for all areas of activities of daily living and as incontinent of bowel and bladder.

On 5/16/18 at 9:46 a.m., RN (registered nurse) #1 was observed preparing for administration of medications to Resident #423. Prior to preparing any medications, RN #1 was observed obtaining a blood glucose level from Resident #423 on 5/16/18 at 9:54 a.m., she obtained the glucometer device from the medication cart drawer, went to the resident and obtained the sample, and afterwards, returned the glucometer device back to the drawer of the medication cart. RN #1 did not sanitize the glucometer before or after use.

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F 880	Continued From page 221 On 5/16/18 at 11:46 a.m., RN #1 stated that the glucometer should be sanitized before and after each use. When asked if she had used it on any other resident prior to Resident #423, RN #1 stated, "yes." When asked if she had sanitized the glucometer after using it on the other resident, prior to using it on Resident #423, RN #1 stated, "no." On 5/16/18 at 11:58 a.m., RN #2, the unit manager was notified of the concern. On 5/16/18 at 3:57 p.m., the ASM #1 (the Administrator) and ASM #2 were notified of the findings. ASM #2 stated that RN #1 just froze up, that she had done ok on med pass observations conducted by the facility and an independent individual, in order to be checked off on the task as a new nurse. A review of the manufacturer's user's guide booklet of the glucometer device, documented, "The EVENCARE G3 Meter should be cleaned and disinfected between each patient." No further information was provided.	F 880		

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RELEASED TO REHAB DUTY

Dear Elena Rosales:

We are pleased to advise you that your treating physician has released you to return to work with temporary limitations regarding your work assignment. As you are aware, it is HCR ManorCare's policy to offer rehabilitative duty that will enable you to return to work within those limitations while you recover with the goal of an ultimate return to full duty.

Your physician has released you to return to work with the following restrictions:

- No: lifting/carrying over 5lbs
- No: standing, walking, climbing, sitting for > 1 hour at a time
- Breaks every hour to prevent aggravation of injury, and stiffness

You are to return to work on June 21, 2018 at 7:00am. Your duties will consist of: Transcribing orders, contact family members, contact MDs and/or Pharmacists, lab review, answer phone at nurse's station, organize nurse station area, documentation, chart audits, make patient appointments, med pass, answer call lights, feed residents, which are within your physicians' restrictions. Your hours will be 7:00a.m.-3:30p.m. and your rate of pay will remain the same.

On Wednesday, June 20, 2018, you confirmed that you will be returning to work on June 21, 2018.

Please sign, date and return this letter as acknowledgment of its receipt. We are pleased you will be returning as you have been missed. Should you have any questions, please feel free to contact Briane Accius-Lamy at 703-345-2906.

Sincerely,

Briane Accius-Lamy
Staffing and Payroll Coordinator

______________________________ ____________________

Elena Rosales Date

(Original: Personnel File, Copy: To Employee)

(This should be mailed certified and regular mail to the employee with a copy to the Corporate Workers' Compensation Department.)