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	495365	A. BUILDING _____ B. WING _____	C 08/30/2018

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MAPLE GROVE HEALTH CARE CENTER	POST OFFICE BOX 2409 LEBANON, VA 24266

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 08/28/18 through 08/30/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 08/28/18 through 08/30/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 56 at the time of the survey. The final survey sample consisted of 14 current Resident reviews and 3 closed record reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure an accurate MDS assessment for one of 17 residents Resident #7 The findings included: The facility staff failed to complete an accurate MDS in regards to Resident #7's feeding tube	F 641	Kissito Healthcare shares the state's focus on the health, safety and well being of facility residents. Although the facility does not agree with some of the findings and conclusions of the surveyors, we have implemented a plan of correction to demonstrate our continuing effort to provide quality care to our residents.	10/11/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/27/2018

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

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F 641	Continued From page 1 documentation. Per the clinical record review Resident #7 was admitted to the facility on 6/15/17 with the following diagnoses of, but not limited to Malignant Neoplasm of Larynx, Dysphagia, Pneumonia, Generalized Anxiety Disorder, Dysphagia following Cerebral Infarction and Unspecified Protein Calorie Malnutrition. On the Quarterly MDS Assessment with an ARD (Assessment Reference Date) of 5/23/18, the resident was coded as having memory problems with short term and OK long-term memory.Also reflected was modified independence with daily decision making, with some difficulty in new situations only. Resident was ordered to receive supplemental tube feeding and a mechanically altered diet at this time. The surveyor performed a review of Resident #7's clinical record on 8/29 and 8/30/18. During this review, the surveyor noted on the quarterly MDS assessment with ARD of 5/23/18, under Section K 0510 nutritional approaches, feeding tube was not checked. On 8/29/18 at 11:30 am, the surveyor notified the MDS nurse #1 of the above documented findings for Resident #7 in regards to feeding tube under section K of the MDS. The MDS nurse and surveyor reviewed the clinical record together at this time and it was clarified that feeding tube was failed to be checked under section K. At 11:55 am, MDS nurse #1 returned to the conference room and provided the surveyor a	F 641	F641- Section K of the MDS for Resident #17 was modified on 8/30/2018 to accurately reflect the tube feeding. An audit of current residents in the center with tube feeding was conducted to ensure that section K of the MDS was accurate. IDT team was educated by the Director of Nursing/ Designee on accurately coding the MDS including section K. The Director of Nursing/Designee will review 5 assessments per week to ensure accuracy of section K of the MDS assessment. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audit will be conducted on a random basis.	

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F 641	Continued From page 2 copy of the MDS with ARD of 05/23/18. MDS nurse #1 stated "Feeding tube should have been checked" as the Resident was receiving supplemental tube feeding at that time. The surveyor notified the administrative team of the above documented findings on 8/30/18 at 11:10 am during pre-exit meeting No further information was provided to the surveyor prior to the exit conference.	F 641		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		10/11/18

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F 690	Continued From page 3 prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review the facility staff failed to ensure adequate foley catheter care for the prevention of urinary tract infections for 1 of 17 Residents, Resident #39. The findings included: The facility staff failed to ensure the Resident's foley catheter drainage bag/drainage tubing did not touch the floor. Resident #39 was admitted to the facility on 02/01/13 and readmitted on 04/28/18. Diagnoses included but not limited to multiple sclerosis, chronic obstructive pulmonary disease, neurogenic bladder, dysphagia, anemia, bipolar disorder, gastroesophageal reflux disease, depression and hypothyroidism. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/26/18 coded the Resident as 14 out of 15 in section C, cognitive patterns. Section H, bowel and bladder, coded the Resident as having an indwelling (foley) catheter.	F 690	F690 – Resident #39's Foley catheter drainage bag was removed from floor and drainage bag was replaced and secured to the bed frame. An Audit of current residents with Foley catheters in the center was conducted to ensure proper catheter care and placement of catheter drainage bags to be off the floor. Clinical staff will be been educated by the Director of Nursing/ Designee on the center's policy for catheter care and to ensure the Foley drainage bag is secured off the floor. The Director of Nursing/ designee will during morning rounds via direct observation to ensure the observe proper catheter care and to ensure the drainage bags are secured off the floor. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the	

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F 690	Continued From page 4 Surveyor observed Resident #39 on 08/28/18 at approximately 1610. Resident was resting in bed, alert and oriented. Surveyor observed Resident's foley catheter drainage bag lying on the floor beside of Resident's bed. Surveyor spoke with Resident at this time and Resident stated that she currently has a UTI (urinary tract infection). Resident #39's clinical record was reviewed on 08/28/18. It contained a laboratory report for a urinalysis and urine culture dated 08//23/18 which indicated the Resident has a UTI. The clinical record also contained a physician's order for Cipro 500 mg q 12 hours x 7 days for UTI. Surveyor spoke with the infection control nurse on 08/30/18 at approximately 0830 regarding Resident #39. Infection control nurse stated that Resident's foley catheter drainage bag should not be lying in the floor and that this could possibly contribute to a UTI. Surveyor requested and was provided with a copy of policy entitled "Catheter Care" on 08/30/18. The policy read in part, "When checking urinary catheters and containers, follow these rules: 13. Make sure the catheter tubing and drainage bag are kept off the floor". The concern of the Resident's foley catheter drainage bag lying in the floor was discussed with the administrative team during a meeting on 08/30/18 at approximately 1155. No further information was provided prior to exit.	F 690	problem no longer exists, audit will be conducted on a random basis.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		10/11/18

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F 695	Continued From page 5 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to accurately assess and monitor the need for oxygen for 1 of 17 Residents, Resident #48. The findings included: For Resident #48 the facility failed to accurately assess the Resident's need for oxygen. Resident #48 was admitted to the facility on 07/10/18. Diagnoses included but not limited to hypertension, end stage renal disease, diabetes mellitus, dementia, and chronic obstructive pulmonary disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/17/18 coded the Resident as having both short and long term memory impairment with modified independent cognitive skills for daily decision making. Surveyor observed Resident #48 on 08/28/18 at approximately 1100. Resident was seated in wheelchair at bedside with family member in attendance. Resident was alert but confused and	F 695	F695 No action for Resident #48 due to time frame had already passed. Current residents in the center receiving oxygen therapy have the potential to be affected. Licensed Nurses were educated by the Director of Nursing/Designee on the center's policy for oxygen therapy including documentation in the progress notes the indication for usage. The Director of Nursing/Designee will review oxygen orders 5X weekly in clinical meeting to ensure indications for usage is documented in the progress notes. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audit will be conducted on a random basis.	

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F 695	Continued From page 6 did not appear to be in any distress. Resident was not observed to be using oxygen at this time. Surveyor observed Resident #48 again on 08/29/18 at approximately 1025. Resident was seated in wheelchair at bedside with family member in attendance. Resident had oxygen in use at this time. Resident #48's clinical record was reviewed on 08/28/18. It contained a signed POS (physician's order summary) for the month of August which read in part, "oxygen sat checks every day and prn (as needed) every day shift for routine". The Resident's eMAR (electronic medication administration record) was reviewed and contained an entry which read in part, "oxygen sat checks every day and prn (as needed) every day shift for routine". The Resident's recorded oxygen sats ranged from 94-99%. Resident #48's progress notes were reviewed and the surveyor could not locate any notes related to Resident #48's oxygen usage. The surveyor requested and was provided with a copy of "Nursing Home Standing Orders" which read in part, "IV. Symptom Treatment H. Shortness of breath---First check pulse oximeter readings if 02 sat is <90 % (less than), administer 02 at 2L/per min via nasal cannula and have physician review on next round". The surveyor spoke with the DON (director of nursing) on 08/30/18 at approximately 1145 regarding Resident #48's oxygen usage. DON stated that he would expect nurses to document reason for oxygen usage in progress notes. The concern of the facility staff not assessing and	F 695		

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F 695	Continued From page 7 monitoring the need for oxygen usage was discussed with the administrative team during a meeting on 08/30/18 at approximately 1155. No further information was provided prior to exit.	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		10/11/18

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F 758	Continued From page 8 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 2 of 17 Residents were free of unnecessary psychotropic medications, Residents #25 and #48. The findings included: 1. For Resident #25 the facility staff failed to provide monitoring for the antidepressant medication Cymbalta. Resident #25 was admitted to the facility on 06/06/18 and readmitted on 08/06/18. Diagnoses included but not limited to anemia, hypertension, diabetes mellitus, hyperlipidemia, depression, chronic obstructive pulmonary disease, chronic kidney disease, generalized anxiety disorder and dysphagia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 08/13/18	F 758	F758 Resident #25's antidepressant is being monitored as required. Resident #48's physician was notified and order received for the PRN Ativan to be for 14 days. An Audit of residents on psychotropic medication in the center was conducted to ensure completion of the Side Effects Monthly Flow Sheet in their entirety. In addition, PRN psychoactive medications was reviewed to ensure each med has a stop date for 14 days. Director of Nursing/designee will educate Licensed Nurses on completing the monitoring flow sheets for psychoactive medications including the electronic monitoring flow sheet as part of the	

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F 758	Continued From page 9 coded the Resident as 15 of 15 in section C, cognitive patterns. This is an admission MDS. Resident #25's CCP (comprehensive care plan) was reviewed and contained a care plan for "Resident at risk for adverse effect related to psychotropic medication secondary to dx (diagnosis) of depression". Interventions for this care plan were listed as monitor behaviors related to psychotropic medications as needed and observed for adverse effects related to psychotropic medications. Resident #25's clinical record was reviewed on 0828/18. It contained a signed POS (physician's order summary) which read in part, "Cymbalta Capsule Delayed Release Particles 30 mg Give 1 capsule by mouth two times a day for depression". The Resident's clinical record also contained a "Side Effects Monthly Flow Sheet" for the months of July and August 2018. This flow sheet had not been completed on any day for July and had only been partially completed for August. The surveyor spoke with the DON (director of nursing) on 08/30/18 at approximately 1145 regarding Resident #25. DON stated that Resident had been in and out of hospital, but that the flow sheet should have been completed on the days Resident was in facility. The concern of not monitoring the medication was discussed with the administrative team during a meeting on 08/30/18 at approximately 1155. No further information was provided prior to exit. 2. For Resident #48 the facility staff failed to	F 758	EMAR. In addition, education included PRN medications need to have a 14 day stop date and the physician must see the resident prior to reordering and document in the medical record the continued indication for use. Director of Nursing/ Designee will review side effects flow sheet documentation 5x/ weekly in clinical meeting to ensure completion of and accuracy of side effects documentation. In addition, PRN psychoactive medications will be reviewed 2 times weekly to ensure the 14 day stop date. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audit will be conducted on a random basis.	

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F 758	Continued From page 10	F 758		

provide an end date for the prn medication Ativan and administered the prn medication Ativan without indications for use.

Resident #48 was admitted to the facility on 07/10/18. Diagnoses included but not limited to hypertension, end stage renal disease, diabetes mellitus, dementia, and chronic obstructive pulmonary disease.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/17/18 coded the Resident as having both short and long term memory impairment with modified independent cognitive skills for daily decision making. Section E, behavior indicated that the Resident had no symptoms of psychosis and had behavioral symptoms of rejecting care 1 to 3 days during the look back period. This is an admission MDS.

Resident #48's CCP (comprehensive care plan) was reviewed and contained care plans which read in part, "Resident has behaviors or history of behaviors of Resident will become agitated with staff, refusing to be transferred via Hoyer lift" and "Resident at risk for adverse effect related to psychotropic medication secondary to dx (diagnosis) of anxiety, depression". Interventions for this care plan were listed as monitor behaviors related to psychotropic medications as needed, MD review for appropriateness, and observed for adverse effects related to psychotropic medications.

Resident #48's clinical record was reviewed on 08/28/18. It contained a POS (physician's order summary) which read in part, "Monitor and document behaviors related to the psychoactive

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F 758	Continued From page 11 medication of: Celexa, Ativan, Buspar. Behavior Codes: 0) none, 1) afraid, 2) Striking out, 3) Angry, 4) Anxiety, 5) Compulsive behaviors, 6) Continuous crying, 8) Continuous screaming/yelling, 9) Danger to others, 10) Danger to self, 12) depressed, 13) Extreme fear, 14) Hallucinations, 15) Paranoia, 16) Delusions, 17) Insomnia, 18) Slapping, 19) Mood change, 20) Spitting, 21) Throwing objects,, 22) Pulling tracheostomy tubing, 23) Pacing every shift for behavior monitoring", and "Ativan Tablet 1 mg Give 1 tablet by mouth every 4 hours as needed for psychosis with psychotic behaviors". The PRN (as needed) order for Ativan did not include a stop date. Resident #48's eMAR (electronic medication administration record) for the month of August 2018 was reviewed and contained entries which read in part, "Ativan Tablet 1 mg Give 1 tablet by mouth every 4 hours as needed for psychosis with psychotic behaviors". This entry had been initialed as having been administered once daily on 08/01-08/16/18, 08/20-08/22/18 and 08/27-08/28/18. Resident #48's clinical record contained a "Behavior Monthly Flow Sheet" with behavior codes of 12) depressed and 4) anxiety to be monitored. This flow sheet was marked as Resident not having exhibited any behaviors of depression and 1 episode of anxiety for the month of August. The Resident's progress notes were reviewed and the surveyor could not locate any progress notes related to Resident's behaviors. The progress notes contained medication administration notes stating that the Ativan had been administered, but did not state what behaviors were being exhibited.	F 758		

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F 758	Continued From page 12 The surveyor spoke with the DON (director of nursing) on 08/29/18 at approximately 1710 regarding Resident #48. DON stated that behaviors in relation to the administration of the medication should have been documented. The concern of not having a stop date and administering the medication Ativan without indications for use was discussed with the administrative team during a meeting on 08/30/18 at approximately 1155. No further information was provided prior to exit.	F 758		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		10/11/18

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F 842	Continued From page 13 all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 842		

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F 842	Continued From page 14 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to maintain a complete and accurate clinical record for five of 17 Residents, Residents #8, #13, #27, #161, and #7. The findings included. 1. For Resident #8, the facility staff failed to accurately complete the Residents "Record of Informed Consent for Psychotropic Medication." The record review revealed that Resident #8 had been admitted to the facility 09/12/17. Diagnoses included, but were not limited to, diabetes, anxiety, Alzheimer's disease, essential hypertension, psychosis, and dementia. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/29/18 had been coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. The Residents clinical record included a form titled "Record of Informed Consent for Psychotropic Medication." Page two of this form read in part. "After careful consideration of the information	F 842	Resident #8's "Record of informed Consent for Psychotropic Medication" was completed on 8/30/18. Resident #13 physician order for tube feeding was received to be discontinued. Physician orders were obtained to discontinue the Dulcolax suppository and the soaps subs enema for resident #27. Resident #161 allergy was removed from the medical record after discussion with resident, family, pharmacy and the physician. Resident #7 is only receiving thickened liquids for oral care and may be kept at the bedside. Current residents in the center have the potential to be affected. Licensed nurses were educated by the Director of Nursing/Designee on the process for completion of the "Record of Informed Consent for Psychotropic Medication" form. In addition, education also included ensuring current physician orders are accurate to for orders for tube feeding, orders for BM protocol for residents with a colostomy and to ensure the accuracy of listed allergies. Licensed	

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F 842	Continued From page 15 provided to me, I hereby: ( ) Give my permission for the use of the above listed psychoactive medication(s). I understand that once that targeted behavior/symptom is controlled, the dose will be gradually reduced to the lowest possible dosage and frequently or discontinued unless contraindicated by the physician/prescriber. ( ) I DO NOT consent to the use of the psychoactive medication(s) as recommended. I acknowledge that my care planning team has advised me that by not accepting the prescriber's recommendations, I may be at additional medical or psychological risks." This form had been signed by the RP (responsible party) and the facility representative on July 14, 2018. However, neither box had been checked. The administrative team was notified of the missing information on this form during a meeting with the survey team on 08/29/18 at 5:11 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #13, the facility failed to maintain an accurate record in regards to the Residents feeding tube. The feeding tube had been discontinued. However, the Residents EHR (electronic health record) included an active order regarding the feeding tube. The clinical record review revealed that Resident #13 had been admitted to the facility 05/29/18.	F 842	nurses were also educated to ensure the documentation for residents using thickened liquids to moisten the mucosa of the mouth and who are NPO to be accurate in the medical record. The Director of Nursing/Designee will review 5 charts per week to ensure the informed consents for psychotropic medications are completed accurately and in their entirety, ensure the accuracy of physician orders and progress notes. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audit will be conducted on a random basis.	

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F 842	Continued From page 16 Diagnoses included but were not limited to, chronic obstructive pulmonary disease, respiratory failure, depressive disorder, dysphagia, diabetes, and gastro-esophageal reflux disease. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/13/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The clinical record included a physicians order dated 07/26/18 to discontinue peg tube. However, the Residents EHR included the order "PEG-May cocktail medications to be administered via PEG." the status was listed as being "Active." During an interview with Resident #13 on 08/29/18 at 3:43 p.m., the Resident stated she no longer had the feeding tube. The administrative team was notified of the inaccurate record during a meeting with the survey team on 08/29/18 at 5:11 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. For Resident #27, the Residents EHR (electronic health record) included orders for dulcolax suppository and soapsuds enema. However, the Resident had a colostomy. The record review revealed that Resident #27	F 842		

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F 842	Continued From page 17 had been admitted to the facility 12/02.17. Diagnoses included, but were not limited to, end stage renal disease, chronic obstructive pulmonary disease, dementia, diabetes, anxiety, and dysphagia. Section C (cognitive patterns) of the Resident quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/04/18 had been coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making. Section H (bladder and bowel) had been coded to indicate the Resident had a colostomy. The Residents EHR included order for soapsuds enema and dulcolax suppository for constipation. During an interview with the DON (director of nursing) on 08/28/18 at 4:14 p.m., the DON stated he had reviewed the Residents EHR and the Resident did not have BM's (bowel movements) as she had a colostomy in place. The DON stated that when the Resident had been readmitted from the hospital the orders came from the facility standing orders and he had discontinued them. The administrative team was notified of the inaccurate record during a meeting with the survey team on 08/29/18 at 5:11 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #161 the facility staff failed to	F 842		

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F 842	Continued From page 18 accurately list Resident's allergies. Resident #161 was admitted to the facility on 08/27/18. Diagnoses included but not limited to chronic obstructive pulmonary disease, coronary artery disease, diabetes mellitus, hypertension, chronic kidney disease, thrombocytopenia, congestive heart failure, and gastric ulcer. Surveyor spoke with Resident #161 on 08/29/18 at approximately 1030. Resident was alert and oriented. Resident #161's clinical record was reviewed on 08/29/18. It contained a POS (physician's order summary) which listed Resident allergies as "Nalbuphine" and "oxycodone". The POS also contained an entry, which read in part, "Roxicodone Tablet 5 mg (oxycodone HCl) Give 1 tablet by mouth every 8 hours as needed for pain". The Resident's eMAR (electronic medication administration record) was reviewed and contained an entry, which read in part, "Roxicodone Tablet 5 mg (oxycodone HCl) Give 1 tablet by mouth every 8 hours as needed for pain". This entry had been initialed as having been administered once each day on 08/27-08/29/18. Surveyor spoke with pharmacist on 08/29/18 at approximately 1155 regarding Resident #161. Pharmacist stated that Resident has a listed allergy to oxycodone, but that she had been receiving it while in the hospital prior to admission to the facility. Surveyor spoke with the DON (director of nursing) on 08/29/18 at approximately 1330 regarding Resident #161's listed allergy to	F 842		

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F 842	Continued From page 19 oxycodone. Surveyor spoke again with DON on 08/29/18 at approximately 1720. DON stated that he had spoken with Resident and family regarding oxycodone allergy. DON stated that Resident and family confirmed that Resident had previously been taking oxycodone with no adverse effects. DON stated that he had consulted with MD to have allergy to oxycodone discontinued. The concern of the Resident's allergy list being incorrect was discussed with the administrative team during a meeting on 08/30/18 at approximately 1155. No further information was provided prior to exit. 5. For Resident #7 the facility failed to sustain an accurate clinical record regarding nursing notes dated 8/22 and 8/24 inaccurate indicating Resident is taking PO (by mouth) fluids well and the Resident is NPO (nothing by mouth). Per the clinical record review Resident #7 was admitted to the facility on 6/15/17 with the following diagnoses of, but not limited to Malignant Neoplasm of Larynx, Dysphagia, Pneumonia, Generalized Anxiety Disorder, Dysphagia following Cerebral Infarction and Unspecified Protein Calorie Malnutrition. Quarterly MDS Assessment with an ARD (Assessment Reference Date) of 5/23/18, the resident was coded as having memory problems with short term and OK long-term memory. The record also reflected modified independence with daily decision making, with some difficulty in new situations only. The clinical record included nursing progress	F 842		

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F 842	Continued From page 20 notes dated 08/22/2018 and 08/24/2018, that indicated resident # 7 was taking PO fluids well. However it also included an Order Summary Report that indicated the Resident was NPO and the current comprehensive care plan indicated the Resident was to have small amount of thickened liquids at bedside to moisten mouth. DON (Director of Nursing) was requested to provide Nursing Progress Notes for 8/22 and 8/24, current Physician orders. On 08/30/18 at 10:59 am during an interview with DON the requested documents were provided and stated Resident#7 was NPO. On 08/30/18 at 12:24pm DON provided amended Physician progress notes to indicate that Resident #7 receives thickened liquids at bedside for oral care only. No further information was provided to the surveyor prior to the exit conference.	F 842		