STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495126	A. BUILDING _____ B. WING _____	C 05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADDELL NURSING AND REHAB CENTER	202 PAINTER ST GALAX, VA 24333

(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 05/01/18 through 05/0318. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard and complaint survey was conducted 05/01/18 through 05/03/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 130 certified bed facility was 124 at the time of the survey. The survey sample consisted of 24 current Resident reviews and 3 closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a 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	F 580		5/31/18

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

Electronically Signed | 05/25/2018

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 580	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and clinical record review it was determined the facility staff failed to notify the physician of a condition change for 1 of 24 residents (Resident #98). (The resident was taking an anticoagulant (coumadin) and was	F 580	Disclaimer: Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding.	

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F 580	Continued From page 2 observed to have blood in her stool. This was not reported to the physician). Findings: The facility staff failed to notify Resident #98's physician of blood found in her stool. The resident's record was reviewed on 5/3/18. Resident #98 was admitted to the facility on 2/21/18. Her diagnoses included DVT (deep vein thrombosis) in her right leg. She was in the facility to take physical therapy to strengthen her body following a long stay in the local hospital. The latest MDS (minimum data set), dated 4/6/18, coded the recent with unimpaired cognitive skills. Her memory and communication skills were intact. The resident's latest CCP (comprehensive care plan) reviewed and revised 4/20/18 documented the resident was taking the anticoagulant, Coumadin. Staff interventions included reporting any changes in the resident's condition to the physician. "Resident will be free from any abnormal bleeding or bruising". The current physician's orders, sighed and dated 2/21/18, documented one 3.5 mg coumadin tablet was to be administered every night at bedtime. This medication was provided to resolve a DVT and prevent additional clotting in the resident's right leg. The nursing notes documented Resident #98 had blood in her stool: 1. 4/18/18 ~ 6:50 AM - "Scant amount of blood tinged discharge when changed her adult brief	F 580	F 580 Resident #98 was assessed and the physician was notified of her status as soon as the issue was identified. The resident had no further bleeding and had no negative outcome ongoing from the incident. Other residents who are ordered anticoagulants were identified. The documentation for the previous two weeks was reviewed for each resident to identify if there was any unusual bleeding. There were no new issues identified. Licensed nursing staff will be reeducated concerning notifying the physician of abnormal bleeding, the relationship of an anticoagulant to abnormal bleeding, and the use of the SBAR for documenting the assessment of the resident observed with any abnormal bleeding. The Director of Nursing or designee will review the previous day/days documentation for all residents on anticoagulants during the daily clinical meeting to identify any abnormal bleeding. This review will be documented for each clinical meeting for 4 weeks and then weekly for 8weeks. The Director of Nursing will report the findings of the monitoring to the monthly QA Committee for review and recommendations for the duration of the monitoring period. The allegation of compliance date for this plan is 5/31/2018	

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F 580	Continued From page 3 this shift. Could not tell origin of discharge. Will continue to monitor." 2. 4/18/18 ~ 10:27 AM - "Noted to have scant amt. (amount) blood in brief of undetermined margin. Will monitor for reoccurrence". 3. 4/29/18 ~ 6:42 PM - "Early in shift resident had frank red blood noted with BM (bowel movement).....Coumadin continues at 3.5 mg...." 4. On 4/30/18 ~ 5:14 PM - "Noted to have small blood clot in BM. The nursing progress notes were reviewed for 4/23/18 and 4/30/18. On these two dates the FNP (nurse practitioner) was in to assess the labwork (PT/INR) conducted on the resident for the effectiveness of the anticoagulant, coumadin. Both reports documented: "No signs or symptoms of excessive bleeding or bruising." There was no documentation the nursing staff had notified the physician or FNP the resident's BM was observed to have frank red blood. On 05/02/18 10:40 AM LPN I was interviewed. She stated, "We did the coumadin level on the 30th. There's been no further bleeding since then. Whenever I did the PT/INR she didn't have anything. I don't remember telling the doctor/FNP. I did tell her son. The resident told me she had some bleeding occasional from hemorrhoids". Resident # 98 was interviewed on 5/2/18 at 10:46 AM. She told the surveyor she thought she did have a hemorrhoid, down there, but she had never had any bleeding from it. She said the staff had found some blood, down there, recently and they said they's keep a check on it. The resident said she was not aware of the hemorrhoid ever bleeding--before or since her admission.	F 580		

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F 580	Continued From page 4 On 5/2/18 the surveyor told the DON of her findings. The DON spoke to a member of the nursing staff and reported to the surveyor the bleeding had been reported to the son because it appeared to be MORE than her usual hemorrhoid bleeding, but not to the doctor. She said she would continue to investigate the matter. On 5/2/18 the administrator, DON and corporate muses met with the survey team. The surveyor explained that on 4 occasions Resident #98 had some unusual bleeding, from her rectum or other origin unknown. No additional information was provided.	F 580		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and employee file review, the facility staff failed to implement the written policies and procedures for 1 of 5 new employee files that were reviewed (Employee #2).	F 607	Disclaimer: Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding.	5/31/18

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F 607	Continued From page 5 The findings included: The surveyor reviewed 5 of the newly hired employee files on 5/2 and 5/3/18. The following were noted to be missing from Employee #2's file: Employee #2 is an agency hired LPN (Licensed Practical Nurse) with hire date of 4/30/18. There was no documentation of a sworn statement or the results from a background check. On 5/3/18 at 8 am, the surveyor notified the administrator of the abo /e documented findings. The administrator stated that she would call the hiring agency company about this. The surveyor notified the administrator and corporate nurse of the above documented findings at 11:45 am. At 11:56 am, the administrator returned to the surveyor and stated, "I have called the agency company and found out that the nurse did complete a Virginia Criminal Background check. The agency mailed it in but they are unable to get any results from the website because they are not an authorized user. They also told me that no results have been sent to them by fax or mail ...We don't have a sworn statement either for this nurse." The surveyor requested a copy of the facility's policy on hiring of new employees. At 12 noon, the surveyor received a copy of the policy titled "Employee Background Screening" from the corporate nurse. It read in part " ...All applicants and new employees must certify that they have not been convicted of any offense that would preclude employment in a nursing facility and that they are not excluded from participating in the Federal health care programs or state	F 607	F 607 Employee #2 now has documentation of passing the background check by the Virginia State Policy and has signed the sworn statement that she has not committed any barrier crimes. Current employee files will be audited to ensure that they are compliant with having a Virginia State Police background check and have signed the sworn statement that they have not committed any barrier crimes. The HR/payroll coordinator has been reeducated concerning the requirement to run the Virginia State Police background check and obtain the signature on the sworn statement in the employment application that they have not committed any barrier crimes from all newly hired employees, including those who are employed by an agency and are working in the building. The Administrator will document review all newly hired employee files for the next 4 weeks. Random reviews of newly hired employee files will be done weekly for 8 weeks. The Administrator will bring the results of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period.	

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F 607	Continued From page 6 healthcare programs ...Each facility shall conduct a criminal background check of all employees, as required by law, upon hire ..." No further information was provided to the surveyor prior to the exit conference on 5/3/18.	F 607	The allegation of compliance date for this plan is 5/31/2018	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		5/31/18

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F 623	Continued From page 7 be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental	F 623		

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F 623	Continued From page 8 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to notify the Ombudsman upon discharge for 1 of 24 residents in the survey sample. (Resident #81) The findings included: Resident #81 was readmitted to the facility on 12/27/17 with the following diagnoses of, but not limited to anemia, high blood pressure, Alzheimer's disease, quadriplegia, anxiety disorder, depression, Psychotic disorder and bronchitis. On the quarterly MDS (Minimum Data	F 623	Disclaimer: Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F 623 The Ombudsman has been notified of the transfer to the hospital of Resident #81 on 12/20/2017.	

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F 623	Continued From page 9 Set) with an ARD (Assessment Reference Date) of 4/5/18, the resident was coded as having short term and long term memory problems and was severely impaired in making daily decisions. Resident #81 was also coded as being totally dependent of 2 or more staff members for dressing, personal hygiene and bathing. The surveyor performed a clinical record review on Resident #81 on 5/1 and 5/2/18. During this review, the surveyor noted that the resident had been discharged to the hospital on 12/20/17 with increased mucous secretions and bronchitis. There was no documentation noted that the Ombudsman's office had been notified of this discharge to the hospital for Resident #81. On 5/2/18 at 5 pm, the surveyor notified the Social Worker of the above documented findings. The Social Worker stated, "I didn't start notifying the Ombudsman's office of any discharges until after 1/19/18. That was when I was instructed by the corporate to begin doing them." The surveyor notified the administrator, director of nursing and corporate nurse of the above documented findings at 5:30 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 5/3/18.	F 623	All residents who have a discharge from the facility are at risk for this issue. The Director of Social Services has been reeducated concerning the requirement that all discharges from the facility be reported to the Ombudsman. The Administrator will review the discharges and the notification documents with the Director of Social Services to ensure that all discharges are included. This will be documented monthly for three months. The Administrator will report the findings of the reviews to the monthly QA meeting for review and recommendations. The allegation of compliance date is 5/31/2018	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or	F 625		5/31/18

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F 625	Continued From page 10 the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to notify the resident representative of the bed hold policy for 1 of 24 residents in the survey sample. (Resident #81) The findings included: Resident #81 was readmitted to the facility on 12/27/17 with the following diagnoses of, but not limited to anemia, high blood pressure, Alzheimer's disease, quadriplegia, anxiety disorder, depression, Psychotic disorder and bronchitis. On the quarterly MDS (Minimum Data	F 625	Disclaimer: Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F 625 Resident #81 was readmitted to the same room on 12/27/2017. Residents discharged to the hospital are	

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F 625	Continued From page 11 Set) with an ARD (Assessment Reference Date) of 4/5/18, the resident was coded as having short term and long-term memory problems and was severely impaired in making daily decisions. Resident #81 was also coded as being totally dependent of 2 or more staff members for dressing, personal hygiene and bathing. The surveyor performed a clinical record review on Resident #81 on 5/1 and 5/2/18. During this review, the surveyor noted that the resident had been discharged to the hospital on 12/20/17 with increased mucous secretions and bronchitis. The surveyor could not find any documentation that the resident representative was notified of the bed hold policy. On 5/2/18 at 5:15 pm, the surveyor interviewed the admissions nurse and business office Employee #1. The surveyor asked if the resident representative for Resident #81 was notified of the bed hold policy when the resident was discharged to the hospital on 12/20/17. The admissions nurse stated, "The nurse on the floor sends with the resident a standard letter that explains the bed hold policy when they are transferred to the hospital. Then I will call the family on the next business day and explain the bed hold policy to them over the phone. If they wish to do a bed hold, then I will transfer the call to the business office and they will set up a time for the family to come in and talk to them about that." The surveyor asked if there was documentation that such a discussion occurred with Resident #81's family. The admission nurse stated that she would check but this documentation would be on the A/R (Accounts Receivable) side and not the clinical side.	F 625	at risk for this issue. The Admission Director has been reeducated concerning the need to call resident/resident representative on the following business day after discharge to the hospital to verify whether they wish to pay to have a bed hold for their bed at the facility. The Administrator will review the discharges with the Admissions Director on the next business day after a discharge to the hospital to validate that the bed hold had been verified with the resident or resident representative. This review will be documented for all discharges to the hospital for one month and then 5 discharges a month for the next two months. The Administrator will report the findings of these reviews to the monthly QA meeting for review and recommendations. The allegation of compliance for this plan is 5/31/2018	

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F 625	Continued From page 12 At 5:30 pm, the admissions nurse returned to the surveyor and stated, "I cannot find any documentation on the A/R side and I can't find the date on my calendar of when I would had called them." At 5:45 pm, the surveyor notified the administrator, director of nursing and corporate nurse of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 5/3/18.	F 625		
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, it was determined that the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) assessment for 1 of 24 Residents in the sample survey, Resident #118. The Findings Included: For Resident #118 the facility staff failed to ensure a complete and accurate 30 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 3/31/18. The facility staff failed to code the correct weight in Section K. Swallowing/Nutritional K0200.B. Additionally, the facility staff failed to code/capture a significant weight loss in Section K. Swallowing/Nutritional Status in Section K. 0300.	F 641	Disclaimer: Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F 641 A correction has been completed and accepted on 5/3/2018 for the 30 Day MDS assessment with an ARD of 3/31/2018 for Resident #118 with accurate weight and significant weight loss included. Residents who are assessed by the MDS assessment process are at risk for this issue.	5/31/18

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F 641	Continued From page 13 Resident #118 was a 97 year old female who was admitted on 3/3/18. Admitting diagnoses included, but were not limited to: hypertension, dysphagia, hypoxemia, muscle weakness and Gastro-Esophageal Reflux (GERD). The most current MDS located in the clinical record was a Quarterly MDS assessment with an ARD of 4/5/18. The facility staff coded that Resident #118 had a Cognitive Summary Score 7. The facility staff also coded that Resident #118 required limited (2/2) to extensive (3/2) assistance with Activities of Daily Living (ADL's). In Section K. 0200. B. Weight the facility staff coded that Resident #118 weighed 122 pounds. On May 1, 2018 at 11 a.m., the surveyor reviewed Resident #118's clinical record. Further review of the clinical record produced Resident #118's weight record. The weight record documented the following weights: 3/3/18 131 pounds 3/5/18 131 pounds 3/8/18 121.6 pounds 3/10/18 122 pounds 3/15/18 122 pounds 3/17/18 120.8 pounds 3/22/18 116 pounds 3/24/18 117 pounds 3/31/18 121.6 pounds Further review of the clinical record produced a 30 Day Medicare MDS assessment with an ARD of 3/31/18. The facility staff coded that Resident #118 had a Cognitive Summary Score of 7. The facility staff also coded that Resident #118 required limited (2/2) to extensive (3/2) assistance with ADL's. In Section K. 0200. B.	F 641	The Dietary Manager has been reeducated by the Regional Dietician that the correct weight be entered and a significant weight loss be captured when appropriate. Weights and weight loss will be checked for accuracy for assessments done in the last month. The MDS Coordinator will review the weights and the weight loss entries for the assessments newly completed. This will be documented for 2 assessments a week for 4 weeks, 1 assessment a week for 8 weeks. The MDS Coordinator will bring the results of the monitoring to the monthly QA committee for review and recommendations for the duration of the monitoring period. The allegation of compliance date is 5/31/2018	

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F 641	Continued From page 14 Weight the facility staff coded that Resident #118 weighed 117 pounds. In Section K. 0300. Weight Loss the facility staff coded that Resident #118 did not have a significant weight loss of 5% or more in the past month or 10% weight loss in the last 6 months. The surveyor identified that Resident #118's 30 Day Medicare MDS with the ARD of 3/31/18 was coded inaccurately for weight. The facility staff coded that Resident #118 weighed 117 pounds. However, Resident #118's weight was 121.6 on 3/31/18. The weight of 121.6 should have been coded on the MDS. Additionally, the surveyor identified that Resident #118 had a 7.18% weight loss in 30 days. Therefore, in Section K. 0300 Resident #118 should have been coded for a Significant weight loss, as Resident #118 had a 7.18% weight loss in 30 days. On May 1, 2018 at 11:20 a.m. the surveyor notified the MDS Nurse, who was a Registered Nurse, that Resident #118's 30 Day Medicare MDS assessment with the ARD of 3/31/18 was inaccurate. The surveyor reviewed Resident #118's weight record with the MDS Nurse. The surveyor pointed out that Resident #118's weight was 121.6 on 3/31/18; therefore, the weight should have been 122 on the MDS instead of the 117 pounds. The surveyor also pointed out that Resident #118 had a 7.18% weight loss from 3/3/18 to 3/31/18 and that the facility had not coded Resident #118 for a significant weight loss in the past 30 days. The MDS Nurse stated that she had "Missed" that on the MDS. On May 2, 2018 at 3:45 p.m., the survey team	F 641		

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F 641	Continued From page 15 met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #118's 30 Day Medicare MDS with the ARD of 3/31/18 was inaccurate. The surveyor notified the AT that the facility staff had coded the incorrect weight and had not coded Resident #118 for a significant weight loss in the past 30 days. No additional information was provided to the survey team as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #118.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure that 1 of 24 residents in the final survey sample receive treatment in accordance with professional standards of practice, Resident #65. The findings included: The facility staff failed to administer Xanax 0.5	F 684	Disclaimer: Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F 684 Resident #65 has been assessed and	5/31/18

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F 684	Continued From page 16 mg bid as ordered by the physician for Resident # 65. Resident # 65 is an 86-year-old-female who was originally admitted to the facility on 5/23/17, with a readmission date of 1/6/18. Diagnoses included but were not limited to: anxiety disorder, major depressive disorder, hypertension, heart failure, and atrial fibrillation. The clinical record for Resident # 65 was reviewed on 5/1/18 at 10:16 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/27/18/ Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff coded that Resident # 65 has a BIMS (brief interview for mental status) score of 9/15, which indicated moderate cognitive impairment. The current plan of care for Resident # 65 was reviewed and revised on 3/2/18. The facility staff has documented a focus area as "At risk for adverse effects related to psychoactive medication use: Anxiety, Depression." Interventions included but were not limited to: "Monitor med for side effects: sedation, hypotension, EPS (extrapyramidal symptoms), anticholinergic symptoms, headache, insomnia, anorexia, constipation." The physician signed the current physician's orders for Resident # 65 on 4/11/18. The current orders included but was not limited to: "Xanax Tablet 0.5 mg (milligram) (Alprazolam) Give 1 tablet enter ally two times a day for anxiety." Upon review of the "Nursing Notes" for Resident	F 684	there is no lasting issues related to the missing medications on 2/23/2018 and 2/24/2018. Other residents prescribed Xanax are at risk for this issue. A MAR to cart check for Xanax has been completed for those residents and there were no medications missing at this time. Licensed nursing staff has been reeducated related to ordering controlled medications when there is 48 hours to the last dose to allow time for the written prescription to be received from the physician. If the medication is not available at the time that medication is due, the nurse must contact the RN on call for problem solving. The reeducation will also include when to access the emergency meds when medications are not available. During the morning clinical meeting, the Director of Nursing or designee will review the progress notes written since the last clinical meeting to identify any documentation of controlled medications not available. Immediate follow up will occur if there is any medication documented as not available. This will be documented at each clinical meeting for 4 weeks and then weekly for 8 weeks. The Director of Nursing will report the results of the monitoring to the monthly QA meeting for review and recommendations for the duration of the monitoring period.	

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F 684	Continued From page 17 # 65, facility staff documented a nursing note on 2/22/18 at 6:16 pm. The note stated, "N.O. (new order) received via (Physician's name withheld) per telephone to hold Xanax x 1 night d/t (due to) no refills left on script. Script re-faxed to office to be signed in AM (morning)." Facility staff documented a progress note on 2/23/18 at 9:43 am, "New order received to hold Xanax x 1 dose d/t (due to) no refills left on resident's script. Script re-faxed to office to be signed in yesterday." Facility Staff documented a nursing note on 2/24/18 at 9:21 am. "MD (medical doctor) order to hold Xanax 0.5 mg for 1 dose, Pharmacy has been notified several times to send medication, will notify again, script has been signed by MD and faxed." Facility staff documented a nursing note on 2/24/18 at 10:35 am. "Spoke with pharmacy, re faxed script to pharmacy, pharmacy will send medication on the next run." Facility staff documented a progress note on 2/24/18 at 10:17 pm. "N.O. received per telephone via (physician's name withheld) to hold Xanax until it arrives from pharmacy." Upon review on the electronic MAR (medication administration record) for Resident # 65, the surveyor noted orders to hold Xanax 0.5 mg for the 8 pm dose on 2/22/18, the 8 am dose on 2/23/18, the 8 pm dose on 2/23/18, the 8 am dose on 2/24/18, and the 8 pm dose on 2/24/18. Resident # 65 did not receive her scheduled doses on the above dates because facility staff documented that the Xanax 0.5 mg had not come	F 684	The allegation of compliance date for this plan is 5/31/2018.	

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F 684	Continued From page 18 in from the pharmacy. On 5/1/18 at 10:40 am, the surveyor reviewed a list of medications that were on hand in the facility stat box. In the "Control Box" was 4 tabs of Alprazolam 0.5 mg. On 5/1/18 at 10:45 am, the surveyor requested of LPN (licensed practical nurse) # 1 could provide a list of the medications that were removed from the stat box during the last week of February 2018. On 5/1/18 at 11:16 am, LPN # 1 provided the surveyor with a copy of all medications that had been removed from the stat box during the last week of February 2018. There were no medications removed from the stat box for Resident # 65 during this time. On 5/2/18 at 3:56 pm, the administrative team was made aware of the above findings, and that Resident # 65 did not receive her scheduled doses of Xanax 0.5 mg, when the medication was on hand in the facility stat box. No further information regarding this issue was presented to the survey team prior to the exit conference on 5/3/18.	F 684		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §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- §483.45(d)(1) In excessive dose (including	F 757		5/31/18

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F 757	Continued From page 19 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued· or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure that 1 of 24 Residents in the sample survey were free of unnecessary medications, Resident # 97. The Findings Included: For Resident #97 the facility staff failed to follow physician ordered parameters for Glimepiride, a diabetes medication. Resident #97 was a 91 year old female who was admitted on 3/28/18. Admitting diagnoses included, but were not limited to: atrial fibrillation, pleural effusion, chronic kidney disease, hypertension, and diabetes mellitus. The most current Minimum Data Set (MDS) assessment located in the clinical record was a 14 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 4/11/18.	F 757	Disclaimer: Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F 757 Resident #97 has been assessed and there are no apparent lasting effects from this issue. The order for glimepiride has been re written and no longer has the parameters for blood sugar levels with administration for Resident #97. Other resident prescribed glimepiride orders have been reviewed and there are no other orders that have blood sugar parameters with administration	

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F 757	Continued From page 20 The facility staff coded that Resident #97 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #97 required extensive assistance (3/2) with Activities of Daily Living (ADL's). On May 1, 2018 at 8 a.m., the surveyor observed Resident #97 sitting up in her bed and feeding herself her breakfast. On May 1, 2018 at 9:40 a.m., the surveyor reviewed Resident #97's clinical record. Review of the clinical record produced physician orders. The physician orders included, but were not limited to: "Accucheck blood sugars BID two times a day for DM (diabetes mellitus). Glimepiride 100mg Give 1 capsule by mouth one time a day for DM HOLD FOR BLOOD GLUCOSE 150." (sic) Continued review of the clinical record produced the April Medication Administration Records (MAR's). Review of the April 2018 MAR's documented that the facility staff were obtaining the accucheck (blood sugar) at 6:30 a.m. and 4:30 p.m. The April 2018 MAR's also documented that the facility staff were administering the Glimepiride 100mg at 9 a.m. The surveyor noted that the facility staff were administering the Glimepiride two and a half (2 ½) hours after the blood sugar was obtained at 6:30 a.m. The surveyor also noted that Resident #97 was receiving the Glimepiride after she had eaten her breakfast. The surveyor continued to review the April 2018 MAR's. The surveyor noted that the facility staff had administered the Glimepiride 14 times during the month of April 2018 when Resident #97's	F 757	Nursing staff have been reeducated that if a medication order is written with parameters, that those parameters must be followed according to the order. The Director of Nursing or designee will review new orders during the morning clinical meeting to identify any glimepiride orders that have blood sugar parameters and ensure that the medication is scheduled in a timely manner to the obtaining the results of the blood glucose monitoring. This will be documented at each morning clinical meeting for 4 weeks and then weekly for 8 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QA meeting for review and recommendations for the duration of the monitoring period. The allegation of compliance date is 5/31/2018	

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F 757	Continued From page 21 blood sugar was less than 150. On May 1, 2018 at 10:40 a.m., the surveyor requested for the Infection Control Nurse (ICN), who was a Licensed Practical Nurse (LPN), to speak with the surveyor about Resident #97. The surveyor reviewed Resident #97's clinical record with the ICN. The surveyor pointed out the specific physician order for the facility staff to obtain the accucheck (blood sugar) twice a day. The surveyor also reviewed the physician order for the Glimepiride 100mg every day with the ICN. The surveyor then reviewed the April 2018 MAR's with the ICN. The surveyor pointed out that the accucheck's (blood sugars) were being obtained at 6:30 a.m. and 4:30 p.m. The surveyor informed the ICN that the Glimepiride was being administered at 9:30 a.m. - 2 ½ hours after the accucheck (blood sugar) was obtained. The surveyor pointed out that the facility staff were not holding the Glimepiride, as ordered by the physician, when the accucheck (blood sugar) was less than 150. The surveyor informed the ICN that the physician order for obtaining the accucheck (blood sugar) was ordered twice a day and that the surveyor did not understand why the accucheck (blood sugar) was being obtained 2 ½ hours prior to the medication being given. The surveyor also noted the ICN that the surveyor did not understand why the medication was being given after Resident #97 ate breakfast. Lastly, the surveyor notified the ICN that the facility staff were not holding the Glimepiride when the accucheck (blood sugar) was less than 150. On May 2, 2018 at 3:45 p.m., the survey team met with the Administrator (Adm), Director of Nursing (DON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative	F 757		

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F 757	Continued From page 22 Team (AT) that Resident #97 had a physician order to obtain a accucheck (blood sugar) twice a day and that the facility staff were obtaining the blood sugar at 6:30 a.m. and 4:30 p.m. The surveyor also informed the AT that Resident #97 had a physician order for Glimepiride every day and to hold the medication if the accucheck (blood sugar) was less than 150. The surveyor informed the AT that the facility staff were obtaining the accucheck (blood sugar) 2 ½ hours prior to the administration of the Glimepiride. Lastly, the surveyor notified the AT that Resident #97's blood sugar was less than 150 multiple times in the month of April 2018 and that the facility staff did not hold the Glimepiride. No additional information was provided to the survey team as to why the facility staff failed to follow physician ordered parameters for the administration of the Glimepiride.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		5/31/18

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F 761	Continued From page 23 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to discard expired medications for 2 of 5 medications carts. The findings included: For the medication cart on main floor the facility staff failed to discard an expired vial of Lantus insulin and an expired Lantus insulin pen. For the med cart on 2nd floor, the facility staff failed to discard an expired Novolog insulin pen. The surveyor observed the medication cart on main floor on 05/01/18 at approximately 1015 with LPN #1. It contained a vial of Lantus insulin with an opened date of 03/15/18 and a discard after date of 04/12/18. The surveyor asked LPN #1 how long the insulin should be kept after opening and she stated that some were 28 days; some were 30 days or longer. The surveyor observed the medication cart on 2nd floor on 05/01/18 at approximately 1035 with LPN #2. It contained a Novolog insulin pen with an opened date of 03/28/18. Surveyor asked LPN #2 how long the insulin should be kept after opening, and she stated that it should be	F 761	Disclaimer: Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F-761 The opened Lantus Insulin vial and Lantus insulin pen on main floor med cart dated 03/15/18 has been discarded on 05/01/18. The opened Novolog Insulin pen on second floor med cart dated 03/28/18 has been discarded on 05/01/18. Other current residents who are ordered insulin were identified. All five medication carts checked for Insulin open date and compared to expiration date. There were no Insulins expired from date open date. Licensed nursing staff will be reeducated on labeling date open on all insulins at the time of opening vials. Licensed staff will check daily all insulin open dates and discard on expiration date. This reeducation will include removing and	

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F 761	Continued From page 24 discarded between 28-30 days, depending on the insulin. She also stated that the Novolog insulin pen should have already been discarded. The surveyor requested and received a copy of "Insulin Storage Recommendations" on 05/01/18 at approximately 1045. This form listed both Novolog and Lantus insulins as being good for 28 days after being opened. The surveyor also received a copy of the facility guidelines for insulin, which read in part "Expiration Dates once vials opened ....". Both Lantus and Novolog were listed as expiring 28 days after opening. No further information was provided prior to exit.	F 761	discarding expired Lantus and Novolog Insulin 28 days after opening date. The Director of Nursing or designee will review insulins for a date opened label and expiration. This will be documented daily for 7 days, 5 days a week for three weeks and then weekly for eight weeks thereafter. This review will be documented for each clinical meeting. The Director of Nurs.ng will report the findings of the monitoring to the monthly QA Committee for review and recommendations for the duration of the monitoring period. The allegation of compliance date for this plan is 05/31/2018	
F 842 SS=D	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;	F 842		5/31/18

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F 842	Continued From page 25 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential 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;	F 842		

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F 842	Continued From page 26 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to ensure complete and accurate clinical records for 5 of 24 Residents in the survey sample, Resident #46, Resident #50, Resident #28, Resident #115 and Resident #81. The Findings Included: 1. For Resident #46 the facility staff failed to ensure complete and accurate April and May 2018 Medications Administration Records (MAR's) and Physician Order Sheets (POS's). Resident #46 was a 76 year old male who was admitted on 12/22/17. Admitting diagnoses included, but were not limited to: diabetes mellitus, aphasia, cerebrovascular accident with hemiplegia, depression and hypothyroidism. The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) 3/12/18. The facility staff coded that Resident #46 had short and long term memory impairment (1/1) and moderately impaired with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that	F 842	Disclaimer: Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F 842 The medications ordered for Resident #46 have all been changed to via PEG tube. Resident #50 has been assessed and has had no change of condition.The family of Resident #28 have supplied the dates of pneumonia and influenza vaccination administration and this information has been entered into the clinical record. The medications ordered for Resident #115 have all been reviewed and there is an accurate indication listed for each medication. The current behavior monitoring for Resident #81 is reflective of the resident□s behavior and appropriate coding is being used. Licensed nursing staff have been reeducated for the following issues:	

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F 842	Continued From page 27 Resident #46 required extensive (3/3) to total nursing care (4/2) with ADL's. In Section K. 0510. Nutritional Approaches tne facility staff coded that Resident #46 had a feeding tube. On May 1, 2018 at 3:23 p.m. the surveyor reviewed Resident #46's clinical record. Review of the clinical record produced signed physician orders. The surveyor noted that some of Resident #46's medicati on were ordered by mouth while other medications were ordered via PEG tube (Percutaneous endoscopic gastrostomy tube). The physician orders read in part ... "Aspirin tablet Give 325 via PEG-tube one time a day for prolact (prophylactically), Docusate Sodium Liquid Give 10ml via PEG-Tube two time a day for constipation, Isosorbide Mononitrate Tablet 20mg Give 1 tablet by mouth two times a day for HTN (hypertension), Lopressor Tablet (Metoprolol Tartrate) Give 25mg via PEG-Tube two times a day for htn (hypertension), Paxil Tablet 10MG (PARoxetine HCl) Give 2 tablet via PEG-Tube one time a day for depression, Plavix Tablet 75mg (Clopidogrel Bisulfate) Give 1 tablet via PEG-Tube on time a day for CAD (coronary artery disease), PriLOSEC capsule Delayed Release (Omeprazole) Give 40 mg by mouth one time a day for GERD, Sennosides Tablet 8.6mg Give 2 tablet via PEG Tube one time a day for constipation, Synthroid Tablet 175 mcg (Levothyroxine Sodium) Give 175 mcg via PEG-Tube one time a day every Sun (Sunday), Tue (Tuesday), Wed (Wednesday), Thu (Thursday), Fri (Friday), Sat (Saturday) for thyroid disorder brand name only, Zetia Tablet 10mg (Ezetimibe) Give 10 mg via PEG-Tube one time a day for cholesterol notify md (doctor) of unusual	F 842	Orders must be followed as written by the physician. The ordered route must be utilized. All documentation must be completed prior to the end of the shift. There must be no holes in the documentation. When seeking consent for pneumonia or influenza vaccinations, the expectation is to obtain dates of administration if the consent is refused related to previous administration. The expectation that only appropriate coding be used when documenting in the behavioral monitoring in Point Click Care The Director of Nursing or designee will review in the morning clinical meeting the newly written orders to ensure route consistency with the rest of the medications ordered for the resident, review that all documentation is complete, verify historical dates on vaccinations for those residents who have refused vaccinations related to having received them previously, and review that the behavior monitoring documentation has utilized the code provided. This will be documented with each clinical meeting for 4 weeks and then weekly for 8 weeks with immediate follow up for any issues identified. The Director of Nursing will report the findings of the monitoring to the monthly QA committee for review and	

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F 842	Continued From page 28 muscle spasms." (sic) Continued review of the clinical record produced the April and May 218 MAR's that documented that the medications were being administer by both PEG tube and by mouth. On May 1, 2018 at 3:40 p.m., the surveyor observed the Director of Nursing (DON) walking down the hallway towards the surveyor. The surveyor requested the DON to speak with the surveyor about Resident #46. The surveyor notified the DON that Resident #46 had a PEG tube and that some of his medications were ordered by mouth while others were ordered to be administered by the PEG tube. The surveyor reviewed the physician orders and April 2018 MAR's with the DON. The surveyor pointed out that some medications were ordered by mouth and some by PEG tube. The surveyor notified the DON that some of the medications were ordered to be administered at the exact same times. Yet some of the medications were being by mouth and others administered by PEG tube. The surveyor asked the DON how Resident #46 received his medications and the DON stated that he received all his medications by the PEG tube. On May 2, 2018 at 3:45 p.m., the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administration Team (AT) that the facility staff failed to ensue complete and accurate POS's and MAR's for Resident #46. The surveyor notified the AT that the facility staff failed to ensure complete and accurate POS's, and April and May 2018 MAR's. The surveyor notified the AT that the POS's and MAR's failed to accurately document how Resident #46 received	F 842	recommendations for the duration of the monitoring period. The allegation of compliance date is 5/31/2018.	

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his medications.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure complete and accurate POS's and MAR's for Resident #46.

2. For Resident #50 the facility staff failed to ensure complete and accurate April 2018 Medication Administration Records (MAR's).

Resident #50 was an 83 year old male who was originally admitted on 1/23/18 and readmitted on 3/7/18. Admitting diagnoses included, but were not limited to: hydrocephalus, apraxia, Parkinson's disease, diabetes mellitus, hypertension, sepsis, dementia and a myocardial infarction.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Significant Change MDS assessment with an Assessment Reference Date (ARD) of 3/14/18. The facility staff coded that Resident #50 had a Cognitive Summary Score of 9. The facility staff also coded that Resident #50 required extensive assistance (3/2) with Activities of Daily Living (ADL's).

On May 1, 2018 at 11:50 a.m., the surveyor reviewed Resident #50's clinical record. Review of the clinical record produced the April 2018 Medication Administration Records (MAR's). Review of the April 2018 MAR's revealed that the MAR's were inaccurate. The April 2018 MAR's identified 13 holes-indicating that the facility staff had not documented the administration of medications and treatments.

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On May 1, 2018 at 12:10 p.m. the surveyor notified the Director of Nursing (DON) that Resident #50's April 2018 MAR's were inaccurate. The surveyor reviewed Resident #50's clinical record with the DON and specifically pointed out the holes in the April 2018 MAR's. The surveyor notified the DON that Resident #50's April 2018 MAR's were inaccurate/incomplete.

On May 2, 2018 at 3:45 p.m., the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administration Team (AT) that the facility staff failed to ensure complete and accurate April 2018 MAR's for Resident #50. The surveyor notified the AT that the April 2018 MAR's had multiple holes where the facility staff had not documented the administration of medications and treatments.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure complete and accurate April 2018 MAR's for Resident #50.

3. The facility staff failed to ensure that Influenza and Pneumococcal vaccination dates were in the clinical record for Resident # 28.

Resident # 28 is a 91-year-old-female who was admitted to the facility on 1/23/18. Diagnoses included but were not limited to: anxiety disorder, hypertension, unspecified dementia with behavioral disturbance, anemia, and type 2 diabetes mellitus.

The clinical record for Resident # 28 was reviewed on 5/1/18 at 3:18 pm. The most recent MDS (minimum data set) assessment was a

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quarterly assessment with an ARD (assessment reference date) of 4/27/18. Section C of the MDS assesses cognitive patterns. In Section C 0500, the facility staff documented that Resident # 28 had a BIMS (brief interview for mental status) score of 00/15, which indicated that Resident # 28 had severe cognitive impairment. Section O of the MDS assesses special treatments, procedures, and programs. In Section O0250 A., the question "Did the resident receive the influenza vaccine in this facility for this year's influenza season?" The facility staff coded "0" which indicated "No." In Section 0250 C., the facility staff documented that Resident # 28 received the influenza vaccine outside of the facility. In Section O300 A., the question "Is the resident's pneumococcal vaccination up to date?" The facility staff documented "1" which indicated "yes."

Upon further review of the clinical record, the surveyor noted an "Informed Consent For Influenza Vaccine." A check mark was placed beside "I hereby DO NCT GIVE the facility permission to administer the influenza vaccination." Handwritten directly above this statement was "up to date." The resident's representative signed this document on 1/23/18. The surveyor also noted the "Informed Consent For Pneumococcal Vaccine" in the clinical record for Resident # 28. There was a checkmark beside "I hereby DO NOT GIVE the facility permission to administer a pneumococcal vaccine." Handwritten directly above this statement was "up to date." The resident's representative signed this document on 1/23/18.

Upon review of the Immunization Section in the clinical record for Resident # 28, the only

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F 842	Continued From page 32 immunization listed as administered was "Annual Mantoux Screening" documented as given on 1/31/18. On 5/2/18, at 9:18 am, the surveyor spoke with MDS coordinator # 1. Surveyor reviewed the clinical record for Resident # 28 specifically Section O of the MDS and the immunization section, along with MDS coordinator # 1. The surveyor asked MDS coordinator # 1 where she got the dates for the Influenza, and Pneumococcal Vaccinations to document in the MDS that the vaccinations had been administered outside of the facility and were up to date. On 5/2/18 at 9:22 am, MDS coordinator # 1 provided the surveyor with a copy of the informed consent forms as mentioned above. MDS coordinator # 1 stated to the surveyor that they go by the "up to date" that is written on the consent form when coding the MDS. The surveyor then asked MDS coordinator # 1, how is the facility to know when Resident # 28 is to receive the pneumococcal vaccine or if she is even eligible if there is no date and type of vaccination documented in the clinical record. MDS Coordinator # 1 stated to the surveyor, "I see what you mean." On 5/2/18 at 11:29 am, the surveyor discussed not being able to locate influenza and pneumococcal vaccination dates in the clinical record for Resident # 28 with LPN (licensed practical nurse) # 1. LPN # 1 reviewed the clinical record along with the surveyor and agreed that there were no influenza and pneumococcal vaccination dates located anywhere in the clinical record for Resident # 28.	F 842		

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F 842	Continued From page 33 On 5/2/18 at 3:46 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. The facility staff failed to ensure that for Resident #115 had diagnoses listed for some medications correspond with the accurate indications for use. Resident # 115 was originally admitted to the facility on 3/28/17 with a readmission date of 4/1/18. Diagnoses included but were not limited to: acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, hypertension, and heart failure. The clinical record for Resident # 115 was reviewed on 5/1/18 at 2:31 pm. The most recent MDS (minimum data set) was a 14-day assessment with an ARD (assessment reference date) of 4/15/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 115 has a BIMS (brief interview for mental status) score of 14/15, which indicated that Resident # 115 was cognitively intact. The current physician's orders for Resident # 115 that was signed by the physician on 4/1/18 contained orders that included but was not limited to: "Atorvastatin Calcium tablet 40 mg (milligrams) Give 40 mg by mouth one time a day for HTN (hypertension)," "Coreg tablet 6.25 mg (Carvedilol) Give 6.25 mg by mouth 2 times a day for A fib (atrial fibrillation)," and "SIngulair tablet 10 mg (Montelukast Sodium) Give 10 mg by	F 842		

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mouth at bedtime for CHF (congestive heart failure)." The surveyor noted that the diagnoses listed for these medications did not correspond with the indications for use.

No further information was provided to the survey team prior to the exit conference of 5/3/18.

5. The facility staff failed to maintain a complete and accurate clinical record for Resident #81.

Resident #81 was readmitted to the facility on 12/27/17 with the following diagnoses of, but not limited to anemia, high blood pressure, Alzheimer's disease, quadriplegia, anxiety disorder, depression, Psychotic disorder and bronchitis. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/5/18, the resident was coded as having short term and long-term memory problems and was severely impaired in making daily decisions. Resident #81 was also coded as being totally dependent of 2 or more staff members for dressing, personal hygiene and bathing.

The surveyor performed a clinical record review on Resident #81 on 5/1 and 5/2/18. During this review, the surveyor noted that on the MAR (Medication Administration Record) for the months of January, February, March and April 2018, the behavioral monitoring documentation did not follow the key that the staff was to use when documenting targeted behaviors.

On 5/3/18 at 7:30 am, the surveyor notified the director of nursing of the above documented findings. The DON reviewed the months listed above for accurate documentation in using the key on the MAR for the targeted behaviors. The DON stated, "I can't tell what the staff was

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F 842	Continued From page 35 meaning by this documentation. The key on the side of the MAR is how they are to be documenting. They simply didn't use this when they were documenting." The surveyor notified the corporate nurse of the above documented findings at 8:30 am. No further information was provided to the surveyor prior to the exit conference on 5/3/18.	F 842		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to provide evidence that the QAA (quality assessment and assurance) meetings were held quarterly. The findings included.	F 868	Disclaimer: Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding.	5/31/18

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F 868	Continued From page 36 The facility failed to provide evidence to the survey team that the QAA meeting were held quarterly. The facility did not provide evidence for the meeting(s) that should have been held for the quarter of April/May/June 2017 and the documentation that was provided for the quarter of Jan/Feb/March 2018 did not include any signatures. The surveyor meet with the administrator on 05/03/18 at approximately 9:45 a.m. to review the facility QA (quality assurance) program. This administrator had been employed at this facility since 04/02/18. When asked for the sign-up sheets for the meetings the administrator was unable to provide any evidence to the surveyor that a meeting was held for the quarter of April/May/June 2017 and the agenda and sign-up sheets for the quarter of January/Feb/March 2018 did not include any signatures. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 868	F 868 The Administrator will be reeducated by the Regional Vice President of Operations as to the policy for the QA meeting process. The next QA meeting has been scheduled. The Regional Vice President will be given a schedule of the QA meetings for the next 12 months. The minutes will be reviewed for the meetings for the next 3 months. This review will be documented for each month and brought to the QA committee meeting by the Administrator. The allegation of compliance date for this plan is 5/31/20	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		5/31/18

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F 880	Continued From page 37 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 38 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to follow infection control guidelines during the wound care observation for 1 of 24 residents in the survey sample (Resident #20). The findings included: Resident #20 was readmitted to the facility on 1/29/17 with the following diagnoses of, but not limited to anemia, neurogenic bladder, quadriplegia, Multiple Sclerosis, anxiety disorder and depression. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/13/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #20 was also coded as being totally dependent on 1 staff member for dressing and 2 or more staff members for personal	F 880	Disclaimer: Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F-880 Resident #20 wound vac dressing was changed using clean technique while preparing field, during dressing change and clean up after wound care. Identify and look at other residents on a wound vac dressing change. Reeducate Licensed Nursing staff wound vac dressing change using clean technique. This will include cleaning scissors before and after use. Cleaning	

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F 880	Continued From page 39 hygiene and bathing. The surveyor observed wound care being performed on Resident #20 on 5/3/18 at 10:30 am. The resident had a Stage 3 pressure ulcer to the right coccyx area. LPN (Licensed Practical Nurse) #1 performed the wound care. The surveyor made the following observations: LPN #1 did not clean the bandage scissors before and after while performing the wound care. The bedside table that was used to place the clean wound care supplies on was not cleaned prior to the beginning of the wound care. LPN #1 touched the wound vac container with dirty gloves that she had removed the old dressing with. The wound was cleansed with wound care cleaner but the nurse did not use a circular motion from the inside to outside of the wound. LPN #1 and the aide washed their hands at the sink in the resident's room. On the side of the sink in which they were using, there were 2 wash clothes, 2 towels and a blanket. Water was being splashed on these linens while they were washing their hands. The aide then dried her hands, picked up the 2 wash clothes, rolled them and then placed one washcloth in each of the resident's hands. The blanket was then used to cover the resident in bed. LPN #1 had a red trash bag lying on the resident's bed during wound care in which she placed the old dressings. The top edges of the trash bag had fallen inside the bag and the nurse proceeded to lift the top by the edges and tie it close. The surveyor notified the corporate nurse and director of nursing of the above documented observations made during wound care that was	F 880	the surface that will be used to place the wound care supplies. No touching of anything in the room with dirty gloves. Cleaning the wound in a circular motion from the inside to the outside with wound cleaner as ordered. That nothing can be stored within the splash area of the sink in the room that could be contaminated during hand washing. Discarding the old dressing in a garbage bag that is in the garbage can to ensure that there is no contamination of the bag and that there is no need to use a red bag for the discarding of the used wounddressing. Licensed Nursing staff who will be assigned patient assignments will perform return demonstration for wound vac dressing change using clean technique while maintaining infection prevention and control. Director of Nursing or designee will observe a wound vac dressing change once a week for twelve weeks. The Director of Nursing will report the findings of the monitoring to the monthly QA Committee for review and recommendations for the duration of the monitoring period. The allegation of compliance date for this plan is 5/31/2018	

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F 880	Continued From page 40 performed by LPN #1 on Resident #20. The director of nursing stated, "This is definitely something that we will work on to make better." At 11:45 am, the surveyor went to LPN #1 and reviewed the above documented observations that were made during wound care. LPN #1 stated, "I was so nervous, I just don't remember." No further information was provided to the surveyor prior to the exit conference on 5/3/18.	F 880		