STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495354	A. BUILDING _____ B. WING _____	R-C 09/27/2018

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{F 000}	INITIAL COMMENTS An unannouced Medicare/Medicaid revisit to the standard survey conducted 8/7/18 through 8/9/18, was conducted on 9/25/18 through 9/27/18. New findings with corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Uncorrected deficiencies are identified within this report. No complaints were investigated during the survey. The census in this 136 certified bed facility was 116 at the time of the survey. The survey sample consisted of eight current Resident reviews (Residents #101 through # 108) and one closed record review (Resident #109).	{F 000}		
{F 656} SS=D	. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	{F 656}		11/5/18

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

Electronically Signed | 10/11/2018

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{F 656}	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to develop a care plan for one of 9 residents , Resident #105. Resident #105 did not have a care plan to address interventions for vision. The Findings Include: Resident #105 was admitted to the facility on 5/9/13. Diagnoses for Resident #105 included: Alzheimer's, dementia, depression, and anxiety. The most current MDS (minimum data set) was a quarterly with an ARD (assessment reference	{F 656}	1. The care plan for Resident #105 has been updated to include interventions for moderate vision impairment as identified in section B1000 of Resident #105's MDS (minimum data set). 2. The Clinical Manager or designee will conduct a 100% audit of current residents to ensure that their care plans are reflective of, and include interventions for, residents' vision status as identified in section B1000 of the MDS (minimum data set). Discrepancies will be addressed with the licensed nurses and care plans	

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{F 656}	Continued From page 2 date) of 7/23/18. Resident #105 was assessed with a cognitive score of 01, indicating severely cognitively impaired. Section B1000 indicated that Resident #105 had moderate vision impairment. Section V of the most current full assessment dated 1/22/18 indicated vision was triggered for a care plan to be put in place. On 9/25/18 Resident #105's care plan was reviewed. A care plan for vision indicated that Resident #105 had moderate impairment with limited vision and unable to read newspaper, but no interventions were documented on the care plan for vision impairment. On 9/26/18 at 9:20 AM, the assistant director of nursing (ADON) was interviewed concerning the above finding. The ADON reviewed the care plan for vision and verbalized that she (ADON) did not realize there were no interventions for vision and thought it may because Resident #105 does not wear glasses. This surveyor stated that according to the care plan and MDS, Resident #105 can't read small print (newspaper), and asked, what interventions could be put in place for resident's that can't read small print. The ADON verbalized that resident could be fitted with reading glasses, be read too, or get larger printed materials. On 9/26/18 at 3:40 PM the above information was presented to the director of nursing (DON) and administrator. No other information was provided prior to exit conference on 9/27/18.	{F 656}	updated as appropriate. 3. The Staff Development Coordinator or designee will conduct education with licensed nursing staff on the facility policy for completion of the comprehensive care plan including ensuring that the care plan accounts for vision impairment as appropriate. 4. The Director of Nursing or designee will conduct audits of 20% of comprehensive care plans to ensure they are reflective of, and include interventions for, vision status as identified in section B1000 of the MDS (minimum data set) weekly X4 weeks, then monthly X2 months. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and further action as may be required. 5. Date of Completion: 11/5/2018	
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii)	F 659		11/5/18

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F 659	Continued From page 3 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to implement interventions on the care plan for one of 9 residents, Resident #106. Resident #106 was not weighed daily as indicated per the edema protocol, an intervention on the initial care plan. The Findings Include: Resident #106 was admitted to the facility on 9/20/18. Diagnoses for Resident #106 included: Left femur fracture, chronic atrial fibrillation, kidney disease, and edema. The most current MDS (minimum data set) was not completed at the time of the survey as Resident #106 was newly admitted, but according to progress notes, Resident #106 was cognitively intact. On 9/26/18 Resident #106's medical record was reviewed to include the current initial care plan created on 9/20/18. A care plan for skin integrity was developed due to wounds and edema. One of the interventions for skin integrity included "Edema protocol will be followed for my edema to both lower extra-am [sic] on tx [treatment] for	F 659	1. The care plan for Resident #106 was updated at the time of survey to include interventions that are specific to management of the Resident's edema. 2. The Clinical Manager or designee will conduct a 100% audit of current residents to identify risk for edema. Any discrepancies will be addressed with the licensed nurses and care plans will be updated and interventions implemented to reflect the resident's needs. 3. The Staff Development Coordinator or designee will conduct education with licensed nursing staff on the facility policy and protocols for completion and utilization of the comprehensive care plan and creating interventions for edema. 4. The Director of Nursing or designee will conduct audits of 20% of current residents to identify risk for edema, and that any identified risk is care planned with specific interventions implemented. This audit will be conducted weekly X4 weeks, then monthly X2 months. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI)	

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F 659	Continued From page 4 edema." The care plan did not outline edema protocol. Medications were also reviewed and indicated that Resident #106 was on Lasix for edema. Review of Resident #106's Treatment Administration Record (TAR) indicated that Resident #106 was supposed to be weighed daily, but did not evidence that weights were being done. On 9/26/18 at 11:00 AM, a nurse on unit 3 was asked for a copy of the edema protocol. At this time the nurse manager, RN (registered nurse) #1 began to assist the surveyor. RN #1 was asked abou the edema protocol. RN #1 went to a filing cabinet and pulled out a protocol titled "Post-Acute Protocol: CHF (congestive heart failure)." The protocol included: "Weights will be taken the same time and place each day with the same (or similar) clothing using the same scale." After reviewing the protocol this surveyor stated that the protocol was for CHF. RN #1 verbalized that the nurses also used the protocol for edema. On 9/26/18 at 11:20 AM, the MDS coordinator (RN #2) was interviewed regarding Resident #106's edema protocol. RN #2 was asked if there was a specific edema protocol. RN #2 turned to some of the nursing staff at the nurses station and asked for the edema protocol. A nurse presented the same protocol that the unit 3 nurse had presented. RN #2 was asked to come to the conference room to review Resident #106's chart. This surveyor showed documentation of initialing the	F 659	Committee for review and further action as may be required. 5. Date of Completion: 11/5/2018	

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F 659	Continued From page 5	F 659		

edema protocol on 9/20/18 and showed where instructions for daily weights was transferred onto the TAR, but did not evidence that daily weights were actually being done. At this time this surveyor and RN #2 reviewed the weights that were documented in the electronic chart which evidenced that Resident #106 was weighed on 9/20/18 (when the Resident was admitted) and on 9/26/18. According to documentation Resident #106 weighed 154 pounds on 9/20/18 and 160 pounds on 9/26/18 totaling a 6 pound increase in 6 days.

RN #2 verbalized that sometimes the nurses will document weights in the progress notes. RN 2 and this surveyor then reviewed all progress notes and did not observe that weights were being documented.

RN #2 verbalized that the physician had been in and wrote an order to get weights on Resident #106 on Monday, Wednesday, and Friday. The physician's order was not written until 9/24/18, so according to the edema protocol, daily weights should have been completed from 9/20/18 through 9/24/18.

On 9/26/18 at 3:40 PM, the above information was presented to the director of nursing (DON) and administrator. The DON verbalized that she was unaware of the facility having a edema protocol and did not think the CHF protocol applied to edema. The DON verbalized as far as she knew Resident #106 did not have a diagnoses of CHF. When asked why Resident #106 on Lasix, the DON verbalized for edema. This surveyor stated that the intervention on the care plan was for the edema protocol.

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F 659	Continued From page 6 On 9/27/18 at 9:10, the DON presented hospital records and stated that Resident #106 did not have a diagnoses of CHF and the nurse put Resident #106 on the edema protocol because of a family history of heart disease. The DON verbalized that the edema protocol was not initialized because there is no edema protocol. The surveyor stated that 2 different units were asked for an edema protocol and both units showed the CHF protocol and verbalized that is what was being used for the edema protocol. This surveyor also verbalized if the facility did not initialize an edema protocol when it was initiated on the care plan, then the facility was not implementing the interventions on the care plan. No other information was provided prior to exit conference on 9/27/18.	F 659		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, the facility staff failed to follow physician's orders for one of 9 residents , Resident #106.	F 684	1. At the time of the survey, the weight discrepancy for resident #106 was reviewed with the physician with no new orders written.	11/5/18

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F 684	Continued From page 7 Resident #106 did not get weighed as ordered. The Findings Include: Resident #106 was admitted to the facility on 9/20/18. Diagnoses included: Left femur fracture, chronic atrial fibrillation, kidney disease, and edema. The most current MDS (minimum data set) was not completed at the time of the survey as Resident #106 was newly admitted, but according to progress notes Resident #106 was cognitively intact. On 9/26/18 Resident #106's medical record was reviewed. Review of physician orders documented an order written on 9/24/18 that read "Weigh pt (patient) on M W F (Monday Wednesday Friday) before breakfast. On Wednesday 9/26/18, Resident #106 was observed in the dinning room eating breakfast. At this time Resident #106 was unterviewed. During the conversation, Resident #106 was asked if the staff had weighed her this morning prior to breakfast. Resident #106 stated that the staff did not weigh her, but was weighed when she was first admitted. On 9/26/18 at 10:10 AM, certified nursing assistant (CNA #1) was interviewed regarding Resident #106's weight. CNA #1 stated she had just gotten Resident #106's weight and her weight was 160 pounds. CNA #1 was asked if she knew of any specific orders regarding when to weigh Resident #106. CNA #1 verbalized that the nurses give the CNAs a list of Residents to be weighed each Wednesday, because Wednesday	F 684	2. The Clinical Manager or designee will conduct a 100% audit of current residents who have a physician order for weights to ensure weights have been completed per physician orders. Any discrepancies will be addressed with the physician and licensed nurses. 3. The Staff Development Coordinator or designee will conduct education with licensed nursing staff on the process of following physician orders to include physician orders for weights. 4. The Director of Nursing or designee will conduct audits of 20% of current residents who have physician ordered weights to ensure they have been completed per physician orders. This audit will be conducted weekly X4 weeks, then monthly X2 months. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and further action as may be required. 5. Date of Completion: 11/5/2018	

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F 684	Continued From page 8	F 684		

is weekly weigh day for Residents, but had no specific instructions for when to weigh Resident #106.

This surveyor then explained to CNA #1 that Resident #106 was supposed to be weighed before breakfast on Monday, Wednesday, and Friday. CNA #1 stated she was not aware of an order and did not get a weight before breakfast as occupational therapy was working with Resident #106 prior to breakfast. Then Resident #106 went down to eat breakfast and was weighed after breakfast.

On 9/26/18 at 10:20 AM, license practical nurse (LPN) #1, the nurse assigned to Resident #106, was interviewed regarding Resident #106's order for weights. LPN #1 verbalized that she was aware of the order for weights to be obtained at specific times due to edema in Resident #106 legs. Occupational therapy was working with Resident #106 early on 9/26/18 and she (LPN #1) did not realize that Resident #106 had returned from therapy and had already eaten breakfast prior to getting weighed.

On 9/26/18 at 3:40 PM the above information was presented to the director of nursing (DON) and administrator.

No other information was provided prior to exit conference on 9/27/18.