State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495144	A. BUILDING _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSBURG HEALTHCARE CENTER	287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced Medicare/Medicaid standard survey, and Virginia state licensure inspection was conducted 9-18-17 through 9-21-17. Substantial Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. One complaint was investigated during the survey. The census in this 120 certified bed facility was 106 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through #19 and #23) and 3 closed record reviews (Residents #20 through #22).	F 000	This plan of correction is prepared and executed because it is required by the provisions of state and federal law and not because Petersburg Healthcare Center admits or denies the validity of the allegations and citations listed on the pages of this Statement of Deficiencies. CommuniCare-Petersburg Healthcare Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is of such character as to limit our capability to render adequate care. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction:	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: COV 32.1-126.01(A) Based on staff interview and employee record review the facility staff failed to ensure 1 of 24 employees (Employee #14) had a criminal record check completed by the Virginia State Police. For Employee #14, the criminal background check was completed by a third party screening service. The findings included: Employee #14 was hired on 6/27/17. The background check was completed by a third party screening service. The results from the screening service document that the criminal history search was performed for Petersburg City, Hopewell City, and the "Eastern District of VA". On 9/21/17, the	F 001	COV 32.1- 126.01 (A) 1. Employee #14 had a criminal Virginia background check completed on 09/19/2017. 2. Current employees were audited to ensure they have a correct Virginia background check completed by Human Resources/ designee on 09/26/2017. 3. Administrator/ designee educated Human Resources/ designee on proper completion of Virginia background checks on 10/03/2017.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 10-11-2017

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F 001	Continued From Page 1 Human Resources (HR) Manager stated that the third party screening company did not use the Virginia State Police criminal database to complete the criminal background check. She stated that the third party used their own search. The HR Manager provided a criminal background search conducted with the Virginia State Police dated 9/19/17. There were no identifiable issues documented. The issue was reviewed with the Administrator and Director of Nursing on 9/21/17 at 12:00 p.m. The facility policy titled "Abuse, Neglect and Exploitation Policy" was reviewed. The section titled "Screening" read "2. A criminal background check will be completed to meet state requirements" and "d. Criminal State Background Checks". The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: Resident Rights 12 VAC 5-371-220 (H). Please Cross Reference to F-157 notification. Freedom from Abuse, Neglect, and Exploitation. 12 VAC 5-371-110 (B.1-3) Cross Reference to F-225 Freedom from Abuse, Neglect, and Exploitation. 12 VAC 5-371-110 (B.1-3) Cross Reference to F-226 Resident Rights 12 VAC 5-371-140(D)(15)(d). Please	F 001	4. A Virginia background check audit will be conducted on a weekly basis for 12 weeks to ensure correct Virginia background check is completed by the Human Resources/designee on new hires. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement committee to ensure compliance and the need for further monitoring for three (3) months. Resident Rights 12 VAC 5-371-220 (H). Please cross reference to F-157 notification. Freedom from Abuse, Neglect, Exploitation. 12 VAC 5-371-110 (B1-3) Cross reference to F-225. Freedome from Abuse, Neglect, Exploitation. 12 VAC 5-371-110 (B.1-3) Cross Reference to F-226. Resident Rights 12 VAC 5-371-140(D)(15)(d). Please Cross Reference to F-241.	11/03/2017

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F 001	Continued From Page 2 Cross-Reference to F-241. Resident Assessment 12 VAC 5-371-250 (B.2) Cross Reference to F-274 Comprehensive Person Centered Care Planning 12 VAC 5-371-250 (C) Cross Reference to F-280 Comprehensive Person Centered Care Planning 12 VAC 5-371-200 (B)(1)(ii). Please Cross-Reference to F-281. Quality of Life/Quality of Care 12 VAC 5-371-220 (A)&(B). Please Cross-Reference to F-309. (Harm level deficiency) Quality of Care 12 VAC 5-371-220 Cross Reference to F-315 Quality of Care 12 VAC 5-371-220 (A/B/D). Please Cross-Reference to F-323. (Harm level deficiency) Pharmacy Services 12 VAC 5-371-220 (B). Please Cross-Reference to F-329. Pharmacy Services 12 VAC 5-371-220(B) Cross Reference to F-333 Pharmacy Services 12 VAC 5-371-180 Cross Reference to F-334 Physician Services 12 VAC 5-371-240(F) Cross Reference to F-387 Pharmacy Services 12 VAC 5-371-300(A, B) Cross Reference to	F 001	Resident Assessment 12 VAC 5-371-250 (B.2) Cross Reference to F-274. Comprehensive Person Centered Care Planning. 12VAC 5-371-250 (C) Cross Reference to F-280. Comprehensive Person Centered Care Planning 12 VAC 5-371-200 (B)(1)(ii). Please Cross-Reference to F-281 Quality of Life/ Quality of Care 12 VAC 5-371-220n(A)&(B). Please Cross-Reference to F-309 (Harm Level deficiency) Quality of Care 12 VAC-371-220 Cross Reference to F- 315 Quality of Care 12VAC 5-371-220 (A/B/D). Please Cross reference to F – 323. (Harm level deficiency) Pharmacy Services 12 VAC 5-371-220 (B). Please Cross Reference to F-329. Pharmacy Services 12 VAC 5-371-220 (B) Cross Reference to F-333.	

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F 001	Continued From Page 3 F-425 Infection Control 12 VAC 5-371-180 (A) Cross-Reference to F-441. Quality Assurance and Process Improvement 12 VAC 5 - 371 - 190 Cross Refernce to F-518 Resident Rights 12 VAC - 371 - 150 Based on the Code of Virginia, facility document review, and staff interview, the facility staff failed to complete sex offender registry checks on all admissions prior to admission, and further failed to inform Residents upon admission how to access the sex offender registry. The facility could provide no policies on sex offender requirements related to protections of the facility population with regard to sex offenders and Virginia state law. The findings included: On 9-18-17 upon entrance to the facility at 2:00 p.m., the Administrator was asked to provide (within 24 hours)evidence that the facility was receiving automatic sex offender notifications from the Virginia State Police, and also to provide proof that registry checks were conducted on all those admitted to care, and asked how the facility made admitted Residents aware of the sex offender registry, and how to access it. On 9-19-17 the administrator gave proof of receiving automatic alerts of new sex offenders registered in the area from the Virginia state police, however, stated they had not been completing background checks for sex offender status of admissions, and had just started this 7-20-17. The Administrator further stated they had not been educating new admissions and or	F 001	Pharmacy Services 12 VAC 5-371-180 Cross Reference to F-334. Physician Services 12 VAC 5-371-240(F) Cross Reference to F-386. Pharmacy Services 12 VAC 5-371-300(A, B) Cross Reference to F425. Infection Control 12 VAC 5-371-180 (A) Cross Reference to F-441. Quality Assurance and Process Improvement 12 VAC 5-371-190 Cross Reference to F-518. 12 VAC 371 150 (g) 1. Facility did not notify residents how or where to obtain Virginia sex offender registry information for current residents. They were notified on or by 10/10/2017. Sex offender registry was checked for current residents on 07/20/2017. 2. Current residents were notified of how and where to access the Virginia sex offender registry by the Admissions Director/ designee by phone or letter by 10/09/2017. Current residents were checked against the Virginia Sex Offender registry on 10/03/2017.	

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F 001	Continued From Page 4 their responsible parties of how to access the registry, and stated she had no policies with regard to these protections. The facility abuse policies were reviewed, and made no mention of these protections. The facility administrator and Director of Nursing were made aware of the deficient practice at the end of day debriefings on 9-19-17, 9-20-17, and 9-21-17. No further information was provided by the facility.	F 001	3. The administrator educated the Admissions Director/ designee how and where to access the Virginia sex offender registry on 10/03/2017. 4. A weekly audit of new admissions will be conducted by the Admissions Director/ designee to ensure new residents know how to access the Virginia sex offender registry times twelve weeks and new admissions will be checked against the Virginia Sex Offender Registry. Results from audits will be forwarded to the Quality Assurance Meeting to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9-18-17 through 9-21-17. Substantial Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The census in this 120 certified bed facility was 106 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through #19 and #23) and 3 closed record reviews (Residents #20 through #22).	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 157	Federal Tags F 157 1. Resident #2's physician was notified of the delay in xray on 08/10/2017 at 0440. 2. Current resident's xray reports for the month of September 2017 were reviewed to ensure timely notification of physician on 10/04/2017. 3. Licensed nurses will be educated on proper/ timely physician notification of xray results by DON/ Designee on or before 11/03/2017. 4. A weekly audit of facility xrays will be conducted to ensure timely physician notification by the DON/ Administrator/ designee times twelve weeks. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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

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 157	Continued From page 1 (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). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed for one Resident (Resident # 2) in a survey sample of 23 residents to notify the Physician of a delay in obtaining an X-ray ordered for an injury of unknown origin. For Resident # 2, the facility staff failed to notify the Physician of an 8 1/2-hour delay in obtaining an X-ray after the order was received for an injury of unknown origin discovered. The findings included:	F 157		

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F 157	Continued From page 2 Resident #2, a 91year old female, was admitted to the facility on 3/2/2012. Her diagnoses included but were not limited to: Major Depressive Disorder with severe Psychotic Symptoms, Pseudobulbar Affect, Cardiac Pacemaker, Anemia, Acute embolism and thrombosis. Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/3/2017 was coded as a Quarterly assessment. She was coded as having short and long term memory deficits, severe cognitive impairments. She was also coded as needing extensive to total assistance of one person to perform all of her activities of daily living with the exception of transfers. For transfers, she was coded as needing total assistance of two staff members. She was coded as always incontinent of bowel and bladder. On 9/19/2017 at 8:45, Resident # 2's clinical record was reviewed. Review of Resident # 2's clinical record revealed nursing note entries: "8/9/2017 17:15 (5:15 p.m.) "Called to room by CNA (Certified Nursing Assistant) ____. Stated Res.(Resident) right hand was swollen and Res. was guarding and protecting her right hand. Upon assessment res. noted alert and verbally responsive, right hand at wrist area warm to touch, bruising to hand and forearm edema to hand. Res. pulls away when assessment performed, right hand elevated on pillow res. medicated for pain. Physician notified orders received continue to observe."	F 157		

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F 157	Continued From page 3 "8/9/2017 17:30 (5:30 p.m.) Mobile X ray called at 17:30 order given. Claim # 24702593 Stat (immediately). Call to Mobile X-ray @ 19:05 (7:05 p.m.) No attendant at facility. New claim ticket 24703467. Attendant due to call facility no time of arrival 21:30 (9:30 p.m.), call from mobile x-ray attendant to arrive in 2 1/2 hours. Will continue to monitor and refer." "8/10/2017 01:00 (1:00 a.m.) Res up in w/c (wheelchair) @ (at) the beginning of shift, right wrist and hand monitored, swelling remain to top hand purple discoloration noted, right hand moved without difficulty, no discomfort noted. 8/10/2017 02:15 (2:15 a.m.) Mobile X-ray in to do X-ray of right lower arm. 8/10/2017 04:40 (4:40 a.m.) X-ray report back, x-ray show spiral fracture of distal third ulna with some displacement. No wrist FX (fracture), there is osteopenia. Dr. was notified, order given to send to the ER (Emergency Room)." The Physician ordered the X-ray on 8/9/2017 at 5:30 p.m. and the Mobile X-ray was not completed until 8/10/2017 at 2:15 a.m. due to "no attendant at facility." There was no documentation that the Physician was notified of the delay in obtaining the mobile X-ray. The Physician was notified of the results of the X-ray which revealed a spiral fracture of the ulna on 8/10/2017 at 4:40 a.m., 11 hours after the order for X-ray was received upon discovery of the injury. During the end of day debriefing on 9/21/2017,	F 157		

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F 157	Continued From page 4 the DON, Administrator and Corporate consultant were informed of the findings. No further information was provided.	F 157		
F 225 SS=E	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment,	F 225	F 225 1. Resident #2's investigation was reinvestigated on 10/09/2017 . Resident #4's roommate was interviewed on 09/20/2017. Resident #7's investigation was reported on 06/20/2017. Resident #8's investigation was reported on 06/28/2017. 2. Facility reported incidents from September 2017 were reviewed to ensure timely completion, thorough investigations, and timely reporting to reporting agencies occurred by DON/Administrator/ designee on 10/05/2017. 3. Facility staff will be educated on the need to immediately report incidents/ suspicion of abuse to supervisor by Administrator/ designee on or before 11/03/2017. 4. Facility reported incidents will be reviewed timely and reported as they occur per abuse policy. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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F 225	Continued From page 5 including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to thoroughly investigate and report injuries of unknown origin in a timely manner for 4 residents (Residents #4, #2, #7, and #8) in the survey sample of 23 residents.	F 225		

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F 225	Continued From page 6 1. For Resident #4, the facility staff failed to interview her cognitively intact roommate (Resident #1) who witnessed the fall involving an improper transfer by staff, that resulted in a leg fracture. 2. For Resident # 2, the facility staff failed to thoroughly investigate and failed to report to the State agency timely of an injury of unknown origin involving a spiral fracture of the ulna. "The ulna is one of two bones that give structure to the forearm. ... It joins with the humerus on its larger end to make the elbow joint, and joins with the carpal bones of the hand at its smaller end. Together with the radius, the ulna enables the wrist joint to rotate. Ulna Bone Anatomy, Diagram & Function | Body Maps - Healthline www.healthline.com/human-body-maps/ulna-bone 3. For Resident #7, the facility staff failed to report to the facility administration about a significant (insulin) medication error timely. They further failed to report the escalating situation (hospitalization) to the State agency timely, within the allotted time frame, of a serious injury caused by the error. 4. For Resident #8, the facility staff failed to report to the state agency timely, of a fracture of unknown origin. The Findings included: Resident #4 was an 88 year old who was	F 225		

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F 225	Continued From page 7 admitted to the facility on 2/22/06. Resident #4's diagnoses included Proximal Tibia Displaced Metaphyseal and Impacted Plateau Fractures (crushed bone), Muscle Weakness-Generalized, Age-Related Osteoporosis, Schizophrenia, Psychotic Disorder, Hypertension, and Alzheimer's Disease. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 6/7/17, coded Resident #4 as having a Brief Interview of Mental Status Score of 7 - indicating severely impaired cognition. For transfers, she was coded as requiring the extensive physical assistance of two persons. In the area of functional limitation in range of motion, she was coded as having lower extremity impairment on both sides. Her mobility device was a manual wheelchair. On 9/19/17 a review was conducted of facility documentation, revealing Resident #4's Care Plan, which read, "Initiated 3/9/10. Revised 7/18/17. I am at risk for and have had an actual fall related to: Cognitive impairment with decreased safety awareness. I am easily distracted and have poor insight/judgement. I am incontinent and I am dependent for ADLs (Activities of Daily Living). Assist resident with all transfers." The Care Plan had not been revised to include the requirement of the extensive physical assistance of two.persons for transfers. On 9/19/17 at 8:30 A.M., an observation was conducted of Resident #4, who was in her bed. When asked about how her leg was feeling, Resident #4 smiled and appeared to be confused. Suddenly, her roommate who was identified and put into the sample as Resident #1, made an	F 225		

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F 225	Continued From page 8 unsolicited statement. She said, "One of the aides named Carolyn (CNA A) came in here by herself and dropped her on the floor while putting her in her wheelchair. She slipped out of her hands and fell on the floor. She broke her leg and went to the hospital. She came back here with a leg brace on, and had it on for a month and a half." Resident #1's Brief Interview of Mental Status Score was 14, indicating no cognitive impairment. Resident #4's clinical record contained the following x-ray report, "6/28/17 10:23 A.M. Findings: Four views of the left knee. Proximal tibia displaced metaphyseal and impacted plateau fractures, are partially obscured by severe tricompartmental osteoarthritis with large osteophytes and loss of joint space. Effusion. On 9/19/17 a review of facility documentation was conducted, revealing a Facility Reported Incident on 6/29/17. It read, "Injury of Unknown Origin. Resident assessment revealed left tibia plateau fracture. Documents reveal resident had a fall on 6/25/17. Investigation pending." On 7/3/17, the facility follow-up read, "Upon investigation, June 25, 2017, (CNA A - Certified Nursing Assistant) transferred (Resident #4) from the bed to the wheelchair." According to the report, only one staff member conducted the transfer instead of two. CNA A's signed statement (dated 6/25/17) read, "I set her down in the chair. I walked away. I heard a noise. I turned around I saw resident body in front of wheelchair Resident butt was on the floor in between the leg rest. The leg rest was extended. Resident left leg was under her butt." This incident occurred during the day shift at 7:50	F 225		

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F 225	Continued From page 9 A.M. The clinical record contained the following Nursing Progress Note, "6/25/17/ 10:51 P.M. Resident resting in bed, respirations unlabored, lung fields clear, no coughing or congestion noted. No dizzy spells noted. Bed in lowest position, call bell in reach. Staff monitoring Q 2 hours." For the next three days, until 6/28/17 there was no further post-fall monitoring (7 continuous shifts). On 6/28/17 the Nursing Progress Note read, " Vital signs 99.2-90-22-138/86-96%. Resident noted with edema to left knee and lower leg bruising present to lower leg. Resident C/O (complains of) pain when touched, will not allow CNA to dress her. Resident medicated for pain Tylenol Tabs 2 PO (by mouth) for left leg pain. DR made aware STAT x-ray of left FIB TIB and left knee (left lower leg)." Resident #4 was admitted to the hospital at 7:00 A.M. and returned to the facility at 6:45 P.M. New orders for pain medication, use of knee immobilizer, and no weight bearing to left leg were given by the resident's MD (Medical Doctor) at the facility. The nursing Progress noted read, "SRMC (hospital) called report. No surgery indicated at this time because its to extensive. Keep knee immobilizer in place." On 9/19/17 at 4:05 P.M., an interview was conducted with CNA A in the conference room. The Director of Nursing, who had conducted the investigation, was present. When asked why she transferred Resident #4 without the assistance of another staff member, CNA A stated, "The way I was trained the person demonstrated that the resident needed only 1 person for transfers.	F 225		

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F 225	Continued From page 10 When CNA A was informed that Resident #1 witnessed the fall, she admitted that Resident #1 was in the room, but said that "the curtain was pulled." There was no documentation that the curtain had been pulled. When the Director of Nursing was asked why Resident #1 wasn't interviewed regarding the fall, she stated, "Because I didn't know that she was in the room and I didn't ask." On 9/19/17 at 5:00 P.M. the facility Administrator (Administration A) was notified of the findings. On 9/20/17 the Administrator submitted following (name of facility)_____ Plan of Correction; "Findings: Facility failed to properly investigate two injuries of unknown origins. The facility failed to interview all potential witnesses. Resident: (#4) Fell on 6/25/17, and on 6/28/17 diagnosed with a left knee fracture. Resident: (#2) Diagnosed with a fracture of unknown origin. 100% of residents with hi risk for injuries related to falls were reviewed to ensure proper transfers were being performed." The Plan of Correction also stated that all facility residents were assessed for proper transfer techniques and initiated on 9/19/17. Nursing staff were in-serviced. In addition, CNA A had been suspended pending investigation, and had subsequently resigned. The Plan also stated that all department heads were in-serviced on the proper way to complete an investigation. 2. For Resident # 2, the facility staff failed to thoroughly investigate and failed to report to the State agency timely of an injury of unknown origin	F 225		

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F 225	Continued From page 11 involving a spiral fracture of the ulna. Resident #2, a female, was admitted to the facility on 3/2/2012. Her diagnoses included but were not limited to: Major Depressive Disorder with severe Psychotic Symptoms, Pseudobulbar Affect, Cardiac Pacemaker, Anemia, Acute embolism and thrombosis. Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/3/2017 was coded as a Quarterly assessment. She was coded as having short and long term memory deficits, severe cognitive impairments. She was also coded as needing extensive to total assistance of one person to perform all of her activities of daily living with the exception of transfers. For transfers, she was coded as needing total assistance of two staff members. She was coded as always incontinent of bowel and bladder. On 9/19/2017, Resident # 2's clinical record was reviewed. Review of the Nurse's Notes revealed entries: "8/9/2017 17:15 (5:15 p.m.) "Called to room by CNA (Certified Nursing Assistant) ____. Stated Res.(Resident) right hand was swollen and Res. was guarding and protecting her right hand. Upon assessment res. noted alert and verbally responsive, right hand at wrist area warm to touch, bruising to hand and forearm edema to hand. Res. pulls away when assessment performed, right hand elevated on pillow res. medicated for pain. Physician notified orders received continue to observe."	F 225		

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F 225	Continued From page 12 8/9/2017 17:30 (5:30 p.m.) Mobile X ray called at 17:30 order given. Claim # 24702593 Stat. Call to Mobile X-ray @ 19:05 (7:05 p.m.) No attendant at facility. New claim ticket 24703467. Attendant due to call facility no time of arrival 21:30 (9:30 p.m.), call from mobile x-ray attendant to arrive in 2 1/2 hours. Will continue to monitor and refer." "8/10/2017 01:00 (1:00 a.m.) Res up in w/c (wheelchair) @ (at) the beginning of shift, right wrist and hand monitored, swelling remain to top hand purple discoloration noted, right hand moved without difficulty, no discomfort noted. 8/10/2017 02:15 (2:15 a.m.) Mobile X-ray in to do X-ray of right lower arm. 8/10/2017 04:40 (4:40 a.m.) X-ray report back, x-ray show spiral fracture of distal third ulna with some displacement. No wrist FX (fracture), there is osteopenia. Dr. was notified, order given to send to the ER (Emergency Room). 8/10/2017 05:18 (5:18 a.m.) Resident out to hospital via ambulance." Documentation revealed that on 8/9/2017 at 5:30 p.m., the clinician ordered an X-ray of Resident # 2's right hand. The X-ray was obtained 8/10/2017 at 2:15 a.m. and Resident #2 was determined to have a "spiral fracture of the distal third of the ulna." The physician ordered for Resident #2 to be evaluated by the hospital Emergency Room. Resident # 2 was transported to the Emergency Room at 5:18 a.m. Review of the X-ray from the hospital: X-ray of Resident #2's right forearm and right	F 225		

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F 225	Continued From page 13 wrist obtained 8/10/2017, read by the radiologist 8/10/2017 at 4:22 a.m. revealed results: Forearm AP and LAT, Right "Findings: There is fracture of the distal third of the ulna with mild displacement. The radius is intact. There is osteopenia. Radial head is normal. Conclusion: Spiral type fracture of the distal third of the ulna with some displacement. Soft tissue swelling." Wrist AP and LAT, Right: Comparison: 9/2/2016 Results Findings: There is no fracture of the wrist. There is osteopenia. The radiocarpal joint space is normal. There is spiral fracture of the distal third of the ulna with some displacement. Conclusion: No fracture of the wrist itself. There is fracture of the distal third of the ulna with displacement." Review of the Emergency Room Documentation revealed Resident # 2 was seen by the ER physician at 5:42 a.m. The ER notes on page 7 of 12 under History of Present Illness stated "Patient had fallen earlier in the evening." Also stated "there x-ray showed a right ulnar fracture. She does have some wrist swelling without any obvious fracture seen on her x-ray." The Physical examination results on page 8 of 12 included statements under Musculoskeletal: "Right upper extremity with deformity midshaft. Significant bruising and swelling at the hand and wrist., not normal ROM (Range of Motion), not normal strength." A Sugar Tong splint was placed by the ER technician on the right side. The facility began an investigation into Resident # 2's injury of unknown origin, her fractured ulna.	F 225		

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F 225	Continued From page 14 Review of the investigation revealed one handwritten note by RN (Registered Nurse) A who worked 8/8/2017 on 11-7 shift and 5 typed witness statements, typed by the Director of Nursing and each signed by the witnesses. Each of the typed witness statements listed the date of occurrence as 8/10/2017, four (CNA A, CNA F, CNA G and CNA H) were signed on 8/11/2017 and one was signed by CNA-I on 8/14/2017. The actual date of discovery of the injury was 8/9/2017. Further review of the witness statements revealed no witness statements from the LPNs who worked 8/8/2017 on 7-3 shift, 8/8/2017 on 3-11 shift, 8/9/2017 on 7-3 shift, 8/9/2017 on 3-11 shift. There were no witness statements from CNAs (Certified Nursing Assistants) who worked 8/8/17 on 3-11 shift, and 8/8/2017 on 11-7 shift There was no Witness statement from the LPN (Licensed Practical Nurse) who worked on 7-3 shift on 8/9/2017, the shift prior to discovery of the injury and no witness statement from Licensed Practical Nurse (LPN D) who assessed the injury on 3-11 shift on 8/9/2017. There was a handwritten note presented as a witness statement from RN A who worked with Resident # 2 on 8/8/2017 11-7 shift. Review of the note revealed the name of the resident was not listed and it was not dated. RN A stated the CNA reported discoloration on the right hand. RN A stated she assessed the right hand and did not see anything other than discoloration. The note included statements of "On Tuesday night, I worked with the resident. On the last round the CNA report a discoloration. I assessed the right hand and did not see anything, just the discoloration. hand moved without difficulties. no	F 225		

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F 225	Continued From page 15 s/s (signs and symptoms) of discomfort noted at that time. Resident did not get up on 11-7 shift." There was no documentation in the nurses notes of the concern reported by the CNA and no assessment of the right hand was found in the clinical record. There was no Witness statement from the CNA on 11-7 shift on 8/8/17 who reported this discoloration to RN A. An interview was conducted with the DON who stated an investigation of the injury of unknown origin had been conducted and the facility was unable to substantiate abuse. When asked why there were no statements from the LPN who initially assessed the right arm on 8/9/2017 and other staff members assigned to work with Resident # 2, the DON stated the LPN wrote a nurses' note. The DON was asked to provide all documentation of the investigation of the injury of unknown origin. On 9/19/2017 at 5 p.m., the administrator and DON were informed of the failure of the staff to thoroughly investigate the injury of unknown origin and interview all potential witnesses. The Administrator stated Serious Injuries must be reported to the State Agency within no more than 2 hours of discovery. The Administrator also stated a thorough investigation should have been completed at the time of the discovery of the injury of unknown origin and that another investigation was currently being conducted. Review of the Investigation Planning Tool revealed documentation on Page 2 Under "Other	F 225		

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F 225	Continued From page 16 Potentially Affected Residents (identify any residents who may have been affected, use the Abuse QIS (Quality Indicator Survey)questions for the interview able residents and do a skin observation on non-interview able residents to attach documentation)": In-service on abuse attach, skin sweep attach, Abuse question "ask do you feel safe" attach. Review of the Midnight Census Report for 8/9/2017 Attachment revealed documentation of responses to the Question: Do You Feel Safe? asked of the residents on Wing 1. There were 20 answers of "yes" written next to the names of residents on Wing 1. There were five answers of n/a (not applicable) and the word "out" was written next to one resident's name. There was no answer written for 28 residents. And there were two empty beds listed on the census for Wing 1. The response of "n/a" was written on two of the 3 residents on the 300 hall and no response written for the other resident on that hall. There was one empty bed on the 300 hall. The Census showed 56 occupied beds, 4 empty beds but one resident's name had been handwritten in one room on Wing 1, indicating a total census of 57 residents on Wing 1 and the 300 hall combined. There were 51 occupied beds and 9 empty beds on Wing 2 on the Census on 8/9/2017. 40 residents replied yes, 3 were listed as discharged, 2 were in the hospital and one was listed as "n/a". There was no answer listed for 5 residents on Wing 2. Review of the Facility Reported Incident sent to the State Agency on 8/10/2017 revealed the form was faxed in the State Agency on 8/10/2017 at 5:32 PM by the previous administrator. Review of the Intake Information Form from the State Agency showed the Director of Nursing contacted the State Agency on 8/10/2017 at 8:29 AM.	F 225		

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F 225	Continued From page 17 Review of the clinical record revealed the injury of unknown origin was discovered on 8/9/2017 at 5:15 PM. Review of the Facility Policy on Abuse, Neglect and Exploitation on Page 2 of 23, Effective 5/1/2017 revealed statements "For the purpose of this policy, immediately is to be interpreted "as soon as possible, but no more than two hours after the alleged incident of abuse or serious bodily injury is discovered and within 24 hours for all other allegations" Under "Injury of Unknown Origin: an injury should be classified as an injury of unknown origin when both of the following conditions are met: a) the source of the injury was not observed by any person. ** The rest of the definition for Injury of Unknown Origin was missing from the document. On the next page other definitions continued with "involuntary seclusion." The copy of the Abuse policy given to the surveyors only included 3 pages (pages 1, 2 and 3 of 23). The top of the document stated there were 23 pages to the policy. On 9/20/2017, the Administered presented a Plan of Correction with findings "Facility failed to properly investigate two injuries of unknown origins. The facility failed to interview all potential witnesses." The plan included statement that 100 % of residents with high risk for injuries related to falls were reviewed to ensure proper transfers were being performed." The plan of correction was presented after the survey team discovered a thorough investigation was not done. On 9/20/2017 during the end of day debriefing, the facility Administrator and Director of Nursing were informed of the findings. The Administrator again stated Serious Injuries must be reported to	F 225		

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F 225	Continued From page 18 the State Agency within no more than 2 hours of discovery. The Administrator also stated a thorough investigation should have been completed at the time of the discovery of the injury of unknown origin and that another investigation was currently being conducted. No further information was provided. 3. For Resident #7, the facility staff failed to report to the facility administration about a significant (insulin) medication error timely. They further failed to report the escalating situation (hospitalization) to the State agency timely, within the allotted time frame, of a serious injury caused by the error. Resident #7 was admitted to the facility on 6-22-16 with diagnoses that included; Diabetes, chronic kidney disease, Hypertension, hyperkalemia, seizures, hyponatremia, gout, peripheral vascular disease, history of urinary tract infections, history of clostridium difficile, history of sacral pressure ulcer with infection, and dermatitis. Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7-3-17 was coded as a significant change assessment. Resident #7 was coded as having memory loss, and severe cognitive loss. Resident #7 was coded as requiring extensive assistance to total dependence on one to two staff members for all ADL's (activities of daily living), and always incontinent of bowel with a Foley urinary catheter for bladder elimination. On 9-19-17 a thorough review of the resident's clinical record was conducted. Nursing progress	F 225		

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F 225	Continued From page 19 notes were reviewed and revealed that on 6-20-17 at 12:55 p.m. the Resident was "cold/clammy/diaphoretic with blood sugar of 31." The note goes on to say that the Resident received a subcutaneous injection of Glucagon in her left upper arm. On 6-20-17 at 3:03 p.m. a nursing note describes that the Resident had a blood sugar reading of 34 at 2:00 p.m., as the doctor order the blood sugar recheck in 1 hour after the glucagon given at approximately 1:00 p.m. (12:55), and at 3:00 p.m. the Resident's blood sugar was 158, and at 3:30 it was documented as 138. On 6-20-17 at 5:25 p.m., the Resident was sent to the hospital via 911 to the emergency room (ER) for evaluation of hypoglycemia, and facility staff documented in the nursing notes that the Resident's blood sugar was 116 milligrams/deciliter at the time of transfer. Review of hospital emergency room records revealed that EMS (emergency medical services) ambulance reported to the hospital that they administered oral glucagon to the Resident, and after administration, the Resident's blood sugar was now 78, at the time of transfer. Further review of the hospital record revealed that at 7:16 p.m., on 6-20-17 the Resident's blood sugar had again dropped to 46, and by 11:00 p.m. it had gone up to 79, after intravenous (IV) Dextrose 10% 1000 ml (milliliters) was given and Dextrose 5% 1000 ml to include sodium chloride and potassium chloride was given. The Resident was admitted to the hospital and remained for 7 days, until 6-26-17, when she was returned to the facility. Interviews were conducted on 9-19-17, and 9-20-17 with the Administrator and Director of Nursing (DON) with regard to this situation. They	F 225		

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F 225	Continued From page 20 stated that the Resident had received 18 units of regular rapid acting (Humalog) insulin at 9:00 a.m., on 6-20-17, instead of the (Humulin N) Isophane long acting insulin, which was ordered to be given at that time. Prior to the administration of the wrong insulin, the Resident's blood sugar at 6:00 a.m., was 82. Review of physician's orders and the Medication Administration Record (MAR) revealed that the Resident was ordered to have, and receiving the following 2 types of insulin; 1. Humulin (N) inject 18 units subcutaneously every 12 hours for diabetes at 9:00 a.m., and 9:00 p.m. 2. Humalog (lispro) inject as per sliding scale every 6 hours; at 12 midnight, 6:00 a.m., 12:00 noon, 6:00 p.m. if blood sugar 351 to 400 give 20 units subcutaneously, if 401 to 450 give 25 units, if 451 to 500 give 30 units, if 501 to 502 give 35 units and call doctor. If blood sugar less than 60 or greater than 501 call doctor. The Administrator and DON went on to say that the nurse who had given the wrong insulin had not realized the error until another nurse saw the Resident and asked what the medication nurse had given to the Resident. The medication nurse showed the second nurse the vial of regular insulin and the second nurse reported the error. The nurse who made the error was terminated. At the time of the incident, the administrator was not the same individual acting as administrator at the time of survey.	F 225		

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F 225	Continued From page 21 Facility policy was reviewed, and revealed that all current standards and requirements were in place in the documents. The previous Administrator sent a "Facility Reported Incident" (FRI) to the state agency on Wednesday 6-21-17, and a follow up report on Tuesday 6-27-17. Both were late. The Resident was admitted to the hospital on Tuesday 6-20-17 for hypoglycemia, and the initial report should have occurred (within 2 hours of hospitalization) the same day. The follow up 5 day report should have occurred no later than 6-26-17, the 5th business day. The investigation showed no realization that the same orders which produced the error were reinstituted when the Resident returned from the hospital. The Humulin N (long acting) insulin was finally decreased, and administration time changed on 7-1-17, 5 days after the Resident returned, and the Regular humalog sliding scale insulin was continued as before. No re-education of staff was included in the investigation packet reviewed by surveyors, and was not provided by administration as evidence of re-training. In conclusion, the investigation, reporting, and education for this incident were not completed as required by federal mandate. The Administrator and DON (Director of Nursing) were made aware of the deficient practices at the end of day debriefs on 9-19-17, 9-20-17, and 9-21-17. No further information was presented by the facility. 4. For Resident #8, the facility staff failed to report to the state agency timely, of a fracture of unknown origin.	F 225		

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F 225	Continued From page 22 Resident #8 was admitted to the facility on 10-19-07 with diagnoses that included; Diabetes, psychosis, Hypertension, hypokalemia, high cholesterol, anemia, vitamin d deficiency, congestive heart failure, osteo-arthritis, anorexia, Alzheimers disease, and history of urinary tract infections. Resident #8's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7-6-17 was coded as a significant change assessment. Resident #8 was coded as having memory loss, and severe cognitive loss. Resident #8 was coded as requiring extensive assistance to total dependence on one to two staff members for all ADL's (activities of daily living), with the exception of eating, which only required set up for her to eat independently. The Resident was coded as always incontinent of bowel and bladder elimination. On 9-19-17 a thorough review of the resident's clinical record was conducted. Nursing progress notes were reviewed and revealed that on Tuesday 6-27-17 at 1:21 p.m. the Resident's"MD (doctor) was made aware of swelling to right hand. Order received to obtain a two viewed x-ray of Resident's right hand." The notes go on to say the Resident was guarding the hand because of pain, and exhibited facial grimacing as well. No description was given as to how the serious injury occurred. The X-ray was completed and resulted on 6-27-17 and signed by the Radiologist at 2:43 p.m. on that day. The diagnosis was "Acute fracture of the fourth metacarpal probably in satisfactory position." This revealed a fractured	F 225		

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F 225	Continued From page 23 hand (broken bone in the hand). The facility did not report the injury (fracture) of unknown origin to the state agency until Wednesday 6-28-17, and the report should have been within 2 hours of the identification of the fracture. The 5 day follow up report of investigation was not submitted to the state agency until 7-5-17 (7 business days), and also late. In conclusion, the reporting for this incident was not completed as required by federal mandate. The Administrator and DON were made aware of the deficient practice at the end of day debriefs on 9-19-17, 9-20-17, and 9-21-17. No further information was presented by the facility.	F 225		
F 226 SS=E	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation	F 226	F 226 1. Resident #2's investigation was reinvestigated on 10/09/2017. Resident #4's roommate was interviewed on 09/20/2017. Resident #7's investigation was reported on 06/20/2017. Resident #8's investigation was reported on 06/28/2017. 2. Facility reported incidents from September 2017 were reviewed to ensure timely completion, thorough investigations, and timely reporting to reporting agencies occurred by DON/Administrator/ designee on 10/05/2017.	

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F 226	Continued From page 24 requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed for 4 residents (Residents #4, #2, #7, #8) in the survey sample of 23 residents, to operationalize their abuse policies. 1. For Resident #4, the facility staff failed to operationalize abuse policies in a timely manner. The facility staff waited almost three months to suspend and thoroughly investigate a CNA involved in an improper transfer, that resulted in a leg fracture. 2. For Resident # 2, the facility staff failed to operationalize the abuse policies regarding investigation and timely reporting of injuries of unknown origin. 3. For Resident #7, the facility staff failed to operationalize (put into practice) their policies in regard to investigating, educating, and timely reporting to agencies of serious injury concerning	F 226	3. Facility staff will be educated on the need to immediately report incidents/ suspicion of abuse to supervisor by Administrator/ designee on or before 11/03/2017. 4. Facility reported incidents will be reviewed timely and reported as they occur per abuse policy. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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F 226	Continued From page 25 incident of an insulin medication error. 4. For Resident #8, the facility staff failed to operationalize (put into practice) their policies in regard to investigating, educating, and timely reporting to agencies of serious injury of a fracture of unknown origin. The Findings included: Resident #4 was an 88 year old who was admitted to the facility on 2/22/06. Resident #4's diagnoses included Proximal Tibia Displaced Metaphyseal and Impacted Plateau Fractures (crushed bone), Muscle Weakness-Generalized, Age-Related Osteoporosis, Schizophrenia, Psychotic Disorder, Hypertension, and Alzheimer's Disease. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 6/7/17, coded Resident #4 as having a Brief Interview of Mental Status Score of 7 - indicating severely impaired cognition. For transfers, she was coded as requiring the extensive physical assistance of two persons. In the area of functional limitation in range of motion, she was coded as having lower extremity impairment on both sides. Her mobility device was a manual wheelchair. On 9/19/17 a review was conducted of facility documentation, revealing Resident #4's Care Plan, which read, "Initiated 3/9/10. Revised 7/18/17. I am at risk for and have had an actual fall related to: Cognitive impairment with decreased safety awareness. I am easily distracted and have poor insight/judgement. I am	F 226		

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incontinent and I am dependent for ADLs (Activities of Daily Living). Assist resident with all transfers." The Care Plan had not been revised to include the requirement of the extensive physical assistance of two persons for transfers.

On 9/19/17 a 8:30 A.M., an observation was conducted of Resident #4, who was in her bed. When asked about how her leg was feeling, Resident #4 smiled and appeared to be confused. Suddenly, her roommate who was identified and put into the sample as Resident #1, made an unsolicited statement. She said, "One of the aides named Carolyn (CNA A) came in here by herself and dropped her on the floor while putting her in her wheelchair. She slipped out of her hands and fell on the floor. She broke her leg and went to the hospital. She came back here with a leg brace on, and had it on for a month and a half." Resident #1's Brief Interview of Mental Status Score was 14, indicating no cognitive impairment.

Resident #4's clinical record contained the following x-ray report, "6/28/17 10:23 A.M. Findings: Four views of the left knee. Proximal tibia displaced metaphyseal and impacted plateau fractures, are partially obscured by severe tricompartmental osteoarthritis with large osteophytes and loss of joint space. Effusion.

On 9/19/17 a review of facility documentation was conducted, revealing a Facility Reported Incident on 6/29/17. It read, "Injury of Unknown Origin. Resident assessment revealed left tibia plateau fracture. Documents reveal resident had a fall on 6/25/17. Investigation pending." On 7/3/17, the facility follow-up read, "Upon investigation, June 25, 2017, (CNA A - Certified Nursing Assistant)

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transferred (Resident #4) from the bed to the wheelchair." According to the report, only one staff member conducted the transfer instead of two.

CNA A's signed statement (dated 6/25/17) read, "I set her down in the chair. I walked away. I heard a noise. I turned around I saw resident body in front of wheelchair Resident butt was on the floor in between the leg rest. The leg rest was extended. Resident left leg was under her butt." This incident occurred during the day shift a 7:50 A.M.

The clinical record contained the following Nursing Progress Note, "6/25/17/ 10:51 P.M. Resident resting in bed, respirations unlabored, lung fields clear, no coughing or congestion noted. No dizzy spells noted. Bed in lowest position, call bell in reach. Staff monitoring Q 2 hours." For the next three days, until 6/28/17 there was no further post-fall monitoring (7 continuous shifts).

On 6/28/17 the Nursing Progress Note read, " Vital signs 99.2-90-22-138/86-96%. Resident noted with edema to left knee and lower leg bruising present to lower leg. Resident C/O (complains of) pain when touched, will not allow CNA to dress her. Resident medicated for pain Tylenol Tabs 2 PO (by mouth) for left leg pain. DR made aware STAT x-ray of left FIB TIB and left knee (left lower leg)." Resident #4 was admitted to the hospital at 7:00 A.M. and returned to the facility at 6:45 P.M. New orders for pain medication, use of knee immobilizer, and no weight bearing to left leg were given by the resident's MD at the facility. The nursing Progress noted read, "SRMC (hospital) called report. No

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F 226	Continued From page 28 surgery indicated at this time because its to extensive. Keep knee immobilizer in place." On 9/19/17 at 4:05 P.M., an interview was conducted with CNA A in the conference room. The Director of Nursing, who had conducted the investigation, was present. When asked why she transferred Resident #4 without the assistance of another staff member, CNA A stated, "The way I was trained the person demonstrated that the resident needed only 1 person for transfers. When CNA A was informed that Resident #1 witnessed the fall, she admitted that Resident #1 was in the room, but said that "the curtain was pulled." There was no documentation that the curtain had been pulled. When the Director of Nursing was asked why Resident #1 wasn't interviewed regarding the fall, she stated, "Because I didn't know that she was in the room and I didn't ask." On 9/19/17 at 5:00 P.M. the facility Administrator (Administration A) was notified of the findings. On 9/20/17 the Administrator submitted following _____ Plan of Correction; "Findings: Facility failed to properly investigate two injuries of unknown origins. The facility failed to interview all potential witnesses. Resident: (#4) Fell on 6/25/17, and on 6/28/17 diagnosed with a left knee fracture. Resident: (#2) Diagnosed with a fracture of unknown origin. 100% of residents with high risk for injuries related to falls were reviewed to ensure proper transfers were being performed." The Plan of Correction also stated that all facility	F 226		

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F 226	Continued From page 29 residents were assessed for proper transfer techniques and initiated on 9/19/17. Nursing staff were in-serviced. In addition, On 9/20/17, CNA A had been suspended pending investigation, and had subsequently resigned. The Plan also stated that all department heads were in-serviced on the proper way to complete an investigation. The Administrator submitted an Abuse, Neglect and Exploitation Policy dated 5/1/17. It read, "After completing the statement (s), the employee(s) will be asked to vacate the facility until further investigation of the incident is completed." 2. For Resident # 2, the facility staff failed to operationalize the abuse policies regarding investigation and timely reporting of injuries of unknown origin. Resident #2, a female, was admitted to the facility on 3/2/2012. Her diagnoses included but were not limited to: Major Depressive Disorder with severe Psychotic Symptoms, Pseudobulbar Affect, Cardiac Pacemaker, Anemia, Acute embolism and thrombosis. Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/3/2017 was coded as a Quarterly assessment. She was coded as having short and long term memory deficits, severe cognitive impairments. She was also coded as needing extensive to total assistance of one person to perform all of her activities of daily living with the exception of transfers. For transfers, she was coded as needing total assistance of two staff members. She was coded as always incontinent of bowel and bladder.	F 226		

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F 226	Continued From page 30 Review of Resident # 2's clinical record revealed nursing note entries: "8/9/2017 17:15 (5:15 p.m.) "Called to room by CNA (Certified Nursing Assistant) ____. Stated Res.(Resident) right hand was swollen and Res. was guarding and protecting her right hand. Upon assessment res. noted alert and verbally responsive, right hand at wrist area warm to touch, bruising to hand and forearm edema to hand. Res. pulls away when assessment performed, right hand elevated on pillow res. medicated for pain. Physician notified orders received continue to observe." Documentation revealed that on 8/9/2017 at 5:30 p.m., the clinician ordered an X-ray of Resident # 2's right hand. The X-ray was obtained 8/10/2017 at 2:15 a.m. and at 4:40 a.m., the report returned showing Resident #2 was determined to have a "spiral fracture of the distal third of the ulna." The physician was notified and ordered for Resident #2 to be evaluated by the hospital Emergency Room. Resident # 2 was transported to the Emergency Room at 5:18 a.m. The facility began an investigation into the injury of unknown origin, her fractured ulna. Review of the investigation revealed there were no witness statements from the LPNs who worked 8/8/2017 on 7-3 shift, 8/8/2017 on 3-11 shift, 8/9/2017 on 7-3 shift, 8/9/2017 on 3-11 shift. There were no witness statements from CNAs who worked 8/8/17 on 3-11 shift, and 8/8/2017 on 11-7 shift. The handwritten note presented as a witness statement from RN A did not name the resident and was not dated. The note included statements	F 226		

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of " On Tuesday night, I worked with the resident. On the last round the CNA report a discoloration. I assessed the right hand and did not see anything, just the discoloration. hand moved without difficulties. no s/s (signs and symptoms of discomfort noted at that time. Resident did not get up on 11-7 shift." There was no documentation in the nurses notes of this concern and assessment. There was no Witness statement from the CNA on 11-7 shift on 8/8/17 who reported this discoloration to RN A.

An interview was conducted with the DON who stated an investigation of the injury of unknown origin had been conducted and the facility was unable to substantiate abuse. When asked why there were no statements from the LPN who initially assessed the right arm on 8/9/2017 and other staff members assigned to work with Resident # 2, the DON stated the LPN wrote a nurses note. The DON was asked to provide all documentation of the investigation of the injury of unknown origin.

On 9/19/2017 at 4:02 p.m., the CNA F was interviewed by the surveyor in the presence of the Director of Nursing and three other surveyors in the facility conference room. CNA F stated she remembered taking care of Resident # 2 on 8/9/2017 during the day shift. CNA F stated she put Resident # 2 to bed at the end of the shift by herself. CNA F stated Resident # 2 did not have any problems or swelling noted on her right arm when she last saw her. CNA F stated she was trained to transfer Resident # 2 using one person because of her size. CNA F stated Resident # 2 was small and could be transferred by one person. CNA F stated she did not know the MDS

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F 226	Continued From page 32 coded Resident # 2 has needing 2 staff persons to transfer. CNA F stated she did not know what was written on the CNA Kardex. CNA F again stated she had taken care of Resident# 2 and was trained to transfer the resident by herself. Review of the clinical record revealed the injury of unknown origin was discovered on 8/9/2017 at 5:15 PM. Review of the Intake Information Form from the State Agency showed the Director of Nursing contacted the State Agency on 8/10/2017 at 8:29 AM via telephone. Review of the Facility Reported Incident sent to the State Agency on 8/10/2017 revealed the form was faxed in the State Agency on 8/10/2017 at 5:32 PM by the previous administrator. A thorough review of the investigation done at the time revealed no information regarding how the injury of unknown origin might have happened. There was no documentation that Resident #2 had sustained a fall or any other incident. The investigation did indicate the CNA had transferred Resident #2 from her wheelchair back to bed by herself. Review of the nursing notes revealed no other injuries, falls, or unusual occurrences had occurred in the time period just before the identification of the fracture of the ulna. The investigation was not thorough. The facility staff failed to interview all potential witnesses. The facility notified the State Agency of the Injury of Unknown Origin (a fractured ulna) on 8/10/2017 at 8:29 AM and submitted a Fri on 8/10/2017 at 5:32 PM. On 9/19/2017 at 5 p.m., the administrator and DON were informed of the failure of the staff to thoroughly investigate the injury of unknown	F 226		

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F 226	Continued From page 33 origin, interview all potential witnesses and failed to report timely to the State Agency. The Director of Nursing stated the staff immediately removed the side rails because it was thought that Resident # 2 might have caught her arm in the rail. The Director of Nursing also stated Resident # 2 liked to bang her arms on the rails too. The Administrator stated Serious Injuries must be reported to the State Agency within no more than 2 hours of discovery. The Administrator also stated a thorough investigation should have been completed at the time of the discovery of the injury of unknown origin and that another investigation was currently being conducted. A copy of a Physician's progress note dated 8/14/2017 was also presented and revealed documentation stating "pt had ulnar shaft fracture (right). Seen by orthopedics. No fall. Pt likely got hurt with side railing. Seen by Orthopedics, soft cast was place, now railing removed." Review of the nurses' notes, and care plan revealed was no documentation of side rails being used and no documentation of use of padding on the side rails if Resident # 2 had a history of banging her arms on the rails. Review of the Investigation Planning Tool revealed documentation on Page 2 Under "Other Potentially Affected Residents (identify any residents who may have been affected, use the Abuse QIS (Quality Indicator Survey) questions for the interview able residents and do a skin observation on non-interview able residents to attach documentation)": In-service on abuse attach, skin sweep attach, Abuse question "ask	F 226		

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F 226	Continued From page 34 do you feel safe" attach. Review of the Midnight Census Report for 8/9/2017 Attachment revealed documentation of responses to the Question: Do You Feel Safe? asked of the residents on Wing 1. There were five answers of n/a (not applicable) and the word "out" was written next to one resident's name. The Census showed 56 occupied beds, 4 empty beds but one resident's name had been handwritten in one room on Wing 1, indicating a total census of 57 residents on Wing 1. There was no answer written for 28 residents. The documentation of the question, Do you feel safe? being asked of residents on Wing 2 revealed there were 51 occupied beds and 9 empty beds on Wing 2 on the Census on 8/9/2017. 40 residents replied yes, 3 were listed as discharged, 2 were in the hospital and one was listed as "n/a" On Page 4 revealed statements: "Base on interview with Staff (Resident # 2) had side rail place on her bed and an order for Geri sleeves. On August 9, 2017 7-3 shift CNA_____place (Resident name) in her bed with the Geri sleeves in place and she put her side rails up. On 3-11 shift _____CNA noted Resident name side rails in place and up however her Geri sleeves were off and lying in her bed. (Resident # 2) may have struck her right arm on the half side rail which could have cause the displace oblique fracture to her right ulna. Resident # 2 x-ray reveal osteopenia. Side rails have been removed at this time. The facility conducted interviews with alert and oriented residents-no negative findings were found. Skin sweeps were performed with no negative findings. Base on the interview of staff, x-ray report and Physician progress note we are unable to substantiate abuse."	F 226		

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F 226	Continued From page 35 On 9/20/2017, the survey team was informed that CNA F was suspended by the facility administration and subsequently resigned on that same day during the survey. Review of the Facility Policy on Abuse, Neglect and Exploitation on Page 2 of 23, Effective 5/1/2017 revealed statements "For the purpose of this policy, immediately is to be interpreted "as soon as possible, but no more than two hours after the alleged incident of abuse or serious bodily injury is discovered and within 24 hours for all other allegations" Under "Injury of Unknown Origin: an injury should be classified as an injury of unknown origin when both of the following conditions are met: a) the source of the injury was not observed by any person. ** The rest of the definition for Injury of Unknown Origin was missing from the document. On the next page other definitions continued with "involuntary seclusion." The copy of the Abuse policy given to the surveyors only included 3 pages (pages 1, 2 and 3 of 23). The top of the document stated there were 23 pages to the policy. The other 20 pages were not presented to the surveyor. On 9/20/2017 during the end of day debriefing, the facility Administrator and Director of Nursing were informed of the findings. The Administrator again stated Serious Injuries must be reported to the State Agency within no more than 2 hours of discovery. The Administrator also stated a thorough investigation should have been completed at the time of the discovery of the injury of unknown origin and that another investigation was currently being conducted.	F 226		

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F 226	Continued From page 36 No further information was provided. 3. For Resident #7, the facility staff failed to operationalize (put into practice) their policies in regard to investigating, educating, and timely reporting to agencies of serious injury concerning incident of an insulin medication error. Resident #7 was admitted to the facility on 6-22-16 with diagnoses that included; Diabetes, chronic kidney disease, Hypertension, hyperkalemia, seizures, hyponatremia, gout, peripheral vascular disease, history of urinary tract infections, history of clostridium difficile, history of sacral pressure ulcer with infection, and dermatitis. Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7-3-17 was coded as a significant change assessment. Resident #7 was coded as having memory loss, and severe cognitive loss. Resident #7 was coded as requiring extensive assistance to total dependence on one to two staff members for all ADL's (activities of daily living), and always incontinent of bowel with a Foley urinary catheter for bladder elimination. On 9-19-17 a thorough review of the resident's clinical record was conducted. Nursing progress notes were reviewed and revealed that on 6-20-17 at 12:55 p.m. the Resident was "cold/clammy/diaphoretic with blood sugar of 31." On 6-20-17 at 5:25 p.m., the Resident was sent to the hospital via 911 to the emergency room (ER) for evaluation of hypoglycemia, and facility staff documented in the nursing notes that the Resident's blood sugar was	F 226		

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F 226	Continued From page 37 116 milligrams/deciliter at the time of transfer. Review of hospital emergency room records revealed that EMS (emergency medical services) ambulance reported to the hospital that they administered oral glucagon to the Resident, and after administration, the Resident's blood sugar was now 78, at the time of transfer. Further review of the hospital record revealed that at 7:16 p.m., on 6-20-17 the Resident's blood sugar had again dropped to 46, and by 11:00 p.m. it had gone up to 79, after intravenous (IV) Dextrose 10% 1000 ml (milliliters) was given and Dextrose 5% 1000 ml to include sodium chloride and potassium chloride was given. The Resident was admitted to the hospital and remained for 7 days, until 6-26-17, when she was returned to the facility. Interviews were conducted on 9-19-17, and 9-20-17 with the Administrator and Director of Nursing (DON) with regard to this situation. They stated that the Resident had received 18 units of regular rapid acting (Humalog) insulin at 9:00 a.m., on 6-20-17, instead of the (Humulin N) Isophane long acting insulin, which was ordered to be given at that time. The Administrator and DON went on to say that the nurse who had given the wrong insulin had not realized the error until another nurse saw the Resident and asked what the medication nurse had given to the Resident. The medication nurse showed the second nurse the vial of regular insulin and the second nurse reported the error. The nurse who made the error was terminated. At the time of the incident, the administrator was not the same individual acting as administrator at the time of survey.	F 226		

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F 226	Continued From page 38 Facility policy was reviewed, and revealed that all current standards and requirements were in place in the documents. The previous Administrator sent a "Facility Reported Incident" (FRI) to the state agency on Wednesday 6-21-17, and a follow up report on Tuesday 6-27-17. Both were late. The Resident was admitted to the hospital on Tuesday 6-20-17 for hypoglycemia, and the initial report should have occurred (within 2 hours of hospitalization) the same day. The follow up 5 day report should have occurred no later than 6-26-17, the 5th business day. The investigation showed no realization that the same orders which produced the error were reinstituted when the Resident returned from the hospital. The Humulin N (long acting) insulin was finally decreased, and administration time changed on 7-1-17, 5 days after the Resident returned, and the Regular humalog sliding scale insulin was continued as before. No re-education of staff was included in the investigation packet reviewed by surveyors, and was not provided by administration as evidence of re-training. The Administrator and DON were made aware of the deficient practices at the end of day debriefs on 9-19-17, 9-20-17, and 9-21-17. No further information was presented by the facility. 4. For Resident #8, the facility staff failed to operationalize (put into practice) their policies in regard to investigating, educating, and timely reporting to agencies of serious injury of a fracture of unknown origin.	F 226		

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Resident #8 was admitted to the facility on 10-19-07 with diagnoses that included; Diabetes, psychosis, Hypertension, hypokalemia, high cholesterol, anemia, vitamin d deficiency, congestive heart failure, osteo-arthritis, anorexia, Alzheimer disease, and history of urinary tract infections.

Resident #8's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7-6-17 was coded as a significant change assessment. Resident #8 was coded as having memory loss, and severe cognitive loss. Resident #8 was coded as requiring extensive assistance to total dependence on one to two staff members for all ADL's (activities of daily living), with the exception of eating, which only required set up for her to eat independently. The Resident was coded as always incontinent of bowel and bladder elimination.

On 9-19-17 a thorough review of the resident's clinical record was conducted. Nursing progress notes were reviewed and revealed that on Tuesday 6-27-17 at 1:21 p.m. the Resident's"MD (doctor) was made aware of swelling to right hand. Order received to obtain a two viewed x-ray of Resident's right hand." The notes go on to say the Resident was guarding the hand because of pain, and exhibited facial grimacing as well. No description was given as to how the serious injury occurred.

The X-ray was completed and resulted on 6-27-17 and signed by the Radiologist at 2:43 p.m. on that day. The diagnosis was "Acute fracture of the fourth metacarpal probably in

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F 226	Continued From page 40 satisfactory position." This revealed a fractured hand (broken bone in the hand). The facility did not report the injury (fracture) of unknown origin to the state agency until Wednesday 6-28-17, and the report should have been within 2 hours of the identification of the fracture by federal law. The 5 day follow up report of investigation was not submitted to the state agency until 7-5-17 (7 business days), and also late. The Administrator and DON were made aware of the deficient practice at the end of day debriefs on 9-19-17, 9-20-17, and 9-21-17. No further information was presented by the facility.	F 226		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide a dignified living experience for 1 resident (Resident #23) in the survey sample of 23 residents. The facility staff declined to honor toileting, and incontinence care requests. The Findings included:	F 241	F 241 1. Resident #23 was interviewed regarding her concerns related to incontinence/ toiletting on 09/21/2017 by the Administrator. A facility reported incident was initiated on 09/21/2017 for resident #23's concerns. 2. Current residents had a bowel and bladder screener completed to ensure they received proper incontinence and toileting	

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F 241	Continued From page 41 Resident #23 was a 77 year old who was admitted to the facility on 7/23/16. Resident #23's diagnoses included Irritable Bowel Syndrome with Diarrhea, Overactive Bladder, Pain in Unspecified Joint, and Muscle Weakness-Generalized. The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 7/27/17, coded Resident #23 as having a Brief Interview of Mental Status Score of 15, indicating intact cognition and independent decision-making ability. Resident #23 was coded as requiring the extensive assistance of 1 person for transfers. She was coded as having an impairment of both lower extremities, and as being frequently incontinent of bowel and bladder. Resident #23 required a wheelchair with the physical assistance of 1 person for locomotion. On 9/21/17 at 10:42 A.M., Resident #23 stated to the Surveyor, Administrator (Administrator/Executive Director (ED)/Administration A), and Director of Nursing (DON Administration B) that she had been verbally abused by 2 staff members. She stated that her evening shift aide (Certified Nursing Assistant 3-11 P.M.) no longer treated her with respect, and that her attitude toward her had changed. Resident #23 stated that the aide would be angry with her and refuse to assist her with incontinence care and toileting. Resident #23 also stated that her day shift aide was always rude to her and refused to toilet her. Resident #23 stated, "They make me put on my own diaper. I can't stand up. My legs hurt. They take a long time to answer the call bell, then they put me in my wheelchair and run out of the room when I ask to help me go to the bathroom. They make me use	F 241	care by UM/ designee on 10/03/2017. Current residents kardexs' were updated as of 10/04/2017 by UM/designee. 3. Staff will be educated on resident rights and dignity when providing incontinent care/ toiletting by ADON/ designee on or before 11/03/2017. 4. A weekly audit of 5 residents will be completed by UM/designee of CNAs performing incontinent care times twelve weeks to ensure dignified incontinent care/ toileting is being provided. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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F 241	Continued From page 42 a diaper, which I can't pull up." On 9/19/17 a Group Interview was conducted with 8 residents. Two of the residents stated that the facility staff were not providing them with incontinence care on a consistent basis. On 9/21/17 a review was conducted of Resident #23's clinical record. Resident #23's Care Plan read, "Self-care impairment. Toileting and transfer assistance as needed. Pain Management. Chronic bilateral knee pain. On 9/21/17 at 12:45 P.M., the facility Administrator submitted the following written statement: "9/21/17. In regards to (Resident #23) interview on 9/21/17 at 10:42 A.M. Facility ED/DON will thoroughly investigate concerns for (Resident #23) brought in regards to 2 staff members (CNAs)."	F 241		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by:	F 274	F 274 1. Resident #2 had significant change MDS completed on 10/03/2017. Resident #3 had a significant change MDS completed on 10/02/2017. 2. Current residents with an ARD between September 1st through September 20th 2017 Section G of the ADLs were audited to ensure any significant changes were captured by MDS coordinator/ designee on 10/04/2017.	

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F 274	Continued From page 43 Based on staff interview, clinical record review and facility documentation review, the facility staff failed to complete a SCSA (significant change in status assessment) within 14 days after determination of a change in status for 2 Residents (Residents #2 and # 3) in the survey sample of 23 residents. 1. For Resident #2, the facility staff failed to assess the Resident for a significant change in condition after the Resident's functional status in transferring, dressing, and toileting changed and declined from extensively dependent on staff to totally dependent on staff between May and August 2017. 2. Resident #3, had significant improvements between April and July 2017 in the areas of bed mobility, transfer, locomotion, toilet use, personal hygiene, and bathing however, the facility staff failed to complete a significant change MDS after the improved activities of daily living (ADL's) were identified. Findings included: 1. For Resident #2, the facility staff failed to assess the Resident for a significant change in condition after the Resident's functional status in transferring, dressing, and toileting changed and declined from extensively dependent on staff to totally dependent on staff between May and August 2017. Resident #2, a female, was admitted to the facility on 3/2/2012. Her diagnoses included but were not limited to: Major Depressive Disorder with severe Psychotic Symptoms, Pseudobulbar Affect, Cardiac Pacemaker, Anemia, Acute	F 274	3. MDS coordinators will be educated by the Administrator/ designee on requirements for significant MDS changes. 4. A weekly audit of section G of the MDS (that have been completed that week) will be conducted to ensure significant changes are captured in regards to ADLs times twelve weeks by the MDS coordinator/ designee. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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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 274	Continued From page 44 embolism and thrombosis. Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/3/2017 was coded as a Quarterly assessment. She was unable to be coded with a Brief interview for mental status (BIMS), indicating severe cognitive impairment. She was coded as needing extensive to total assistance of one person to perform all of her activities of daily living with the exception of transfers. For transfers, she was coded as needing total assistance of two staff members. She was coded as always incontinent of bowel and bladder. The most recent MDS with an ARD of 8/3/2017 was compared to the previous Quarterly Assessment with an ARD of 5/5/2017. The changes experienced by Resident # 2 between these two assessments follow below: The 5/5/2017 Quarterly assessment revealed Resident #2 was coded as requiring extensive assistance in (ADL's) activities of daily living, with transferring, dressing, and toileting. The Resident was coded as always incontinent of bowel and bladder. The 8-3-17 Quarterly assessment revealed Resident #2 was coded with no cognitive impairment. The Resident was coded as totally dependent on staff for (ADL's) activities of daily living, with transferring, dressing, and toileting. The Resident was coded as frequently incontinent of bowel and bladder. Review of these documents revealed significant changes in transferring, dressing and toileting, after the 5/5/2017 MDS assessment and	F 274		

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	495144	A. BUILDING _____ B. WING _____	09/21/2017

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F 274	Continued From page 45 continued through the 8/3/2017 MDS assessment without a significant change assessment being completed. Guidance was provided in "Long Term Care Resident Assessment Instrument User's Manual V 3.0, May 2013, p. 2-15: Significant Change in Status (SCSA) (Comprehensive) A0310A= 04 14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days) Z0400B=14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)" On 9/21/2017 at 12:00 PM, RN (Registered Nurse) (A) responsible for MDS documentation in the facility was made aware of the need for a significant change assessment. She stated a correction would be sent to CMS (Centers for Medicare & Medicaid Services). On 9/21/2017 at the end of the day debrief the Administrator and DON (director of nursing) were notified of findings. No further documentation was provided. 2. Resident #3, had significant improvements between April and July 2017 in the areas of bed mobility, transfer, locomotion, toilet use, personal hygiene, and bathing however, the facility staff failed to complete a significant change MDS after	F 274		

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F 274	Continued From page 46 the improved activities of daily living (ADL's) were identified. Resident #3 was admitted to the facility on 4/4/16 with the diagnoses of, but not limited to, chronic kidney disease stage III, diabetes mellitus, chronic pain, hypertension, and cerebrovascular disease with left sided weakness. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 8/2/17. The MDS coded Resident #3 with no cognitive impairment; required limited assistance from staff for bed mobility, transfers, dressing, toileting, hygiene, and bathing. On 9/18/17 at 2:25 p.m., Resident #3 was observed sitting in a wheelchair, in his room watching television. He was alert and conversational. Resident #3 stated during resident interview that the staff help him when needed but he does "a lot by myself." On 9/19/17 at 10:00 a.m. Resident #3's clinical record was reviewed. The review revealed an annual MDS with an ARD of 4/11/17 and a quarterly MDS with an ARD of 7/12/17. Section G-Functional Status coded section G0110 Activities of Daily Living (ADL) Assistance Self-Performance as follows: ARD 4/11/17: Bed mobility=3 (Extensive assistance required from staff), Transfer=3, Locomotion on and off unit=3, Dressing=3, Toilet use=3,	F 274		

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F 274	Continued From page 47 Personal hygiene=3, Bathing=3, and Section H Bladder and Bowel-Bowel Continence=3 (Always incontinent). ARD 7/12/17: Bed mobility=2 (Limited assistance required from staff), Transfer=2, Locomotion on and off unit=1 (Supervision), Dressing=3, Toilet use=2, Personal hygiene=2, Bathing=2, Section H Bladder and Bowel-Bowel Continence=0 (Always continent). As guided by the MDS manual, a Significant Change MDS includes a change of decline or improvement in 2 or more areas which include Section G and Section H. On 9/19/17 at 1:30 p.m. and 2:45 p.m. an interview was conducted with the MDS nurse, Registered Nurse-A (RN-A). The question of why a significant change MDS wasn't done was asked and a review of the areas of change were discussed. RN-A was not the staff member who completed the prior assessments. On 9/19/17 at 3:50 p.m. RN-A stated "As MDS I would have done a significant change MDS. I'm doing one now." The Administrator and Director of Nursing were informed of the failure to complete a significant change MDS. No further information was	F 274		

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F 274	Continued From page 48 provided by the facility staff.	F 274		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs.	F 280	F 280 Careplan Revision 1. Resident #4 careplan was revised to include extensive physical assist of two persons on 09/20/2017 by Unit Manager/ designee. Resident #2's careplan was revised to ensure her falls from August & September 2017 were in careplan 10/09/2017 by Unit Manager/ designee. 2. Current resident's careplans were reviewed to ensure physical assistance and falls (from September 2017) have been updated in their careplans on 10/09/2017 by UM/ designee. 3. Licensed nursing staff will be educated on careplan revision by DON/ Designee on or before 11/03/2017. 4. Weekly audits of residents' careplans will be completed to ensure revisions for physical assistance and falls have been completed times twelve by the Unit Manager/ DON/ Designee. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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F 280	Continued From page 49 (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (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	F 280		

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F 280	Continued From page 50 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed, for 2 residents (Residents #4, #2) in the survey sample of 23 residents, to review and revise the care plan. 1. For Resident #4, the facility staff failed to update the care plan to include the requirement for the extensive physical assistance of two staff persons for transfers. 2. For Resident #2, the facility staff failed to revise the care plan after each fall or incident. The Findings included: Resident #4 was an 88 year old who was admitted to the facility on 2/22/06. Resident #4's diagnoses included Proximal Tibia Displaced Metaphyseal and Impacted Plateau Fractures (crushed bone), Muscle Weakness-Generalized, Age-Related Osteoporosis, Schizophrenia, Psychotic Disorder, Hypertension, and Alzheimer's Disease. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 6/7/17, coded Resident #4 as having a Brief Interview of Mental Status Score of 7 - indicating severely impaired cognition. For transfers, she was coded as requiring the extensive physical assistance of two persons. In the area of functional limitation in range of motion, she was coded as having lower extremity impairment on	F 280		

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F 280	Continued From page 51 both sides. Her mobility device was a manual wheelchair. On 9/19/17 a review was conducted of facility documentation, revealing Resident #4's Care Plan, which read, "Initiated 3/9/10. Revised 7/18/17. I am at risk for and have had an actual fall related to: Cognitive impairment with decreased safety awareness. I am easily distracted and have poor insight/judgement. I am incontinent and I am dependent for ADLs (Activities of Daily Living). Assist resident with all transfers." The Care Plan had not been revised to include the requirement of the extensive physical assistance of two persons for transfers. On 9/19/17 a 8:30 A.M., an observation was conducted of Resident #4, who was in her bed. When asked about how her leg was feeling, Resident #4 smiled and appeared to be confused. Suddenly, her roommate who was identified and put into the sample as Resident #1, made an unsolicited statement. She said, "One of the aides named Carolyn (CNA A) came in here by herself and dropped her on the floor while putting her in her wheelchair. She slipped out of her hands and fell on the floor. She broke her leg and went to the hospital. She came back here with a leg brace on, and had it on for a month and a half." Resident #1's Brief Interview of Mental Status Score was 14, indicating no cognitive impairment. Resident #4's clinical record contained the following x-ray report, "6/28/17 10:23 A.M. Findings: Four views of the left knee. Proximal tibia displaced metaphyseal and impacted plateau fractures, are partially obscured by severe tricompartmental osteoarthritis with large	F 280		

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F 280	Continued From page 52 osteophytes and loss of joint space. Effusion. On 9/19/17 a review of facility documentation was conducted, revealing a Facility Reported Incident on 6/29/17. It read, "Injury of Unknown Origin. Resident assessment revealed left tibia plateau fracture. Documents reveal resident had a fall on 6/25/17. Investigation pending." On 7/3/17, the facility follow-up read, "Upon investigation, June 25, 2017, (CNA A - Certified Nursing Assistant) transferred (Resident #4) from the bed to the wheelchair." According to the report, only one staff member conducted the transfer instead of two. CNA A's signed statement (dated 6/25/17) read, "I set her down in the chair. I walked away. I heard a noise. I turned around I saw resident body in front of wheelchair Resident butt was on the floor in between the leg rest. The leg rest was extended. Resident left leg was under her butt." This incident occurred during the day shift a 7:50 A.M. The clinical record contained the following Nursing Progress Note, "6/25/17/ 10:51 P.M. Resident resting in bed, respirations unlabored, lung fields clear, no coughing or congestion noted. No dizzy spells noted. Bed in lowest position, call bell in reach. Staff monitoring Q 2 hours." For the next three days, until 6/28/17 there was no further post-fall monitoring (7 continuous shifts). On 6/28/17 the Nursing Progress Note read, " Vital signs 99.2-90-22-138/86-96%. Resident noted with edema to left knee and lower leg bruising present to lower leg. Resident C/O (complains of) pain when touched, will not allow	F 280		

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F 280	Continued From page 53 CNA to dress her. Resident medicated for pain Tylenol Tabs 2 PO (by mouth) for left leg pain. DR (Doctor) made aware STAT x-ray of left FIB TIB and left knee (left lower leg)." Resident #4 was admitted to the hospital at 7:00 A.M. and returned to the facility at 6:45 P.M. New orders for pain medication, use of knee immobilizer, and no weight bearing to left leg were given by the resident's MD (medical doctor) at the facility. The nursing Progress noted read, "SRMC (hospital) called report. No surgery indicated at this time because its to extensive. Keep knee immobilizer in place." On 9/19/17 at 4:05 P.M., an interview was conducted with CNA A in the conference room. The Director of Nursing, who had conducted the investigation, was present. When asked why she transferred Resident #4 without the assistance of another staff member, CNA A stated, "The way I was trained the person demonstrated that the resident needed only 1 person for transfers. When CNA A was informed that Resident #1 witnessed the fall, she admitted that Resident #1 was in the room, but said that "the curtain was pulled." There was no documentation that the curtain had been pulled. When the Director of Nursing was asked why Resident #1 wasn't interviewed regarding the fall, she stated, "Because I didn't know that she was in the room and I didn't ask." The Director of Nursing was also asked why Resident #4's Care Plan had not been updated. She stated that she didn't have an answer. On 9/19/17 at 5:00 P.M. the facility Administrator (Administration A) was notified of the findings. On 9/20/17 the Administrator submitted following	F 280		

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F 280	Continued From page 54 _____ Plan of Correction; "Findings: Facility failed to properly investigate two injuries of unknown origins. The facility failed to interview all potential witnesses. Resident: (#4) Fell on 6/25/17, and on 6/28/17 diagnosed wit a left knee fracture. Resident: (#2) Diagnosed with a fracture of unknown origin. 100% of residents with hi risk for injuries related to falls were reviewed to ensure proper transfers were being performed." The Plan of Correction also stated that all facility residents were assessed for proper transfer techniques and initiated on 9/19/17. Nursing staff were in-serviced. In addition, CNA A had been suspended pending investigation, and had subsequently resigned. The Plan did not address updating the residents' Care Plans in a timely manner. The facility Administrator submitted a written note that read, "No policy on careplan revisions." 2. For Resident #2, the facility staff failed to revise the care plan after each fall or incident. Resident #2, a female, was admitted to the facility on 3/2/2012. Her diagnoses included but were not limited to: Major Depressive Disorder with severe Psychotic Symptoms, Pseudobulbar Affect, Cardiac Pacemaker, Anemia, Acute embolism and thrombosis. Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of	F 280		

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F 280	Continued From page 55 8/3/2017 was coded as a Quarterly assessment. She was coded as having short and long term memory deficits, severe cognitive impairments. She was also coded as needing extensive to total assistance of one person to perform all of her activities of daily living with the exception of transfers. For transfers, she was coded as needing total assistance of two staff members. She was coded as always incontinent of bowel and bladder. 7 incidents were documented in the Nurses Notes regarding falls. Documentation revealed Resident # 2 had 3 falls prior to the Injury of Unknown Origin on 8/9/2017 (3/13/2017, 3/28/2017 and 7/9/2017) and 3 falls since (8/23/2017, 8/28/2017 and 9/9/2017). There were no new interventions listed on the care plan after 4 of the falls. 3/13/2017 12:45 p.m.-Fall from wheelchair with staff attempting to redirect from door. Resident observed lying on the floor on her right side per dietary person. No apparent injury. RP notified. Investigation conducted: Dietary person stated Resident # 2 slid from the wheelchair when she reached out for the rail. She did not hit her head. No apparent injury. Care plan was not revised. Review of the Fall Investigation and Post Fall analysis for this fall revealed documentation that Resident # 2 slid out of the wheelchair. Possible cause was listed as "posture in W/C (wheelchair)" and recommendation was listed as "Dumping W/C". There was no new intervention listed on the care plan.	F 280		

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F 280	Continued From page 56 3/28/2017 at 11:57 a.m. Resident observed on the floor in front of her wheelchair. Left upper arm bruise. Physician and RP notified. No revision of care plan noted. Nurses notes written after the fall documented the bed was in a low position, but it is not written on the care plan as an intervention. 8/28/2017 10:20 a.m. Location: Hallway. Witnessed fall: Resident observed on floor on back by bottom hall of Wing One exit door. Reported by PT (Physical Therapy) Resident was pulling on bar on exit door and slipped from chair. Immediate Action taken: Resident assessed for injuries-slight redness to mid to lower back, no broken skin, PTA (Physical Therapy Assistant stated resident did not hit head. Scalp is intact, to redness bumps or bruising. Cast remains intact to right hand, cap (capillary) refills WNL (within normal limits.) Purple/yellowish bruising to hand prior to fall. ROM WNL to upper and lower extremities. Resident two person assist back into wheelchair. Physician notified 8/28/2017 at 11:17 a.m., RP notified 8/28/2017 at 5:17 p.m. Intervention: Dycem to Wheelchair recommended." This intervention was not listed on the Care plan. 9/9/2017 at 13:32 (1:32 p.m.) Location: Resident's room. Incident description: During rounds from staff, Resident was found on the floor on her right side. No injuries observed. Stated "Resident has mobility issues. She also has a prior right arm fracture." No revision of care plan was noted.	F 280		

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F 280	Continued From page 57	F 280		

The Director of Nursing was asked to provide a list of Falls/ Incidents from March 2017 to September 2017 along with interventions put in place after each incident. On 9/21/2017 at 8:15 a.m., a list was presented with 3 incidents listed as Fall without injury on 8/23/2017, 8/28/2017 and 9/9/2017. One incident dated 7/9/2017 was listed under "Found on Floor incidents". And the Injury of Unknown Origin Incident on 8/9/2017 was listed. The Director of Nursing stated those were the only incidents or falls of which she was aware. There was no documentation of the falls on 3/13/2017 and 3/28/2017 on the list presented to the surveyor. The list provided by the DON included handwritten interventions that were not listed on the care plan.

There were no revisions noted to the care plan after falls on 3/13/2017, 3/28/2017 and 8/28/2017 and 9/9/2017.

There was an extensive care plan revision on 8/11/2017 after the injury of unknown origin. New areas were added to the care plan to include Bone Fracture, Acute pain related to fracture of wrist and ADL (Activities of Daily Living Deficit) to include many interventions but not limited to: right arm splint, check capillary refill each shift, handle gently when moving or positioning. Maintain, body alignment, support injured area with pillows and immobilize part as appropriate.

The only other new revisions to the care plan related to falls since March 2017 were:

7/12/2017- Therapy for wheelchair positioning
8/24/2017-Bilateral floor mats at bedside while in

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F 280	Continued From page 58 bed Thorough review of the care plan also revealed no documentation of the intervention of use of side rails or half side rails for Resident # 2. There is no evidence of when the use of side rails was implemented, if there was an order or consent. During the end of day debriefing on 9/20/2017, the facility Administrator and Director of Nursing were made aware of the findings. No further information was provided.	F 280		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (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 resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility failed to follow the professional standards of practice for 5 residents (Residents #1, #16, #2, #14, and #6) in the survey sample of 23 residents. 1. For Resident #1, the facility staff failed to document physician ordered dressing changes. 2. For Resident #16, the facility staff failed to document the administration of two medications,	F 281	F 281 1. Resident # 16 medications were reviewed on 10/04/2017. Resident #1 dressing order was clarified on and documented on 09/20/2017 . Resident #2's September's MARS and TARs were audited to ensure they are now being administered per physician's orders on 10/04/2017. Resident # 14 depakote's orders were clarified on 09/21/2017. Resident #6 fall alarm was reapplied on 09/19/2017 1PM.	

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F 281	Continued From page 59 Allopurinol Tablet 300 MG and Docusate Sodium Tablet 100 MG. 3. For Resident # 2, the facility staff failed to ensure medications and treatments were administered per physician's orders. 4. For Resident #14, the facility staff failed to clarify a physician's order for the medication Depakote after an order to increase the medication was received. Resident #14 had orders for and was receiving Depakote 125 mg (milligrams) and Depakote 250 mg two times a day from 2/22/17 to 9/21/17. 5. for Resident #6, the facility staff failed to apply a fall alarm per physician's orders from 9:00 a.m., to 1:00 p.m. on 9-19-17. The Findings included: 1. Resident #1 was a 61 year old who was admitted to the facility on 1/1/17. Resident #1's diagnoses included Presence of Arteriocoronary Bypass Graft, Presence of Heart Assist Device (LVAD Unit), Arteriosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Diabetes Mellitus Type 1, Muscle Weakness - Generalized, Difficulty Walking, Contractures of Both Hands, Major Depressive Disorder, Hemoglobinuria, and Hyperlipidemia. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 8/14/17, coded Resident #1 as having a Brief Interview of Mental Status Score of 14, indicating that she was cognitively intact and was independent in decision-making. She was also coded as having adequate vision and hearing.	F 281	2. Current residents POSs were audited for September 2017 by UM/ designee on 10/05/2017. 3. License nurses will be educated on proper documentation, and clarification when needed on physician orders by DON/designee on or before 11/03/2017. 4. Weekly audits times 12 will be completed on eMARs/ eTARs by UM/designee to ensure proper documentation has been completed if needed. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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F 281	Continued From page 60 On 9/18/17 a review was conducted of facility documentation, revealing a complaint which was submitted to the office of Long Term Care on 1/25/17. The complaint alleged that Resident #1's LVAD unit had drainage around it and that the bandages were not changed daily. On 9/19/17 at 8:45 A.M. an observation was conducted of Resident #1 in her room. When asked if she had any concerns about the care she received at the facility, Resident #1 responded, "They are supposed to check my heart machine. They never check it. This bandage is supposed to be changed every day. They don't." The bandage attached to Resident#1's abdomen on her left side was dated "9/17/17 on 3-11" shift, along with the nurse's initials. The bandage had not been changed per physician's order on 9/18/17. On 9/19/17 a review was conducted of Resident #1's clinical record. During the month of February 2017, the dressing had only been documented as having been changed from 2/23/17 thru 2/27/17. During the month of March 2017, the dressing had been changed every day. During the month of April 2017, the dressing had only been documented as having been changed on 4/13/17, 4/28/17, 4/29/17, and 4/30/17. During the month of May 2017, the dressing had only been documented as having been changed from 5/2/17 thru 5/14/17. There was no documentation of dressing changes for June thru September 2017. On 9/19/17 the Director of Nursing (DON Administration B) was asked to observe Resident #1's dressing. The DON confirmed that the	F 281		

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F 281	Continued From page 61 dressing was supposed to be changed daily, and hadn't been changed since 9/17/17. She stated, "It's important to change it daily to make sure that it isn't causing any type of infection. (name) Clinic came in and did an inservice on how to clean it and take care of it." The DON submitted a signature sheet and training summary entitled, "8/31/17. (Name) Advance Heart Failure Center - Left Ventricular Assist Device, Sterile Dressing Change." Resident #1 had been admitted to the facility 1/1/17, but the facility staff did not obtain training for the care of her device until 8/31/17. The facility staff did not have any written instructions for the care of the Assistive device. After the surveyor's request on 9/18/17, the facility obtained a copy of the manufacturer's instructions for the device on 9/20/17. The manufacturer's instructions for the Heartmate 2 LVAS (Left Ventricular Assist System) on Page 108 read, "It is extremely important to keep the exit site where the percutaneous lead goes through your skin clean and dry at all times. Follow aseptic technique any time you change the bandage or touch or handle the exit site. IMPORTANT! Watch the exit site for signs of infection, such as redness, swelling, drainage, bleeding, or a bad smell. IMMEDIATELY tell your doctor or hospital contact person if there are any signs of infection." Resident #1's clinical record contained the following note from the hospital, "1/19/17. Her son called on 1/18/17 to report drainage and pain from (Resident #1) his mother's drieline exit site. She was brought on on 1/19/17 for a wound assessment. The gauge dressing was noted to be saturated with thick, tan drainage. The skin surrounding the drieline exit site was macerated,	F 281		

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F 281	Continued From page 62 and a scanty amount of serosanguinous drainage was expressed with palpation of the surrounding tissue. Admitted due to suspected drieline infection. " The hospital subsequently identified the infection as MSRA (Methicillin-resistant Staphylococcus Aureus). Resident #1 was hospitalized from 1/19/17 thru 2/21/17. On 9/21/17 at 2:16 P.M. a review was conducted of the facility's Infection Control Program. The DON stated, "sterile technique should have been implemented during (Resident #1's name) dressing changes, including pulling the curtain, putting on a mask, gloves, setting up a sterile field, and cleaning the site. This training was done on 8/31/17. I don't know why it wasn't done on a daily basis. It should have been done on a daily basis since we were trained in August. It is important to keep infection from the drive line." The facility did not have a written policy on sterile technique for dressing changes. On 9/21/17 the facility Administrator (Administration A) was informed of the findings. No further information was received. 2. For Resident #16, the facility staff failed to document the administration of two medications during August 2017. The Director of Nursing (Administration B) stated that the facility utilizes Lippincott as a nursing standard reference. Resident #16 was an 82 year old who was admitted to the facility on 1/24/17. Resident #16's diagnoses included Cerebrovascular Disease, Gout, and Constipation, unspecified.	F 281		

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F 281	Continued From page 63 The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 7/3/17, coded Resident #16 as having a Brief interview of Mental Status Score of 13, indication that he was independent in decision making ability. He was also coded as requiring the extensive physical assistance of two staff persons for transfers, having the functional limitation of both legs, and requiring a wheelchair for mobility. On 9/20/17 a review was conducted of Resident #16's clinical record, revealing the Medication Administration Record (MAR) for August 2017. The following medications were not documented as having been administered per signed physician's order: Allopurinol Tablet 300 MG by mouth once daily for Gout. 8/29/17, and 8/30/17 at 9:00 P.M. Docusate Sodium Tablet 100 MG by mouth once daily for Constipation 8/29/17, and 8/30/17 at 4:00 P.M. On 9/20/17 at approximately 9:50 A.M. an interview was conducted with the Director of Nursing (DON-Administration B). She stated that facility staff should document the administration after it is administered. Resident #16's Care Plan read, "4/28/17. Gastrointestinal distress. At risk for constipation. Administer medications as ordered." On 9/19/17 a review was conducted of facility documentation, revealing a Medication Administration policy dated 4/20/17. It read, "Medication will be administered as prescribed. If medication is not given, indicate on MAR reason	F 281		

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F 281	Continued From page 64 it was withheld and physician notified (if applicable)." Guidance is given from Lippincott Solutions, "Safe Medication Administration Practices, General" 10/02/2015. "Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions." On 9/20/17 at approximately 4:45 P.M. the facility Administrator was informed of the findings. No further information was received. 3. For Resident # 2, the facility staff failed to ensure medications and treatments were administered per physician's orders. Resident #2, a 91 year old female, was admitted to the facility on 3/2/2012. Her diagnoses included but were not limited to: Major Depressive Disorder with severe Psychotic Symptoms, Pseudobulbar Affect, Cardiac Pacemaker, Anemia, Acute embolism and thrombosis. Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/3/2017 was coded as a Quarterly assessment. She was coded as having short and long term memory deficits, severe cognitive impairments. She was also coded as needing extensive to total assistance of one person to perform all of her activities of daily living with the exception of transfers. For transfers, she was coded as	F 281		

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F 281	Continued From page 65 needing total assistance of two staff members. She was coded as always incontinent of bowel and bladder. On 9/19/2017 at 8:45 AM, review of the clinical record was conducted. Review of the Medication Administration Record (MAR) for August 2017 revealed missing documentation of medications: Aspirin 81 milligrams one tablet by mouth every day. 8/28/2017 at 9 AM Cetirizine 10 milligrams one tablet by mouth every day. 8/28/2017 at 9 AM Clopidogrel 75 milligrams one tablet by mouth every day. 8/28/2017 at 9 AM Escitalopram 10 milligrams one tablet by mouth every day. 8/28/2017 at 9 AM Losartan 25 milligrams one tablet by mouth every day. 8/28/2017 at 9 AM Milk of Magnesia 30 milliliters by mouth at bedtime. 8/28/2017 at 8 PM Prevastatin 40 milligrams one tablet by mouth at bedtime. 8/28/2017 at 8 PM Docusate Sodium 100 milligrams by mouth two times a day. 8/28/2017 at 9 AM, 8/28/2017 at 5 PM Levetiracetam 250 milligrams by mouth every 12 hours. 8/28/2017 at 9 AM, 8/28/2017 at 9 PM Metoprolol 25 milligrams by mouth two times a day. 8/28/2017 at 9 AM, 8/28/2017 at 5 PM Review of the Treatment Administration Record (TAR) for August 2017 revealed missing documentation of : Barrier Cream to buttocks and peri-area every shift and as necessary after each incontinent episodes, may keep at bedside every shift for	F 281		

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F 281	Continued From page 66 skin protectant. Missing on 8/12/2017 night shift, 8/18/2017 evening shift Bilateral Geri-Sleeves to arms every day every shift may remove for hygiene every shift. Missing on 8/12/2017 night shift, 8/18/2017 evening shift Check placement of pressure reducing wheelchair cushion every shift for Pressure relief. Missing on 8/12/2017 night shift, 8/18/2017 evening shift Review of the Treatment Administration Record (TAR) for September 2017 revealed missing documentation of : Barrier Cream to buttocks and peri-area every shift and as necessary after each incontinent episodes, may keep at bedside every shift for skin protectant. Missing on 9/4/2017 evening shift, 9/8/2017 evening shift Bilateral floor mats at bedside while in bed every shift for fall. Missing on 9/4/2017 evening shift, 9/8/2017 evening shift Bilateral Geri-Sleeves to arms every day every shift may remove for hygiene every shift Missing on 9/4/2017 evening shift, 9/8/2017 evening shift Check placement of pressure reducing wheelchair cushion every shift for Pressure relief. Missing on 9/4/2017 evening shift, 9/8/2017 evening shift Turn and repositioned every 2 hours and as needed every shift Missing on 9/4/2017 evening shift, 9/8/2017 evening shift On 9/20/2017 at 4:45 PM, an interview was conducted with the Director of Nursing who stated that nurses were expected to administer medications and treatments as ordered by the physician and document on the MAR and TAR at the time of administration. The DON stated the facility's profession guidance was provided by	F 281		

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F 281	Continued From page 67 Lippincott. Guidance for nursing standards for the administration of medication and treatments is provided by "Lippincott", which stated "After administering a medication or treatment, record it immediately on the appropriate record form." On 9/20/2017 at approximately 5:00 PM during the end of day debriefing, the Administrator and Director of Nursing (DON) were informed of the missing documentation of administration of medications and treatments for Resident # 2. The DON stated the facility had some computer issues on 8/29/2017 and 8/30/2017 and nurses had to manually write on MARs and TARs but there was no explanation for missing documentation on the other dates found during survey. The DON presented a copy of the Medication Administration Policy. Review of the facility policy on "Medication Administration" from "Operational Policy and Procedure Manual Revised 4/20/2017 revealed on Page 1 of 4, Under Policy The purpose of this policy is to provide guidance for the process for providing monitoring that all medications are received and administered in a timely manner. Under Procedure: 1. Administration Preparedness a. Medication will be administered as prescribed" Page 4 of 4 was written: "If medication is not given, indicate on MAR reason it was withheld and physician notified (if applicable)"	F 281		

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F 281	Continued From page 68 Valid Physician's orders were evident for the medications and treatments not documented as having been administered. During the end of day debriefing on 9/21/2017, the DON, Administrator and Corporate consultant were informed of the findings. No further information was provided. 4. For Resident #14, the facility staff failed to clarify a physician's order for the medication Depakote after an order to increase the medication was received. Resident #14 had orders for and was receiving Depakote 125 mg (milligrams) and Depakote 250 mg two times a day from 2/22/17 to 9/21/17. Resident #14 was admitted to the facility on 8/19/11 with the diagnoses of, but not limited to, dementia, depression, and anxiety. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 6/28/17. The MDS coded Resident #14 with moderately impaired cognition; required extensive assistance from staff for transfers, dressing, toileting, and hygiene. On 9/20/17 at 1 p.m. Resident #14 was observed sitting in a wheelchair in her room. She was alert and conversational. Resident #14 stated lunch was great and stated her sister will be coming in for church services that day. Resident #14 did not display and negative behaviors or symptoms of depression.	F 281		

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F 281	Continued From page 69 On 9/20/17 at 2:30 p.m. Resident #14's clinical record was reviewed. The review revealed physician's orders which included: 1/9/17 Depakote Sprinkles Capsule Delayed Release 125 mg Give 1 capsule by mouth two times a day related to Major Depressive Disorder and 2/22/17 DepakoteTablet Delayed Release 250 mg Give 1 tablet by mouth two times a day related to Major Depressive Disorder. Both the 125 mg and 250 mg orders were listed and signed as administered on the Medication Administration Record (MAR) from 2/22/17 until 9/21/17. On 9/20/17 at 4 p.m. the Administrator and Director of Nursing were informed of the Depakote orders. The pharmacy review sheet and physician notes were requested. On 9/21/17 at 9:30 a.m. the Depakote orders on the MAR were reviewed with the nurse (Licensed Practical Nurse-LPN-B) who administered the medications to Resident #14 that morning with the Registered Nurse Unit Manager (RN-B) present. LPN-B showed surveyor the opened and empty medication package which revealed Resident #14 received both the 125 mg and 250 mg of Depakote. It was discussed with LPN-B and RN-B that when the medication was increased to 250 mg that the 150 mg was not discontinued. Clarification whether the physician wanted both orders or not was requested. On 9/21/17 at 11:00 a.m., RN-B stated she called	F 281		

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F 281	Continued From page 70 the doctor and he discontinued the 125 mg of Depakote. When asked what should have been done, RN-B stated "nursing and pharmacy should have clarified it." Facility policy titled "Medication Administration" with a reviewed date of 4/20/17 included: "...II. Safety Precautions: a. Observed the "five rights" for administration i. the right resident ii. the right time iii. the right medicine iv. the right dose v. the right method of administration..." "...III. Basic Safety in Administration a. Medication i. Read labels multiple times comparing to MAR 1. Review original physician order if discrepancy a. Do not provide if discrepancies continue..." On 9/21/17 at 1:05 p.m. the Administrator and Director of Nursing were informed of the failure to clarify the Depakote orders. 5. For Resident #6, the facility staff failed to apply a physician ordered fall alarm from 9:00 a.m. to 1:00 p.m. on 9-19-17. Resident #6 was admitted to the facility on 3-30-16, with the diagnoses including; Huntington's disease, hypertension, seizures, dementia, depression, and anemia. The most recent Minimum Data Set (MDS) was a	F 281		

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F 281	Continued From page 71 quarterly assessment with an Assessment Reference Date (ARD) of 6-22-17. The MDS coded Resident #6 with severely impaired cognition, and requiring extensive assistance from staff for all activities of daily living. On 9-19-17, beginning at 9:00 a.m. observations of the Resident were completed up until 1:00 p.m. Resident #6 was observed laying in a low bed with a scoop mattress, pads on the floor of both sides of the bed, a padded foot board on the bed, and wedges on top of and under the mattress for Resident positioning. The Resident was awake, alert, non-verbal, and kicking her legs over the side of the bed almost continuously. On one occasion the Resident was halfway out of the bed, with her legs completely out of the bed, and the Resident's buttocks were on the edge of the bed. A staff member followed the surveyor into the room and repositioned the Resident. On 9-19-17 Resident #6's clinical record was reviewed. The review revealed physician's orders which included: 12-5-16 "personal bed alarm every shift." No bed alarm was applied to the Resident for 4 hours on 9-19-17 until after the 1:00 p.m. observation. Surveyors returned to the facility at 2:00 p.m., and a bed alarm was in place on the Resident at that time. The Resident's care plan was reviewed and included the bed alarm in the interventions for "Fall Risk" . The facility policy titled "Treatment Administration" was reviewed, and revealed the following:	F 281		

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F 281	Continued From page 72 "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. "The purpose of this policy is to provide guidance for the process for providing monitoring that all treatments are received and administered in a timely manner." The facility Director of Nursing (DON) stated "Lippincott" as the facility reference for nursing standards. Both medication and treatment administration policies from the facility followed the standard, however, staff did not follow the facility policy nor nursing standard. On 9-19-17, 9-20-17, and 9-21-17 at the end of day debriefs, the Administrator and Director of Nursing were informed of the failure of staff to apply the fall alarm as ordered to Resident #6 for 4 hours on 9-19-17. The facility provided no further information.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 309	F 309 1. Resident # 10's nurse responsible for not documenting Levemir insulin on 09/03/2017 was disciplined. 2. Residents receiving insulin will be audited for the month of September 2017 by UM/ designee to ensure documentation occurred. On 10/09/2017. Any failure to document insulins were addressed by the nurse managers. 3. Licensed nurses will be educated on documenting administration of insulin by DON/designee on or before 11/03/2017.	

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F 309	Continued From page 73 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, including but not limited to the following: (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. (l) Dialysis. The facility must ensure that residents who require dialysis receive 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 staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure the highest practicable well being for 1 Resident (Residents #10) a survey sample of 23 Residents. For Resident # 10, the facility staff failed to document the administration of Levimir Insulin on 9/3/2017 as ordered by the physician. The findings included: Resident #10 was an 84 year old female who was admitted to the facility on 12/2/2008. Resident	F 309	4. A weekly audit of residents receiving insulin will be reviewed weekly times twelve weeks by the DON/designee to ensure proper documentation and follow through. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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F 309	Continued From page 74 #10's diagnoses included Diabetes Mellitus, Contracture Left hip, Contracture right hip, Bipolar Disorder, Hypertension, Major Depressive Disorder, and Macular Degeneration. Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/3/2017 was coded as an Annual assessment. She was coded as having a BIMS (Brief Interview for Memory Status) Score of 8/15 indicating severe cognitive impairment. She was also coded as needing extensive to total assistance of one person to perform all of her activities of daily living with the exception of eating. For eating, she was coded as needing supervision and set up only. She was coded as always incontinent of bowel and bladder. On 9/20/17 a review was conducted of Resident #10's clinical record. Review of the Medication Administration Record (MAR) for September 2017 revealed missing documentation of the medication: Levemir Flex Pen Solution inject 36 units subcutaneously every 12 hours not documented on 9/3/2017 at 9 PM On 9/20/2017 at 1:35 PM, an interview was conducted with LPN A (Licensed Practical Nurse A) who stated that nurses were expected to administer medications and treatments as ordered by the physician and document on the MAR and TAR at the time of administration. On 9/20/2017 at 4:45 PM, an interview was conducted with the Director of Nursing who stated that nurses were expected to administer	F 309		

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F 309	Continued From page 75 medications and treatments as ordered by the physician and document on the MAR and TAR at the time of administration. The DON stated the facility's profession guidance was provided by Lippincott. Guidance for nursing standards for the administration of medication and treatments is provided by "Lippincott", which stated "After administering a medication or treatment, record it immediately on the appropriate record form." There were valid physician orders for the following medication that was not documented on the Medication Administration Record (MAR), or in the Nursing Progress Notes as having been administered. On 9/20/17 at 5:10 P.M. the facility Administrator (Administration A), and Director of Nursing (DON-Administration B) were notified of the findings. The DON stated that the nurses should have administered the medication as ordered. No further information was received.	F 309		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the	F 315	F 315 1. Resident #23 had a bowel and bladder screener completed on 09/25/2017. Resident #23's kardex was updated on 09/25/2017 to include how to perform incontinence care for resident.	

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F 315	Continued From page 76 facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide toileting assistance for 1 resident (Resident #23) in the survey sample of 23 residents. The facility staff declined to honor toileting assistance requests. The Findings included:	F 315	2. Current residents had a bowel and bladder screener completed on 10/03/2017. Current residents' kardexs were updated to ensure how to care for incontinence was included on kardex on 10/05/2017. These were completed by Unit Manager/ designee. 3. Nursing staff will be educated on how to complete a bowel and bladder screener, how to update resident kardexs, and how to use the resident kardex by DON/designee on or before 11/03/2017. 4. A weekly audit of new admissions will be completed on new admissions' bowel & bladder screeners to ensure completed and kardexs are updated by the Unit Manager/designee. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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F 315	Continued From page 77 Resident #23 was a 77 year old who was admitted to the facility on 7/23/16. Resident #23's diagnoses included Irritable Bowel Syndrome with Diarrhea, Overactive Bladder, Pain in Unspecified Joint, and Muscle Weakness-Generalized. The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 7/27/17, coded Resident #23 as having a Brief Interview of Mental Status Score of 15, indicating intact cognition and independent decision-making ability. Resident #23 was coded as requiring the extensive assistance of 1 person for transfers. She was coded as having an impairment of both lower extremities, and as being frequently incontinent of bowel and bladder. Resident #23 required a wheelchair with the physical assistance of 1 person for locomotion. On 9/21/17 at 10:42 A.M., Resident #23 stated to the Surveyor, Administrator (Administrator/Executive Director (ED)/Administration A), and Director of Nursing (DON Administration B) that she had been verbally abused by 2 staff members. She stated that her evening shift aide (Certified Nursing Assistant 3-11 P.M.) no longer treated her with respect, and that her attitude toward her had changed. Resident #23 stated that the aide would be angry with her and refuse to assist her with incontinence care and toileting. Resident #23 also stated that her day shift aide was always rude to her and refused to toilet her. Resident #23 stated, "They make me put on my own diaper. I can't stand up. My legs hurt. They take a long time to answer the call bell, then they put me in my wheelchair and run out of the room when I ask to help me go to the bathroom. They make me use a diaper, which I can't pull up."	F 315		

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F 315	Continued From page 78 On 9/19/17 a Group Interview was conducted with 8 residents. Two of the residents stated that the facility staff were not providing them with incontinence care on a consistent basis. On 9/21/17 a review was conducted of Resident #23's clinical record. Resident #23's Care Plan read, "Self-care impairment. Toileting and transfer assistance as needed. Pain Management. Chronic bilateral knee pain. On 9/21/17 at 12:45 P.M., the facility Administrator submitted the following written statement: "9/21/17. In regards to (Resident #23) interview on 9/21/17 at 10:42 A.M. Facility ED/DON will thoroughly investigate concerns for (Resident #23) brought in regards to 2 staff members (CNAs)."	F 315		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323	F 323 1. Resident #2 was assessed for assistance needed for proper transfer technique on 09/26/2017 by Therapy/designee. Resident #4 was assessed for assistance needed for proper transfer technique on 09/20/2017 by Therapy/ designee. Resident #6's alarm was reapplied on 09/19/2017. 2. Residents with alarms orders were reviewed for effectiveness of intervention on or by 10/10/2017 by DON/designee. Current residents requiring two person assist for transfers were assessed for proper transfer technique by Um/designee on 10/05/2017.	

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F 323	Continued From page 79 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to provide the assistance of 2 staff persons for a transfer, instead using one person transfer for 2 residents (Resident # 2 and # 4) resulting in harm for one Resident (Resident # 4) who sustained a fall and fracture of the leg. And the facility staff failed to apply a bed alarm for one resident (Resident # 16) all in a survey sample of 23 residents. 1. For Resident #2, the facility staff failed to provide the assistance of two staff persons for a transfer from the wheelchair to bed. 2. For Resident #4, the facility staff failed to provide the assistance of 2 staff persons for a transfer from the bed to the wheelchair, resulting in a fall and fracture of the leg. 3. For Resident #6, the facility staff failed to apply a fall alarm per physician's orders from 9:00 a.m., to 1:00 p.m. on 9-19-17. The findings included: 1. For Resident #2, the facility staff failed to perform a two person transfer for Resident #2,	F 323	3. Nursing staff will be inserviced on alarm usage and application by DON/designee. Nursing staff will be educated on or by 11/03/2017 on all residents' requiring two person assist during transfers by DON/designee. 4. A weekly audit of alarms will be completed to ensure in place by Unit Manager/designee times twelve weeks. A weekly audit of residents requiring two person assistance during transfers will be completed times twelve by ADON/designee. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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F 323	Continued From page 80 instead using a one person transfer from the wheelchair to bed. Resident #2, a 91-year-old female, was admitted to the facility on 3/2/2012. Her diagnoses included but were not limited to: Major Depressive Disorder with severe Psychotic Symptoms, Pseudobulbar Affect, Cardiac Pacemaker, Anemia, Acute embolism and thrombosis. Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/3/2017 was coded as a Quarterly assessment. She was coded as having short and long term memory deficits, severe cognitive impairments. She was also coded as needing extensive to total assistance of one person to perform all of her activities of daily living with the exception of transfers. For transfers, she was coded as needing total assistance of two staff members. She was coded as always incontinent of bowel and bladder. On 9/19/2017, Resident # 2's clinical record was reviewed. Review of the Nurse's Notes revealed entries: "8/9/2017 17:15 (5:15 p.m.) "Called to room by CNA (Certified Nursing Assistant) ____. Stated Res.(Resident) right hand was swollen and Res. was guarding and protecting her right hand. Upon assessment res. noted alert and verbally responsive, right hand at wrist area warm to touch, bruising to hand and forearm edema to hand. Res. pulls away when assessment performed, right hand elevated on pillow res. medicated for pain. Physician notified orders	F 323		

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F 323	Continued From page 81 received continue to observe." Documentation revealed that on 8/9/2017 at 5:30 p.m., the clinician ordered an X-ray of Resident # 2's right hand. The X-ray was obtained 8/10/2017 at 2:15 a.m. and Resident #2 was determined to have a "spiral fracture of the distal third of the ulna." The facility began an investigation into the injury of unknown origin, her fractured ulna. The investigation was unable to determine the cause of the injury and unable to substantiate abuse. Review of the investigation revealed a statement from the CNA (certified nursing assistant) (CNA F) that cared for Resident #2 during the 7-3 shift of 8/9/2017 provided ADL (Activities of Daily Living) care throughout the day who stated she did not notice any injuries during her shift. Review of the Witness statement from CNA F (typed by Director of Nursing and signed by the witness on 8/11/2017) included statements: " I work with _____ on Wednesday, August 8/9/17 on the 7-3 shift. I gave her a bath in bed in the morning. I didn't notice anything. I got her up and put her in the chair for breakfast. She rolled around in her wheeled chair. About 2:20 I put her back in the bed. I put her side rails up and pull her blanket over her." When interviewed, the DON stated the CNAs have a Kardex for each Resident that provides guidance for their needs. The facility staff was asked to provide a copy of the Kardex. Review of the MDS assessment in effect during August, 2017 revealed Resident # 2 required a two-person total assist for transfers and one	F 323		

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F 323	Continued From page 82 person extensive assist for bed mobility. On 9/19/2017 at 4:02 p.m., the CNA F was interviewed by the surveyor in the presence of the Director of Nursing and three other surveyors in the facility conference room. CNA F stated she remembered taking care of Resident # 2 on 8/9/2017 during the day shift. CNA F stated she put Resident # 2 to bed at the end of the shift by herself. CNA F stated Resident # 2 did not have any problems or swelling noted on her right arm when she last saw her. CNA F stated she was trained to transfer Resident # 2 using one person because of her size. CNA F stated Resident # 2 was small and could be transferred by one person. CNA F stated she did not know the MDS coded Resident # 2 has needing 2 staff persons to transfer. CNA F stated she did not know what was written on the CNA Kardex. CNA F again stated she had taken care of Resident# 2 and was trained to transfer the resident by herself. On 9/19/2017 at 4:10 p.m., CNA B was observed in the hallway near Unit 1. An interview was conducted with CNA who stated she worked on Unit 1 and was familiar with Resident # 2. CNA B stated it required 2 people to transfer Resident # 2. The CNA Kardex for Resident # 2 was not in the book designated for Unit 1. The facility staff stated they did not know where the CNA Kardex for Resident # 2 was located. On 9/19/2017 at 4:15 p.m., an interview was conducted with the Unit Manager on Unit 1 (LPN A) who stated Resident # 2 required 2 people to transfer.	F 323		

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F 323	Continued From page 83 The investigation indicated the CNA had transferred Resident #2 from her wheelchair back to bed by herself. On 9/19/2017 at 5 p.m., the administrator and DON were informed of the failure of the staff to perform a two person transfer for Resident #2, instead using a one person transfer. During the end of day debriefing on 9/19/2017, the facility Administrator was informed that CNA F was interviewed earlier that day and told the surveyors and Director of Nursing that she transferred Resident # 2 by herself as she had been shown during her orientation by another CNA. On 9/20/2017 at 4 p.m., an interview was conducted with the Director of Nursing who stated CNA F told her that she used a "Stand and Pivot" technique to transfer Resident # 2 by herself. The DON was asked if she was aware that the MDS dated 8/3/2017 coded Resident # 2 as requiring total assist of two staff persons for transfers. The DON stated she did see that on the MDS. On 9/21/2017 at approximately 1:00 p.m., three copies of the CNA Kardex were presented. Two copies were labeled with a print date of 9/18/2017. One form had handwritten on the right of the form "Transfer 2 assist". Another copy of the CNA Kardex was presented to the surveyor with a print date of 9/21/2017. The categories generated by the computer were Safety, toileting, personal hygiene/oral care, mobility, monitoring, bathing, dressing, resident care and transferring. Under transferring was written by computer "Requires 2 assist for transfers." This copy had the web address of the computer system written at the bottom of the page and dated 9/21/2017. There was no explanation for why the CNA	F 323		

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F 323	Continued From page 84 Kardex had been unavailable during the first days of survey. Facility staff stated they could not find it. The DON presented a handwritten note on 9/21/2017 at 9 a.m. that was dated 9/20/2017 and stated during her interview with CNA F, she "stated that she stand Pivot with one person assist" for Resident # 2 and the note was signed by the DON. During the end of day debriefing on 9/21/2017, the facility administrator and DON were informed of the failure of the staff to perform a two person transfer for Resident #2, instead using a one person transfer. No further information was provided. 2. For Resident #4, the facility staff failed to provide the assistance of 2 staff persons for a transfer from the bed to the wheelchair, resulting in a fall and fracture of the left leg, which is harm. Resident #4 was an 88 year old who was admitted to the facility on 2/22/06. Resident #4's diagnoses included Proximal Tibia Displaced	F 323		

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F 323	Continued From page 85 Metaphyseal and Impacted Plateau Fractures (crushed bone), Muscle Weakness-Generalized, Age-Related Osteoporosis, Schizophrenia, Psychotic Disorder, Hypertension, and Alzheimer's Disease. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 6/7/17, coded Resident #4 as having a Brief Interview of Mental Status Score of 7 - indicating severely impaired cognition. For transfers, she was coded as requiring the extensive physical assistance of two persons. In the area of functional limitation in range of motion, she was coded as having lower extremity impairment on both sides. Her mobility device was a manual wheelchair. On 9/19/17 a review was conducted of facility documentation, revealing Resident #4's Care Plan, which read, "Initiated 3/9/10. Revised 7/18/17. I am at risk for and have had an actual fall related to: Cognitive impairment with decreased safety awareness. I am easily distracted and have poor insight/judgement. I am incontinent and I am dependent for ADLs (Activities of Daily Living). Assist resident with all transfers." The Care Plan had not been revised to include the requirement of the extensive physical assistance of two persons for transfers. On 9/19/17 a 8:30 A.M., an observation was conducted of Resident #4, who was in her bed. When asked about how her leg was feeling, Resident #4 smiled and appeared to be confused. Suddenly, her roommate who was identified and put into the sample as Resident #1, made an unsolicited statement. She said, "One of the aides named Carolyn (CNAA) came in here by	F 323		

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herself and dropped her on the floor while putting her in her wheelchair. She slipped out of her hands and fell on the floor. She broke her leg and went to the hospital. She came back here with a leg brace on, and had it on for a month and a half." Resident #1's Brief Interview of Mental Status Score was 14, indicating no cognitive impairment. She was also coded as having adequate vision and hearing.

Resident #4's clinical record contained the following x-ray report, "6/28/17 10:23 A.M. Findings: Four views of the left knee. Proximal tibia displaced metaphyseal and impacted plateau fractures, are partially obscured by severe tricompartmental osteoarthritis with large osteophytes and loss of joint space. Effusion.

On 9/19/17 a review of facility documentation was conducted, revealing a Facility Reported Incident on 6/29/17. It read, "Injury of Unknown Origin. Resident assessment revealed left tibia plateau fracture. Documents reveal resident had a fall on 6/25/17. Investigation pending." On 7/3/17, the facility follow-up read, "Upon investigation, June 25, 2017, (CNA A - Certified Nursing Assistant) transferred (Resident #4) from the bed to the wheelchair." According to the report, only one staff member conducted the transfer instead of two.

CNA A's signed statement (dated 6/25/17) read, "I set her down in the chair. I walked away. I heard a noise. I turned around I saw resident body in front of wheelchair Resident butt was on the floor in between the leg rest. The leg rest was extended. Resident left leg was under her butt." This incident occurred during the day shift a 7:50 A.M.

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F 323	Continued From page 87 The clinical record contained the following Nursing Progress Note, "6/25/17/ 10:51 P.M. Resident resting in bed, respirations unlabored, lung fields clear, no coughing or congestion noted. No dizzy spells noted. Bed in lowest position, call bell in reach. Staff monitoring Q 2 hours." For the next three days, until 6/28/17 there was no further post-fall monitoring (7 continuous shifts). On 6/28/17 the Nursing Progress Note read, " Vital signs 99.2-90-22-138/86-96%. Resident noted with edema to left knee and lower leg bruising present to lower leg. Resident C/O (complains of) pain when touched, will not allow CNA to dress her. Resident medicated for pain Tylenol Tabs 2 PO (by mouth) for left leg pain. DR (doctor) made aware STAT x-ray of left FIB TIB and left knee (left lower leg)." Resident #4 was admitted to the hospital at 7:00 A.M. and returned to the facility at 6:45 P.M. New orders for pain medication, use of knee immobilizer, and no weight bearing to left leg were given by the resident's MD at the facility. The nursing Progress note read, "SRMC (hospital) called report. No surgery indicated at this time because its to extensive. Keep knee immobilizer in place." On 9/19/17 at 4:05 P.M., an interview was conducted with CNA A in the conference room. The Director of Nursing, who had conducted the investigation, was present. When asked why she transferred Resident #4 without the assistance of another staff member, CNA A stated, "The way I was trained the person demonstrated that the resident needed only 1 person for transfers. When CNA A was informed that Resident #1 witnessed the fall, she admitted that Resident #1	F 323		

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F 323	Continued From page 88 was in the room, but said that "the curtain was pulled." There was no documentation that the curtain had been pulled. When the Director of Nursing was asked why Resident #1 wasn't interviewed regarding the fall, she stated, "Because I didn't know that she was in the room and I didn't ask." On 9/19/17 at 5:00 P.M. the facility Administrator (Administration A) was notified of the findings. On 9/20/17 the Administrator submitted following Petersburg Plan of Correction; "Findings: Facility failed to properly investigate two injuries of unknown origins. The facility failed to interview all potential witnesses. Resident: (#4) Fell on 6/25/17, and on 6/28/17 diagnosed wit a left knee fracture. Resident: (#2) Diagnosed with a fracture of unknown origin. 100% of residents with hi risk for injuries related to falls were reviewed to ensure proper transfers were being performed." The Plan of Correction also stated that all facility residents were assessed for proper transfer techniques and initiated on 9/19/17. Nursing staff were in-serviced. In addition, CNA A had been suspended pending investigation, and had subsequently resigned. The Plan also stated that all department heads were in-serviced on the proper way to complete an investigation. The following day, on 9/20/17, another resident who was identified and placed in the sample as Resident #16, was also transferred with 1 staff instead of 2, utilizing a hoyer lift. Resident #16 was an 82 year old who as admitted to the facility	F 323		

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F 323	Continued From page 89 on 1/24/17. Resident #16's diagnoses included Cerebrovascular Disease, Gout, and Constipation, unspecified. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 7/3/17, coded Resident #16 as having a Brief interview of Mental Status Score of 13, indicating that he was independent in decision making ability. He was also coded as requiring the extensive physical assistance of two staff persons for transfers, having functional limitation of both legs, and requiring a wheelchair for mobility. The Administrator and Director of Nursing were present when the surveyor confirmed the improper transfer with Resident #16, who was cognitively intact. Resident #16 stated that CNA D used a hoyer lift to transfer him by herself from his bed to his wheelchair. The Administrator later reported that CNA D had received disciplinary action for performing an improper transfer after being inserviced the previous day.	F 323		

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3. For Resident #6, a Resident with a fall history, and a fall risk, the facility staff failed to apply a physician ordered fall alarm from 9:00 a.m. to 1:00 p.m. on 9-19-17.

Resident #6 was admitted to the facility on 3-30-16, with the diagnoses including; Huntington's disease, hypertension, seizures, dementia, depression, and anemia.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 6-22-17. The MDS coded Resident #6 with severely impaired cognition, and requiring extensive assistance from staff for all activities of daily living.

On 9-19-17, beginning at 9:00 a.m. observations of the Resident were completed up until 1:00 p.m. Resident #6 was observed laying in a low bed

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F 323	Continued From page 91 with a scoop mattress, pads on the floor of both sides of the bed, a padded foot board on the bed, and wedges on top of and under the mattress for Resident positioning. The Resident was awake, alert, non-verbal, and kicking her legs over the side of the bed almost continuously. On one occasion the Resident was halfway out of the bed, with her legs completely out of the bed, and the Resident's buttocks were on the edge of the bed. A staff member followed the surveyor into the room and repositioned the Resident. On 9-19-17 Resident #6's clinical record was reviewed. The review revealed physician's orders which included: 12-5-16 "personal bed alarm every shift." No bed alarm was applied to the Resident for 4 hours on 9-19-17 until after the 1:00 p.m. observation. Surveyors returned to the facility at 2:00 p.m., and a bed alarm was in place on the Resident at that time. The Resident's care plan was reviewed and included the bed alarm in the interventions for "Fall Risk" . The facility policy titled "Treatment Administration" was reviewed, and revealed the following: "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. "The purpose of this policy is to provide guidance for the process for providing monitoring that all treatments are received and administered in a timely manner."	F 323		

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F 323	Continued From page 92 The facility Director of Nursing (DON) stated "Lippincott" as the facility reference for nursing standards. Both medication and treatment administration policies from the facility followed the standard. On 9-19-17, 9-20-17, and 9-21-17 at the end of day debriefs, the Administrator and Director of Nursing were informed of the failure of staff to apply the fall alarm to Resident #6 for 4 hours on 9-19-17. This omission presented a hazard, and accident precursor for Resident #6. The facility provided no further information.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329	F 329 1. Resident # 14's Depakote dosage was clarified by the physician on 09/21/2017. 2. Current residents' on Depakote were reviewed for adequate dosing on 10/05/2017 by DON/ Designee. 3. Licensed nurses will be educated on verifying increases or decreases in Depakote order changes by DON/ Designee on or by 11/03/2017. 4. A weekly audit of Depakote orders will be performed to ensure Depakote increases and/ or decreases are proper transcribed by the DON/ Designee times twelve. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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F 329	Continued From page 93 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (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; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure one (Resident #14) of 23 residents in the survey sample, was free from unnecessary medication. Resident #14 received two different doses of the medication Depakote (ordered for the treatment of depression) from 2/22/17 through 9/21/17. When the physician was notified on 9/21/17 that the original order for Depakote 125 mg (milligrams) had not discontinued at the time 250 mg was ordered, the physician discontinued the 125 mg order. The findings included: Resident #14 was admitted to the facility on 8/19/11 with the diagnoses of, but not limited to, dementia, depression, and anxiety. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment	F 329		

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Reference Date (ARD) of 6/28/17. The MDS coded Resident #14 with moderately impaired cognition; required extensive assistance from staff for transfers, dressing, toileting, and hygiene.

On 9/20/17 at 1 p.m. Resident #14 was observed sitting in a wheelchair in her room. She was alert and conversational. Resident #14 stated lunch was great and stated her sister will be coming in for church services that day. Resident #14 did not display and negative behaviors or symptoms of depression.

On 9/20/17 at 2:30 p.m. Resident #14's clinical record was reviewed. The review revealed physician's orders which included:

1/9/17 Depakote Sprinkles Capsule Delayed Release 125 mg Give 1 capsule by mouth two times a day related to Major Depressive Disorder and

2/22/17 DepakoteTablet Delayed Release 250 mg Give 1 tablet by mouth two times a day related to Major Depressive Disorder.

Both the 125 mg and 250 mg orders were listed and signed as administered on the Medication Administration Record (MAR) twice daily from 2/22/17 until 9/21/17.

On 9/20/17 at 4 p.m. the Administrator and Director of Nursing were informed of the Depakote orders. The pharmacy review sheet and physician notes were requested.

On 9/21/17 at 9:30 a.m. the Depakote orders on the MAR were reviewed with the nurse (Licensed

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F 329	Continued From page 95 Practical Nurse-LPN-B) who administered the medications to Resident #14 that morning with the Registered Nurse Unit Manager (RN-B) present. LPN-B showed surveyor the opened and empty medication package which revealed Resident #14 received both the 125 mg and 250 mg of Depakote. It was discussed with LPN-B and RN-B that when the medication was increased to 250 mg that the 150 mg was not discontinued. Clarification whether the physician wanted both orders or not was requested. On 9/21/17 at 11:00 a.m., RN-B stated she called the doctor and he discontinued the 125 mg of Depakote. When asked what should have been done, RN-B stated "nursing and pharmacy should have clarified it." Facility policy titled "Medication Administration" with a reviewed date of 4/20/17 included: "...II. Safety Precautions: a. Observed the "five rights" for administration i. the right resident ii. the right time iii. the right medicine iv. the right dose v. the right method of administration..." "...III. Basic Safety in Administration a. Medication i. Read labels multiple times comparing to MAR 1. Review original physician order if discrepancy a. Do not provide if discrepancies continue..." Physician notes that were reviewed did not have documented evidence that Resident #14 was to receive both 125 mg and 250 mg of Depakote. A	F 329		

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F 329	Continued From page 96 Valproic Acid level (a blood test to monitor the levels of Depakote circulating in the blood) laboratory result dated 7/11/17 was observed in the record which was within normal range. Physician orders included a Valproic Acid level every 6 months Review of the pharmacy "Medication Regimen Review Summary" and "Pharmacy Review" progress notes from 2/23/17 through 9/12/17 did not have any medication irregularities documented. Pharmacy note dated 1/24/17 included: "...Depakote 125 mg BID..." (BID=twice a day) and, Pharmacy note dated 2/23/17 included: "...Behavior noted Depakote 250 mg BID (increased)..." On 9/21/17 at 1:05 p.m. the Administrator and Director of Nursing were informed of the failure to clarify the Depakote orders which resulted in unnecessary medication administration.	F 329		
F 333 SS=G	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff	F 333	F 333 1. Resident #14's Depakote orders were clarified by the physician on 09/21/2017. Resident #7 was hospitalized on 06/20/2017. 2. Current residents' on insulin were reviewed for September 2017 to ensure correct medicine and amount of medicine was given on 10/05/2017 on 10/06/2017. Current residents receiving Depakote were reviewed for correct dosing 10/05/2017 by DON/ designee.	

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PETERSBURG HEALTHCARE CENTER	287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805

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F 333	Continued From page 97 failed to ensure two (Residents #7 and Resident #14) of 23 residents in the survey sample, were free from significant medication errors. Resident #7's medication error resulted in harm. 1. For Resident #7, the facility staff administered the wrong insulin causing the Resident to be hospitalized for 7 days. 2. Resident #14 received two different doses of the medication Depakote (ordered for the treatment of depression) from 2/22/17 through 9/21/17. When the physician was notified on 9/21/17 that the original order for Depakote 125 mg (milligrams) had not discontinued at the time 250 mg was ordered, the physician discontinued the 125 mg order. The findings included: Resident #7 was admitted to the facility on 6-22-16 with diagnoses that included: Diabetes, chronic kidney disease, Hypertension, hyperkalemia, seizures, hyponatremia, gout, peripheral vascular disease, history of urinary tract infections, history of clostridium difficile, history of sacral pressure ulcer with infection, and dermatitis. Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7-3-17 was coded as a significant change assessment. Resident #7 was coded as having memory loss, and severe cognitve loss. Resident #7 was coded as requiring extensive assistance to total dependence on one to two staff members	F 333	3. Licensed nurses will be educated on proper Depakote dosing by verifying with the physician whether it is an increase or decrease, 5 rights of medication administration, and transcription process by DON/ Designee on or by 11/03/2017. 4. A weekly audit of insulin and Depakote orders will be performed to ensure right medication, right dosage, and medicines have been transcribed correctly for twelve weeks by the Unit Manager/ Designee. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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F 333	Continued From page 98 for all ADL's (activities of daily living), and always incontinent of bowel with a Foley urinary catheter for bladder elimination. On 9-19-17 a thorough review of the resident's clinical record was conducted. Nursing progress notes were reviewed and revealed the following; On 6-20-17 at 12:55 p.m. the Resident was "cold/clammy/diaphoretic with a blood sugar of 31." The note goes on to state that the Resident received a subcutaneous injection of Glucagon in her left upper arm by Registered Nurse (RN) B. On 6-20-17 at 3:03 p.m. a nursing note by Licensed Practical Nurse (LPN) F described that the Resident had a blood sugar reading of 34 at 2:00 p.m., as the doctor ordered the blood sugar recheck in 1 hour after the glucagon given at approximately 1:00 p.m. (12:55). At 3:00 p.m. LPN F documented that the Resident's blood sugar was 158, and at 3:30 it was documented by her as 138 milligrams/deciliter (mg/dL). On 6-20-17 at 5:25 p.m., the Resident was sent to the hospital via 911 to the emergency room (ER) for evaluation of hypoglycemia, by the 3p-11p shift nurse, and facility staff documented in the nursing notes that the Resident's blood sugar was 116 at the time of transfer. This does not agree with the hospital records of transfer. Review of hospital emergency room records revealed that EMS (emergency medical services) ambulance reported to the hospital that they administered oral glucagon to the Resident, and after administration, the Resident's blood sugar was now 78, at 5:39 p.m., (15 minutes after the facility note), and at the time of transfer.	F 333		

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F 333	Continued From page 99 Further review of the hospital record revealed that at 7:16 p.m., on 6-20-17, the Resident's blood sugar had again dropped to 46, and by 11:00 p.m. it had gone up to 79, after intravenous (IV) Dextrose 10% 1000 ml (milliliters) was given and Dextrose 5% 1000 ml to include sodium chloride and potassium chloride was given. The Resident was admitted to the hospital and remained for 7 days, until 6-26-17, when she was returned in the evening, to the facility. Interviews were conducted on 9-19-17, and 9-20-17 with the Administrator and Director of Nursing (DON) with regard to this situation. They stated that the Resident had received 18 units of regular rapid acting (Humalog) insulin at 9:00 a.m., on 6-20-17, instead of the (Humulin N) Isophane long acting insulin, which was ordered to be given at that time. Prior to the administration of the wrong insulin, the Resident's blood sugar at 6:00 a.m., was 82. Review of physician's orders and the Medication Administration Record (MAR) revealed that the Resident was ordered to have, and was receiving, the following 2 types of insulin; 1. Humulin (N) long acting insulin, inject 18 units subcutaneously every 12 hours for diabetes at 9:00 a.m., and 9:00 p.m. 2. Humalog (lispro) rapid acting insulin, inject as per sliding scale every 6 hours; at 12 midnight, 6:00 a.m., 12:00 noon, and 6:00 p.m. if blood sugar is 351 to 400 give 20 units subcutaneously, if 401 to 450 give 25 units, if 451 to 500 give 30 units, if 501 to 502 give 35 units and call doctor.	F 333		

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F 333	Continued From page 100 If blood sugar less than 60 or greater than 501 call doctor. The Administrator and DON went on to state that the nurse (LPN F) who had given the wrong insulin had not realized the error until another nurse (RN B), stumbled upon it. RN B went into Resident #7's room at lunch time, saw the Resident, and asked what medication (LPN F) had given to the Resident. The medication nurse (LPN F) went to the medication cart, and showed (RN B) the vial of regular insulin. RN B validated the series of events as correct in a written statement. The nurse who made the error was terminated, and unavailable for interview. At the time of the incident, the administrator was not the same individual acting as administrator at the time of survey, and so the current Administrator could only answer as to the information left by the former Administrator. The Resident's care plan was reviewed, and revealed interventions for administering medications as ordered, labs as ordered, and with changes in condition/manifestation of clinical signs or symptoms, and to observe for low blood sugar symptoms of sweating, flushing, change in mental status, lethargy, etc. The nursing staff notes revealed that no assessments occurred from 9:00 a.m., until 12:55 p.m. when the Resident was in severe distress and the 12:00 p.m. blood sugar reading taken by RN B revealed a critical level of 31. The facility medication management policy was reviewed, and revealed that all current standards and requirements were in place for medication administration within the documents. An excerpt of that policy follows:	F 333		

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F 333	Continued From page 101 "The facility policy entitled "Medication Administration" with a review date of 4-20-17 included: "...II. Safety Precautions: a. Observed the "five rights" for administration i. the right resident ii. the right time iii. the right medicine iv. the right dose v. the right method of administration..." "...III. Basic Safety in Administration a. Medication i. Read labels multiple times comparing to MAR 1. Review original physician order if discrepancy a. Do not provide if discrepancies continue..." Guidance is given for Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004), which apply to the activity of medication administration and treatment administration. To prevent medication errors, follow the six rights of 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 6. The right documentation." Same source, p. 707, "A medication order is	F 333		

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F 333	Continued From page 102 required for every medication or treatment you administer to a client...Regardless of how you receive an order, compare the prescriber's written orders with the medication administration record (MAR/TAR) when the medication is initially ordered. Verify medication information whenever new MARs are written or distributed or when clients transfer from one nursing unit or health care setting to another. Once you determine that information on the client's MAR is accurate, use the MAR/TAR to compare, prepare and administer medications." The previous Administrator sent a "Facility Reported Incident" (FRI) to the state agency on Wednesday 6-21-17, and a follow up report on Tuesday 6-27-17 in regard to the serious medication error. Both were late. The Resident was admitted to the hospital on Tuesday 6-20-17 for hypoglycemia, and the initial report should have occurred (within 2 hours of hospitalization) the same day. The follow up 5 day report should have occurred no later than 6-26-17, the 5th business day. The investigation showed no realization that the same orders which produced the error were reinstituted when the Resident returned from the hospital. The Humulin N (long acting) insulin was decreased, and administration time was changed to avoid confusion in the orders on 7-1-17, 5 days after the Resident returned, and the Regular humalog sliding scale insulin was continued as before. No re-education of staff was included in the investigation packet reviewed by surveyors, and was not provided by administration as evidence of re-training. Other instances of issues were found	F 333		

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F 333	Continued From page 103 during this survey with regard to administration of insulin within the facility, and those are documented in other deficiencies, contained within this survey statement of deficiencies (SOD) report. In conclusion, the investigation, reporting, and education, for this incident were not completed as required by federal mandate. The current Administrator and DON were made aware of the harm level deficient practice for this Resident with regard to insulin administration at the end of day debriefs on 9-20-17, and 9-21-17. No further information was presented by the facility. 2. Resident #14 received two different doses of the medication Depakote (ordered for the treatment of depression) from 2/22/17 through 9/21/17. When the physician was notified on 9/21/17 that the original order for Depakote 125 mg (milligrams) had not discontinued at the time 250 mg was ordered, the physician discontinued the 125 mg order. Resident #14 was admitted to the facility on 8/19/11 with the diagnoses of, but not limited to, dementia, depression, and anxiety. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 6/28/17. The MDS coded Resident #14 with moderately impaired cognition; required extensive assistance from staff for transfers, dressing, toileting, and hygiene.	F 333		

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F 333	Continued From page 104 On 9/20/17 at 1 p.m. Resident #14 was observed sitting in a wheelchair in her room. She was alert and conversational. Resident #14 stated lunch was great and stated her sister will be coming in for church services that day. Resident #14 did not display and negative behaviors or symptoms of depression. On 9/20/17 at 2:30 p.m. Resident #14's clinical record was reviewed. The review revealed physician's orders which included: 1/9/17 Depakote Sprinkles Capsule Delayed Release 125 mg Give 1 capsule by mouth two times a day related to Major Depressive Disorder and 2/22/17 DepakoteTablet Delayed Release 250 mg Give 1 tablet by mouth two times a day related to Major Depressive Disorder. Both the 125 mg and 250 mg orders were listed and signed as administered on the Medication Administration Record (MAR) twice daily from 2/22/17 until 9/21/17. On 9/20/17 at 4 p.m. the Administrator and Director of Nursing were informed of the Depakote orders. The pharmacy review sheet and physician notes were requested. On 9/21/17 at 9:30 a.m. the Depakote orders on the MAR were reviewed with the nurse (Licensed Practical Nurse-LPN-B) who administered the medications to Resident #14 that morning with the Registered Nurse Unit Manager (RN-B) present. LPN-B showed surveyor the opened and empty medication package which revealed Resident #14 received both the 125 mg and 250	F 333		

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F 333	Continued From page 105 mg of Depakote. It was discussed with LPN-B and RN-B that when the medication was increased to 250 mg that the 150 mg was not discontinued. Clarification whether the physician wanted both orders or not was requested. On 9/21/17 at 11:00 a.m., RN-B stated she called the doctor and he discontinued the 125 mg of Depakote. When asked what should have been done, RN-B stated "nursing and pharmacy should have clarified it." Facility policy titled "Medication Administration" with a reviewed date of 4/20/17 included: "...II. Safety Precautions: a. Observed the "five rights" for administration i. the right resident ii. the right time iii. the right medicine iv. the right dose v. the right method of administration..." "...III. Basic Safety in Administration a. Medication i. Read labels multiple times comparing to MAR 1. Review original physician order if discrepancy a. Do not provide if discrepancies continue..." Physician notes that were reviewed did not have documented evidence that Resident #14 was to receive both 125 mg and 250 mg of Depakote. A Valproic Acid level (a blood test to monitor the levels of Depakote circulating in the blood) laboratory result dated 7/11/17 was observed in the record which was within normal range. Physician orders included a Valproic Acid level every 6 months	F 333		

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F 333	Continued From page 106 Review of the pharmacy "Medication Regimen Review Summary" and "Pharmacy Review" progress notes from 2/23/17 through 9/12/17 did not have any medication irregularities documented. On 9/21/17 at 1:05 p.m. the Administrator and Director of Nursing were informed of the failure to clarify the Depakote orders which resulted in unnecessary medication administration and significant medication error. No further information was provided by the facility staff.	F 333		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334	F 334 1. Resident #3 was offered a pneumovaccine on 10/02/2017, but refused because resident stated he had within the past 5 years. Resident #3 received the pneumovaccine on 12/22/2015. 2. Current residents were audited to ensure a pneumovaccine was offered to them by the UM/ designee on 09/24/2017. Current residents that accepted the pneumovaccine will receive the pneumovaccine. Current residents that declined will have documentation in the medical chart as to why. 3. Licensed nurses will be educated on offering and documenting receiving/ declining pneumovaccine by ADON/Designee on or before 11/03/2017.	

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F 334	Continued From page 107 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the	F 334	4. A weekly audit will be performed on new admission residents to ensure they are offered and documented on regarding the pneumovaccine for twelve weeks by the UM/designee. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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F 334	Continued From page 108 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed for one (Resident #3) of 23 residents in the survey sample, to offer and/or evaluate the need for the pneumococcal (pneumonia) vaccine. Resident #3's clinical record had documented that he was not eligible to receive and also that he previously received the pneumococcal vaccine however, the facility staff failed to determine the date he received the vaccine or document the reason he was not eligible to receive it. The findings included: Resident #3 was admitted to the facility on 4/4/16 with the diagnoses of, but not limited to, chronic kidney disease stage III, diabetes mellitus, chronic pain, hypertension, and cerebrovascular disease with left sided weakness. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 8/2/17. The MDS coded Resident #3 with no cognitive impairment; required limited assistance from staff for bed mobility, transfers, dressing, toileting, hygiene, and bathing. On 9/18/17 at 2:25 p.m., Resident #3 was observed sitting in a wheelchair, in his room watching television. He was alert and conversational.	F 334		

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F 334	Continued From page 109 On 9/19/17 at 10:00 a.m. Resident #3's clinical record was reviewed. The review revealed on comparison MDS' with an ARD of 4/11/17 and 7/12/17 Section O Special Treatments, Procedures, and Programs-O0300 Pneumonia Vaccine, was documented as A.1=Yes, the resident's Pneumococcal vaccination is up to date and A.0=No, B.1.=Not eligible-medical contradiction respectively. On 9/19/17 at 11:20 a.m. the MDS nurse, Registered Nurse-A (RN-A) was asked why the pneumonia vaccine was documented as "not eligible." On 9/19/17 at 1:30 p.m. RN-A stated the pneumonia vaccine was ineligible "could be because he had it within 5 years but didn't have a date of administration." At 2:45 p.m. RN-A presented a "Admit/Discharge/Transfer Forms" from Resident #3's discharging hospital with a "Print Date/Time:" of 4/15/16 at 11:31 a.m. which included: "Pneumonia Vaccine Given: NO... Why Was The Pneumococcal Vaccine (sic) Not Received?: Previously immunized..." On 9/19/17 at 5:35 p.m. the Administrator and Director of Nursing were informed of Resident #3 not having documentation of when the pneumococcal vaccine was administered or evaluation of why he was "not eligible." The facility policy was requested. On 9/20/17 at 9:00 a.m. the Administrator (Admin-A) provided Resident #3's immunization record and facility policy. The immunization record had Resident #3's flu vaccine documented	F 334		

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F 334	Continued From page 110 as received on 9/23/16 and the Pneumovax Dose 1 with no date given and "Consent Status" as "Not Eligible." Facility policy titled "Resident Pneumococcal Vaccine" with a reviewed date of 4/20/17 included: "Policy: ...The purpose of this policy is to educate staff and notify residents and responsible parties in an effort to reduce the severity and episodes of certain types of pneumonia. The CDC recommends that individuals over the age of 65 years old be vaccinated against pneumococcal pneumonia, and in particular, those who also have chronic lung diseases such as COPD (chronic obstructive pulmonary disease), those who smoke cigarettes, those who have diabetes and other conditions that may lower their resistance to infection. Residents will be provided with education regarding pneumococcal pneumonia and will be offered the pneumococcal vaccine upon admission..." Procedure: "...B. Residents in the facility will be offered the pneumococcal pneumonia vaccine, unless medically contraindicated or the resident has already been immunized. 1. Residents newly admitted to the facility will be asked if they have received a pneumonia vaccine in the past. a) In the event the resident does indicate they have received a pneumonia vaccine in the past, the nurse will inquire if they have a record to verify the date and the exact product..." No further information was provided by the facility staff.	F 334		

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F 386	Continued From page 111	F 386		
F 386 SS=D	483.30(b)(1)-(3) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS (b) Physician Visits The physician must-- (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign, and date progress notes at each visit; and (3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to ensure Physician orders for recertification were signed timely for one resident (Resident # 10) in a survey sample of 23 residents. For Resident # 10, the facility staff failed to ensure Physicians orders for recertification were signed timely. Resident # 10 was not seen by the physician between 6/14/2017 and 8/30/2017 resulting in 77 days between signed recertification orders. The findings included: Resident #10 was an 84 year old female who was admitted to the facility on 12/2/2008. Resident #10's diagnoses included Diabetes Mellitus, Contracture Left hip, Contracture right hip, Bipolar	F 386	F 386 1. Resident # 10's physician order sheets were signed by a physician on 08/30/2017. 2. Current residents' physician order sheets were audited to ensure timely visits on 10/05/2017 by Medical Records/ designee. 3. Medical Records/ designee will be educated by Administrator on proper time frames/ timely physician visits on 10/11/2017. 4. A weekly audit of physician order sheets for timely visits will be completed for 12 weeks to ensure compliance by the Medical Record/ designee. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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F 386	Continued From page 112 Disorder, Hypertension, Major Depressive Disorder, and Macular Degeneration. Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/3/2017 was coded as an Annual assessment. She was coded as having a BIMS (Brief Interview for Memory Status) Score of 8/15 indicating severe cognitive impairment. She was also coded as needing extensive to total assistance of one person to perform all of her activities of daily living with the exception of eating. For eating, she was coded as needing supervision and set up only. She was coded as always incontinent of bowel and bladder. On 9/20/17 at 8:45 AM, a review was conducted of Resident #10's clinical record. Review of Resident # 10's clinical record revealed the most recently signed Physicians "Order Summary Report" form was dated as having been signed on 8/30/2017 to recapitulate and reinstitute the Resident's medication, and treatment orders. A thorough review of Resident # 10's clinical record revealed the previously signed Physician's Order Summary Report form was dated as signed on 6/14/2017. On 9/20/2017 at 4:45 PM, the Administrator and Director of Nursing were informed that the last signed Physicians Orders Sheet noted in the clinical record was dated on 8/30/2017 and the one prior was dated on 6/14/2017, resulting in 77 days between signatures. The Director of Nursing and Administrator stated the physicians should sign to recertify orders every 60 days. No further information was provided.	F 386		

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F 425	Continued From page 113	F 425	F425	
F 425 SS=E	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to identify and report medication irregularity for one (Resident #14) of 23 residents in the survey sample The pharmacy did not identify and report to the facility staff that Resident #14 received two different doses of the medication Depakote (ordered for the treatment of depression) from 2/22/17 through 9/21/17. When the physician was notified on 9/21/17 that the original order for Depakote 125 mg (milligrams) had not discontinued at the time 250 mg was ordered, the physician discontinued the 125 mg order. The findings included: Resident #14 was admitted to the facility on 8/19/11 with the diagnoses of, but not limited to, dementia, depression, and anxiety.	F 425	1. Resident #14's Depakote dosage was clarified on 09/21/2017. 2. Current residents' on Depakote were reviewed to ensure orders are transcribed correctly on 10/05/2017 by DON/ Designee. 3. Licensed nurses will be educated on transcription of medications related to Depakote dosing by DON/ Designee on or by 11/03/2017. 4. A weekly audit of residents receiving Depakote will be performed to ensure proper transcription has occurred by the DON/ Designee times twelve weeks. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months. 11/03/2017	

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F 425	Continued From page 114 The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 6/28/17. The MDS coded Resident #14 with moderately impaired cognition; required extensive assistance from staff for transfers, dressing, toileting, and hygiene. On 9/20/17 at 1 p.m. Resident #14 was observed sitting in a wheelchair in her room. She was alert and conversational. Resident #14 stated lunch was great and stated her sister will be coming in for church services that day. Resident #14 did not display and negative behaviors or symptoms of depression. On 9/20/17 at 2:30 p.m. Resident #14's clinical record was reviewed. The review revealed physician's orders which included: 1/9/17 Depakote Sprinkles Capsule Delayed Release 125 mg Give 1 capsule by mouth two times a day related to Major Depressive Disorder and 2/22/17 DepakoteTablet Delayed Release 250 mg Give 1 tablet by mouth two times a day related to Major Depressive Disorder. Both the 125 mg and 250 mg orders were listed and signed as administered on the Medication Administration Record (MAR) twice daily from 2/22/17 until 9/21/17. On 9/20/17 at 4 p.m. the Administrator and Director of Nursing were informed of the Depakote orders. The pharmacy review sheet and physician notes were requested.	F 425		

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F 425	Continued From page 115 On 9/21/17 at 9:30 a.m. the Depakote orders on the MAR were reviewed with the nurse (Licensed Practical Nurse-LPN-B) who administered the medications to Resident #14 that morning with the Registered Nurse Unit Manager (RN-B) present. LPN-B showed surveyor the opened and empty medication package which revealed Resident #14 received both the 125 mg and 250 mg of Depakote. It was discussed with LPN-B and RN-B that when the medication was increased to 250 mg that the 150 mg was not discontinued. Clarification whether the physician wanted both orders or not was requested. On 9/21/17 at 11:00 a.m., RN-B stated she called the doctor and he discontinued the 125 mg of Depakote. When asked what should have been done, RN-B stated "nursing and pharmacy should have clarified it." Facility policy titled "Medication Administration" with a reviewed date of 4/20/17 included: "...II. Safety Precautions: a. Observed the "five rights" for administration i. the right resident ii. the right time iii. the right medicine iv. the right dose v. the right method of administration..." "...III. Basic Safety in Administration a. Medication i. Read labels multiple times comparing to MAR 1. Review original physician order if discrepancy a. Do not provide if discrepancies continue..." Physician notes that were reviewed did not have	F 425		

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F 425	Continued From page 116 documented evidence that Resident #14 was to receive both 125 mg and 250 mg of Depakote. A Valproic Acid level (a blood test to monitor the levels of Depakote circulating in the blood) laboratory result dated 7/11/17 was observed in the record which was within normal range. Physician orders included a Valproic Acid level every 6 months. Review of the pharmacy "Medication Regimen Review Summary" and "Pharmacy Review" progress notes from 2/23/17 through 9/12/17 did not have any medication irregularities documented. Pharmacy note dated 1/24/17 included: "...Depakote 125 mg BID..." (BID=twice a day) and, Pharmacy note dated 2/23/17 included: "...Behavior noted Depakote 250 mg BID (increased)..." Pharmacy note dated 3/21/17 and 4/24/17 included: "...This patient with no recommendations or irregularities noted at this time..." The most recent Pharmacy review dated 9/12/17 included lab "Notes" but no recommendations or irregularities listed. On 9/21/17 at 1:05 p.m. the Administrator and Director of Nursing were informed of the failure of the pharmacy reviews to identify and report the medication irregularity. No further information was provided by the facility staff.	F 425		
F 441	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL,	F 441		

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F 441 SS=D	Continued From page 117 PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 441	F 441 1. Resident #1's sterile dressing changes were initiated on 09/20/2017. 2. Current residents with the LVAD device were reviewed to ensure a sterile dressing change was completed as ordered by Unit Manager/designee on 10/04/2017. 3. Licensed nursing staff will be inserviced on LVAD sterile dressing techniques by DON/ designee on or before 11/03/2017. 4. A weekly audit of residents with LVAD sterile dressing changes will be reviewed to ensure sterile dressing changes are being performed per physician order weekly times twelve weeks by the DON/ designee. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

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F 441	Continued From page 118 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility failed, for 1 resident (Resident #1) in the survey sample of 23 residents, to implement the infection control program. The facility staff failed to provide sterile dressing changes.	F 441		

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F 441	Continued From page 119 The Findings included: Resident #1 was a 61 year old who was admitted to the facility on 1/1/17. Resident #1's diagnoses included Presence of Artocoronary Bypass Graft, Presence of Heart Assist Device (LVAD Unit), Arteriosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Diabetes Mellitus Type 1, Muscle Weakness - Generalized, Difficulty Walking, Contractures of Both Hands, Major Depressive Disorder, Hemoglobinuria, and Hyperlipidemia. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 8/14/17, coded Resident #1 as having a Brief Interview of Mental Status Score of 14, indicating that she was cognitively intact and was independent in decision-making. She was also coded as having adequate vision and hearing. On 9/18/17 a review was conducted of facility documentation, revealing a complaint which was submitted to the office of Long Term Care on 1/25/17. The complaint alleged that Resident #1's LVAD unit had drainage around it and that the bandages were not changed daily. On 9/19/17 at 8:45 A.M. an observation was conducted of Resident #1 in her room. When asked if she had any concerns about the care she received at the facility, Resident #1 responded, "They are supposed to check my heart machine. They never check it. This bandage is supposed to be changed every day. They don't." The bandage attached to Resident#1's abdomen on her left side was dated "9/17/17 on 3-11" shift, along with the nurse's initials. The bandage had	F 441		

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F 441	Continued From page 120 not been changed per physician's order on 9/18/17. On 9/19/17 a review was conducted of Resident #1's clinical record. During the month of February 2017, the dressing had only been documented as having been changed from 2/23/17 thru 2/27/17. During the month of March 2017, the dressing had been changed every day. During the month of April 2017, the dressing had only been documented as having been changed on 4/13/17, 4/28/17, 4/29/17, and 4/30/17. During the month of May 2017, the dressing had only been documented as having been changed from 5/2/17 thru 5/14/17. There was no documentation of dressing changes for June thru September 2017. On 9/19/17 the Director of Nursing (DON Administration B) was asked to observe Resident #1's dressing. The DON confirmed that the dressing was supposed to be changed daily, and hadn't been changed since 9/17/17. She stated, "It's important to change it daily to make sure that it isn't causing any type of infection. (name) Clinic came in and did an inservice on how to clean it and take care of it." The DON submitted a signature sheet and training summary entitled, "8/31/17. (name) Advance Heart Failure Center - Left Ventricular Assist Device, Sterile Dressing Change." Resident #1 had been admitted to the facility 1/1/17, but the facility staff did not obtain training for the care of her device until 8/31/17. The facility staff did not have any written instructions for the care of the Assistive device. After the surveyor's request on 9/18/17, the facility obtained a copy of the manufacturer's instructions for the device on 9/20/17. The manufacturer's	F 441		

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F 441	Continued From page 121 instructions for the Heartmate 2 LVAS (Left Ventricular Assist System) on Page 108 read, "It is extremely important to keep the exit site where the percutaneous lead goes through your skin clean and dry at all times. Follow aseptic technique any time you change the bandage or touch or handle the exit site. IMPORTANT! Watch the exit site for signs of infection, such as redness, swelling, drainage, bleeding, or a bad smell. IMMEDIATELY tell your doctor or hospital contact person if there are any signs of infection." Resident #1's clinical record contained the following note from the hospital, "1/19/17. Her son called on 1/18/17 to report drainage and pain from (Resident #1) his mother's drieline exit site. She was brought on on 1/19/17 for a wound assessment. The gauge dressing was noted to be saturated with thick, tan drainage. The skin surrounding the drieline exit site was macerated, and a scanty amount of serosanguinous drainage was expressed with palpation of the surrounding tissue. Admitted due to suspected drieline infection." The hospital subsequently identified the infection as MSRA (Methicillin-resistant Staphylococcus Aureus). Resident #1 was hospitalized from 1/19/17 thru 2/21/17. On 9/21/17 at 2:16 P.M. a review was conducted of the facility's Infection Control Program. The DON stated, "sterile technique should have been implemented during Resident #1's dressing changes, including pulling the curtain, putting on a mask, gloves, setting up a sterile field, and cleaning the site. This training was done on 8/31/17. I don't know why it wasn't done on a daily basis. It should have been done on a daily basis since we were trained in August. It is important to keep infection from the drive line." The facility did	F 441		

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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 441	Continued From page 122 not have a written policy on sterile technique for dressing changes. On 9/21/17 the facility Administrator (Administration A) was informed of the findings. No further information was received.	F 441		
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview the facility staff failed to ensure that employees were educated on emergency procedures. Three employees did not know which electrical outlets to use while the generator was running. Three employees did not know the hurricane emergency procedures. The findings included: Registered Nurse B (RN B) supervised Wing 2. She was interviewed on 9/20/17 at 9:20 a.m. When asked which electrical outlets needed to be used while the generator was running, RN B stated she did not know. She was asked to find the answer to the question at the conclusion of the interview. RN B returned, stating that the red outlets on Wing 1 were to be used while the generator was running. RN B was asked what she was supposed to do with her residents on Wing 2 who had medical equipment that needed	F 518	F 518 1. Staff members in question were inserviced on facility emergency preparedness (related to generators, electrical outlets, and hurricanes/ tornadoes) plans by 11/03/2017 by ED/designee. 2. Staff will be educated on emergency preparedness (related to generators, electrical outlets, and hurricanes/ tornadoes) by ED/designee. 3. Current staff will be educated on facility emergency preparedness on or before 11/03/2017 by the ED/ Designee. Facility orientation will include facility emergency preparedness information. 4. Weekly facility orientation will be reviewed to ensure facility emergency preparedness is included by Administrator/ designee. Results from audits will be forwarded to the Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for further monitoring for three (3) months.	11/03/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495144	A. BUILDING _____ B. WING _____	09/21/2017

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F 518	Continued From page 123	F 518		

to be plugged in if the red outlets were only on Wing 1. RN B stated she would move the residents that required use of the red outlets to the other wing.

Certified Nursing Assistant C (CNA C) was interviewed on 9/20/17 at 9:45 a.m. When asked which electrical outlets need to be used while the generator was running, CNA C stated she did not know. She was asked to find the answer to the question at the conclusion of the interview. CNA C returned, stating that the red outlets were to be used while the generator was running. In addition, CNA C was asked if she had training on extreme weather situations such as hurricanes or tornadoes. CNA C stated that she had not had training on either situation.

Certified Nursing Assistant D (CNA D) was interviewed on 9/20/17 during the afternoon. CNA D was asked if she had training on extreme weather situations such as hurricanes or tornadoes. CNA D stated that the residents should stay in their rooms.

Certified Nursing Assistant E (CNA E) was interviewed on 9/20/17 at 3:50 p.m.. When asked which electrical outlets needed to be used while the generator was running, CNA E stated that the red outlets were to be used while the generator was running. CNA E was asked if she had training on extreme weather situations such as hurricanes or tornadoes. CNA E stated that she was not sure what to do during either weather situation.

The Maintenance Director was interviewed on 9/20/17 at 10:15 a.m. He was asked which outlets staff were to use while the generator was

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	495144	A. BUILDING _____ B. WING _____	09/21/2017

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F 518	Continued From page 124 running. The Maintenance Director stated that all outlets worked while the generator was running. It was reviewed with the Maintenance Director that staff who were interviewed regarding emergency procedures did not know which outlets to use. The issues regarding emergency procedures were reviewed with the Administrator and Director of Nursing on 9/21/17 at 11:30 a.m.	F 518		