DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. BUILDING ______ B. WING ______	R-C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT CENTER	11 DAIRY LANE FREDERICKSBURG, VA 22405

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{E 000}	Initial Comments An unannounced Emergency Preparedness revisit survey, to the standard Emergency Preparedness survey, conducted 12/4/17 through 12/8/17 was conducted 1/30/18 through 2/1/18. The facility was found to be in compliance with 42 CFR Part 483 the Federal Long-Term Care regulations. Corrected deficiencies are identified on the 2567B report.	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 12/4/17 through 12/8/17 was conducted 1/30/18 through 2/1/18. 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 CMA 2567 - B. The census in this 118 certified bed facility was 97 at the time of the survey. The survey sample consisted of 12 current resident reviews (Residents #101 through #112).	{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	{F 580}	1. Physician and responsible party have been notified that the BMP and urinalysis laboratory specimens were not obtained for Resident #110. Physician has discontinued order for Resident #112 to not wear a shoe on the right foot.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator/Executive Director — (X6) DATE: 2-16-18

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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{F 580}	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (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, staff interview, facility	{F 580}	2. All residents with changes of condition have potential to be affected by this deficient practice. Audit was completed by nursing leadership by reviewing 24 hour report and eInteract Changes of condition for the past 30 days to ensure that appropriate notification to physicians and responsible parties has been completed and documented. 3. Education provided to licensed nursing staff by the Nurse Practice Educator regarding notifying physicians and responsible parties of changes in resident condition and documentation of this notification. 4. Clinical Management Team including Director of Nursing Services, Unit Managers will audit 24 hour report, lab book and changes of condition in the Clinical Morning Meeting to ensure that appropriate notifications have been completed and documented. Results of audits will be brought to the QAPI Committee for follow up monthly.	2/23/18

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document review and clinical record review, it was determined the facility staff failed to notify the physician and the responsible party (RP) of a change in condition for two of 12 residents in the survey sample, Resident #110 and Resident #112.

1. The facility staff failed to notify the responsible party (RP) when the BMP (basic metabolic panel) laboratory specimen was not obtained as ordered on 1/23/18 for Resident #110, and failed to notify the physician and the RP when the urinalysis laboratory specimen ordered on 1/24/18 was not obtained for Resident #110.

2. The facility staff failed to notify the physician that Resident #112 refused to follow the physician's order not to wear a shoe on the right foot.

The findings include:

1. Resident #110 was admitted to the facility on 1/13/17 and readmitted on 9/28/17 with diagnoses that included, but are not limited to: kidney failure, heart disease, irregular heartbeat, stroke, high blood pressure and diabetes.

The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 1/15/18 coded Resident #110 as having scored a 9 out of 15 on the brief interview for mental status 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 except for eating which the resident could perform independently after the tray was prepared.

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Review of Resident #110's comprehensive care plan initiated on 1/9/17 and revised on 11/22/17 documented, "Focus. Resident exhibits or is at risk for complications of infection related to UTI (urinary tract infection)...Interventions. Obtain labs (laboratory specimens)/cultures as ordered and report results to physician as indicated." The care plan did not specifically address notifying the RP.

Review of the physician's orders dated 1/22/18 documented, "BMP (basic metabolic panel) [1] on 1/23 (2018)."

Review of the January TAR (treatment administration record) documented, "BMP 1/23." In the 1/23/18 signature box, there were a nurse's initials with a circle around them. On the back of the TAR it was documented, "1/23 5 A (5:00 a.m.) lab (laboratory) unable to draw blood - needs to be drawn."

Review of the nurse's notes for 1/23/18 did not evidence any documentation of notification to the RP the laboratory specimen was not obtained as ordered.

Review of the physician's orders dated 1/24/18 at 5:00 p.m. documented, "UA (urinalysis) + c&s (plus culture and sensitivity) R/O (rule out) UTI (urinary tract infection)."

Review of Resident #110's January TAR documented, "UA/C+S 1/24/18." In the 1/24/18 signature box, there were a nurse's initials with a circle around them. On the back of the TAR, the following was documented, "1/25/18, 11-7 am (11:00 p.m. to 7:00 a.m.) Unable to obtain urine

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specimen."

Review of the nurse's notes for 1/25/18 through 1/27/18 did not evidence documentation that the physician or RP were notified.

An interview as conducted on 1/31/18 at 4:30 p.m. with RN (registered nurse) #1. When asked if the urinalysis specimen had been obtained on Resident #110, RN #1 stated, "No." When asked if the physician or RP had been notified, RN #1 stated, "No." When asked about the process staff are to follow when a physician's order cannot be completed, RN #1 stated, "They should notify the physician at the time they can't get it or I would say in the same shift." RN #1 stated that the RP would be notified as well. When asked why the physician was notified, RN #1 stated, "The physician, because we are not following the order and he may want to give an alternate order." When asked why the RP would be notified, RN #1 stated, "To let the RP know what's happening."

An interview was conducted on 2/1/18 at 10:30 a.m. with LPN (licensed practical nurse) #8, the resident's nurse. When asked when staff would notify the physician or RP, LPN #8 stated, "With any changes, temperature, and color, whatever you see." When asked why the physician is to be notified, LPN #8 stated, "If I need new orders. To tell me what to do." When asked if the physician and RP would be notified if a laboratory or urine specimen could not be obtained, LPN #8 stated yes.

On 2/1/18 at 12:35 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical quality specialist were made aware of the findings.

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Review of the facility's policy titled, "Change of Condition: Notification of" documented, "POLICY. A Center must immediately inform the patient, consult with the patient's physician, and notify, consistent with his/her authority the patient's Health Care Decision Maker (HCDM), where there is: A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment..."

No further information was provided prior to exit.

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient.

[1]. BMP -- There are two types: basic metabolic panel (BMP) and comprehensive metabolic panel (CMP). The BMP checks your blood sugar, calcium, and electrolytes. The BMP also has tests such as creatinine to check your kidney function. This information was obtained from: https://medlineplus.gov/metabolicpanel.html

2. The facility staff failed to notify the physician

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that Resident #112 refused to follow the physician's order not to wear a shoe on the right foot.

Resident #112 was admitted to the facility on 2/24/15 with diagnoses that included but not limited to: stroke, diabetes, high blood pressure and schizophrenia (1).

The most recent MDS, a quarterly assessment, with an ARD of 1/12/18 coded Resident #112 as having scored a 14 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded, as needing assistance from staff for activities of daily living except for meals, which the resident could perform after the tray, was prepared.

An observation was made on 1/30/18 at 1:25 p.m. of Resident #112 in the facility's cafe. The resident was sitting in a wheelchair. His right foot was elevated on the footrest; he had a black shoe on his right foot.

An observation was made on 2/1/18 at 2:20 p.m. of Resident #112. The resident was propelling self in his wheelchair in the hallway. His right foot was elevated on the footrest; he had a black shoe on his right foot.

Review of Resident #112's care plan initiated on 3/2/15 and revised on 11/15/17 documented, "Focus. Resident requires assistance/is dependent for ADL (activities of daily living) care in (bathing, grooming, dressing....) due to chronic disease compromising functional ability. Interventions. No shoe to right foot."

Review of the physician's orders dated and

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signed on 1/3/18 documented, "05/11/15 NO SHOE TO RIGHT FOOT."

Review of the nurse's notes from 1/18/18 to 2/1/18 did not evidence documentation the physician had been notified the resident refused to leave the shoe off the right foot.

An interview was conducted on 2/1/18 at 2:25 p.m. with RN (registered nurse) #3, the assistant director of nursing. When asked what Resident #112 wore on his right foot, RN #3 stated, "He wears the shoes. He refuses not to wear the shoe." RN #3 stated the resident's CNA (certified nursing assistant) told her Resident #112 refused to leave the right shoe off and she told her that was okay. When asked if the physician had been notified, RN #3 stated, "I don't know. I didn't realize it was an order." When asked if the physician should have been notified, RN #3 stated yes.

An interview was conducted on 2/1/18 at 2:40 p.m. with CNA #3, the resident's aide. When asked what she did when Resident #112 refused to leave the right shoe off his right foot, CNA #3 stated, "I've been here since August and he's always worn shoes so I notified my supervisor."

On 2/1/18 at 2:45 p.m., ASM (administrative staff member) #2, the director of nursing was made aware of the findings.

No further information was provided prior to exit.

1. Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when

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they talk. The disorder makes it hard for them to keep a job or take care of themselves. This information was obtained from: https://medlineplus.gov/schizophrenia.html

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{F 656} SS=E 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 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

{F 656}

1. Residents #102 is having bruit and thrill checked per care plan. Resident #107 is receiving tube feeding per order and care plan. Resident's #104 and #109 have non-pharmacological interventions in place per care plan.
2. All residents with AV Fistulas have the potential to be affected. Audits completed for hemodialysis residents with AV Fistula, to check for bruit and thrill every shift and documented. Residents with tube feedings have potential to be affected. Residents with psychotropic medications have potential to be affected. Audit completed by Center Nurse Executive (CNE) of all residents on psychotropic medications to ensure that non-pharmacological interventions are in place.
3. Education provided to the Nursing Leadership Team on the practice

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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, facility document review and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for four of 12 residents in the survey sample, Residents #102, 107, 109 and 104.

1. The facility staff failed to assess Resident 102's hemodialysis shunt for a bruit and a thrill per the comprehensive care plan.

2. The facility staff failed to administer Resident #107's tube feeding as documented on the comprehensive care plan.

3. The facility staff failed to offer non-pharmacological interventions, per the comprehensive care plan, for Resident # 109.

4. The facility staff failed to offer non-pharmacological interventions, per the comprehensive care plan for Resident #104.

The findings include:

1. Resident #102 was admitted to the facility on 3/12/17 and readmitted on 10/3/17 with

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and regulation for following care-planned interventions.

4. Unit Managers will audit hemodialysis residents weekly to ensure that care-planned interventions are in place for monitoring bruit and thrill. Unit Managers will audit resident on tube feeding 5 times/week to ensure that tube feeding is administered per order and care plan. Unit Managers will audit residents on pychotropic medications 3 times/week to ensure that non-pharmacological interventions are being implemented per care plan. Results of these audits will be taken to the QAPI Committee monthly for review. 2/23/18

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diagnoses that included but were not limited to: kidney failure requiring hemodialysis (1), diabetes, heart failure and an amputation of the left lower leg.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/28/17 coded the resident as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. Resident #102 was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could do after the tray was prepared. The resident was coded as receiving dialysis.

Review of the comprehensive care plan initiated on 12/22/17 and updated on 1/18/18 documented, "Focus. Resident exhibits or is at risk for impaired renal function and is at risk for complications related to hemodialysis...1/18/18 AV (arteriovenous) [2] shunt in L (left) upper arm. Interventions. Monitor dialysis access for + (positive) bruit/+thrill [3] q (every) shift and prn (as needed)."

Review of the physician's orders dated 1/18/18 at 2:00 p.m. documented, "Monitor steri strips to (left) upper arm incision site Qshift. Elevate (left) upper extremity on pillow to reduce swelling." There was no documentation regarding checking for the bruit and thrill in the left upper arm AV shunt.

Review of the 1/18/18 at 2:33 p.m. nurse's notes documented, "Resident returned from Appointment this after (sic) S/P (status post) AV Shunt placement in the Left arm. New orders

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noted from (name of physician) about the Left Arm."

Review of the January 2018 MAR (medication administration record) and the January 2018 TAR (treatment administration record) did not evidence documentation regarding checking the bruit and thrill in Resident #102's left upper arm AV shunt.

Review of the nurses' notes from 1/18/18 to 1/31/18 did not evidence documentation regarding checking the bruit and thrill in Resident #102's left upper arm AV shunt.

An interview was conducted on 1/31/18 at 4:07 p.m. with LPN (licensed practical nurse) #2, the resident's nurse. When asked about the process staff follows when a resident has an AV shunt, LPN #2 stated, "We check the site every day. Check for any infection, his is a little swollen." When asked if staff checked the shunt for a bruit and a thrill, LPN #2 stated, "You check that." When asked if she had checked Resident #102's shunt for a bruit and a thrill that day, LPN #2 stated, "I don't remember if I did or not."

An interview was conducted on 1/31/18 at 4:30 p.m. with RN (registered nurse) #1. When asked what assessment staff do when a resident has an AV shunt, RN #1 stated, "You would check the bruit and thrill. It's documented at least once a shift on the MAR." When asked to review Resident #102's January MAR and TAR for the checking of a bruit and thrill, RN #1 stated, "I do not see it on here." When asked why residents had care plans, RN #1 stated, "To make sure we are meeting all the needs of the patient while they are in the building. Anyone with access to the

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care plan can view it." When asked who had access to the care plan, RN #1 stated, "Nurses have access." When asked if staff were expected to implement and follow the care plan, RN #1 stated, "Yes because if don't follow the care plan for lack of better words you're not meeting their needs."

An interview was conducted on 2/1/18 at 12:15 p.m. with LPN #4, the resident's nurse. When asked what assessment staff do when a resident has an AV shunt, LPN #4 stated, "I check if I have a fistula (shunt) or a catheter. It if's a fistula I check the bruit and thrill." When asked why they check for this, LPN #4 stated, "To make sure it's functioning." When asked if she had checked Resident #2's AV shunt for a bruit and thrill, LPN #4 stated, "I just knew about the catheter. I wasn't aware that he had a shunt." When asked how staff got information about the residents, LPN #4 stated, "We get report or we can go back through the chart. The most important things should be given in report." When asked if an AV shunt was important, LPN #4 stated, "Yes!"

An interview was conducted on 2/1/18 at 3:40 p.m. with RN #2, the MDS coordinator. When asked why residents had care plans, RN #2 stated, "Because the care plan is the basis of the care of the resident." When asked if the staff were expected to implement and follow the care plan RN #2 stated yes.

On 2/1/18 at 3:45 p.m. ASM (administrative staff member) #2, the director of nursing was made aware of the findings.

Review of the facility's policy titled, "Person-Centered Care Plan" documented,

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"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. 5. Care plans will be: 5.1 Communicated to appropriate staff, patient, HCDM, family: 5.2 Reviewed and revised a minimum of quarterly and as needed to reflect the response to care and changing needs and goals."

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)

(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care

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professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

1. Hemodialysis - Hemodialysis is a treatment for kidney failure that uses a machine to filter your blood outside your body. This information was obtained from:
https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis

2. AV shunt - An AV graft is a looped, plastic tube that connects an artery to a vein. This information was obtained from:
https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis/vascular-access

3. Bruit and Thrill - A bruit is an audible vascular sound associated with turbulent blood flow. Although usually heard with the stethoscope, such sounds may occasionally also be palpated as a thrill. This information was obtained from:
https://www.ncbi.nlm.nih.gov/books/NBK289/

2. The facility staff failed to administer Resident #107's tube feeding as documented on the comprehensive care plan.

Resident #107 was admitted to the facility on 10/22/15 and readmitted on 4/9/16 with diagnoses that included but were not limited to:

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stroke, depression, obesity and indigestion.

The most recent MDS, a quarterly assessment, with an ARD of 1/10/18 coded the resident as being rarely or never understood and rarely or never understanding. Resident #107 was coded as being severely impaired cognitively. The resident was coded as requiring extensive assistance from staff for all activities of daily living. The resident was coded as receiving tube feedings.

An observation was made on 1/31/18 at 10:40 a.m. of Resident #107. The resident was lying in bed with the tube feeding running at 55 cc's (cubic centimeters) per hour.

An observation was made on 1/31/18 at 11:05 a.m. of Resident #107. The resident was lying in bed with her eyes closed. The tube feeding was off and the tubing was hanging from the pole.

An observation was made on 2/1/18 at 10:15 a.m. of Resident #107. The resident was lying in bed with her eyes opened. The tube feeding was running at 55 cc's per hour.

An observation was made on 2/1/18 at 10:38 a.m. of the Resident's nurse leaving the resident's room after turning off the tube feeding.

Review of the Resident #107's comprehensive care plan initiated on 5/10/17 and revised on 10/27/15 documented, "Focus. Resident is at nutritional risk: impaired swallowing fxn (function) related to dysphagia (difficulty swallowing) as evidence (sic) by need for nutritional support. Interventions. Provide TF (tube feeding) as ordered."

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Review of the physician's orders dated and signed on 1/2/18 documented, "04/09/16 Jevity (1) 1.5 AT 55ML (milliliters)/HR VIA PEG TUBE X (times) 20 HRS - Downtime 10 AM."

Review of the January 2018 TAR documented, "Jevity 1.5 cal (calorie) @ 55 ml/hr x20 hrs. (arrow pointing down) 10 A (a.m.) Down."

An interview was conducted on 1/31/17 at 3:50 p.m. with LPN (licensed practical nurse) #2, the resident's nurse. LPN #2 was asked when Resident #107's tube feeding was to be turned off. LPN #2 stated, "It comes down at 10:00 in the morning." When the above observation was shared, LPN #2 stated, "I thought it was earlier than that."

On 1/31/18 at 5:30 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical quality specialist were made aware of the findings.

An interview was conducted on 1/31/17 at 4:30 p.m. with RN (registered nurse) #1. When asked if it was important to follow the physician's order to discontinue a tube feeding on time, RN #1 stated, "Yes." When asked if letting a tube feeding run 40 minutes longer than ordered was following the physician's order, RN #1 stated, "We're not following the correct amount of tube feeding." When asked why residents had care plans, RN #1 stated, "To make sure we are meeting all the needs of the patient while they are in the building. Anyone with access to the care plan can view it." When asked who had access to the care plan, RN #1 stated, "Nurses have access." When asked if staff were expected to

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follow the care plan, RN #1 stated, "Yes because if don't follow the care plan for lack of better words you're not meeting their needs."

On 2/1/18 at 12:35 p.m. ASM #1, ASM #2 and ASM #3 were made aware Resident #107's tube feeding had not been stopped at the time as noted on the care plan and as ordered by the physician.

Review of the facility's policy titled, "Enteral Management" documented, "PURPOSE. To provide nutrition when patient is unable to consume food and fluids orally."

No further information was obtained prior to exit.

1. Jevity - High-protein, fiber-fortified formula. Complete, balanced nutrition for long- or short-term tube feeding
For supplemental or sole-source nutrition. This information was provided from: http://www.medline.com/product/Jevity-12-Cal-Nutritional-Supplement/Nutrients/Z05-PF11290#

3. The facility staff failed to offer non-pharmacological interventions, per the comprehensive care plan, for Resident # 109.

Resident #109 was admitted to the facility on 11/21/17 with a recent readmission on 1/8/18 with diagnoses that included but were not limited to: repeated falls, chronic wounds on foot, pain, diabetes, high blood pressure, shortness of breath, and Bipolar disorder (a mental disorder characterized by periods of mania and

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depression) [1].

The most recent MDS (minimum data set), a significant change assessment, with an assessment reference date of 1/15/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. Resident #109 was coded as requiring supervision to extensive assistance of one staff member for all of her activities of daily living.

The comprehensive care plan dated, 1/9/18, documented in part, "Resident/patient exhibits or is at risk for distressed/fluctuation mood symptoms related to diagnosis of depression, bipolar disorder and PTSD (post-traumatic stress disorder)." The "Interventions" documented in part, "Encourage resident/patient to seek staff support for distressed mood. Refocus resident/patient to something positive. Allow time for expression of feelings; provide empathy, encouragement and reassurance."

The physician order dated, 1/15/18, documented, "Xanax (used to treat anxiety) (2) 0.25 mg (milligrams) tab (tablet) one PO (by mouth) q8h (every 8 hours) PRN (as needed) anxiety."

The MAR (mediation administration record) for January 2018 was reviewed, and documented Resident #109 had received the Xanax eleven times since 1/18/18. Of those eleven times, only four doses were documented on the reverse side of the MAR.

A review of the nurse's note from 1/18/18 through 2/1/18 was conducted. On 1/18/18 at 6:35 a.m. the nurse documented in part, "Resident c/o

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(complained of) increased anxiety at 6:30 a.m. And attempted to redirect and was not effective and PRN Xanax was given as ordered with effective results.

The nurse's note dated, 1/18/18 at 9:26 p.m. documented in part, "Given as well, Xanax 0.25 mg at 2245 (10:45 p.m.)."

The nurse's note dated, 1/24/18 at 10:00 p.m. documented in part, "Xanax was given at 2200 (10:00 p.m.). There was no further documentation related to anxiety or the administration of Xanax.

The "Behavior Monitoring and Interventions" sheet for January 2018 was completely blank."

When asked why residents had care plans, RN (registered nurse) #1 stated, "To make sure we are meeting all the needs of the patient while they are in the building. Anyone with access to the care plan can view it." When asked who had access to the care plan, RN #1 stated, "Nurses have access." When asked if staff were expected to follow the care plan, RN #1 stated, "Yes because if don't follow the care plan for lack of better words you're not meeting their needs."

An interview was conducted on 2/1/18 at 3:40 p.m. with RN #2, the MDS coordinator. When asked why residents had care plans, RN #2 stated, "Because the care plan is the basis of the care of the resident." When asked if the staff were expected to implement and follow the care plan, RN #2 stated yes.

The administrator, (administrative staff ,member [ASM #1]) director of nursing, ASM #2 and corporate nurse, ASM #3, were made aware of

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the above findings on 2/1/18 at 12:35 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 73.
(2) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008896/

4. The facility staff failed to offer non-pharmacological interventions, per the comprehensive care plan for Resident #104.

Resident #104 was admitted to the facility on 12/4/17 with diagnoses that included but were not limited to: peripheral vascular disease (an abnormal condition of the blood vessels outside the heart) [1], cellulitis of lower limbs, chronic pain, high blood pressure, opioid dependence, and low back pain.

The most recent MDS (minimum data set), a Medicare 14 day assessment, with an assessment reference date of 1/13/18, coded Resident #104 as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he was capable of making his daily decisions. The resident was coded as requiring limited assistance to supervision of one staff member for most of his activities of daily living.

The comprehensive care plan dated, 1/24/18, documented in part, "Resident is at risk for substance abuse (alcohol/drugs) related to a history of addition related to opioids." The

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"Intervention" documented in part, "Provide all effective interventions (e.g., non-pharmacologic, pharmacologic) for behaviors and/or psychiatric disorders, including redirection to assist resident/ patient in controlling substance abuse behaviors."

The physician order dated 1/3/18, documented, "Lorazepam (Ativan) (used to treat anxiety disorders) [2] 1 mg (milligram) PO (by mouth) BID (twice a day) PRN (as needed) for anxiety."

Review of the MAR (medication administration record) for January 2018, documented, "Lorazepam (Ativan) 1 mg PO BID PRN for anxiety." The Lorazepam was documented as given on 1/22/18 at 9:00 p.m., 1/23/18 at 4:00 p.m., 1/25/18 at 5:30 p.m., and 1/26/18 at 4:00 p.m. None of the above doses were documented on the reverse side of the MAR.

Review of the "Behavior Monitoring and Interventions" sheet for January 2018 was conducted. For the doses given on 1/22/18 and 1/23/18, there was no documentation in the corresponding shift when the medication was given. On 1/25/18 and 1/26/18, there was no behavior documentation for the entire day.

Review of the nurse's notes for the above dates and times failed to evidence any documentation of the behavior or the non-pharmacological interventions attempted prior to the administration of the Lorazepam.

When asked why residents had care plans, RN (registered nurse) #1 stated, "To make sure we are meeting all the needs of the patient while they are in the building. Anyone with access to the care plan can view it." When asked who had

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access to the care plan, RN #1 stated, "Nurses have access." When asked if staff were expected to follow the care plan, RN #1 stated, "Yes because if don't follow the care plan for lack of better words you're not meeting their needs."

An interview was conducted on 2/1/18 at 3:40 p.m. with RN #2, the MDS coordinator. When asked why residents had care plans, RN #2 stated, "Because the care plan is the basis of the care of the resident." When asked if the staff were expected to follow the care plan RN #2 stated yes.

The administrator, (administrative staff ,member [ASM #1]) director of nursing, ASM #2 and corporate nurse, ASM #3, were made aware of the above findings on 2/1/18 at 12:35 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 447.
(2) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details

{F 657} SS=D Care Plan Timing and Revision {F 657}
CFR(s): 483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that

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includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview clinical record review the facility staff failed to review and revise the comprehensive care plan for one of 12 residents in the survey sample, Residents #112.

The facility staff failed to revise Resident #112's comprehensive care plan to reflect the residents refusal to keep a shoe off his right foot as ordered and documented on the comprehensive care plan.

The findings include:

Resident #112 was admitted to the facility on 2/24/15 with diagnoses that included but were not limited to: stroke, diabetes, high blood pressure,

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1. Resident #112 has had order discontinued to not wear shoe, and care plan was updated accordingly.
2. All residents have the potential to be affected. Audit was completed on residents to ensure care plans are in place.
3. Education was provided to the nursing staff by the Nurse Practice Educator specific to the regulation to ensure that care plans are revised with changes.
4. Clinical Management Team will review care plans during the morning clinical meetings to ensure that all care plans are revised and updated with changes daily. Results of these audits will be taken to the QAPI Committee monthly for review.

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schizophrenia (1).

The most recent MDS, a quarterly assessment, with an ARD of 1/12/18 coded Resident #112 as having scored a 14 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded, as needing assistance from staff for activities of daily living except for meals, which the resident could perform after the tray, was prepared.

An observation was made of Resident #112 on 1/30/18 at 1:25 p.m. in the facility's cafe. The resident was sitting in a wheelchair. His right foot was elevated on the footrest; he had a black shoe on his right foot.

An observation was made of Resident #112 on 2/1/18 at 2:20 p.m. The resident was propelling himself in his wheelchair in the hallway. His right foot was elevated on the footrest; he had a black shoe on his right foot.

Review of the resident's comprehensive care plan initiated on 3/2/15 and revised on 11/15/17 documented, "Focus. Resident requires assistance/is dependent for ADL (activities of daily living) care in (bathing, grooming, dressing....) due to chronic disease compromising functional ability. Interventions. No shoe to right foot."

Review of the physician's orders dated and signed on 1/3/18 documented, "05/11/15 NO SHOE TO RIGHT FOOT."

An interview was conducted on 2/1/18 at 2:25 p.m. with RN (registered nurse) #3, the assistant director of nursing. When asked what Resident

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#112 wore on his right foot, RN #3 stated, "He wears the shoes. He refuses not to wear the shoe." RN #3 stated the resident's CNA (certified nursing assistant) told her the resident refused to leave the right shoe off and RN #3 told her that was okay. When asked if the physician had been notified, RN #3 stated, I don't know. I didn't realize it was an order." When asked if the physician should have been notified, RN #3 stated yes. When asked if the care plan should have been revised to reflect the residents refusal to not wear a shoe on the right foot, RN #3 stated yes.

An interview was conducted on 2/1/18 at 2:40 p.m. with CNA #3, the resident's aide. When asked what she did when the resident refused to leave the right shoe off, CNA #3 stated, "I've been here since August and he's always worn shoes so I notified my supervisor."

No further information was provided prior to exit.

1. Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves. This information was obtained from: https://medlineplus.gov/schizophrenia.html

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

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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(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 clarify and properly transcribe physician orders for three of 12 residents in the survey sample, Residents #111, #109, and #102.

1. The facility staff failed to clarify Resident #111's physician order for a PRN (as needed) blood pressure medication.

2. The facility staff failed to transcribe a physician order correctly for Resident #109

3. The facility staff failed clarify the blood pressure parameters for the physician ordered Atenolol medication for Resident #102.

The findings include:

1. Resident #111 was admitted to the facility on 1/5/18 with diagnoses that included but were not limited to: stroke, diabetes, high blood pressure, sleep apnea (condition in which the patient has transient periods of apnea during sleep, typically these last less than 30 seconds) [1], depression, and aphasia (the inability to speak or express oneself in writing or to comprehend spoken or written language because of a brain lesion [e.g., the results of a stroke]) [2].

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 1/12/18 coded Resident #111 as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he was capable of making cognitive decisions on a

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1. Resident #111 has had order for blood pressure medication clarified. Resident #109 has had order for accuchecks revised. Resident #102 has had order for Atenelol clarified.
2. All residents with orders for blood pressure medication and monitoring have potential to be affected. Audit completed by Center Nurse Executive of all current residents with blood pressure medications for appropriate orders. All residents with orders for blood glucose monitoring have potential to be affected. Center Nurse Executive completed audit of all current residents with blood glucose monitoring to ensure that orders are clearly written on Medication Administration Record.
3. Education was completed for licensed nurses by the Nurse Practice Educator regarding clarifying and transcribing of orders.

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daily basis. Resident #111 was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living except eating in which he only required supervision after set up assistance was provided.

The physician order dated, 1/18/18, documented, "Hydralazine (used to treat high blood pressure) [3] 10 mg (milligrams) po (by mouth) q (every) 6 hrs. (hours) PRN (as needed) BP (blood pressure) > (greater than) 180/95."

The MAR for January 2018 documented, "Hydralazine 10 mg po q 6 hrs. PRN BP > 180/95." The medication had not been administered.

The comprehensive care plan dated, 1/6/18, documented in part, "Focus: Resident exhibits or is at risk for cardiovascular symptoms or complications related to Dx (diagnosis) HTN (high blood pressure) and CVA (stroke)." The "Interventions" documented in part, "Administer meds (medications) as ordered and assess for effectiveness and side effects and report abnormalities to physician. Assess and monitor vital signs as ordered and report abnormalities to physicians."

An interview was conducted with LPN (licensed practical nurse) #3 on 2/1/18 at 9:15 a.m. The above order was reviewed with LPN #3. When asked how he would follow that order, LPN #3 stated that it would be hard to follow. When asked if the order should have been clarified, LPN #3 stated, "Yes. It would be taking the blood pressure every six hours in order to follow that order."

4. Nursing Leadership Team will monitor blood pressure medications/parameters and Blood Glucose Monitoring weekly to ensure orders accurately followed. Results of these audits will be brought before the QAPI Committee monthly for review. — 2/23/18

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An interview was conducted with administrative staff member (ASM) #2, the director of nursing on 2/1/18 at 9:28 a.m. ASM #2 was asked to review the above order. When asked how a nurse is to follow the order, ASM #2 stated, "Well, when they obtain the blood pressure and if it's above the parameters then they should give it." When asked if it made a difference if the medication was ordered PRN, ASM #2 stated, "If it's a PRN, the resident should be having their blood pressure checked every six hours." When asked if the order should have been clarified, ASM #2 stated, "Absolutely."

According to Fundamentals of Nursing, 6th edition Potter and Perry, 2005, page 846, "A medication order is required for any medication to be administered by a nurse...If the medication order is incomplete, the nurse should inform the prescriber and ensure completeness before carrying out any medication order."

The administrator, ASM #1, the director of nursing, ASM #2 and the corporate nurse, ASM #3, were made aware of the above concern on 2/1/18 at 12:35 p.m.

2. The facility staff failed to transcribe a physician order correctly for Resident #109.

Resident #109 was admitted to the facility on 11/21/17 with a recent readmission on 1/8/18 with diagnoses that included but were not limited to: repeated falls, chronic wounds on right foot, pain, diabetes, high blood pressure, shortness of breath, and Bipolar disorder (a mental disorder characterized by periods of mania and

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depression) [1].

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 1/15/18, coded Resident #109 as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring supervision to extensive assistance of one staff member for all of her activities of daily living. In Section N - Medications, the resident was coded as receiving seven days of insulin injections during the seven-day look back period.

The physician order dated, 1/18/18, documented, "Humalog (short acting insulin to treat diabetes) [2] 100U/ML (units per milliliter) sliding scale to the following AC (before meals) & HS (at bedtime or hour of sleep):
Blood sugar 150 -200 =4 units
Blood sugar 201 - 250 = 8 units
Blood sugar 251 - 300 = 10 units
Blood sugar 301 - 350 = 14 units
Blood sugar 351 - 400 = 17 units
Call MD (medical doctor) < (less than) 70 or > (greater than) 400."

The MAR (medication administration record) for January 2018 documented, "Humalog 100U/ML (units per milliliter) sliding scale to the following AC (before meals) & HS (at bedtime or hour of sleep):
Blood sugar 150 -200 =4 units
Blood sugar 201 - 250 = 8 units
Blood sugar 251 - 300 = 10 units
Blood sugar 301 - 350 = 14 units
Blood sugar 351 - 400 = 17 units
Call MD (medical doctor) < (less than) 70 or >

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(greater than) 400. The times documented were: 8:00 a.m., 12 noon, 6:00 p.m. and 9:00 p.m. There was a squiggly line drawn through the 8:00 a.m. slot for the blood sugar readings and insulin amount given. There was handwritten, "D/C (discontinued)." There was no physician order to discontinue the 8:00 a.m. sliding scale.

An interview was conducted with LPN (licensed practical nurse) #6 on 2/1/18 at 10:35 a.m. LPN #6 was asked to review the orders for Resident #109's blood sugar checks and sliding scale insulin. Once reviewed, LPN #6 was asked if the resident should be getting a blood sugar check at 8:00 a.m., LPN #6 stated, "Yes, unless there is another physician order to cancel it, but normally we check blood sugars before meals."

An interview was conducted with RN (registered nurse) #4, the staff educator, on 2/1/18 at 11:15 a.m., RN #4 was asked to review the orders in Resident #109's record written 1/18/18 and to review the MAR for Resident #109. Once reviewed, RN #4 stated the resident is supposed to get her standard insulin and her insulin per the sliding scale. When asked why the blood sugar checks for 8:00 a.m. were crossed off and marked as discontinued, RN #4 stated, "I have no idea, but that shouldn't be that way."

On 2/1/18 at 11:20 a.m., an interview was conducted with administrative staff member (ASM) #2, the director of nursing. The above physician order and MARs were reviewed with ASM #2. She stated the orders should have been clarified and the orders should have been transcribed so that it's legible. When asked if the Resident #109 is supposed to have blood sugar checks completed at 8:00 a.m., ASM #2 stated,

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"Per the physician order they (Resident #109) should be having blood sugars (checked) at 8:00 a.m. I have no idea what they (the nurses) were thinking. This isn't right."

The facility policy, "Transcription of Orders" documented in part, "Policy: Orders from an authorized licensed independent practitioner are transcribed by a licensed nurse. Written orders may be transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed nurse must verify accuracy and sign off on orders transcribed by a HUC. Purpose: To Communicate all practitioner orders to caregivers regarding patient's care and treatment."

According to "Fundamentals of Nursing-Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished.

The administrator, ASM #2 and ASM #3, the corporate nurse were made aware of the above concern on 2/1/18 at 12:35 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 73.
(2) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c8ecbd7a-0e22-4fc7-a503-faa58c1b6f3f

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3. The facility staff failed to clarify the blood pressure parameters for the physician ordered Atenolol medication for Resident #102.

Resident #102 was admitted to the facility on 3/12/17 and readmitted on 10/3/17 with diagnoses that included but were not limited to: kidney failure requiring hemodialysis (1), diabetes, heart failure and an amputation of the left lower leg.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/28/17, coded Resident #102 as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating, which the resident could do after the tray was prepared. Resident #102 was coded as receiving dialysis.

Review of Resident #102's comprehensive care plan did not address the resident's medication.

Review of the physician's orders dated and signed on 1/4/18 documented, "10/03/17 ATENOLOL (1) 25 MG (milligrams) TABLET. 1 TAB (tablet) BY MOUTH TWICE DAILY FOR HYPERTENSION."

Review of the January 2018 MAR (medication administration record) documented, "Check BP (blood pressure) (with) giving (sic) BP meds (medications). Atenolol 25 mg PO (by mouth) BID (twice a day) (HTN [hypertension]). Further

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review of the January 2018 MAR documented:
- 1/20/18 at 9:00 a.m. the nurse's initials had a circle around them (indicating the medication was not given). "BP 96/56."
- 1/21/18 at 9:00 a.m. the nurse initialed the medication as being given. "BP 96/59."

An interview was conducted on 1/31/17 at 4:00 p.m. with LPN (licensed practical nurse) #2, Resident #102's nurse. When asked why the staff were checking Resident #102's blood pressure when giving the Atenolol, LPN #2 stated to make sure it wasn't too low. When asked what would happen to the resident if the medication was given when the blood pressure was low, LPN #2 stated, "The blood pressure could go lower. We could have trouble getting it back up." When asked what the circle around the nurse's initials on 1/20/18 at 9:00 a.m. meant, LPN #2 stated it meant the medication had not been given. When asked why, LPN #2 stated the blood pressure was low. When asked why the medication was given on 1/21/18 at 9:00 a.m. when the blood pressure was approximately the same as the previous day, LPN #2 stated, "We need to take the order back to him (the doctor) and ask for the parameters."

An interview was conducted on 1/31/18 at 4:20 p.m. with LPN #1, Resident #102's evening shift nurse. When asked to review the January 2018 MAR for the Atenolol doses, LPN #1 stated, "It doesn't have a parameter but if it's below 100 I would hold it. I would clarify it." LPN #1, accompanied by this surveyor, then went and found ASM (administrative staff member) # 4, the nurse practitioner. LPN #1 asked ASM #4 about obtaining the parameters for Resident #102's Atenolol. ASM #4 stated, "I'm more worried about

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the heart rate and you aren't checking it." LPN #1 stated, "Sometimes his (Resident #102's) heart rate is high, 110 to 130." ASM #4 stated, "Did anyone tell us?" LPN #1 stated, "No." ASM #4 then stated, "We need to set some parameters. This needs to be fixed. The Atenolol dose is too high for this resident (Resident #102). Why are you giving it for a BP (blood pressure) that low?"

An interview was conducted on 1/3/18 at 4:30 p.m. with RN #1. When asked to review Resident #102's order for Atenolol and the resident's blood pressures, RN #1 stated, "We should have the doctor clarify it."

On 1/31/18 at 5:30 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical quality specialist were made aware of the findings.

A copy of the policy on clarifying physician orders was requested from ASM #3 on 2/1/18 at 12:35 p.m.

No copy of the policy was provided prior to exit.

According to Medical Surgical Nursing made Incredibly Easy, Lippincott Williams & Wilkins copyright 2004 page 565 Dialysis Monitoring and Aftercare: "At least four times per day, assess circulation at the access site by auscultating for the presence of bruits and palpating for thrills. Unlike most other circulatory assessments, bruits and thrills should be present here. Lack of a bruit at a venous access site during dialysis may indicate a blood clot requiring immediate surgical attention."

{F 684} Quality of Care {F 684}

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SS=E 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 observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow the physician orders for eight of 12 resident in the survey sample, Residents #109, #111, #101, #105, #110, #107, #103, #112 and #102.

1a. The facility staff failed to administer insulin per the physician order for Resident #109.

1b. The facility staff failed to check Resident #109's blood sugars before breakfast on eight occasions during the month of January 2018, as ordered by the physician.

2. The facility staff failed to administer a blood pressure medication per the physician's order for Resident #111.

3. The facility staff failed to obtain vital signs daily per the physician order for Resident #101.

4. The facility staff failed to place physician ordered TED (thromboembolic disease) stockings on Resident #105.

{F 684}

1. Resident #109 is currently receiving insulin and Blood Glucose monitoring per physician's order. Resident #111 is currently receiving blood pressure medication per physician's order. Resident #101 is currently having vital signs obtained and documented per physician's order. Resident #105 has had order for TED hose discontinued. Resident #110 has fluid restrictions documented. Resident #107 is receiving tube feeding per order. Resident #103 is receiving nutrashield per order. Resident #102 is receiving treatments per order.

2. All residents on fluid restrictions were reviewed to ensure that fluid restrictions are documented. Current Resident Treatment Administration Records, and Medication Administration Records were reviewed for the month of February to

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5. The facility staff failed monitor Resident #110's fluid restriction on 1/27/18 - 1/29/18 as ordered by the physician.

6. The facility staff failed to administer Resident #107's tube feeding as ordered by the physician.

7. The facility staff failed to apply the nutrashield to Resident #103's face and limbs as ordered by the physician.

8. The facility staff failed to follow the physician's order to apply a bandage to Resident 102's right lower leg.

The findings include:

1a. Resident #109 was admitted to the facility on 11/21/17 with a recent readmission on 1/8/18 with diagnoses that included but were not limited to: repeated falls, chronic wounds on right foot, pain, diabetes, high blood pressure, shortness of breath, and Bipolar disorder (a mental disorder characterized by periods of mania and depression) [1].

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 1/15/18, coded Resident #109 as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring supervision to extensive assistance of one staff member for all of her activities of daily living. In Section N - Medications, the resident

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determine if there were any other orders not followed/documented.

3. Education completed for the licensed nursing staff by the Nurse Practice Educator related to following physician's orders and documenting on the TARs/MARs accordingly.

4. Unit Managers to audit Fluid Restriction Documentation 5 X week to ensure documentation in place. Unit Managers to audit MARS/TARS 3X week to ensure that orders are being followed and documentation complete. Results of these audits will be brought before the QAPI Committee monthly for review. 2/23/18

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was coded as receiving seven days of insulin injections during the seven-day look back period.

The physician order dated, 1/18/18 documented in part, "Humalog (a short acting insulin) (2) 100U/ml (units per milliliters) Kwppen (sic) inject 10 units, SQ (subcutaneously) TID (three times a day) with meals."

The MAR (medication administration record) for January 2018 documented, "Humalog Pen inject 10 units TID with meals." The medication was documented as given for all morning doses with breakfast from 1/19/18 through 1/31/18. The 6:00 p.m. doses from 1/19/18 through 1/31/18 were documented as given every day as ordered. There were only two doses documented as administered for the ordered 12 noon doses between 1/19/18 through 1/31/18.

The comprehensive care plan dated, 11/30/17 documented in part, "Focus: The resident has a diagnosis of diabetes: insulin dependent." The "Interventions" documented in part, "Administer hypoglycemic mediations as ordered."

An interview was conducted with LPN (licensed practical nurse) #6 on 2/1/18 at 10:35 a.m. LPN #6 was asked to review the orders for Humalog insulin for Resident #109 written on 1/18/18. When asked what insulin the resident should get, LPN #6 stated, "She should get 10 units every day with her meals. LPN #6 was asked to review the MAR. When asked if the resident received her insulin at 12 noon every day per the order, LPN #6 stated, "It isn't documented that she did."

An interview was conducted with RN (registered nurse) # 4, the staff educator; on 2/1/18 at 11:15

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a.m., RN #4 was asked to review the orders for Humalog insulin for Resident #109 written on 1/18/18. When asked what insulin the resident should be receiving, RN #4 stated, "She (Resident #109) should get 10 units of Humalog insulin with every meal." RN #4 was asked to review the MAR for January 2018. When asked if Resident #109 received the insulin prescribed by the physician each day, RN #4 stated the resident did not receive the 12 noon dose of insulin every day per the physician order.

On 2/1/18 at 11:20 a.m., an interview was conducted with administrative staff member (ASM) #2, the director of nursing. The above physician order and MARs were reviewed with ASM #2. She stated the orders should have been clarified and the orders should have been transcribed so that it's legible.

The facility policy, "Diabetic Care Protocol" documented in part, "5. Administer insulin/oral hypoglycemic medications as ordered."

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."

ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse were made aware of the above concern on 2/1/18 at 12:35 p.m.

No further information was provided prior to exit.

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[1] Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 73.
[2] This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c8ecbd7a-0e22-4fc7-a503-faa58c1b6f3f
.

1b. The facility staff failed to check Resident #109's blood sugars before breakfast on eight occasions during the month of January 2018, as ordered by the physician.

The physician order dated, 1/18/18 documented, "Humalog 100 Ut (unit)/ML sliding scale to the following AC (before meals) & HS (bed time/hours of sleep)."

The MAR documented in part, "Humalog 100ut.ML (unit /milliliter) S/S (sliding scale) as follows with meals and HS." The MAR documented the time slots of 8:00 a.m., 12 noon, 6:00 p.m. and 9:00 p.m. Handwritten for the 8:00 a.m. blood sugar check was a squiggly line through the 8:00 a.m. slot, with a D/C (discontinued) at the end of the line. There were no 8:00 a.m. blood sugars checked on 1/24/18 through 1/31/18.

Further review of the clinical record did not evidence any physician order to discontinue the blood sugars at 8:00 a.m.

The comprehensive care plan dated, 11/30/17 documented in part, "Focus: The resident has a diagnosis of diabetes: insulin dependent." The "Interventions" documented in part, "Access and

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record blood glucose (sugar) levels as ordered. Report blood glucose readings to MD (medical doctor) as ordered."

An interview was conducted with LPN (licensed practical nurse) #6 on 2/1/18 at 10:35 a.m. LPN #6 was asked to review the orders for Resident 109's blood sugars and sliding scale insulin. Once reviewed, LPN #6 was asked if the resident should be getting a blood sugar check at 8:00 a.m., LPN #6 stated, "Yes, unless there is another physician order to cancel it but normally we check blood sugars before meals."

An interview was conducted with RN (registered nurse) #4, the staff educator, on 2/1/18 at 11:15 a.m., RN #4 was asked to review the orders in Resident #109's record written on 1/18/18 and to review the MAR for Resident #109. Once reviewed RN #4 stated the resident (Resident #109) is supposed to get her standard insulin and her insulin per the sliding scale. When asked why the blood sugars for 8:00 a.m. were crossed off and marked as discontinued, RN #4 stated, "I have no idea but that shouldn't be that way."

On 2/1/18 at 11:20 a.m., an interview was conducted with administrative staff member (ASM) #2, the director of nursing. The above physician order and MARs were reviewed with ASM #2. She stated the orders should have been clarified and the orders should have been transcribed so that it's legible. When asked if Resident #109 was supposed to have blood sugar checks completed at 8:00 a.m., ASM #2 stated, "Per the physician order they (Resident #109) should be having blood sugars at 8:00 a.m. I have no idea what they (the nurses) were thinking. This isn't right."

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The facility policy, "Diabetic Care Protocol" documented in part, "5. Perform fingerstick blood glucose monitoring as ordered."

ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse were made aware of the above concern on 2/1/18 at 12:35 p.m.

No further information was obtained prior to exit.

2. The facility staff failed to administer a blood pressure medication per the physician's order for Resident #111.

Resident #111 was admitted to the facility on 1/5/18 with diagnoses that included, but are not limited to: stroke, diabetes, high blood pressure, sleep apnea (condition in which the patient has transient periods of apnea during sleep, typically these last less than 30 seconds) [1], depression, and aphasia (the inability to speak or express oneself in writing or to comprehend spoken or written language because of a brain lesion [e.g., the results of a stroke]) [2].

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 1/12/18 coded Resident #111as scoring a 15 on the BIMS (brief interview for mental status) score, indicating that he was capable of making cognitive decisions on a daily basis. Resident #111 was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living except eating in which he only required supervision after set up assistance was provided.

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The physician order dated, 1/18/18, documented, "Hydralazine (used to treat high blood pressure) [3] 10 mg (milligrams) po (by mouth) q (every) 6 hrs. (hours) PRN (as needed) BP (blood pressure) > (greater than) 180/95."

Resident #111's MAR (medication administration record) for January 2018 documented, "Hydralazine 10 mg po q 6 hrs. PRN BP > 180/95." The medication had not been administered.

Resident #111's comprehensive care plan dated, 1/6/18, documented in part, "Focus: Resident exhibits or is at risk for cardiovascular symptoms or complications related to Dx (diagnosis) HTN (high blood pressure) and CVA (stroke)." The "Interventions" documented in part, "Administer meds (medications) as ordered and assess for effectiveness and side effects and report abnormalities to physician. Assess and monitor vital signs as ordered and report abnormalities to physicians."

An interview was conducted with LPN (licensed practical nurse) #3 on 2/1/18 at 9:15 a.m. The above order was reviewed with LPN #3. When asked how he would follow that order, LPN #3 stated that it would be hard to follow. When asked if the order should have been clarified, LPN #3 stated, "Yes. I would have to be taking the blood pressure every six hours in order to follow that order."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing on 2/1/18 at 9:28 a.m. ASM #2 was asked to review the above order. When asked how a nurse is to

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follow that order, ASM #2 stated, "Well, when they obtain the blood pressure and if it's above the parameters then they should give it." When asked if it made a difference if the medication was ordered PRN, ASM #2 stated, "If it's a PRN, the resident should be having their blood pressure checked every six hours." When asked if the order should have been clarified, ASM #2 stated, "Absolutely."

Further review of the clinical record failed to evidence any documentation of Resident #111's blood pressure being taken every six hours.

ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse were made aware of the above concern on 2/1/18 at 12:35 p.m.

No further information was obtained prior to exit.

[1] Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 534.
[2] Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 44.
[3] This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0022003/?report=details.

3. The facility staff failed to obtain vital signs daily per the physician order for Resident #101.

Resident #101 was admitted to the facility on 2/12/13, and recently readmitted on 1/4/17 with diagnoses that included but were not limited to:

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altered mental status, high blood pressure, gout, osteoporosis, and anxiety disorder.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/3/17, coded Resident #101 as scoring a 10 on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to made cognitive daily decisions. The resident was coded as requiring extensive assistance or being totally dependent upon one or more staff members for all of her activities of daily living. Resident #101 was coded as requiring limited assistance of one staff member for eating. The resident was coded as having limitation in her range of motion on both lower extremities (legs).

The physician order dated, 1/16/17 and signed by the physician on 1/2/18, documented, "Vital signs every day - document in (initials of computer program)."

Review of the vital signs in the computer program failed to evidence vital signs for Resident #101 as being taken daily. From 1/18/18 through 1/31/18, the vital signs were only taken seven out of fourteen opportunities.

Resident #101's MAR (medication administration record) for January 2018 documented, "Vital signs every day - document in (initials of computer program)." Handwritten next to this was "On the 10th. *monthly - 3-11." The vital signs were documented as completed on 1/10/18.

The comprehensive care plan dated, 11/15/17 documented, "Focus: Resident exhibits or is at risk for cardiovascular symptoms or

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complications related to A-fib (atrial fibrillation), HTN (high blood pressure) and DVT (deep vein thrombosis)." The "Interventions" documented in part, "Assess and monitor vital signs as ordered and report abnormalities to physician."

An interview was conducted with LPN (licensed practical nurse) #3 on 2/1/18 at 9:25 a.m. LPN #3 was asked to review the above order. When asked if he was taking Resident #101's vital signs daily, LPN #3 stated he was not. When asked if it was a valid order, LPN #3 stated, "Yes, it is, the doctor signed it on 1/2/18. When asked if the order should have been clarified, LPN #3 stated, "Yes."

ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse were made aware of the above concern on 2/1/18 at 12:35 p.m.

No further information was obtained prior to exit.

4. The facility staff failed to place physician ordered TED (thromboembolic disease) stockings on Resident #105.

Resident #105 was admitted to the facility on 8/9/16 with diagnoses that included but were not limited to: high blood pressure, anemia, history of falls, and has a pacemaker.

The most recent MDS (minimum data set) assessment, a significant change assessment with an assessment reference date of 11/6/17, coded Resident #105 as scoring a 15 on the BIMS (brief interview for mental status) score,

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indicating he was capable of making cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living.

The physician order dated, 9/26/16, and signed by the physician on 1/2/18, documented, "TED Hose (anti-embolism stockings) Knee: apply to bilateral lower extremities every morning and remove at bedtime for edema."

The TAR (treatment administration record) for January 2018 documented, "TED hose knee; apply to bilateral lower extremities every morning and remove at bedtime for edema." The TED stockings were not documented as having been put on, on 1/18/18, 1/19/18, 1/22/18 through 1/25/18 and then from 1/27/18 through 1/31/18.

An observation was made of Resident #105 with LPN (licensed practical nurse) #6 on 1/31/18 at 2:40 p.m. LPN #6 verified Resident #105 had on regular men's sock with shoes on. When asked if he was supposed to have TED stockings on, LPN #6 stated, "I will have to check." She reviewed the TAR and stated yes he was supposed to have them on, but the CNA (certified nursing assistant) can put them on." When asked if she is responsible, LPN #6 stated, "Yes, I have to verify that they are on before I sign off on the TAR."

An interview was conducted with CNA #2, the CNA assigned to Resident #105 on 1/31/18, on 1/31/18 at 2:45 p.m. When asked if Resident #105 was to have TED stockings on, CNA #2 stated, "He only had one in the drawer today." When asked what she is supposed to do when you can't put them on, CNA #2 stated, "Notify the

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nurse." When asked if she notified the nurse today, CNA #2 stated, "No, I didn't."

The facility policy, "Anti-embolitic (TED) Stockings" documented in part, "1. Verify order. 9. Apply stockings to patient's legs per order. If possible, apply stocking in the morning before patient gets out of bed." 10. Remove stockings were per or as needed."

ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse were made aware of the above concern on 2/1/18 at 12:35 p.m.

No further information was provided prior to exit.

5. The facility staff failed to monitor Resident #110's fluid restriction on 1/27/18 through 1/29/18 as ordered by the physician.

Resident #110 was admitted to the facility on 1/13/17 and readmitted on 9/28/17 with diagnoses that included but were not limited to: kidney failure, heart disease, irregular heartbeat, stroke, high blood pressure and diabetes.

The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 1/15/18 coded Resident #110 as having scored a 9 out of 15 on the brief interview for mental status 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 except for eating which the resident could perform independently after the tray was prepared.

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Review of Resident #110's care plan initiated on 1/9/17 and revised on 1/26/18 documented, "Focus. Resident exhibits or is at risk for impaired renal function due to ESRD (end-stage renal disease). Interventions. 1/26/18 fluid restriction as ordered with regular diet.

Review of the 1/24/18 physician order documented, "Fluid Restriction to 1000 mL (milliliter) qd (every day)."

Review of Resident #110's intake and output sheets did not evidence documentation of Resident #110's fluid restriction for 1/27/18 through 1/29/18.

On 1/31/18 at 8:15 a.m. request was made to ASM (administrative staff member) #2, the director of nursing for documentation that the fluid restriction was being monitored for Resident #110 from 1/27/18 through 1/29/18.

On 1/31/18 at 4:30 p.m. RN (registered nurse) #1 stated, "We can't find them." When asked if staff were expected to monitor the resident's fluid restriction RN #1 stated they were. When asked why the staff should monitor and document the resident's fluid restriction, RN #1 stated that the staff were responsible for following the physician's order.

On 1/31/18 at 5:30 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical quality specialist were made aware of the findings.

An interview was conducted on 2/1/18 at 9:40 a.m. with LPN (licensed practical nurse) #8, the resident's nurse. When asked why the physician

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ordered the fluid restriction, LPN #8 stated, "To keep track of the intake and output." When asked why that was important, LPN #8 stated, "Well in case she has edema (swelling) and everybody knows (how much fluid the resident had)." When asked if staff had followed, the physician's order LPN #8 stated, they had not.

A copy of the policy on following physician orders was requested to ASM #3 on 2/1/18 at 12:35 p.m. No copy of the policy was provided prior to exit.

6. The facility staff failed to administer Resident #107's tube feeding as ordered by the physician.

Resident #107 was admitted to the facility on 10/22/15 and readmitted on 4/9/16 with diagnoses that included but were not limited to: stroke, depression, obesity and indigestion.

The most recent MDS, a quarterly assessment, with an ARD of 1/10/18 coded the resident as being rarely or never understood and rarely or never understanding. Resident #107 was coded as being severely impaired cognitively. The resident was coded as requiring extensive assistance from staff for all activities of daily living. The resident was coded as receiving tube feedings.

An observation was made on 1/31/18 at 10:40 a.m. of Resident #107. The resident was lying in bed with the tube feeding running at 55 cc's (cubic centimeters) per hour.

An observation was made on 1/31/18 at 11:05 a.m. of Resident #107. The resident was lying in bed with her eyes closed. The tube feeding was

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off and the tubing was hanging from the pole.

An observation was made on 2/1/18 at 10:15 a.m. of Resident #107. The resident was lying in bed with her eyes opened. The tube feeding was running at 55 cc's per hour.

An observation was made on 2/1/18 at 10:38 a.m. of the Resident's nurse leaving the resident's room after turning off the tube feeding.

Review of the Resident #107's comprehensive care plan initiated on 5/10/17 and revised on 10/27/15 documented, "Focus. Resident is at nutritional risk: impaired swallowing fxn (function) related to dysphagia (difficulty swallowing) as evidence (sic) by need for nutritional support. Interventions. Provide TF (tube feeding) as ordered."

Review of the physician's orders dated and signed on 1/2/18 documented, "04/09/16 Jevity (1) 1.5 AT 55ML (milliliters)/HR VIA PEG TUBE X (times) 20 HRS - Downtime 10 AM."

Review of the January 2018 TAR documented, "Jevity 1.5 cal (calorie) @ 55 ml/hr x20 hrs. (arrow pointing down) 10 A (a.m.) Down."

An interview was conducted on 1/31/17 at 3:50 p.m. with LPN (licensed practical nurse) #2, the resident's nurse. LPN #2 was asked when Resident #107's tube feeding was to be turned off. LPN #2 stated, "It comes down at 10:00 in the morning." When the above observation was shared, LPN #2 stated, "I thought it was earlier than that."

On 1/31/18 at 5:30 p.m. ASM (administrative staff

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member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical quality specialist were made aware of the findings.

An interview was conducted on 1/31/17 at 4:30 p.m. with RN (registered nurse) #1. When asked if it was important to follow the physician's order to discontinue a tube feeding on time, RN #1 stated, "Yes." When asked if letting a tube feeding run 40 minutes longer than ordered was following the physician's order, RN #1 stated, "We're not following the correct amount of tube feeding."

On 2/1/18 at 12:35 p.m. ASM #1, ASM #2 and ASM #3 were made aware Resident #107's tube feeding had again not been stopped at the time as noted on the care plan and as ordered by the physician.

Review of the facility's policy titled, "Enteral Management" documented, "PURPOSE. To provide nutrition when patient is unable to consume food and fluids orally."

No further information was obtained prior to exit.

1. Jevity - High-protein, fiber-fortified formula. Complete, balanced nutrition for long- or short-term tube feeding
For supplemental or sole-source nutrition. This information was provided from:
http://www.medline.com/product/Jevity-12-Cal-Nutritional-Supplement/Nutrients/Z05-PF11290#

7. The facility staff failed to apply the nutrashield to Resident #103's face and limbs as ordered by

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the physician.

Resident #103 was admitted to the facility on 1/15/11 and readmitted on 5/5/16 with diagnoses that included but were not limited to: dementia, difficulty swallowing and depression.

The most recent MDS, a quarterly MDS, with an ARD of 11/17/18 coded Resident #103 as having short and long term memory difficulties and as being severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the resident's care plan initiated on 9/13/17 and updated on 12/5/17 documented, "Resident is at risk for skin breakdown...Interventions. Treatments as ordered."

Review of the physcian's orders dated 1/9/18 documented, "NUTRASHIELD (1) on shower days to face + (plus) limbs."

Review of the January 2018 MAR (medication administration record) documented, "NUTRASHIELD on shower days to face + limbs Tues/Friday." Further review of the January 2018 MAR did not evidence documentation that the Nutrashield have been applied on 1/26/18 or 1/30/18.

On 2/1/18 at 10:30 a.m., an unsuccessful attempt was made to contact the nurse who cared for Resident #103 on 1/26/18 and 1/30/18.

A request was made on 2/1/18 at 12:35 p.m. of ASM (administrative staff member) #2, the director of nursing for documentation regarding

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the Nutrashield being applied as ordered.

On 2/1/18 at 2:35 p.m., ASM #2 stated there was no evidence the resident ever received the nutrashield as ordered. ASM #2, the director of nursing was made aware of the concerns at that time.

No further information was provided prior to exit.

1. Nutrashield - Protects from minor skin irritation associated with diaper rash caused from wetness, urine and/or stool. Temporarily protects and helps relieve chapped or cracked skin.This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=39985

8. The facility staff failed to follow the physician's order to apply a bandage to Resident 102's right lower leg.

Resident #102 was admitted to the facility on 3/12/17 and readmitted on 10/3/17 with diagnoses that included but were not limited to: kidney failure requiring hemodialysis (1), diabetes, heart failure and an amputation of the left lower leg.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/28/17 coded Resident #102 as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring

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assistance from staff for all activities of daily living except for eating which the resident could do after the tray was prepared. The resident was coded as receiving dialysis.

An observation was made of Resident #102 on 1/31/18 at 8:17 a.m. The resident was sitting up in the wheelchair eating breakfast. The resident was wearing shorts. There was no dressing observed on the right lower leg.

Review of the resident's care plan did not evidence documentation regarding the resident's right lower leg dressing order.

Review of the physician's order dated and signed on 1/13/18 at 12:20 p.m. documented, "D/C (discontinue) acewrap to RLE (right lower extremity) to be wrapped (with) Profore Lite (2) 3 layer compression weekly + (plus) prn (as needed) if soiled or falls down."

Review of the January 2018 TAR (treatment administration record) documented, "RLE profore lite 3 layer compression weekly + PRN if soiled or falls down." Further review of the January 2018 TAR revealed on 1/22/18 documentation of the nurse's initial with a circle around them indicating the treatment had not been done. On the back of the TAR the nurse documented,"(Illegible) not done d/t (due to) Resident out of facility for dialysis." On 1/29/18 the box for the dressing was left blank.

Review of the nurse's notes from 1/22/18 through 1/29/18 did not evidence documentation that the right lower leg dressing had been applied as ordered.

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On 2/1/18 at 10:30 a.m., an attempt to contact the nurse who cared for the resident on those days was unsuccessful.

A request was made on 2/1/18 at 12:35 p.m. of ASM (administrative staff member) #2, the director of nursing for documentation regarding the Resident #102 receiving the dressing to the right lower leg as ordered by the physician.

On 2/1/18 at 2:35 p.m., ASM #2 stated there was no evidence that the resident ever received the right lower leg dressing as ordered for the date in question. ASM #2 was made aware of the concern at that time.

No further information was provided prior to exit.

1. Hemodialysis - Hemodialysis is a treatment for kidney failure that uses a machine to filter your blood outside your body. This information was obtained from: https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis

2. Profore lite -- Using materials science, two-layer compression systems with controlled compression and a low profile were developed. These materials allow for a more consistent bandage application with better control of the applied compression, and their low profile is compatible with most footwear, increasing patient acceptance and compliance with therapy. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3839010/

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

{F 689} Continued From page 56

§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, and facility document review, it was determined the facility staff failed to implement interventions to prevent falls for one of 12 residents in the survey sample, Resident #101.

Resident #101 was observed in her bed and her physician ordered fall mat was observed folded up against the closet door.

The findings include:

Resident #101 was admitted to the facility on 2/12/13 with a recent readmission on 1/4/17 with diagnoses that included but were not limited to: altered mental status, high blood pressure, gout, osteoporosis, and anxiety disorder.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/3/17, coded Resident #101 as scoring a 10 on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance or being totally dependent upon one or more staff members for all of her activities of daily living. The resident was coded

{F 689}

1. Resident #101 has her fall mats in place while in bed consistent with order and resident's care plan.
2. All residents with care-plan interventions for fall mats have potential to be affected. All residents with orders for fall mats were reviewed to ensure that fall mats were in place per order.
3. Re-Education was provided for facility staff by the Nurse Practice Educator, related to Fall Prevention and ensuring that fall interventions are in place per order and care plan
4. The Interdisciplinary Team will monitor for fall mat placement rounds. Unit Managers will audit residents with orders/Care Plans for all fall mats 5 times/week for 6 weeks and randomly thereafter to ensure the fall mats are in place per order. Results of these audits will be brought before the QAPI Committee monthly for review.

2/23/18

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as having limitation in her range of motion on both lower extremities (legs).

Observation was made of Resident #101 during the initial tour conducted on 1/30/18 at 9:45 a.m. The resident was in her bed and her fall mat was observed folded up against the closet door.

The physician order dated, 1/16/17, signed by the physician on 1/2/18, documented, "Fall mat at bedside at all times - check placement every shift."

The comprehensive care plan dated, 11/15/17 documented in part, "Focus: Resident is at risk for falls: Impaired mobility, history of falls/fractures." The "Interventions" documented in part, "Fall matt at bedside at all times."

An interview was conducted with LPN (licensed practical nurse) #3 on 2/1/18 at 9:25 a.m. When asked if Resident #101 was to have a fall mat, LPN #3 stated, "Yes, she has to have it at all times when she's in bed." When asked how often staff check for placement of the fall mat, LPN #3 stated, "Every shift." The above observation on 1/30/18 at 9:45 a.m. was shared with LPN #3 and LPN #9. LPN #3 stated, "I saw it and realized it wasn't down so I put it down." LPN #9 stated, "I had asked (name of CNA) to get her dressed that morning, she must not have put the fall mat back down afterwards."

In Fundamentals of Nursing, 7th edition, 2009; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 5. "Client safety is a priority in health care. You need to protect clients from physical and emotional injury by continually assessing for and eliminating safety hazards. Clients fall due to

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many factors, such as improper transfer techniques, client age, side effects of medications, impaired mobility, or confusion. Learn your agency's fall prevention program for reducing client falls. Programs that use a multidimensional approach in designing fall prevention strategies have the greatest reduction in fall rates."

The administrator (administrative staff member - ASM) #1, ASM #2, the director of nursing, and ASM #3, the corporate clinical nurse, were made aware of the above finding on 2/1/18 at 12:35 p.m.

A copy of the policy on following physician orders was requested to ASM #3 on 2/1/18 at 12:35 p.m. No copy of the policy was provided prior to exit.

{F 690} SS=D Bowel/Bladder Incontinence, Catheter, UTI
CFR(s): 483.25(e)(1)-(3) {F 690}

§483.25(e) Incontinence.
§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

Provider's Plan of Correction:

1. Indwelling catheter for Resident #106 was discontinued and removed.
2. All residents with indwelling catheter have the potential to be affected. 100% audit was completed to ensure proper diagnosis for all current residents and new admits with indwelling catheters.

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(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview and facility document review, it was determined the facility staff failed to assess for the appropriate use of an indwelling catheter for one of 12 residents in the survey sample, Resident #106.

Resident #106 was admitted to the facility with an indwelling catheter on 1/22/18. The facility failed to complete any assessment to determine if the use of a catheter was appropriate for Resident #106 or if the catheter should be removed and the clinical record failed to document a diagnosis requiring an indwelling catheter.

The findings include:

Resident #106 was admitted to the facility on 1/22/18 with diagnoses that included but were not

3. Education was provided to the nursing staff by the Nurse Practice Educator or the Nursing Supervisor related to review new admits with indwelling catheters to determine if they have an appropriate reason/diagnosis for continued use or request order to discontinue.

4. The Unit Managers will audit all residents with indwelling catheters, including new admissions, 5 times/week for 6 weeks and then randomly thereafter to ensure proper diagnosis is obtained for new orders of indwelling catheter insertion. Results of audits will be brought to the QAPI Committee for follow up monthly.

Completion date: 2/23/18

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limited to: hepatic failure, chronic pain, chronic obstructive pulmonary disease (general term for chronic nonreversible lung disease) [1], high blood pressure, anxiety, diabetes, and recent hip fracture.

There was no completed MDS (minimum data set) assessment at the time of survey. The "Nursing Assessment - Initial" dated 1/22/18 documented Resident #106 was alert and oriented to person, place and time. The assessment documented Resident #106 had had a recent fall with a fracture. The form documented the resident had an indwelling catheter in place.

Resident #106 was observed on 1/30/18 at 1:13 p.m. up in a wheelchair with an indwelling catheter in place. The resident was observed on 1/31/18 at 8:11 a.m., 11:15 a.m. and 1:20 p.m. with an indwelling catheter in place and a drainage bag attached to the bed or wheelchair.

Observation was made of Resident #106 on 1/31/18 at approximately 2:00 p.m. The resident was in the therapy gym working with therapy.

An interview was conducted with Resident #106 on 1/31/18 at 1:20 p.m., regarding her Foley catheter. Resident #106 stated it (Foley catheter) was inserted while she was in the hospital. When asked if she used a catheter at home, Resident #106 stated, "No."

The physician note dated, 1/23/18 documented in part, "Genitourinary: Foley (brand name of indwelling catheters)." Review of all other physician and nurse practitioner notes did not reveal documentation of the indwelling catheter.

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The physician order dated, 1/24/18, documented in part, "Foley catheter Dx (diagnosis): Immobility related to hip fx (fracture) secondary to fall r/t (related to) incontinence."

Review of the nurse's notes did not reveal any documentation related to the indwelling catheter.

The comprehensive care plan dated, 1/23/18, documented in part, "Focus: Resident required indwelling Foley catheter: immobility secondary to right hip fracture related to incontinence." The "Interventions" did not document the justification for the use of the catheter.

An interview was conducted with LPN (licensed practical nurse) #4 on 1/31/18 at 1:39 p.m., regarding Resident #106's indwelling catheter. LPN #4 stated, "She came in with it and the nurse practitioner wrote it was because of her immobility and because she (Resident #106) had fallen in the hospital while going to the bathroom." The physician order dated 1/24/18 was reviewed with LPN #4. When asked if the diagnosis on the physician order was an acceptable diagnosis for the use of an indwelling catheter in the facility, LPN #4 stated, "I don't think it is. She's not immobile now and works with therapy."

An interview was conducted with administrative staff member (ASM) #4, the nurse practitioner who wrote the above order. When asked why Resident #106 has an indwelling catheter, ASM #4 stated, "She came in from the hospital with it. She fell in the hospital trying to get to the bathroom and fractured her hip." When asked if she qualifies for the use of a catheter in the facility, ASM #4 stated, she wanted to look at the

{F 690} Continued From page 62 {F 690}

chart and get back with this writer.

An interview was conducted with RN (registered nurse) #3, the assistant director of nursing, on 1/31/18 at 1:50 p.m. When asked if any resident can have an indwelling catheter, RN #3 stated, "No, its use must meet the criteria for use. RN #3 stated, "Obstruction caused by BPH (benign prostatic hypertrophy), retention, and neurogenic bladder." When asked if immobility is an acceptable diagnosis for the use of a catheter, RN #3 stated, "No." When asked if incontinence is an acceptable diagnosis for the use of a catheter, RN #3 stated, "No." When asked if falls were an acceptable diagnosis for the use of a catheter, RN #3 stated, "Absolutely not."

An interview was conducted with ASM #2, the director of nursing, on 1/31/18 at 2:00 p.m. When asked what the justifications are for a resident to have an indwelling catheter, ASM #2 stated, "BPH, retention, neurogenic bladder." When asked if immobility, history of falls and incontinence were justifiable reasons for the use of an indwelling catheter, ASM #2 stated, "No." A request was made to ASM #2, for any assessment that was completed for Resident #106's use of an indwelling catheter. No assessments were provided prior to exit.

ASM #4 returned to this writer and stated, "I should have started her (Resident#106) on bladder training and coordinated with therapy to remove the catheter. She was admitted after having a fall in the hospital attempting to go to the bathroom. I didn't want her to fall. She also had some redness on her bottom when she arrived. When asked if she was aware of the regulation for the use of an indwelling catheter in the nursing

{F 690} Continued From page 63 {F 690}

home, ASM #4 stated, "I'm new to the nursing home. I just came a few months ago."

The facility policy, "Catheter: Urinary - Justification for Use." documented in part, "Policy: Patients who have urinary catheters will be assessed to determine appropriateness for use based on the following criteria: Indwelling: Urinary retention that cannot be treated or corrected medically or surgically, for which alternate therapy is not feasible and which is characterized by (must have all three): Documented post void residual volumes in a range over 200 mls (milliliters), Inability to manage the retention/incontinence with intermittent catheterizations and persistent overflow incontinence, symptomatic infections and/or renal dysfunction. Contamination of Stage III or IV wounds with urine which has impeded healing despite appropriate person care for the incontinence or terminal illness or severe impairment which makes positioning or clothing changes uncomfortable or which is associated with intractable pain. Physician/Advanced practice provider will document a valid clinical indication for the use of the catheter and ongoing assessment. If patient's situation does not meet any of the criteria, notify physician/advanced practice provider to obtain orders for catheter removal."

A request was made on 2/1/18 at approximately 9:30 a.m. to ASM #2, the director of nursing, for any assessments that were completed for Resident #106's use of an indwelling catheter. No assessments were provided prior to exit.

The administrator (administrative staff member) ASM #1, ASM #2, the director of nursing, and

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ASM #3, the corporate clinical nurse, were made aware of the above finding on 2/1/18 at 12:35 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.

{F 690}

{F 693} SS=D Tube Feeding Mgmt/Restore Eating Skills
CFR(s): 483.25(g)(4)(5)

{F 693}

§483.25(g)(4)-(5) Enteral Nutrition
(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it

1. Tube feeding for Resident #107 was stopped and removed.
2. All residents who receive tube feedings have potential to be affected. An audit was completed by nursing management of all current residents with tube feeding orders to ensure that orders are being carried out accordingly
3. Education was provided to nursing staff by the Nurse Practice Educator related to the Tube Feeding Administration policy and following physician's order for Tube Feed administration.
4. Unit Managers will monitor/audit residents with tube feedings 5 times/week for 6 weeks and randomly thereafter to ensure that

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was determined, the facility staff failed to administer a tube feeding as ordered by the physician for one of 29 residents in the survey sample, Resident #107.

The facility staff left Resident #107's tube feeding during a physician prescribed downtime of 10:00 a.m. until 2:00 p.m.

The findings include:

Resident #107 was admitted to the facility on 10/22/15 and readmitted on 4/9/16 with diagnoses that included but were not limited to: stroke, depression, obesity and indigestion.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 1/10/18 coded the resident as being rarely or never understood and rarely or never understanding. The resident was coded as being severely impaired cognitively. The resident was coded as requiring extensive assistance from staff for all activities of daily living. The resident was coded as receiving tube feedings.

An observation was made on 1/31/18 at 10:40 a.m. of Resident #107. The resident was lying in bed with the tube feeding running at 55 cc's (cubic centimeters) per hour.

An observation was made on 1/31/18 at 11:05 a.m. of Resident #107. The resident was lying in bed with her eyes closed. The tube feeding was off and the tubing was hanging from the pole.

An observation was made on 2/1/18 at 10:15 a.m. of Resident #107. The resident was lying in bed with her eyes opened. The tube feeding was

Provider's plan of correction:

the orders are followed accordingly. Results of these audits will be brought before the QAPI Committee monthly for review. — 2/23/18

{F 693} Continued From page 66 {F 693}

running at 55 cc's per hour.

An observation was made on 2/1/18 at 10:38 a.m. of the Resident's nurse leaving the resident's room after turning off the tube feeding. Direct line of sight of the resident's room was maintained from 10:15 a.m. until 10:38 a.m.

Review of the resident's care plan initiated on 5/10/17 and revised on 10/27/17 documented, "Focus. Resident is at nutritional risk: impaired swallowing fxn (function) related to dysphagia (difficulty swallowing) as evidence (sic) by need for nutritional support. Interventions. Provide TF (tube feeding) as ordered."

Review of the physician's orders dated and signed on 1/2/18 documented, "04/09/16 Jevity (1) 1.5 AT 55ML (milliliters)/HR VIA PEG TUBE X (times) 20 HRS - Downtime 10 AM."

Review of the January 2018 TAR documented, "Jevity 1.5 cal (calorie) @ 55 ml/hr x20 hrs. (arrow pointing down) 10 A Down."

An interview was conducted on 1/31/17 at 3:50 p.m. with LPN (licensed practical nurse) #2, the resident's nurse. LPN #2 was asked when Resident #107's tube feeding was to be turned off. LPN #2 stated, "It comes down at 10:00 in the morning." When the above observation was shared, LPN #2 stated, "I thought it was earlier than that."

An interview was conducted on 1/31/17 at 4:30 p.m. with RN (registered nurse) #1. When asked if it was important to follow the physician's order to discontinue the tube feeding on time, RN #1 stated, "Yes." When asked if letting the tube

{F 693} Continued From page 67 {F 693}

feeding run 40 minutes longer than ordered was acceptable, RN #1 stated, "No. We're not following the correct amount of tube feeding. We would need to get a clarification to give correct amount."

On 1/31/18 at 5:30 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical quality specialist were made aware of the findings.

On 2/1/18 at 12:35 p.m. ASM #1, ASM #2 and ASM #3 were made aware Resident #107's tube feeding had again not been stopped at the time as noted on the care plan and as ordered by the physician.

Review of the facility's policy titled, "Enteral Management" documented, "PURPOSE. To provide nutrition when patient is unable to consume food and fluids orally."

No further information was obtained prior to exit.

1. Jevity - High-protein, fiber-fortified formula. Complete, balanced nutrition for long- or short-term tube feeding
For supplemental or sole-source nutrition. This information was provided from: http://www.medline.com/product/Jevity-12-Cal-Nutritional-Supplement/Nutrients/Z05-PF11290#

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

§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy

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{F 695} Continued From page 68

care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review it was determined the facility staff failed to administer oxygen per the physician orders for one of 12 residents in the survey sample, Resident #101, and failed to store respiratory equipment in a sanitary manner for one of 12 residents in the survey sample, Resident #111.

1. The facility staff failed to administer oxygen to Resident #101 per the physician prescribed flow rate of 3 liters minute. During multiple observations Resident #101's oxygen concentrator flow rate was observes set at 2.5 L/Min (liters per minute).

2. The facility staff failed to store respiratory equipment in a sanitary manner for Resident #111.

The finding include:

1. Resident #101 was admitted to the facility on 2/12/13, with a recent readmission on 1/4/17 with diagnoses that included but were not limited to: altered mental status, high blood pressure, gout, osteoporosis, and anxiety disorder.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/3/17, coded the resident as scoring a 10 on the BIMS (brief

{F 695}

1. Respiratory equipment stored in a clean bag with date. Resident # 111 is receiving oxygen per order at the correct flow rate.
2. All residents utilizing oxygen have potential to be affected by this deficient practice. An audit was completed of all current residents utilizing oxygen to ensure that orders being followed correctly and correct flow rate administered and appropriately stored in clean bags with date.
3. Education was provided to nursing staff by the Nurse Practice Educator on Oxygen Administration to include orders, setting flow rate and storage.
4. Unit Managers to monitor/audit residents receiving oxygen 5 times/week for 6 weeks and randomly thereafter to ensure that orders are followed accordingly with correct flow rates and that respiratory equipment is stored appropriately. Results of these audits will be brought before the QAPI Committee monthly for review.

2/23/18

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interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. Resident #101 was coded as requiring extensive assistance or being totally dependent upon one or more staff members for all of her activities of daily living. The resident was coded as having limitation in her range of motion on both lower extremities (legs). In Section O - Special Treatments, Procedures, and Programs, Resident #101 was not coded as having oxygen during the look-back period.

Resident #101 was observed during the initial tour on 1/30/18 at 9:45 a.m. She was in bed with her oxygen on via a nasal cannula (two small tubes inserted in the nose to deliver oxygen). The oxygen concentrator flow meter was set at 2.5 L/Min (liters per minute). The resident was again observed on 1/30/18 at 1:15 p.m. and 2:02 p.m. with the oxygen concentrator flow meter set at 2.5 L/Min.

The physician orders dated 1/16/17, signed by the physician on 1/2/18, documented, "Oxygen at 3L/min via nasal cannula continuous to maintain sats (oxygen saturation level) greater than 92%."

Review of the nurse's notes from 1/17/18 through 2/1/18 did not reveal any documentation regarding Resident #101's use of oxygen.

The MAR (medication administration record) for January 2018 documented, "Oxygen at 3L/min via nasal cannula continuous to maintain sats (oxygen saturation level) greater than 92%." The oxygen was signed off as being administered as ordered on 1/30/18.

The comprehensive care plan dated, 11/15/17,

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documented in part, "Focus: Resident exhibits or is at risk for fluid volume excess as evidence by edema." The "Interventions" documented in part, "O2 (oxygen) as ordered."

An interview was conducted with LPN (licensed practical nurse) #3 on 2/1/18 at 9:25 a.m. When asked how to read an oxygen concentrator for the physician prescribed oxygen flow rate, LPN #3 stated to read the level (flow rate of oxygen) you get parallel to the flowmeter and the line should cut the ball in half. The observation of Resident #101's oxygen rate on 1/30/18 was shared with LPN #3. LPN #3 stated you have to keep checking it as sometimes it does go down on its own.

The facility policy, "Oxygen: Nasal Cannula" documented in part, "11. Connect the cannula to the nipple adapter or humidifier and set the flow rate to the prescribed liter flow."

The oxygen concentrator manufacturer's user manual documented, under "NOTE: To properly read the flow meter, locate the prescribed flow rate line on the flow meter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min. line prescribed..."

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

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administration."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical quality specialist were made aware of the findings on 2/1/18 at 12:35 p.m.

No further information was provided prior to exit.

2. The facility staff failed to store Resident #111's respiratory equipment in a sanitary manner.

Resident #111 was admitted to the facility on 1/5/18 with diagnoses that included but were not limited to: stroke, diabetes, high blood pressure, sleep apnea (condition in which the patient has transient periods of apnea during sleep, typically these last less than 30 seconds) [1], depression, and aphasia (the inability to speak or express oneself in writing or to comprehend spoken or written language because of a brain lesion [e.g., the results of a stroke]) [2].

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 1/12/18 coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating that he was capable of making cognitive decisions on a daily basis. Resident #111 was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living except eating in which he only required supervision after set up assistance was provided. In - Section O - Special Treatments, Procedures and Programs, the resident was coded as having used a BiPap/CPAP outside of the facility but was not coded as using a BiPap/CPAP while a

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resident in the facility. The resident was not coded as receiving oxygen during the lookback period.

C-PAP, Continuous Positive Airway Pressure, is a machine used to assist people who are diagnosed with sleep apnea. A C-Pap machine increased air pressure in the throat so that the airway does not collapse when you breathe in. Bi - PAP, bi-level Positive Airway Pressure, is a machine used to assist people who are diagnosed with sleep apnea. Bi Pap machine can be set for breathing in and breathing out pressure settings. (3)

Observation was made of Resident #111's room on 1/31/18 at 8:20 a.m. The resident was lying in his bed with the head of the bed elevated. His CPAP mask was sitting on top of the nightstand, uncovered. The nebulizer were stored in a bag hanging off the handle of the nightstand. The oxygen tubing was stored in a plastic bag hanging off the oxygen concentrator. The resident's room was observed again on 1/31/18 at 11:20 a.m. and 3:45 p.m.; the CPAP mask was still sitting on the nightstand, uncovered, the nebulizer and oxygen tubing were in a plastic bag.

The comprehensive care plan dated, 1/6/18 documented in part, "Focus: Resident exhibits or is at risk for respiratory complications related to sleep apnea - CPAP/BIPAP." The "Interventions" documented in part, "Will use CPAP. O2 (oxygen) as ordered via nasal cannula."

On 2/1/18 at 8:15 a.m., Resident #111's room was observed with LPN (licensed practical nurse) #3. The CPAP mask and nebulizer was observed

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to be sitting on top of the nightstand. Neither were in a plastic bag. The plastic bag was hanging off the handle of the nightstand drawer. The oxygen concentrator was noted to have a nasal cannula wrapped around the top handle of the concentrator. When asked if he saw anything out of place in the room, LPN #3 stated, "All of the respiratory equipment should be bagged if it's not in use."

The facility policy, "Oxygen: Nasal Cannula" documented in part, "16. Replace entire set-up every seven days. Date and store in treatment bag when not in use." The facility policy, "Bi-Level Positive Airway Pressure (BiPAP/Continuous Positive Airway Pressure (CPAP) including Trilogy" did not address the storage of the equipment when not in use."

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc.; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment."

The administrator, director of nursing and corporate nurse were made aware of the above findings on 2/1/18 at 12:35 p.m.

No further information was provided prior to exit.

[1] Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 534.
[2] Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 44.
[3] This information was obtained from the

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following website:
www.webmd.com/sleep-disorders/sleep-apnea.

{F 695}

{F 698} Dialysis
SS=D CFR(s): 483.25(l)

{F 698}

§483.25(l) Dialysis.
The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide dialysis care and services for one of 12 residents in the survey sample.

The facility staff failed to assess Resident #102's AV shunt inserted on 1/18/18 for the bruit and thrill per the comprehensive care plan.

The findings include:

Resident #102 was admitted to the facility on 3/12/17 and readmitted on 10/3/17 with diagnoses that included but were not limited to: kidney failure requiring hemodialysis [1], diabetes, heart failure and an amputation of the left lower leg.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/28/17 coded Resident #102 as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily

1. Resident #102 has bruit and thrill being monitored and documented on Medication Administration Record
2. All residents on dialysis with shunts have the potential to be affected. 100% audit of all current residents on dialysis was completed by nursing leadership to ensure that bruit and thrill is monitored and documented.
3. Nurse Practice Educator provided education for licensed nursing staff related to Dialysis monitoring to include monitoring of bruit and thrill.
4. Unit Managers to monitor documentation of bruit and thrill monitoring for all dialysis residents 3 times/week. Results of these audits will be brought before the QAPI Committee monthly for review.

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{F 698} Continued From page 75 {F 698}

decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could do after the tray was prepared. The resident was coded as receiving dialysis.

Review of the care plan initiated on 12/22/17 and updated on 1/18/18 documented, "Focus. Resident exhibits or is at risk for impaired renal function and is at risk for complications related to hemodialysis...1/18/18 AV (arteriovenous) [2] shunt in L (left) upper arm. Interventions. Monitor dialysis access for + (positive) bruit/+thrill [3] q (every) shift and prn (as needed)."

Review of the physician's orders dated 1/18/18 at 2:00 p.m. documented, "Monitor steri strips to (left) upper arm incision site Qshift. Elevate (left) upper extremity on pillow to reduce swelling." There was no documentation regarding checking the bruit and thrill in the left upper arm AV shunt.

Review of the 1/18/18 at 2:33 p.m. nurse's notes documented, "Resident returned from Appointment this after (sic) S/P (status post) AV Shunt placement in the Left arm. New orders noted from (name of physician) about the Left Arm."

Review of Resident #102's January 2018 MAR (medication administration record) and the January 2018 TAR (treatment administration record) did not evidence documentation regarding checking the bruit and thrill in the left upper arm AV shunt.

Review of Resident #102's nurses' notes from 1/18/18 through 1/31/18 did not evidence documentation regarding checking the bruit and

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thrill in the left upper arm AV shunt.

An interview was conducted on 1/31/18 at 4:07 p.m. with LPN (licensed practical nurse) #2, Resident #102's nurse. When asked about the process staff follows when a resident has an AV shunt, LPN #2 stated, "We check the site every day. Check for any infection, his (Resident #102) is a little swollen." When asked if staff checked the shunt for a bruit and a thrill, LPN #2 stated, "You check that." When asked if she had checked Resident #102's shunt for a bruit and a thrill that day LPN #2 stated, "I don't remember if I did or not."

An interview was conducted on 1/31/18 at 4:30 p.m. with RN (registered nurse) #1. When asked what assessment staff do when a resident has an AV shunt, RN #1 stated, "You would check the bruit and thrill. It's documented at least once a shift on the MAR." When asked to review Resident #102's January 2018 MAR and TAR for the checking of the bruit and thrill, RN #1 stated, "I do not see it on here."

An interview was conducted on 2/1/18 at 12:15 p.m. with LPN #4, the resident's nurse. When asked what assessment staff do when a resident has an AV shunt, LPN #4 stated, "I check if I have a fistula (shunt) or a catheter. It if's a fistula I check the bruit and thrill." When asked why this was done, LPN #4 stated, "To make sure it's functioning." When asked if she had checked Resident #2's shunt for a bruit and thrill, LPN #4 stated, "I just knew about the catheter. I wasn't aware that he had a shunt." When asked how staff received information about the residents, LPN #4 stated, "We get report or we can go back through the chart. The most important things

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should be given in report." When asked if an AV shunt was important, LPN #4 stated, "Yes!"

A telephone interview was conducted on 2/1/18 at 12:30 p.m. with LPN #7, the resident's nurse. When asked how staff assessed a dialysis resident, LPN #7 stated, "If they have a fistula you check the bruit and the thrill." When asked if Resident #102 had a fistula, LPN #7 stated, "He has a shunt. It was just put in." When asked if he had checked the shunt for the presence of a bruit and thrill, LPN #7 stated, "No because it wasn't active."

On 2/1/18 at 3:45 p.m. ASM (administrative staff member) #2, the director of nursing was made aware of the findings.

Review of the facility's policy titled, "Hemodialysis: Graft and Fistula Care" documented, "2. Evaluate access site daily and on return from dialysis center. Observe for signs of complications. 3. Notify physician/mid-level provided and hemodialysis center for 3.4. Absence of bruit or thrill.

No further information was provided prior to exit.

According to Medical Surgical Nursing made Incredibly Easy, Lippincott Williams & Wilkins copyright 2004 page 565 Dialysis Monitoring and Aftercare: "At least four times per day, assess circulation at the access site by auscultating for the presence of bruits and palpating for thrills. Unlike most other circulatory assessments, bruits and thrills should be present here. Lack of a bruit at a venous access site during dialysis may indicate a blood clot requiring immediate surgical attention."

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1. Hemodialysis - Hemodialysis is a treatment for kidney failure that uses a machine to filter your blood outside your body. This information was obtained from: https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis

2. AV shunt - An AV graft is a looped, plastic tube that connects an artery to a vein. This information was obtained from: https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis/vascular-access

3. Bruit and Thrill - A bruit is an audible vascular sound associated with turbulent blood flow. Although usually heard with the stethoscope, such sounds may occasionally also be palpated as a thrill. This information was obtained from: https://www.ncbi.nlm.nih.gov/books/NBK289/

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---

F 758

1. Resident #104 and #109 are currently having non-pharmacological interventions offered and documented related to the use of psychotropic medications.
2. All residents on psychotropic medications have potential to be affected. Center Nurse Executive completed audit of all current residents on psychotropic medications to

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§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 in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide non-pharmacological interventions prior to the administration of anti-anxiety medications for two of 12 residents in

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ensure non-pharmacological interventions were in place and documented per care plan.

3. Nurse Practice Educator provided education to licensed nursing staff related to providing and documenting non-pharmacological interventions and appropriate use of psychotropic medications.

4. Unit Managers to audit documentation of Non-Pharmacological interventions 3 times/week. Results of these audits will be brought before the QAPI Committee monthly for review. 2/23/18

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the survey sample, Residents #104 and #109.

1. The facility staff failed to offer non-pharmacological interventions prior to the administration of Lorazepam for Resident #104.

2. The facility staff failed to offer non-pharmacological interventions prior to the administration of Xanax for Resident #109.

The findings include:

1. Resident #104 was admitted to the facility on 12/4/17 with diagnoses that included but were not limited to: peripheral vascular disease (an abnormal condition of the blood vessels outside the heart) [1], cellulitis of lower limbs, chronic pain, high blood pressure, opioid dependence, and low back pain.

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 1/13/18, coded Resident #104 as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he was capable of making his daily decisions. The resident was coded as requiring limited assistance to supervision of one staff member for most of his activities of daily living.

The physician order dated 1/3/18, documented, "Lorazepam (Ativan) (used to treat anxiety disorders) [2] 1 mg (milligram) PO (by mouth) BID (twice a day) PRN (as needed) for anxiety."

Review of Resident #104's MAR (medication administration record) for January 2018, documented, "Lorazepam (Ativan) 1 mg PO BID PRN for anxiety." The Lorazepam was

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documented as having been given on 1/22/18 at 9:00 p.m., 1/23/18 at 4:00 p.m., 1/25/18 at 5:30 p.m., and 1/26/18 at 4:00 p.m. There was no documentation on the reverse side of the MAR for any of the above doses.

Review of Resident #104's "Behavior Monitoring and Interventions" sheet for January 2018, revealed there was no documentation in the corresponding shift when the Lorazepam was given on 1/22/18 and 1/23/18. On 1/25/18 and 1/26/18, there was no behavior documentation for the entire day.

Review of the nurse's notes for the above dates and times failed to evidence any documentation of any behavior or non-pharmacological interventions attempted prior to the administration of the Lorazepam.

The comprehensive care plan dated, 1/24/18, documented in part, "Resident is at risk for substance abuse (alcohol/drugs) related to a history of addiction related to opioids." The "Intervention" documented in part, "Provide all effective interventions (e.g., non-pharmacologic, pharmacologic) for behaviors and/or psychiatric disorders, including redirection to assist resident/ patient in controlling substance abuse behaviors."

An interview was conducted with LPN (licensed practical nurse) #6 on 2/1/18 at 10:37 a.m., regarding what steps she takes when a resident complains of being anxious or having anxiety. LPN #6 stated, "First I try to find the cause. I check their vital signs and assess how long they have felt this way, check if anything to calm them down before giving the medication." When asked if she attempts anything prior to giving mediation,

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LPN #6 stated, "Yes, I can stay with them, talk to them. Then I check to see if they have any medication for it." When asked where staff document interventions attempted prior to the administration of the medication, LPN #6 stated, "It's in the computer in the nurse's notes." The MAR and nurse's notes for Resident #104 were reviewed with LPN #6 and failed to reveal any documentation for the dates above when the Lorazepam was administered to Resident #104. LPN #6 stated she had only just taken over that hallway the last two days.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 2/1/18 at 11:20 a.m., regarding the process staff follows when a resident complains of being anxious or having anxiety, ASM #2 stated that the nurse should assess the resident, offer alternate interventions and if they don't work, call the doctor to obtain mediations. After medication, the nurse should go back and reassess what effect the medication had on the resident. When asked where the staff document these interventions, ASM #2 stated there is a behavior sheet or the nurse's notes in the computer. The MAR and behavior sheets for Resident #104 were reviewed with ASM #2. ASM #2 agreed there was no documentation of non-pharmacological interventions.

The facility policy, "Behaviors: Management of Symptoms" documented in part, "If the form is being used for patients receiving psychotropic medications including antipsychotics, use of the form will be continued for as long as the patient is taking the medication."

The administrator, director of nursing and

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corporate nurse were made aware of the above findings on 2/1/18 at 12:35 p.m.

No further information was provided prior to exit.

[1] Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 447.
[2] This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details

2. The facility staff failed to offer non-pharmacological interventions prior to the administration of Xanax for Resident #109.

Resident #109 was admitted to the facility on 11/21/17 with a recent readmission on 1/8/18 with diagnoses that included but were not limited to: repeated falls, chronic wounds on the right foot, pain, diabetes, high blood pressure, shortness of breath, and Bipolar disorder (a mental disorder characterized by periods of mania and depression) [1].

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 1/15/18, coded Resident #109 as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring supervision to extensive assistance of one staff member for all of her activities of daily living.

The physician order dated, 1/15/18, documented,

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"Xanax (used to treat anxiety) [2] 0.25 mg (milligrams) tab (tablet) one PO (by mouth) q8h (every 8 hours) PRN (as needed) anxiety."

The MAR (mediation administration record) for January 2018 was reviewed. The MAR documented the resident had received the Xanax eleven times since 1/18/18. Of those eleven times, only four doses were documented on the reverse of the MAR.

A review of the nurse's notes from 1/18/18 through 2/1/18 was conducted. On 1/18/18 at 6:35 a.m. the nurse documented in part, "Resident c/o (complained of) increased anxiety at 6:30 a.m., and attempted to redirect and was not effective and PRN Xanax was given as ordered with effective results.

The nurse's note dated, 1/18/18 at 9:26 p.m. documented in part, "Given as well, Xanax 0.25 mg at 2245 (10:45 p.m.)."

The nurse's note dated, 1/24/18 at 10:00 p.m. documented in part, "Xanax was given at 2200 (10:00 p.m.)." There was no further documentation related to anxiety or the administration of Xanax.

The "Behavior Monitoring and Interventions" sheet for January 2018 was completely blank.

The comprehensive care plan dated, 1/9/18, documented in part, "Resident/patient exhibits or is at risk for distressed/fluctuation mood symptoms related to diagnosis of depression, bipolar disorder and PTSD (post-traumatic stress disorder)." The "Interventions" documented in part, "Encourage resident/patient to seek staff

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support for distressed mood. Refocus resident/patient to something positive. Allow time for expression of feelings; provide empathy, encouragement and reassurance."

An interview was conducted with LPN (licensed practical nurse) #6 on 2/1/18 at 10:37 a.m., regarding what steps she takes when a resident complains of being anxious or having anxiety. LPN #6 stated, "First I try to find the cause. I check their vital signs and assess how long they have felt this way, check if anything to calm them down before giving the medication." When asked if she attempts anything prior to giving mediation, LPN #6 stated, "Yes, I can stay with them, talk to them. Then I check to see if they have any medication for it." When asked where staff document interventions attempted prior to the administration of the medication, LPN #6 stated, "It's in the computer in the nurse's notes." The MAR and nurse's notes for Resident #109 were reviewed with LPN #6 and failed to reveal any further documentation for the dates above when the Xanax was administered to Resident #109. LPN #6 stated she had only just taken over that hallway the last two days.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 2/1/18 at 11:20 a.m., regarding the process staff follows when a resident complains of being anxious or having anxiety, ASM #2 stated that the nurse should assess the resident, offer alternate interventions and if they don't work, call the doctor to obtain mediations. After medication, the nurse should go back and reassess what effect the medication had on the resident. When asked

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where the staff document these interventions, ASM #2 stated there is a behavior sheet or the nurse's notes in the computer. The MAR and behavior sheets for Resident #109 were reviewed with ASM #2. ASM #2 agreed that there was no documentation of non-pharmacological interventions.

The administrator, director of nursing and corporate nurse were made aware of the above findings on 2/1/18 at 12:35 p.m.

No further information was provided prior to exit.

[1] Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 73.
[2] This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008896/?report=details

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

§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.

1. Dietary Services Director labeled and covered the identified pitchers.
2. All residents have potential to be affected. Kitchen is being maintained with food being stored, prepared, distributed and served in accordance with professional standards of food service safety.

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(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§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 document review, it was determined that the facility staff failed to label and store food in a sanitary manner.

The facility staff failed to label three half-gallon pitchers filled with punch and iced tea with the date and facility staff failed to cover three half-gallon pitches of punch and iced tea.

The findings include:

A kitchen observation was conducted on 1/30/18 at 10:40 a.m. with OSM (other staff member) #3, the dietary manager. An observation was made in the main kitchen refrigerator. There were 4 half-gallon pitchers. Two pitchers were full and contained punch and two pitchers were full and contained iced tea. There was no date label on one punch pitcher and two ice tea pitchers. Two of the ice tea pitchers did not have lids and one punch pitcher did not have a lid.

An interview was conducted on 1/30/18 at 10:43 a.m. with OSM #3. When asked if the pitchers should have labels, OSM #3 stated, "Yes." When asked if the pitchers should have lids on them, OSM #3 stated, "Yes."

Review of the facility's policy titled, "Refrigerated / Frozen Storage" documented, "POLICY. Food

{F 812}

3. Dietary staff re-inserviced by the Regional Dietary Manager regarding the storage of food in accordance with professional standards of food service safety.
4. Center Executive Director/designee will audit the kitchen 7 times/week for 6 weeks, and then 2 times/week thereafter, to ensure that food storage is in accordance with professional standards of food service safety. Results of these audits will be brought before the QAPI Committee monthly for review.

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stored under refrigeration/freezer storage are maintained in a safe and sanitary manner. PURPOSE. To prevent damage, spoilage, and contamination of products. PROCESS. 2. Refrigeration 1.4 All foods are labeled with name of product and the date received and "use by" date one opened."

On 1/31/18 at 5:30 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical quality specialist were notified of the findings.

No further information was provided prior to exit.

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{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;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential

{F 842}

1. The orders for daily vital signs and assistance with meals for Resident #101 have been discontinued. Resident #102 is receiving medications per order. Fluid restriction for resident #110 is followed and documented.
2. All residents have a potential to be affected. Audit was completed by nursing leadership by reviewing 24 hour report and eInteract Changes of condition for the past 30 days to ensure that appropriate documentation has

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all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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been completed.

3. Education was provided to the licensed nursing staff by the Nurse Practice Educator regarding on accurate documentation and signing off the MAR when medication is given. Nurse Practice Educator provided 1:1 education with physicians related to accurate documentation.

4. Unit Manager or Shift Supervisor will audit the MARs for incomplete documentation daily. Results of audits will be brought to the QAPI Committee for follow up monthly. 2/23/18

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(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 observation, 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 three of 12 residents in the survey sample, Residents #101, #102, and #110.

1. The facility staff failed to discontinue a physician order that was no longer valid for Resident #101.

2 a. The facility staff failed to document medications had been administered as ordered by the physician for Resident #102.

2 b. The facility staff failed to document accurately that Resident #102 did not have a urinary catheter.

3. The facility staff failed to document medications had been administered to Resident #110 as ordered by the physician.

The findings include:

1. Resident #101 was admitted to the facility on 2/12/13 with a recent readmission on 1/4/17 with diagnoses that included but were not limited to: altered mental status, high blood pressure, gout, osteoporosis, and anxiety disorder.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an

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assessment reference date of 11/3/17, coded Resident #101 as scoring a 10 on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to made cognitive daily decisions. The resident was coded as requiring extensive assistance or being totally dependent upon one or more staff members for all of her activities of daily living. Resident #101 was coded as requiring limited assistance of one staff member for eating. The resident was coded as having limitation in her range of motion on both lower extremities (legs).

Resident #101 was observed for three meals during the survey process. Each time the resident was in bed with the head of her bed elevated. The resident was feeding herself. There was no staff assistance provided.

The physician orders dated, 7/15/17 and signed by the physician on 1/2/18, documented, "Staff to feed resident due to continued poor intake."

The comprehensive care plan dated, 3/11/13 and revised on 1/31/18, documented in part, "Resident is at nutritional risk r/t (related to) h/o (history of) weight loss, FTT (failure to thrive) variable p.o. (by mouth) and assist w/ (with) meals prn (as needed)." The "Interventions" documented in part, "Supervise/cue/assist as needed with meals."

An interview was conducted with CNA (certified nursing assistant) #1 on 1/31/18 at 3:55 p.m. When asked if Resident #101 requires staff feed her, CNA #1 stated, "No."

An interview was conducted with LPN (licensed practical nurse) #3 on 1/31/18 at 3:50 p.m. When

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asked if Resident #101 requires a staff member to feed her, LPN #3 stated, "No."

The physician order was reviewed with LPN #3 on 2/1/18 at 9:45 a.m. When asked if it was a valid order, LPN #3 stated, "Yes, it is, but that order needs to be changed. She no longer needs to have that order. It was put in place when she was losing a lot of weight."

The facility policy, "Clinical Record: Charting and Documentation" documented in part, "Purpose: To provide a complete account of the patient's total stay from admission through discharge, provide information about the patient that will be used in developing a plan of care, and as a tool for measuring the quality of care provided to the patient.

On 2/1/18 at 12:35 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical quality specialist were notified of the above findings.

No further information was provided prior to exit.
2 a. The facility staff failed to document medications had been administered as ordered by the physician for Resident #102.

Resident #102 was admitted to the facility on 3/12/17 and readmitted on 10/3/17 with diagnoses that included but were not limited to: kidney failure requiring hemodialysis (1), diabetes, heart failure and an amputation of the left lower leg.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/28/17 coded the resident as

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having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could do after the tray was prepared. The resident was coded as receiving dialysis.

Review of the physician's orders dated and signed on 1/218 documented:
"COENZYME Q10 GLUTEN-FREE, S/F (sugar free) 200 MG (milligram) CAPSULE, 1 CAP BY MOUTH TWICE DAILY; DIVALPROEX SODIUM 250 MG, 3 TABS (tablets) BY MOUTH TWICE DAILY; VIRT-CAPS 1 MG CAPSULE 1 CAP BY MOUTH TWICE DAILY."

Review of the January 2018 MAR (medication administration record) documented: "COENZYME Q10 (1) GLUTEN-FREE, S/F (sugar free) 200 MG (milligram) CAPSULE, 1 CAP BY MOUTH TWICE DAILY; DIVALPROEX SODIUM (2) 250 MG, 3 TABS (tablets) BY MOUTH TWICE DAILY; VIRT-CAPS (3) 1 MG CAPSULE 1 CAP BY MOUTH TWICE DAILY." Further review of the January 2018 MAR failed to evidence documentation the medications were administered on 1/22/18.

An interview was conducted on 2/1/18 at 9:40 a.m., with LPN (licensed practical nurse) #4, the nurse caring for Resident #102 on 1/22/18. When asked about the process staff follows to document medications administered, LPN #4 stated it (medications) is documented in the MAR. When asked why staff documented medications, LPN #4 stated, "So we know we did them and when they were given." LPN #4 was

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asked to review the 1/22/18 medications on Resident #102's MAR. When asked what the blank spaces meant on 1/22/18, LPN #4 stated, "I just didn't get it signed off."

On 2/1/18 at 12:35 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical quality specialist were made aware of the findings.

Review of the facility's policy titled, "Clinical Record: Charting and Documentation" documented, "POLICY. Only authorized personnel or individuals may provide documentation in the clinical record that shall include the medical plan of treatment, assessment, interventions, responses to care and treatment by multiple health care providers or identification of significant changes, accidents, or unusual occurrences that may impact the patient's physical or emotional well being and the plans for the patient at discharge. PURPOSE. To provide a complete account of the patient's total stay from admission through discharge, provide information about the patient that will be used in developing a plan of care, and as a tool for measuring the quality of care proved to the patient. PROCESS. 3. Be concise, accurate, complete, factual, and objective. 7. Document treatments, medications, vital signs, and weight as required/requested."

No further information was provided prior to exit.

1. Coenzyme Q10 - Coenzyme Q10 (commonly known as CoQ10) is a compound that is made naturally in the body. The body uses it for cell growth and to protect cells from damage that could lead to cancer. This information was

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obtained from:
https://www.cancer.gov/about-cancer/treatment/cam/patient/coenzyme-q10-pdq

2. Divalproex - Depakote is indicated as monotherapy and adjunctive therapy in the treatment of patients with complex partial seizures that occur either in isolation or in association with other types of seizures. This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=08a65cf4-7749-4ceb-6895-8f4805e2b01f

3. Virt-caps - Virt-Caps is an orally administered prescription vitamin B dietary supplement formulated for the dietary management of persons who require increased amounts of folic acid and pyridoxine; it also includes vitamin C. Virt-Caps should be administered under the supervision of a licensed medical practitioner. This information as obtained from:
https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=93ecc6fb-bde7-44b0-be29-7df42b26d6a0

2 b. The facility staff failed to document accurately that Resident #102 did not have a urinary catheter.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/28/17 coded the resident as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating Resident #102 was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living

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except for eating which the resident could do after the tray was prepared. The resident was coded as being occasionally incontinent of urine.

Review of the resident's care plan initiated on 10/13/17 and revised on 1/31/18 documented, "Focus. Resident is at risk for skin breakdown as evidenced by incontinence and limited mobility." Further review of the care plan did not evidence that the resident had a urinary catheter.

Review of the physician's orders dated and signed on 1/2/18 did not evidence documentation that the resident had an order for a urinary catheter.

Review of the January 2018 TAR (treatment administration record) did not evidence documentation that the resident had a urinary catheter.

Review of the 1/30/18 12:00 a.m. physician's progress note documented, "Genitourinary (1): Indwelling foley (urinary catheter) in place."

Review of the 1/31/18 at 7:51 p.m. nurse practitioner's note documented, "Genitourinary: Indwelling foley in place." The nurse practitioner was not available for interview.

An interview was conducted on 2/1/18 at 11:20 a.m. with ASM (administrative staff member) #4, another nurse practitioner. When asked if Resident #102 had a urinary catheter, ASM #4 stated he did not. When asked how the provider staff documented on the medical record, ASM #4 stated some of the information could be auto-populated into the new note from an old note. ASM #4 stated, "If someone hits the wrong

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macro it will pull over the information from the previous visit." When asked to review the 1/30/18 and 1/31/18 progress notes, ASM #4 stated, "That's not correct. It is our responsibility to make sure it's correct."

An interview was conducted on 2/1/18 at 11:35 a.m. with ASM #6, the physician. When asked if Resident #102 had a urinary catheter, ASM #6 stated he did not. When asked to review Resident #102's 1/30/18 progress note, ASM #6 stated, "That's a mistake, he probably had one at some time. We have to edit those notes and correct them. Every 60 days I go around and edit my notes."

On 2/1/18 ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical quality specialist were made aware of the findings.

No further information was obtained prior to exit.

1. Genitourinary -- of, relating to, affecting, or being the organs of reproduction and urination. This information was obtained from: https://www.merriam-webster.com/dictionary/genitourinary#medicalDictionary

3. The facility staff failed to document medications had been administered to Resident #110 as ordered by the physician.

Resident #110 was admitted to the facility on 1/13/17 and readmitted on 9/28/17 with diagnoses that include but are not limited to: kidney failure, heart disease, irregular heartbeat,

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stroke, high blood pressure and diabetes.

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The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 1/15/18 coded the resident as having scored a 9 out of 15 on the brief interview for mental status 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 except for eating which the resident could perform independently after the tray was prepared.

Review of the physician's orders dated and signed on 1/2/18 documented, "10/11/17 -- AMLODIPINE BESYLATE 5mg (milligram) TABLET. 1 TAB (tablet) BY MOUTH EVERY DAY FOR HYPERTENSION (high blood pressure); 10/11/17 ASPIRIN 325MG TABLET. 1 TAB BY MOUTH EVERY DAY FOR HEART HEALTH."

Review of the January 2018 MAR (medication administration record) documented, " AMLODIPINE BESYLATE (1) 5mg TABLET. 1 TAB BY MOUTH EVERY DAY FOR HYPERTENSION (high blood pressure); ASPIRIN 325MG TABLET. 1 TAB BY MOUTH EVERY DAY FOR HEART HEALTH." Further review of the January 2018 MAR did not evidence documentation the medication had been administered on 1/18/18.

An interview was conducted on 2/1/18 at 9:40 a.m., with LPN (licensed practical nurse) #4, the resident's nurse. When asked about the process staff follows to document medication was administered, LPN #4 stated it (medication) is documented in the MAR. When asked why staff

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{F 842}	Continued From page 99 documented medications, LPN #4 stated, "So we know we did them and when they were given." An interview was conducted on 2/1/18 at 9:55 a.m. with LPN #8, the resident's nurse. When asked about the process staff follows to document medication was administered, LPN #8 stated the medication was signed off on the MAR. When asked to review Resident #102's 1/18/18 MAR, LPN #8 stated, "It means I forgot to sign them off." When asked if staff were expected to document the medications administered to residents', LPN #8 stated they were. On 2/1/18 ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical quality specialist were made aware of the findings. No further information was provided prior to exit. 1 Amlodipine besylate -- Amlodipine besylate tablets are indicated for the treatment of hypertension, to lower blood pressure. Lowering blood pressure reduces the risk of fatal and nonfatal cardiovascular events, primarily strokes and myocardial infarctions. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1cec7a02-b7a5-49e1-ab64-3a4dab4149d2	{F 842}		
{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	{F 880}	1. All staff will practice proper contact precaution per facility policy. All staff will practice good handwashing before and after wound care with each	

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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, 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

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demonstrate good handwashing during meal service. All oxygen equipment will be stored appropriately with dates.

2. All residents on precautions have potential to be affected. All residents receiving assistance with meals have potential to be affected. House audit completed of all respiratory supplies storage in resident rooms to ensure appropriate infection control storage is in place.

3. Education was provided to nursing and non-nursing staff by the Nurse Practice Educator or the Nursing Supervisor related to good handwashing practice during meal service, oxygen practice standards and care of oxygen equipment and Isolation precautions. Nurse Practice Educator provided 1:1 training related to Contact Precautions and Infection

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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, facility document review and clinical record review, it was determined that the facility staff failed to maintain infection control practices for three of 12 residents in the survey sample and failed to maintain infection control practices during the dining observation in the Cafe.

1. The facility staff failed to follow infection control practices during a wound care observation for Resident #105. ASM (administrative staff member) #5, the nurse practitioner, failed to wash her hands after removing gloves and failed to remove the isolation gown worn during the measurement of Resident #5's wounds before measuring the roommates wounds.

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Control practices with wound care, with the Nurse Practioner.

4. Unit Managers and Supervisor will audit staff good handwashing practice during meal time 5 times a week for 6 weeks and then randomly thereafter. Unit Managers and Supervisor will perform room rounds and audit respiratory supply storage 5 times a week for 6 weeks and then randomly thereafter to ensure safety. Unit Managers and Supervisor will audit Isolations precautions practice 5 times/week for 6 weeks and then randomly thereafter. Results of audits will be brought to the QAPI Committee for follow up monthly.

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2. The facility staff failed to store respiratory care equipment in a manner to prevent infections for Resident #111.

3. The facility staff failed to follow infection control practices by covering the tip of Resident #107's tube feeding tubing.

4. The facility staff failed to follow infection control practices by not changing gloves or washing their hands appropriately during the dining observation on 1/30/18 and 1/31/18 in the Cafe.

The findings include:

1. Resident #105 was admitted to the facility on 8/9/16 with diagnoses that included but were not limited to: high blood pressure, anemia, history of falls, and has a pacemaker.

The most recent MDS (minimum data set) assessment, a significant change assessment with an assessment reference date of 11/6/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating he was capable of making cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living. In Section M - Skin Conditions, the resident was coded as having one pressure ulcer.

The physician order dated, 1/19/18, documented, "Stool for C-Diff (clostridium difficile). Contact Isolation."

Clostridium difficile is a gram-positive anaerobic bacterium most often associated with

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antibiotic-associated diarrhea. Symptoms may range from asymptomatic carrier states to severe pseudomembranous colitis and are caused by toxins produced by the organism. Although c-difficile infection can be caused by almost any antibiotic that disrupts the intestinal flora, it's classically associated with clindamycin use. Patients at high risk for this disorder include those that are taking many kinds of antibiotics immunosuppressed individuals, and those in nursing homes. C-difficile may be transmitted directly from patient to patient via contaminated hands of facility personnel (most common) or indirectly through contaminated equipment such as bedpans, urinals, call bells, ...and surfaces such as bedrails, floors, and toilet seats ...because spores of c-difficile are resistant to most commonly used facility disinfectants the patients room may be contaminated even after the patient has been discharged. (1)

Observation was made of administrative staff member (ASM) #5, the nurse practitioner, on 1/31/18 at 10:10 a.m. assessing and measuring the wound. ASM #5 put on her disposable gown and gloves. She proceeded to measure Resident #105's wound on his right great toe and his right hip. After she finished measuring the wounds, she removed her gloves. She then put on another pair of gloves. She did not wash her hands. She did not remove her gown. She went to the other side of the room to measure the roommates wound. She proceeded to measure the roommates wound. The CNA (certified nursing assistant) questioned ASM #5 if she need to wash her hands; ASM #5 told the CNA that she just changed her gloves. When asked if she washed her hands between residents, ASM #5 stated that she had not. When asked if she

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should be wearing an isolation gown from measuring Resident #105's wound over to measure the roommate's wounds, ASM #5 did not respond. When asked if the staff should wash their hands with soap and water after caring for a resident with suspected C-Diff, ASM #5 stated, "I don't know if he has it or not. The culture isn't back yet." When asked, if C-Diff is suspected, shouldn't it be treated as if he had it until it is ruled out, ASM #5 stated, "Yes, I guess so."

The facility policy, "Contact Precautions" documented in part, "Policy: In addition to Standard Precautions, Contact Precautions will be used for diseases transmitted by direct or indirect contact with the patient or the patient's environment. 4. Staff must use barrier precautions when entering the room. Wear gown and gloves. Wear eye protection is splashing of infectious material is likely. Change gloves and gowns during care if glove/gowns come in direct contact with infectious materials. Change gown and gloves and perform hand hygiene before provided care to other patient in the room."

The facility policy, "Clostridium Difficile" documented in part, "1. Maintain Contact Precautions for 48 hours after the diarrheal episodes stop, or the patient's stool returned to baseline. 2. Maintain stringent hand washing and explain precautions and proper hand washing to patient and visitor."

The administrator, director of nursing and corporate nurse were made aware of the above findings on 1/31/18 at 5:30 p.m.

No further information was provided prior to exit.

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(1) Springhouse Handbook of Diseases- Causes, Signs and Symptoms, Patient Care- 2007 Springhouse Corporation pages 217-219.

2. The facility staff failed to store respiratory care equipment in a manner to prevent infections for Resident #111.

Resident #111 was admitted to the facility on 1/5/18 with diagnoses that included but were not limited to: stroke, diabetes, high blood pressure, sleep apnea (condition in which the patient has transient periods of apnea during sleep, typically these last less than 30 seconds) [1], depression, and aphasia (the inability to speak or express oneself in writing or to comprehend spoken or written language because of a brain lesion [e.g., the results of a stroke]) [2].

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 1/12/18 coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating that he was capable of making cognitive decisions on a daily basis. Resident #111 was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living except eating in which he only required supervision after set up assistance was provided. In - Section O - Special Treatments, Procedures and Programs, the resident was coded as having used a BiPap/CPAP outside of the facility but was not coded as using a BiPap/CPAP while a resident in the facility. The resident was not coded as receiving oxygen during the lookback

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period.

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C-PAP, Continuous Positive Airway Pressure, is a machine used to assist people who are diagnosed with sleep apnea. A C-Pap machine increased air pressure in the throat so that the airway does not collapse when you breathe in. Bi - PAP, bi-level Positive Airway Pressure, is a machine used to assist people who are diagnosed with sleep apnea. Bi Pap machine can be set for breathing in and breathing out pressure settings. (3)

Observation was made of Resident #111's room on 1/31/18 at 8:20 a.m. The resident was lying in his bed with the head of the bed elevated. His CPAP mask was sitting on top of the nightstand, uncovered. The nebulizer were stored in a bag hanging off the handle of the nightstand. The oxygen tubing was stored in a plastic bag hanging off the oxygen concentrator. The resident's room was observed again on 1/31/18 at 11:20 a.m. and 3:45 p.m.; the CPAP mask was still sitting on the nightstand, uncovered, the nebulizer and oxygen tubing were in a plastic bag.

The comprehensive care plan dated, 1/6/18 documented in part, "Focus: Resident exhibits or is at risk for respiratory complications related to sleep apnea - CPAP/BIPAP." The "Interventions" documented in part, "Will use CPAP. O2 (oxygen) as ordered via nasal cannula."

On 2/1/18 at 8:15 a.m., Resident #111's room was observed with LPN (licensed practical nurse) #3. The CPAP mask and nebulizer was observed to be sitting on top of the nightstand. Neither were in a plastic bag. The plastic bag was

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hanging off the handle of the nightstand drawer. The oxygen concentrator was noted to have a nasal cannula wrapped around the top handle of the concentrator. When asked if he saw anything out of place in the room, LPN #3 stated, "All of the respiratory equipment should be bagged if it's not in use."

The facility policy, "Oxygen: Nasal Cannula" documented in part, "16. Replace entire set-up every seven days. Date and store in treatment bag when not in use." The facility policy, "Bi-Level Positive Airway Pressure (BiPAP/Continuous Positive Airway Pressure (CPAP) including Trilogy" did not address the storage of the equipment when not in use."

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc.; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment."

On 1/31/18 at 5:30 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical quality specialist were made aware of the findings.

No further information was provided prior to exit.

[1] Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 534.
[2] Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 44.
[3] This information was obtained from the following website:

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	495246	A. BUILDING ______ B. WING ______	R-C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT CENTER	11 DAIRY LANE FREDERICKSBURG, VA 22405

(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

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www.webmd.com/sleep-disorders/sleep-apnea.

3. The facility staff failed to follow infection control practices by covering the tip of Resident #107's tube feeding tubing when not in use.

Resident #107 was admitted to the facility on 10/22/15 and readmitted on 4/9/16 with diagnoses that included but were not limited to: stroke, depression, obesity and indigestion.

The most recent MDS, a quarterly assessment, with an ARD of 1/10/18 coded Resident #107 as rarely or never understood and rarely or never understanding. The resident was coded as being severely impaired cognitively. The resident was coded as requiring extensive assistance from staff for all activities of daily living. Resident #107 was coded as receiving tube feedings.

An observation was made on 1/30/18 at 10:40 a.m. of Resident #107. The resident was lying in bed. The tube-feeding pump was next to the bed. The tube feeding bottle was 3/4 full. The tube feeding tubing was hung over the top of the pole with the tubing tip uncovered.

An observation was made on 1/30/18 at 1:20 p.m. of Resident #107. The resident was lying in bed. The tube feeding bottle was 3/4 full. The tube feeding tubing was hanging over the top of the pole with the tubing tip uncovered.

Review of the resident's care plan initiated on 5/10/17 and revised on 10/27/17 documented, "Focus. Resident is at nutritional risk: impaired swallowing fxn (function) related to dysphagia (difficulty swallowing) as evidence (sic) by need

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for nutritional support. Interventions. Provide TF (tube feeding) as ordered."

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Review of the physician's orders dated and signed on 1/2/18 documented, "04/09/16 Jevity (1) 1.5 AT 55ML (milliliters)/HR VIA PEG TUBE X (times) 20 HRS - Downtime 10 AM."

Review of the January 2018 TAR (treatment administration record) documented, "Jevity 1.5 cal (calorie) @ 55 ml/hr x20 hrs. (arrow pointing down) 10 A (a.m.) Down."

An interview was conducted on 1/31/17 at 3:50 p.m. with LPN (licensed practical nurse) #2, the resident's nurse. LPN #2 was asked when Resident #107's tube feeding was to be turned off. LPN #2 stated, "It comes down at 10:00 in the morning." When asked how the tube feeding tubing tip should be treated when the feeding is discontinued, LPN #2 stated, "You cover the tip." When asked why, LPN #2 stated, "Infection control. You don't want to leave it open."

An interview was conducted on 1/31/18 at 4:30 p.m. with RN (registered nurse) #1. When asked what is done to the tip of the feeding tube tubing when it was disconnected from the patient, RN #1 stated, "You put the cap on it." When asked why, RN #1 stated, "For infection control purposes so no bacteria can go up the tubing."

On 1/31/18 at 5:30 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical quality specialist were made aware of the findings.

Review of the facility's policy titled, "Enteral Management" documented, "PURPOSE. To

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provide nutrition when patient is unable to consume food and fluids orally."

No further information was obtained prior to exit.

1. Jevity - High-protein, fiber-fortified formula. Complete, balanced nutrition for long- or short-term tube feeding
For supplemental or sole-source nutrition. This information was provided from:
http://www.medline.com/product/Jevity-12-Cal-Nutritional-Supplement/Nutrients/Z05-PF11290#

4. The facility staff failed to follow infection control practices by not changing gloves or washing their hands appropriately during the dining observation on 1/30/18 and 1/31/18 in the Cafe.

On 1/30/18 at 1:03 p.m., a dining observation was made in the Cafe. OSM (other staff member) #1, the assistant activities staff, was wearing gloves and holding a dessert bowl for a resident while the resident fed himself. OSM #1 then took the bowl and other dirty dishes off the table and placed them in the dirty dish tub on a cart in the cafe. OSM #1 then assisted another resident with dessert and then took the dirty dishes off the table and placed them into the dirty dish tub. OSM #1 then assisted another resident with her utensils by taking the spoon out of the resident's hand and giving her another larger spoon. OSM #1 then wiped her face with her finger. OSM #1 took off her gloves and did not wash her hands. OSM #1 put on another pair of gloves and took a clothing protector off a resident, put the ice tea pitcher on the cart and took the cart out of the cafe. OSM #1 returned to the cafe, removed the gloves and washed her hands.

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On 1/31/18 at 11:58 a.m., a dining observation was made in the cafe. OSM #1 entered the cafe, washed her hands for 5 seconds, and put on a pair of gloves. OSM #1 then put on her glasses and picked up the menus from the counter. She read the menus and then put them down and put her glasses on the top of her head. OSM #1 then took the back of her hand and rubbed under her nose. OSM #1 then refilled a resident's cup by taking the cup, filling it with coffee and then handing the cup back to the resident by holding the cup by the rim. OSM #1 then prepared a resident's plate by chopping up the vegetables and cutting the sandwich." OSM #1 then left the room wearing the gloves and returned in a minute with the gloves off. OSM #1 washed her hands for three seconds. She then put on another pair of gloves and served dessert to all six residents in the cafe by removing the plastic wrap from the top of each bowl. OSM #1's little finger went into the top of one of the resident's dessert, she then served the dessert.

An interview was conducted on 1/31/18 at 1:45 p.m. with ASM (administrative staff member) #3, the clinical quality specialist. When asked what education staff received regarding delivering food, ASM #3 stated, "I would expect they could pass out trays and know the basic infection control processes." When asked if that meant proper glove usage and handwashing, ASM #3 stated, "Yes."

An interview was conducted on 1/31/18 at 1:55 p.m. with OSM #1. When asked if she had received any education on infection control, OSM #1 stated she had. When asked the process staff follow before and after putting on gloves, OSM #1

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stated, "Wash your hands with water and soap for 20 seconds, rinse and dry with paper towels." When asked why staff washed their hands before and after glove use, OSM #1 stated, "It's just that an infection could spread."

On 1/31/18 at 5:30 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the clinical quality specialist were made aware of the findings.

Review of the facility's policy titled, "Hand Hygiene" documented, "POLICY. Adherence to hand hygiene practices is maintained by all Center personnel. This includes hand washing with soap and water....PURPOSE. To improve hand hygiene practices and reduce the transmission of pathogenic microorganisms. PROCESS. 1. Perform hand hygiene: 1.1. Before patient care. 1.4. After patient care. 1.5 After contact with the patient's environment. 2. Hand hygiene techniques: 2.1 To wash hands with soap and water: Wet hands with warm (not hot) water, apply soap to hands, and rub hands vigorously outside the stream of water for 20 seconds; covering all surfaces of the hands and fingers."

No further information was obtained prior to exit.