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{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid second revisit to the first revist which was conducted on 2/4/18 through 2/8/18 was conducted 2/28/18 through 3/1/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567 - B. The census in this 118 certified bed facility was 101 at the time of the survey. The survey sample consisted of 13 current resident reviews (Residents #201 through #213).	{F 000}		
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	{F 656}	1. Residents #207 has physician orders updated and care plans revised to include bed maintained in low position as ordered and care planned. The order and care plan for vital signs for Resident #212 were changed and are being followed accordingly. 2. All residents who require low beds as a fall intervention have the potential to be affected. Audit completed by nurse leadership team for all residents with interventions to utilize low bed to ensure bed in low position.	

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

Administrator/Executive Directa 3-15-18

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

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provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined the facility staff failed to implement the comprehensive care plan for two of 13 residents in the survey sample, Resident #212 and #207.

1. The facility staff failed to obtain vital signs everyday as ordered by the physician and documented in the comprehensive care plan for Resident #212.

2. The facility staff failed to follow the comprehensive care plan and ensure Resident #207's bed was maintained in the low position.

3. Education provided to the Nursing staff and Nursing Leadership Team by the Nurse Practice Educator specific to the practice and regulation for following care-planned interventions and physician orders. This education included updating the CNAs' Kardexes, with interventions on the care plan to ensure that they are followed accordingly.

4. Care plans will be reviewed by the Clinical Management Team during the Clinical Morning Meeting, to ensure all new orders and changes are addressed accordingly on the Care Plan and that the Kardex gets updated. Unit Manager will complete audits 5x/week of all residents with interventions to utilize low bed. Process changed for CNAs to review their assigned Kardex routinely, with oversight by the Nurse Unit Managers/Supervisors. Results of these audits will be taken to the QAPI Committee monthly for review. 3/19/18

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The findings include:

1. Resident #212 was admitted to the facility on 12/30/17 with diagnoses that included but were not limited to: high blood pressure, altered mental status, anxiety, small strokes, depression and elevated cholesterol.

The most recent minimum data set (MDS), a 60 day scheduled assessment, with an assessment reference date (ARD) of 2/24/18 coded the resident as having scored a ten out of 15 on the brief interview for mental status (BIMS) indicating the resident was moderately cognitively impaired. The resident was coded as requiring one to two staff assistance for all activities of daily living.

Review of Resident #212's comprehensive care plan initiated on 1/2/18, documented, "Focus. Resident exhibits or is at risk for cardiovascular symptoms or complications related to HTN (hypertension - high blood pressure)...Interventions. Assess and monitor vital signs as ordered and report abnormalities to physicians."

Review of the physician's orders documented, "12/30/17 (start date) VITAL SIGNS EVERY DAY - DOCUMENT (name of software)."

Review of the medication administration record (MAR) documented, "12/30/17. VITAL SIGNS EVERY DAY -- DOCUMENT IN (name of software)." There were nurse's initials in the 2/25, 2/26, 2/27 and 2/28 boxes indicating the vital signs had been done.

Review of Resident #212's vital signs form in the

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software failed to evidence documentation of the resident's vital signs for 2/25, 2/26, 27 and 2/28/18.

The nurse's notes for February 2018 were reviewed and did not evidence documentation of vital signs.

An interview was conducted on 3/1/18 at 8:50 a.m. with LPN (licensed practical nurse) #2, the resident's nurse. When asked who used the care plan, LPN #2 stated, "Everyone." When asked why a resident had a care plan, LPN #2 stated, "To know the parameters to do for the patient and know what to do for their plan of care while they're here." When asked if staff were expected to follow the care plan, LPN #2 stated they were.

An interview was conducted on 3/1/18 at 10:30 a.m. with RN (registered nurse) #1. When asked who obtained residents' vital signs, RN #1 stated, "The nurses or the CNAs (certified nursing assistants). The nurses are responsible to sign that they were obtained on the MAR (medication administration record)." When asked who documented the vital signs into the chart, RN #1 stated, "Some of the new machines (vital sign machines) can enter it (the vital signs) right into the chart. Otherwise the nurse enters it." RN #1 was asked to review Resident #212's February MAR and vital sign record. When asked if the vital signs for the above dates had been taken, RN #1 stated, "No." When asked if staff were expected to take the vital signs, RN #1 stated, "Yes." When asked why staff did not take the vital signs, RN #1 stated, "I don't think there's a good answer to that. If you didn't do it on your shift there's still two more shifts in the day who could do it." When asked who used the care plan, RN

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#1 stated, "The nurses have access to the care plan and the CNAs have it on the tablet they carry." When asked who made sure the care plan was implemented, RN #1 stated, "The nurses are over the CNAs. The ADONs (assistant directors of nursing) are responsible overall." When asked why a care plan would not be implemented/followed, RN #1 stated, "If it's not appropriate anymore then the nurse should adjust it."

On 3/1/18 at 11:35 a.m. ASM (administrative staff member) #1, the executive director and ASM #2, the nurse executive were made aware of the findings.

Review of the facility's policy titled, "Person-Centered care Plan" documented, "POLICY. The center must develop and implement a baseline person-centered care plan within 48 hours for each patient that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care....PURPOSE. To attain or maintain the patient's highest practicable physical, mental and psychosocial well-being. PRACTICE STANDARDS. 3. The Center must provide the patient and his/her resident representative with a summary of the baseline care plan that includes but is not limited to: 3.3 Any services and treatments to be administered by the Center and personnel acting on behalf of the Center..."

No further information was provided prior to exit.
2. The facility staff failed to implement Resident #207's comprehensive care plan to ensure her bed was maintained in the low position.

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Resident #207 was admitted to the facility on 10/22/2015 with diagnoses that included but were not limited to: paralysis, stroke, difficulty speaking, difficulty swallowing, respiratory failure, dementia and seizures. Resident #207's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/10/18 coded Resident #207 as severely impaired for daily decision-making. Resident #207 was further coded as requiring extensive assistance of two people for bed mobility.

Resident #207 was observed on the following dates/times laying in her bed with the bed at regular height position: 2/28/18 at 2:30 p.m., 2/28/18 at 4:37 p.m. and 3/1/18 at 8:05 a.m.

A review of Resident #207's comprehensive care plan dated 4/9/16 revealed, in part, the following documentation: "Focus: Resident is at risk for falls: Impaired mobility r/t (related to) cognitive deficits, impaired vision and muscle weakness, seizures. Interventions: Utilize low bed."

A review of Resident #207's care card, a communication tool used by the CNAs (certified nursing assistants) revealed, in part, the following documentation: "Safety. Utilize low bed."

On 3/1/18 at 9:15 a.m. LPN (licensed practical nurse) #5, a floor nurse, was asked to look at the position of Resident #207's bed with this writer. LPN #5 was asked to describe the position of Resident #207's bed relative to the height. LPN #5 stated, "The bed is in the regular position." LPN #5 was asked if the regular position was the same as a low bed position. LPN #5 stated, "No it is a regular position, it is not at its' lowest position."

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On 3/1/18 at 9:20 a.m. CNA #2, the aide caring for Resident #207, was asked to look at the position of Resident #207's bed with this writer. When asked to describe the position of the bed relative to the height of the bed CNA #2 stated, "It is not down; it is in the regular position." CNA #2 was asked how she would know what position the bed should be in for a resident. CNA #2 stated, "I would look on my care card." CNA #2 pulled up Resident #207's care card and confirmed that the directive was to utilize a low bed for Resident #207. CNA #2 was asked why the directive was to keep Resident #207 in a low bed. CNA #2 stated, "So she won't fall, she is at risk for falling so we keep the bed low for safety."

On 3/1/18 at 9:53 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked why a resident would be care planned for his/her bed to be in a low position. RN #1 stated, "If the resident is a fall risk the low bed would be utilized to prevent an injury." RN #1 was asked if the care plan should be implemented/followed, RN #1 stated, "Yes, it is the plan of care for that resident."

On 3/1/18 at 11:35 a.m., a meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concerns.
No further information was provided prior to exit.

{F 658} SS=D Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) {F 658}

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility,

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as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for one of 13 residents in the survey sample, Resident #208.

The facility staff failed to clarify Resident #208's physician orders for prn (as needed) pain medication prior to administration.

The findings include:

Resident #208 was admitted to the facility on 3/29/14 with diagnoses that included but were not limited to paralysis post stroke affecting the left side, aphasia (difficulty speaking), major depressive disorder, and unspecified convulsions. Resident #208's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 2/6/18. Resident #208 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #208 was coded as being independent with most ADLS (activities of daily living).

Review of Resident #208's most recent POS (physician order sheet) dated 2/2/18 revealed the following pain medication orders:

Tylenol [1] 160 MG (milligrams)/5 ml (milliliters) solution: 20.3 ML via gast (gastronomy tube) every 6 hours as needed for pain (Mild to

1. Pain-medication order reviewed and revised accordingly for Resident #208 to include parameters for when to administer which medication. Pain assessments will be completed prior to administration of prn pain medications.

2. All residents with pain have a potential to be affected. A 100% audit was completed by the Regional Nurse of all current residents with orders for pain medication, to ensure appropriate parameters in place for when to administer medications. Clarification orders were obtained in collaboration with the Medical Director. Center Nurse Executive reviewed all MARs to ensure that a Pain Monitoring Tools was in place for all residents, to document pain assessment prior to administration of prn pain medications.

3. Education was provided to the licensed nursing staff by the Nurse Practice Educator specific to pain-medication management, to include completion of a pain

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{F 658}	Continued From page 8 Moderate Pain). This order was initiated on 3/29/14. Tramadol [2] 50 mg tablet: 2 tabs (tablets) via peg tube every 6 hours as needed for pain." This order was initiated on 12/20/17. Review of Resident #208's February MAR (Medication Administration Record) revealed that Resident #208 received Tramadol 50 mg on 2/27/18. A pain assessment for 2/27/18 could not be found on the MAR or in the clinical record. On 3/1/18 at 9:53 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked about the process followed if a resident had two pain medication orders (Tylenol and Tramadol) with no parameters one medication order, how she or other nurses would determine which medication to give, RN #1 stated that she would administer the pain medication that was not as strong first. RN #1 stated that she would administer the Tylenol over the Tramadol. When asked if nurses are able to choose which pain medication to give at their discretion, RN #1 stated, "I'd assume we could pick. In the real world a more prudent nurse would clarify the order." On 3/1/18 at approximately 11:35 a.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. ASM #2 stated that the facility used their policies and procedures as a professional standard. On 3/1/18 at 4:00 p.m., an interview was conducted with ASM #5, the physician. ASM #5	{F 658}	assessment when administering prn pain medications, use of pain monitoring tool, and following appropriate parameters for when to administer which prn pain medication. 4. Unit Manager or Supervisor will audit the MAR's 5x/week for 6 weeks, then randomly thereafter, for appropriate documentation of pain assessments and following of parameters. Results of audits will be brought to the QAPI Committee monthly for review.	3/19/18

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stated that he always prescribes Tylenol for mild discomfort, Tramadol for moderate discomfort and Morphine for severe pain/discomfort. ASM #5 stated that he always writes parameters on pain medication orders. When asked when nursing should administer Resident #208's Tramadol when Tylenol is given for mild to moderate discomfort, ASM #5 stated that Tramadol should be used if Resident #208 was having severe pain. ASM #5 confirmed that there were no pain parameters for the Tramadol order. ASM #5 stated that facility staff should have clarified the order.

Review of the facility's pain policy and facility policy titled, "Taking Medications and Treatment Orders" did not address the above concerns.

According to Potter, Patricia A., & Perry, Anne Griffin. Fundamentals of nursing. 6th Edition, St. Louis, MO: Mosby, Inc. Page 419, "....all orders must be assessed, and if one is found to be erroneous....further clarification from the physician is necessary."

[1] Tylenol Tablet 325 mg (Acetaminophen): Treats minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.

[2] Tramadol: analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197.

[3] Morphine: Morphine Sulfate is indicated for the

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management of acute and chronic pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=3f3a870e-f325-475b-8453-fe3d1bb8f54a.

{F 684} Quality of Care
SS=D CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure treatment and care were provided in accordance with professional standards of practice and the comprehensive care plan for two of 13 residents in the survey sample, Resident #205 and Resident #212.

1a. The facility staff failed to obtain and document vital signs as ordered by the physician for Resident #205.

1b. The facility staff failed to monitor and document Resident #205's intake and output as per the physician's order.

{F 658}

{F 684}

1. I&O's and vital signs for Resident #205 are being completed per order. The order and care plan for vital signs for Resident #212 were changed and are being followed accordingly

2. All residents with orders for I&O and daily vital signs have the potential to be affected. A 100% audit was completed by the Regional Nurse of all current residents, to review and ensure physician orders for intake monitoring and vital signs are accurate and followed accordingly. Corrections made accordingly to orders, in collaboration with facility Medical Director.

3. Education was provided to the nursing staff by the Nurse Practice Educator specific to Following Physician orders and reviewing the MARs and TARs at the end of each

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2. The facility staff failed to obtain and document vital signs as ordered by the physician for Resident #212.

The findings include:

1. Resident #205 was admitted to the facility on 3/24/14 and had a readmission on 1/22/18 with diagnoses that included but were not limited to: fractured right hip, chronic pain, high blood pressure, diabetes, kidney failure and chronic lung disease.

The most recent (minimum data set) MDS, a 30 day scheduled assessment, with an assessment reference date (ARD) of 2/17/18 coded the resident as having scored an 11 out of 15 on the brief interview for mental status (BIMS) indicating the resident was moderately impaired cognitively to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living, with the exception of eating, which the resident could perform after the meal tray was set up.

Review of Resident #205's care plan, initiated on 1/23/18 documented, "Focus. Resident at risk for injury or complications related to the use of anticoagulation therapy. Interventions. Obtain vital signs as ordered."

Review of the physician's orders dated and signed on 1/22/18 documented, "CERTIFICATION ORDERS. (A box with a check mark) Skilled level of care. VITAL SIGNS. (A box with a check mark) Specific. QShift (every shift) x (times) 72 hrs (hours) then routine."

Review of the February 2018 medication

shift to ensure that orders were followed accordingly.

4. Unit Managers will audit MARs/TARs 5x/week for six weeks, and then randomly thereafter, to ensure that orders are followed. Process change to include nurses checking MARs/TARs at the end of each shift. Results of these audits will be brought to the QAPI Committee monthly for review. 3/19/18

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administration record (MAR) documented, "01/22/18 VITAL SIGNS EVERY DAY - DOCUMENT IN (name of software)." Review of the MAR evidenced the nurse's initials on each day indicating the vital signs were obtained.

Review of the vital sign summary record did not evidence documentation of the resident's vital signs on 2/26, 2/27 or 2/28/18.

An interview was conducted on 3/1/18 at 10:30 a.m. with RN (registered nurse) #1. When asked who obtained residents' vital signs, RN #1 stated, "The nurses or the CNAs (certified nursing assistants). The nurses are responsible to sign that they were obtained on the MAR (medication administration record)." When asked who documented the vital signs into the chart, RN #1 stated, "Some of the new machines (vital sign machines) can enter it (the vital signs) right into the chart. Otherwise the nurse enters it." RN #1 was asked to review Resident #212's February MAR and vital sign record. When asked if the vital signs for the above dates had been taken, RN #1 stated, "No." When asked if staff were expected to take the vital signs, RN #1 stated, "Yes." When asked why staff did not take the vital signs, RN #1 stated, "I don't think there's a good answer to that. If you didn't do it on your shift there's still two more shifts in the day who could do it." When asked if staff had followed the physician's order, RN #1 stated they had not. When asked if staff were expected to follow the physician's order, RN #1 stated they were.

Review of the facility's policy titled, "VITAL SIGNS" documented, "POLICY. Vital signs (blood pressure, pulse, respiration, temperature) will be monitored as follows for admissions and

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re-admissions: Q shift x 72 hours; Then a minimum of daily for short stay admissions and monthly for long term admissions; or more frequently based on patient condition. Additional monitoring may be done based on nursing judgement, physician/mid-level provider order, or pharmacy recommendation."

On 3/1/18 at 11:35 a.m. ASM (administrative staff member) #1, the executive director and ASM #2, the nurse executive were made aware of the findings.

1b. The facility staff failed to monitor and document Resident #205's intake and output as per the physician's order.

Review of physician's orders for Resident #212 dated and signed on 2/9/18 documented, "Document I & O (intake and output)."

Review of Resident #205's care plan initiated on 1/23/18 did not document monitoring intake and output.

Resident #205's February 2018 intake and output record failed to evidence documentation of the resident's intake on the following dates and shifts:
- 2/24/18 on the 7:00 a.m. to 3:00 p.m. shift,
- 2/25/18 on the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shifts,
- 2/26/18 on the 11:00 p.m. to 7:00 a.m. and 7:00 a.m. to 3:00 p.m. shifts.

An interview was conducted on 3/1/18 at 10:30 a.m. with RN #1. When asked to review the February 2018 intake and output records for Resident #205, RN #1 stated the intake was not

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documented. When asked what that meant, RN #1 stated it wasn't done. When asked if staff had followed the physician's order, RN #1 stated they had not.

An interview was conducted on 3/1/18 at 11:00 a.m. with ASM (administrative staff member) #3, the nurse practitioner. When asked if she wanted Resident #205 to have intake and output monitored and documented, ASM #2 stated, "Yes because she had bilateral edema (swelling) and she has stage two to stage three kidney failure. I ordered intake and output so we know whatever she intakes she outputs, so we know her kidneys are still working."

Review of the facility's policy titled, "Intake and Output" documented, "2. Record all intake amounts (in ccs [cubic centimeters]) including: 2.1 PO (by mouth), amounts taken by mouth...6. Evaluate patient's fluid balance based on daily intake and output records. 7. Document: 7.1 Intake and output totals in patient's medication record."

No further information was provided prior to exit.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc.; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

2. The facility staff failed to obtain and document vital signs as ordered by the physician for

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Resident #212.

Resident #212 was admitted to the facility on 12/30/17 with diagnoses that included but were not limited to: high blood pressure, altered mental status, anxiety, small strokes, depression and elevated cholesterol.

The most recent minimum data set (MDS), a 60 day scheduled assessment, with an assessment reference date (ARD) of 2/24/18 coded the resident as having scored a ten out of 15 on the brief interview for mental status (BIMS) indicating the resident was moderately cognitively impaired. The resident was coded as requiring one to two staff assistance for all activities of daily living.

A review of Resident #212's care plan initiated on 1/2/18 documented, "Focus. Resident exhibits or is at risk for cardiovascular symptoms or complications related to HTN (hypertension - high blood pressure)...Interventions. Assess and monitor vital signs as ordered and report abnormalities to physicians."

Review of the physician's orders documented, "12/30/17 (start date) VITAL SIGNS EVERY DAY - DOCUMENT IN (name of software)."

Review of the medication administration record (MAR) documented, "12/30/17. VITAL SIGNS EVERY DAY -- DOCUMENT IN (name of software)." There were nurse's initials in the 2/25, 2/26, 2/27 and 2/28 boxes indicating the vital signs had been done.

Review of Resident #212's vital signs form in the software failed to evidence documentation of the resident's vital signs for 2/25, 2/26, 2/27 and

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2/28/18.

Review of the February 2018 nurse's notes for Resident #212 did not evidence documentation of vital signs.

An interview was conducted on 3/1/18 at 8:50 a.m. with LPN (licensed practical nurse) #2, the resident's nurse. When asked if the vital signs had been taken, LPN #2 did not have a response. When asked if staff were expected to follow a physician's order, LPN #2 stated yes.

An interview was conducted on 3/1/18 at 10:30 a.m. with RN (registered nurse) #1. When asked who obtained residents' vital signs, RN #1 stated, "The nurses or the CNAs (certified nursing assistants). The nurses are responsible to sign that they were obtained on the MAR (medication administration record)." When asked who documented the vital signs into the chart, RN #1 stated, "Some of the new machines (vital sign machines) can enter it (the vital signs) right into the chart. Otherwise the nurse enters it." RN #1 was asked to review Resident #212's February MAR and vital sign record. When asked if the vital signs had been taken on the dates above, RN #1 stated, "No." When asked if staff were expected to take the vital signs, RN #1 stated, "Yes." When asked why staff did not take the vital signs, RN #1 stated, "I don't think there's a good answer to that. If you didn't do it on your shift there's still two more shifts in the day who could do it."

On 3/1/18 at 11:35 a.m. ASM (administrative staff member) #1, the executive director and ASM #2, the nurse executive were made aware of the findings that staff had not followed the physician's

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order to obtain daily vital signs.

No further information was provided prior to exit.

{F 689} Free of Accident Hazards/Supervision/Devices
SS=D CFR(s): 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility policy review and clinical record review, it was determined the facility staff failed to implement fall preventative measures to ensure a safe environment free from accident hazards for one of 13 residents in the survey sample, Resident #207.

The facility staff failed to ensure Resident #207's bed was maintained in a low position while she was in the bed as per the comprehensive care plan.

The findings include:

Resident #207 was admitted to the facility on 10/22/2015 with diagnoses that include paralysis, stroke, difficulty speaking, difficulty swallowing, respiratory failure, dementia and seizures. Resident #207's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/10/18 coded

{F 684}

{F 689}

1. Resident's #207 has physician orders updated and care plan revised to include bed maintained in low position as ordered and care planned.

2. All residents who require low beds as a fall intervention have the potential to be affected. Audit completed by nurse leadership team for all residents with interventions to utilize low bed, to ensure bed in low position.

3. Education provided to the Nursing staff and Nursing Leadership Team by the Nurse Practice Educator specific to the practice and regulation for following care-planned interventions and physician orders. This education included updating the CNAs' Kardexes with interventions on the care plan to ensure that they are followed accordingly.

4. Care Plans will be reviewed by the Clinical Management Team during the Clinical Morning Meeting, to ensure that all new orders and changes are addressed accordingly on the Care Plan and that the Kardex also gets updated accordingly. Nurse

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Resident #207 as severely impaired for daily decision-making. Resident #207 was further coded as requiring extensive assistance of two people for bed mobility.

Resident #207 was observed on the following dates/times laying in her bed and the bed at a regular position: 2/28/18 at 2:30 p.m., 2/28/18 at 4:37 p.m. and 3/1/18 at 8:05 a.m.

A review of Resident #207's comprehensive care plan dated 4/9/16 revealed, in part, the following documentation: "Focus: Resident is at risk for falls: Impaired mobility r/t (related to) cognitive deficits, impaired vision and muscle weakness, seizures. Interventions: Utilize low bed."

A review of Resident #207's care card, a communication tool used by the CNAs (certified nursing assistants) revealed, in part, the following documentation: "Safety. Utilize low bed."

On 3/1/18 at 9:15 a.m. LPN (licensed practical nurse) #5, a floor nurse, was asked to look at the position of Resident #207's bed with this writer. LPN #5 was asked to describe the position of Resident #207's bed relative to the height. LPN #5 stated, "The bed is in the regular position." LPN #5 was asked if the regular position was the same as a low bed position. LPN #5 stated, "No it is a regular position, it is not at its' lowest position."

On 3/1/18 at 9:20 a.m. CNA #2, the aide caring for Resident #207, was asked to look at the position of Resident #207's bed with this writer. When asked to describe the position of the bed relative to the height of the bed, CNA #2 stated, "It is not down; it is in the regular position." CNA

{F 689}

Unit Managers will audit 5x week all residents with interventions to utilize low bed. Additionally, process changed for CNAs to review their assigned Kardexes routinely, with oversight by the Nurse Unit Managers/ Supervisors. Results of these audits will be brought to the QAPI Committee monthly for review. 3/19/18

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#2 was asked how she would know what position the bed should be in for a resident. CNA #2 stated, "I would look on my care card." CNA #2 pulled up Resident #207's care card and confirmed the directive was to utilize a low bed for Resident #207. CNA #2 was asked why the directive was to keep Resident #207 in a low bed. CNA #2 stated, "So she won't fall, she is at risk for falling so we keep the bed low for safety."

On 3/1/18 at 11:35 a.m., a meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concerns. A policy was requested at this time for safety.

No further information was provided prior to the end of the survey process.

{F 695} SS=D Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)

§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility policy review and clinical record review, it was determined the facility staff failed to obtain a physician's order to provide respiratory services for one of 13 residents in the survey sample,

{F 689}

{F 695}

1. Residents #211 has updated physician orders and revised care plans to include use of oxygen.
2. All residents utilizing oxygen have the potential to be affected. Audits completed by the Center Nurse Executive and Nurse Unit Managers for all residents with Oxygen to ensure that all residents utilizing oxygen had an appropriate order and care plan in place.
3. Education provided to the Nursing staff and Nursing Leadership Team

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{F 695}	Continued From page 20 Resident #211. The facility staff failed to obtain an oxygen order prior to administering oxygen to Resident #211. The findings include: Resident #211 was admitted to the facility on 2/21/18 with diagnoses that included but were not limited to: chronic lung disease, heart disease, high blood pressure and elevated cholesterol. There was no minimum data set completed. Review of the admission note dated 2/26/18 at 2:30 p.m. documented, "A Social History & Initial Assessment was completed today resulting in a BIMS (brief interview for mental status) score of 15.0 (out of a possible 15) indicating the resident was cognitively intact. Review of the care plan initiated on 2/21/18 did not evidence documentation regarding oxygen. An observation was made on 2/28/18 at 11:18 a.m. of Resident #211. The resident was lying in bed with oxygen via a nasal cannua connected to an oxygen concentrator with the flow rate set at two liters. The resident was awake. An observation was made on 2/28/18 of Resident #211. The resident was lying in bed with the oxygen on via nasal cannula connected to an oxygen concentrator with the flow rate set at two liters. Review of the physician's orders dated 2/27/18 did not evidence documentation of an oxygen	{F 695}	by the Nurse Practice Educator specific to Standards of Practice regarding oxygen utilization, to include requiring physician's orders and care plans. 4. Unit Managers will audit their units routinely each week to ensure no residents have been started on oxygen without orders/care plans. Results of these audits will be brought to the QAPI Committee monthly for review.	3/19/18

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order.

Review of the February medication administration record did not evidence documentation of an oxygen order.

Review of the nurses' notes dated 2/23/18 at 10:09 p.m. documented, Resident is adjusting to facility well and is currently on O2 (oxygen) at 2 liters per/min."

Review of the nurse practitioner's note dated 2/24/18 at 12:00 a.m. documented, "On continuous O2 via NC (nasal cannula) at 2.5 Liters."

Review of the nurses' notes dated 2/25/18 at 3:12 a.m. documented, "O2 NC."

Review of the nurses' notes dated 2/26/18 at 4:12 p.m. documented, "o2 (sic) in place no S/S (signs or symptoms) SOB (shortness of breath)/Resp. (respiratory) difficulties at this time.

An interview was conducted on 3/1/18 at 8:20 a.m. with LPN (licensed practical nurse) #1, the resident's nurse. When asked to review Resident #211's physician orders and February 2018 MAR for the oxygen order. LPN #1 stated, "It's not here. She came in with it (from the hospital)." When asked if an order was needed to administer oxygen, LPN #1 stated it should.

An interview was conducted on 3/1/18 at 10:30 a.m. with RN (registered nurse) #1. When asked if oxygen could be administered without an order, RN #1 stated, "No, because you're administering oxygen without an order and it's not something the physician advised or ordered."

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An interview was conducted on 3/1/18 at 11:00 a.m. with LPN #4, the resident's nurse on 2/28/18. When asked if the resident was wearing oxygen on 2/28/18, LPN #4 stated, "Yes." When asked what rate the oxygen was set at, LPN #4 stated, "I'm sure it was on two liters because I went around to check all the machines." When asked if oxygen could be administered without an order, LPN #4 stated, "No. There's supposed to be an order." When asked where the order would be documented, LPN #4 stated, "Actually they just put it on (the orders and MAR)."

Another review of the physician's orders dated 2/2/7/18 at 1:30 p.m. documented, "O2 @ 2L via nc continuously."

Another review of the March 2018 MAR documented, "O2 @ 2L via NC continuously." There was no date documented and there was no documentation that the oxygen had been administered.

An interview was conducted on 3/1/18 at approximately 11:20 a.m. with RN #2, the assistant director of nursing. When asked when the order for the oxygen had been written and then documented on the MAR, RN #2 stated, "I did it today. I forgot to write it."

Review of the facility's policy titled, "Oxygen: Nasal Cannula" documented, "1. Verify order."

No further information was obtained prior to exit.

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects,

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such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

F 697 Pain Management
SS=D CFR(s): 483.25(k)

§483.25(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure a complete pain management program for one of 13 residents in the survey sample, Resident #208.

The facility staff failed to identify, implement and attempt non-pharmacological pain relieving interventions prior to the administration of prn (as needed) Tramadol on 2/27/18.

The findings include:

Resident #208 was admitted to the facility on 3/29/14 with diagnoses that included but were not limited to paralysis post stroke affecting the left side, aphasia (difficulty speaking), major depressive disorder, and unspecified convulsions.

{F 695}

F 697

1. Pain-medication order for Resident #208 reviewed and revised accordingly, to include parameters for when to administer which medication. Pain assessments will be completed prior to administration of prn pain medications.

2. All residents with pain have a potential to be affected. A 100% audit was completed by the Regional Nurse of all current residents with orders for pain medication, to ensure appropriate parameters in place for when to administer which medications. Clarification orders obtained in collaboration with facility Medical Director. Center Nurse Executive reviewed all MARs to ensure that a Pain Monitoring Tool was in place for all residents, to document pain

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Resident #208's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 2/6/18. Resident #208 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #208 was coded as being independent with most ADLS (activities of daily living).

Review of Resident #208's most recent POS (physician order sheet) dated 2/2/18 revealed the following pain medication order: Tramadol [1] 50 mg tablet: 2 tabs (tablets) via peg tube every 6 hours as needed for pain." This order was initiated on 12/20/17.

Review of Resident #208's February MAR (Medication Administration Record) revealed that Resident #208 received Tramadol 50 mg on 2/27/18. A pain assessment for 2/27/18 could not be found on the MAR or in the clinical record. There was no evidence that non-pharmacological pain relief interventions were attempted or offered prior to the administration of Tramadol.

Review of Resident #208's pain care plan dated 4/1/14 and revised 1/22/18 did not address attempting non-pharmacological interventions prior to the administration of pain medications. There care plan did not have any identified non-pharmacological interventions.

On 3/1/18 at 9:53 a.m., an interview was conducted with RN (registered nurse) #1. When asked about the process prior to administering a prn (as needed) pain medication, RN #1 stated she would assess the resident's pain, attempt assessment prior to administration of prn pain medications.

3. Education was provided to the licensed nursing staff by the Nurse Practice Educator specific to pain-medication management, to include completion of a pain assessment when administering prn pain medications, use of pain monitoring tool, and following appropriate parameters for when to administer which prn pain meds.

4. Nurse Unit Manager or Supervisor will audit the MAR's for appropriate documentation of pain assessments and following of parameters 5x/week for six weeks, then randomly thereafter. Results of audits will be brought to the QAPI Committee monthly for review. 3/19/18

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non-pharmacological interventions first, and if those interventions did not work, she would administer the pain medication per physician's order. RN #1 stated she would follow up on the resident's pain and document if the pain medication was effective. When asked where the pain assessment, non-pharmacological interventions attempted and the follow up assessment are documented, RN #1 stated this information should be written on the MAR or in a nursing note. RN #1 stated that non-pharmacological interventions offered should also be documented for a resident who requests their pain medication and declines interventions. When asked if she could tell if this was done on 2/27/18 when Resident #208 was administered the Tramadol, RN #1 reviewed Resident #208's clinical record and stated, "It's not there. I would assume it was not done if not documented, unless the nurse forgot to document."

On 3/1/18 at 10:35 a.m., an interview was conducted with Resident #208. Resident #208 stated that nursing staff always do a pain assessment and follow up when she is in pain. Resident #208 stated that facility staff never attempt or offer non-pharmacological interventions for pain. Resident #208 stated that she is just given the pain medication.

On 3/1/18 at approximately 11:35 a.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Pain Management" did not address the above concerns. No further information was presented prior to exit.

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[1] Tramadol- analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197.

{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}

1. Resident #213 will have non-pharmacological interventions provided and documented accordingly. Pain medication orders for resident #208 were clarified and revised accordingly.

2. All residents with orders for psychotropic medications and/or pain medications have the potential to be affected. 100% audit completed by the Regional Nurse, to review all residents with pain medication orders, with appropriate clarification orders written in collaboration with facility Medical Director. Center Nurse Executive completed audit of all MARs to ensure Behavior Monitoring Sheets were in place as indicated. All residents with psychotropic medication will have a non-pharmacological intervention prior to administration.

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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 resident interview, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure two of 13 residents in the survey sample, Resident #208 and Resident #213, were free from unnecessary medications.

1. The facility staff failed to attempt non-pharmacological interventions prior to the administration of prn (as needed) Xanax [1] to Resident #208 on 2/23/18 and 2/26/18.

2. The facility staff failed to attempt non-pharmacological interventions prior to administering a prn (as needed) anti-psychotic medication to Resident #213.

The findings include:

1. Resident #208 was admitted to the facility on 3/29/14 with diagnoses that included but were not

3. Licensed Nursing staff educated by the Nurse Practice Educator specific to pain-medication documentation and parameters for when to administer which medication, and psychotropic medication documentation to include non-pharmacological interventions attempted prior to administering the medication. Process change to include nurses checking MARs/TARs at the end of each shift.

4. The Nurse Unit Manager or Supervisor will audit residents with Pain medication and Psychotropic medication 5x/week for six weeks to ensure accurate documentation. Results of these audits will be brought before the QAPI Committee monthly for review. 3/19/18

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limited to paralysis post stroke affecting the left side, aphasia (difficulty speaking), major depressive disorder, and unspecified convulsions. Resident #208's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 2/6/18. Resident #208 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #208 was coded as being independent with most ADLS (activities of daily living).

Review of Resident #208's POS (physician order sheet) dated 2/2/18 revealed the following order:

"Xanax [1] 0.5 mg (milligrams) by mouth every 8 hours as needed for anxiety." This order was initiated on 9/6/17 and discontinued on 2/26/18.

Review of Resident #208's February 2018 MAR (medication administration record) revealed that Resident #208 received Xanax on 2/23/18 and 2/26/18.

There was no evidence in the clinical record that non-pharmacological interventions were offered or attempted prior to the administration of Xanax on the above dates. Behavior monitoring sheets for 2/23/18 and 2/26/18 were blank.

Review of Resident #208's psychotropic care plan dated 4/1/14 and revised 1/22/18, did not address non-pharmacological interventions prior to administering psychotropic drugs.

On 3/1/18 at 9:53 a.m., an interview was conducted with RN (registered nurse) #1. When asked about the process followed prior to

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administering prn (as needed) psychotropic drugs, RN #1 stated that she would attempt non-pharmacological interventions before administering the medication and she would document the behavior and intervention on the behavior monitoring sheet. RN #1 stated the behavior monitoring sheet was located in the MAR. RN #1 stated that interventions attempted or offered could also be documented in a nursing note. When asked what it meant if this documentation was nowhere to be found in the clinical record, RN #1 stated, "I would assume that it was not attempted." RN #1 stated that if the interventions were not documented then they were not done. RN #1 stated even if the resident requests the medication, the nurse should be at least offering non-pharmacological interventions and documenting that the interventions were offered and refused.

On 3/1/18 at 10:35 a.m., an interview was conducted with Resident #208. Resident #208 stated that she does not get offered other interventions when she is having anxiety. Resident #208 stated that she receives the medication only when she is experiencing anxiety.

On 3/1/18 at 11:35 a.m., ASM #1 (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Psychotropic Medication Use" documents in part, the following: "Psychotropic medications may be used to address behaviors only if non-drug approaches and interventions were attempted prior to their use."

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did not reveal any nursing notes that evidenced non-pharmacological interventions were attempted prior to administering Zolpidem to Resident #213.

A review of Resident #213's comprehensive care plan dated 2/16/18 revealed, in part, the following documentation: Focus: Resident is at risk for complications related to the use of psychotropic drugs. Medication: Ambien. Date Initiated 2/19/2018. Created on: 2/19/2018. Interventions: Complete behavior monitoring flow sheet. Date Initiated 2/19/2018. Created on 2/19/2018."

A review of Resident #213's behavior monitoring sheets did not reveal any documentation for February.
On 3/1/18 at 9:53 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to describe the process followed when caring for a resident on a prn psychotropic medication. RN #1 stated, "We go to the behavior monitoring flowsheet and document any non-pharmacological interventions attempted, the effectiveness of the interventions and the medication should be given as a last resort." RN #1 was asked what it meant if there was no documentation on the behavior monitoring flowsheet. RN #1 stated, "I would look on the nursing notes, if there was nothing documented in either place then the non-pharmacological interventions were not done." RN #1 was asked if non-pharmacological interventions should be done prior to administering Zolpidem (Ambien). RN #1 stated, "Yes. If the nursing notes and behavior monitoring flowsheets do not speak to what was tried then the medication was given as the first option."

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On 3/1/18 at 11:35 a.m., a meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concerns. A policy was requested at this time regarding prn anti-psychotic medication administration.

No further information was provided prior to the end of the survey process.

[1] Zolpidem is used to treat insomnia (difficulty falling asleep or staying asleep). Zolpidem belongs to a class of medications called sedative-hypnotics. It works by slowing activity in the brain to allow sleep. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a693025.html

{F 758}

{F 812} SS=D Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

{F 812}

1. Regional Senior Dietitian in-serviced all dietary staff on infection-control standards during the survey, and the facility Nurse Practice Educator re-educated all dietary staff as part of this POC.
2. All residents have potential to be affected by this practice.
3. Onsite Dietary Director will be held accountable to ensure 100% compliance by all dietary staff with infection-control standards. All non-compliance issues with staff will prompt individual, formal counseling by the Dietary

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{F 812}	Continued From page 33 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, it was determined the staff failed to serve food in accordance with professional standards for food service safety. 1. The facility staff failed to ensure their gloved fingers did not touch the resident's soup during the dining observation on 2/28/18. 2. The acility staff failed to secure hair in the hair protective net during the 2/28/18 lunch dining observation. The findings include: A dining observation was conducted on 2/28/18 at 12:40 p.m. OSM (other staff member) #2, the dietary aide was observed wearing gloves and preparing dishes to be served. OSM #2 put her thumb inside a full bowl of soup and served it to a resident. OSM #2 then continued with dining service. OSM #2 did not change her gloves. An interview was conducted on 2/28/18 at 2:10 p.m. with OSM #2. When asked when staff wore gloves, OSM #2 stated, "All the time. When I go to work I wash my hands and put on gloves." When asked what staff should do if their gloved finger touched a resident's food, OSM #2 stated, she would not serve it. When asked why, OSM #2 stated, "Germs." An interview was conducted on 2/28/18 at 2:15 p.m. with OSM #3, the dietary manager. When	{F 812}	Director, up to and including possible termination per company policy. New dietary employees will receive education on infection-control practices as part of their orientation, and incumbent dietary staff will receive re-education annually at a minimum. 4. Center Executive Director/designee will audit the dietary staff 7 days/week for six weeks to ensure compliance with infection-control standards. Results of the audits will be brought monthly to the QAPI Committee for review.	3/19/18

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asked what staff should do if their gloved finger touched a resident's food, OSM #3 stated, "Number one, the thumb shouldn't be in a bowl and they shouldn't be serving the resident with gloves on."

Review of the facility's policy titled "Food and Nutrition Services Policies and Procedures" documented, "9. Disposable gloves are single use items and are changed between tasks."

On 2/2828 at 2:25 p.m. ASM #2, the nurse executive was made aware of the findings.

No further information was provided prior to ext.

2. The facility staff failed to secure hair in the hair protective net during the 2/28/18 lunch dining observation.

A dining observation was made in the main dining room on 2/28/18 at 12:40 p.m. OSM (other staff member) #2, the dietary aide was serving soup to a resident. Hair at the back of her neck was not covered with the hair protective net. The hair reached almost to her shoulders.

An interview was conducted on 2/28/18 at 2:10 p.m. with OSM #2. When asked why staff wore hair coverings, OS #2 stated, "So no hairs go in food." When asked when the hair covering was used, OSM #2 stated, "When in the kitchen and in the dining room, always." When asked to check her hair covering and her hair and if her hair was in the protective covering, OSM #2 stated, "No."

An interview was conducted on 2/28/18 at 2:15 p.m. with OSM #3, the dietary manager. When asked why staff wore hair coverings, OSM #3

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{F 812}	Continued From page 35 stated, "So hair doesn't fall into people's food." When asked if it was acceptable for dietary staff to have hair out of the hair covering, OSM #3 stated, "No." An interview was conducted on 2/28/18 at 2:25 with ASM (administrative staff member) #2, the nurse executive. When asked why dietary staff wore hair nets, ASM #2 stated, "To prevent hair from getting into the food." ASM #2 was made aware of the findings at that time. Review of the facility's policy titled, "Food and Nutrition Services Policies and Procedures" documented, "POLICY. Food and Nutrition Services employees present a neat, clean, professional appearance and wear the uniform that meets the established guidelines of the department. PROCESS. 7. Hair restrains such as hats, hair coverings, or nets are worn to effectively keep hair from contacting expose food." On 2/2828 at 2:25 p.m. ASM #2, the nurse executive was made aware of the findings. No further information was provided prior to exit.	{F 812}		
{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	{F 842}	1. Pain-medication order reviewed and revised accordingly for Resident #208, to include parameters for when to administer which medication. Pain assessments will be completed prior to administration of prn pain medications.	

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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 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

2. All residents with pain have a potential to be affected. A 100% audit was completed by the Regional Nurse of all current residents with orders for pain medication, to ensure appropriate parameters in place for when to administer with medications. Clarification orders obtained in collaboration with facility Medical Director. Center Nurse Executive reviewed all MARs to ensure that a Pain Monitoring Tool was in place for all residents to document pain assessment prior to administration of prn pain medications.

3. Education was provided to the licensed nursing staff by the Nurse Practice Educator specific to pain-medication management, to include completion of a pain assessment when administering prn pain medications, use of pain monitoring tool, and following appropriate parameters for when to administer which prn pain meds.

4. Nurse Unit Manager or Supervisor will audit the MAR's

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{F 842}	Continued From page 37 (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; (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, facility document review, and clinical record review, it was determined the facility staff failed to maintain a complete and accurate clinical record for one of 13 residents in the survey sample, Resident #208. The facility staff failed to document a pain assessment and follow-up before and after the administration of pain medication to Resident #208. The findings include: Resident #208 was admitted to the facility on 3/29/14 with diagnoses that included but were not limited to paralysis post stroke affecting the left side, aphasia (difficulty speaking), major depressive disorder, and unspecified convulsions. Resident #208's most recent MDS (minimum	{F 842}	5x/week for 6 weeks, then randomly thereafter, for appropriate documentation of pain assessments and following of parameters. Results of audits will be brought to the QAPI Committee monthly for review.	3/19/18

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data set) assessment was an annual assessment with an ARD (assessment reference date) of 2/6/18. Resident #208 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #208 was coded as being independent with most ADLS (activities of daily living).

Review of Resident #208's most recent POS (physician order sheet) dated 2/2/18 revealed the following pain medication order:

Tramadol [1] 50 mg tablet: 2 tabs (tablets) via peg tube every 6 hours as needed for pain." This order was initiated on 12/20/17.

Review of Resident #208's February MAR (Medication Administration Record) revealed that Resident #208 received Tramadol 50 mg on 2/27/18. A pain assessment prior to the administration of Tramadol and a follow up assessment could not be found in the clinical record.

On 3/1/18 at 9:53 a.m., an interview was conducted with RN (registered nurse) #1, regarding the process followed prior to administering a prn pain medication. RN #1 stated that she would assess the resident's pain, attempt non-pharmacological interventions first, and if those interventions did not work, she would administer the pain medication per physician's order. RN #1 stated she would follow up on the resident's pain and document if the pain medication was effective. When asked where the pain assessment, non-pharmacological interventions attempted and the follow up assessment are documented, RN #1 stated that

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this information should be written on the MAR or in a nursing note. When asked if she could tell if this was done on 2/27/18 when Resident #208 was administered the Tramadol, RN #1 reviewed Resident #208's clinical record and stated, "It's not there. I would assume it was not done if not documented, unless the nurse forgot to document."

On 3/1/18 at 10:35 a.m., an interview was conducted with Resident #208. Resident #208 stated that nursing staff always do a pain assessment and follow up when she is in pain.

On 3/1/18 at approximately 11:35 a.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Charting and documentation," documents in part, the following: "Document treatments, medications, vital signs and weights as required/requested."

Potter and Perry's Fundamentals of Nursing (6th edition) pg. 482 states, "(Clinical) Records need to reflect accountability during the time frame of the entry ...The entry needs to clearly show what was done, when it was done, and by whom..."

[1] Tramadol- analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197.

{F 880} SS=D Infection Prevention & Control {F 880}
CFR(s): 483.80(a)(1)(2)(4)(e)(f)

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{F 880}	Continued From page 40 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	{F 880}	1. All staff who perform wound care will practice good handwashing during wound care with each resident. No negative outcome noted for resident #205 from this practice. Staff who are required to wear a mask will have it on as directed to completely cover nose and mouth. Appropriate infection-control practices will be followed throughout facility. 2. All residents have potential to be affected. Staff will follow appropriate infection-control techniques during wound care and throughout the facility. 3. Education was provided to nursing staff and therapy staff by the Nurse Practice Educator specific to good handwashing practice during wound care and general infection-control practices. Dietary Staff, Housekeeping staff and nursing staff educated on general infection- control practices to include proper use of gloves and hand washing.	

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(F 880)	Continued From page 41 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to maintain infection control standards during the wound care for one of 13 residents, Resident #205 and failed to maintain infection control standards during the dining observation. 1. The facility staff failed to wash their hands after changing gloves during the 3/1/18 wound care observation for Resident #205. 2. The facility staff failed to ensure the protective	(F 880)	4. Nurse Practice Educator will audit staff in all departments randomly 5 days/week, to ensure they are following appropriate infection control practices. Immediate re-education will be conducted for any noncompliance identified. Additionally, Center Nurse Executive will continue to observe wound care 2x/week, to include an observation of therapists performing wound care toward ensuring appropriate infection-control practices are being consistently followed. Results of these audits and observations will be brought to the QAPI Committee monthly for review.	3/19/18

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facial mask was worn during the 2/28/18 lunch dining observation.

The findings include:

1. Resident #205 was admitted to the facility on 3/24/14 and had a readmission on 1/22/18 with diagnoses that included but were not limited to: fractured right hip, chronic pain, high blood pressure, diabetes, kidney failure and chronic lung disease.

The most recent (minimum data set) MDS, a 30 day schedule assessment, with an assessment reference date (ARD) of 2/17/18 coded the resident as having scored an 11 out of 15 on the brief interview for mental status (BIMS) indicating the resident was moderately impaired cognitively to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living with the exception of eating which the resident could perform after the meal tray was set up. The resident was coded as having an unstageable pressure ulcer.

Review of the care plan initiated on 2/14/18 documented "Focus. Resident has actual skin breakdown related to limited mobility to R (right) heel. Interventions. Evaluate wound are daily including surrounding tissue..." The care plan did not specifically address infection control practices.

Review of the physician's orders dated and signed on 2/6/18 documented, "PT (physical therapy) consult to (right) heel DTI (deep tissue injury) for US (ultrasound) mist therapy." Further review of the orders dated 2/7/18 documented, "PT CLARIFICATION ORDER: Pt. (patient) to

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RECEIVE US (ultrasound) MIST tx (treatment) TO (right) HEEL DTI FOLLOWED BY SUREPREP M - F (Monday through Friday). EFFECTIVE 2/8/18."

A wound care observation for Resident #205 was conducted on 3/1/18 at 8:00 a.m. with OSM (other staff member) #1, the physical therapy assistant. OSM #1 washed her hands, put a pair of gloves on her hands, raised the height of the bed to waist level and removed the soft blue boot on the resident's right foot. OSM #1 then removed the gloves and put another pair of gloves on. OSM #1 did not wash her hands. OSM #1 then opened the bag of normal saline irrigant and connected it to the nozzle of the ultrasound machine. OSM #1 then removed the gloves and put on another pair of gloves without washing her hands. OSM #1 plugged in the ultrasound machine and applied the mist treatment to the right heel for five minutes. OSM #1 removed her gloves and put on another pair of gloves without washing her hands. She then applied the sureprep to the heel, removed the gloves and put a sock and the boot back on the resident. OSM #1 then disposed of the normal saline irrigant and washed her hands at the sink for 15 seconds.

An interview was conducted with OSM #1 following the wound care observation. When asked when staff were to wash their hands, OSM #1 stated, "Before and after treatment." When asked what process staff followed when they removed their gloves, OSM #1 stated, "Normally we have a bottle of hand sanitizer on the cart and I would sanitize my hands after I took my gloves off." When asked why she did not wash or sanitize her hands during the wound care observation, OSM #1 stated, "I was nervous."

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An interview was conducted on 3/1/18 at 10:30 a.m. with RN (registered nurse) #1. When asked when staff wash their hands, RN #1 stated, "After you take off your gloves, after they are soiled and after a patient interaction." When asked why staff washed their hands RN #1 stated it was for infection control purposes.

An interview was conducted on 3/1/18 at 11:35 a.m. with ASM (administrative staff member) #2, the nurse executive. When informed of the above wound care observation, ASM #2 stated, "I expect her to wash her hands after changing gloves."

Review of the facility's policy titled, "Wound Dressings: Aseptic" documented, "16. Expose area to be treated. 16.1 Apply clean gloves...16.2 Discard dressing and gloves according to infection control policy. 17. Cleanse hands. 18. Apply gloves."

No further information was provided prior to exit.

In Fundamentals of Nursing, Lippincott Williams and Wilkins page 140-143 concerning hand washing and the use of hand sanitizer: "The hands are conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to the patient, or from a staff member to the patient. Hand hygiene is the single most important procedure in preventing infection....typically hands are washed with soap before coming on duty; before and after direct or indirect patient contact;...before preparing or administering medications...always wash your hands with soap after removing gloves...when using hand sanitizer, apply a small amount of the

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alcohol-based hand rub to all surfaces of the hands. Rub hands together until all of the product has dried (usually about 30 seconds)."

2. The facility staff failed to ensure the protective facial mask was worn during the 2/28/18 lunch dining observation.

A dining observation was made in the main dining room on 2/28/18 at 12:40 p.m., OSM #4, the cook entered the dining room with a facemask under her chin exposing her mouth and nose. OSM #4 delivered a cart of food and returned to the kitchen. At 12:43 p.m., OSM #4 returned to the dining room caring a tray. The facemask covered her mouth but her nose was exposed.

An interview was conducted on 2/28/18 at 2:15 p.m. with OSM #3, the dietary manager. When asked why OSM #4 wears a mask, OSM #3 stated, "She wears a mask because she hasn't had her flu shot." When asked how the mask was to be worn, OSM #3 stated, "Over her mouth and nose." When asked why OSM #4 had to wear a mask, OSM #3 stated, "Because this population is very susceptible to catching stuff." OSM #4 was asked if wearing the mask under the chin or over the mouth was correct, OSM #3 stated, "No."

An interview was conducted on 2/28/18 at 2:25 with ASM (administrative staff member) #2, the nurse executive. When asked why staff wore facemasks, ASM #2 stated, "Because they opted out of the flu vaccine so they have to wear a mask for the whole season." When asked why the staff had to wear the mask, ASM #2 stated, "Because they will be more at risk to our resident

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because they aren't covered." ASM #2 was made aware of the findings at that time.

An interview was conducted on 3/1/18 11:50 a.m. with OSM #4, the cook. When asked why she wore a facemask, OSM #4 stated, "I didn't take the shot (the influenza vaccine). I never took one." When asked why she had to wear the mask, OSM #4 stated, "So I don't give it to anybody else in case I catch the flu." When asked why the mask was under her chin on 2/28/18 during lunch, OSM #4 stated, "Sometimes I can't breathe. I feel like it's smothering me." When asked if she was to wear the mask when she was in the dining room, OSM #4 stated, "It's wrong. I was rushing."

Review of the facility's policy titled, "Universal Influenza Vaccination" documented, "POLICY. (Name of company) requires that all personnel who work in a patient/resident building or whose job requires them to routinely be in a building where patient/resident care is provided ...are immunized against influenza on an annual basis. Vaccination must be obtained by October 31. Individuals who decline vaccination for any reason will be required to wear a surgical mask (excepting in the employee break room). The mandatory masking requirement will extend from November 1 through April 30 and during any declared influenza outbreak by the service location or county. PURPOSE. To protect the health and safety of patients/resident, employees, patient/resident (sic) and employee family members, and the community as a whole from influenza infection. To reduce the risk of transmission of seasonal influenza to patients/residents from unvaccinated personnel. PROCESS. 1.5.1 Masks will be provided and

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must be worn while in the service location if proof cannot be provided. 2. Corrective Actions: 2.1 Non-compliance with receiving the annual influenza vaccination or wearing a mask November 1 through April 30 and during any declared influenza outbreak by the service location or county will result in corrective action up to and including termination."

No further information was provided prior to exit.