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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
F 657	Continued From page 154 be: 5.2 Reviewed and revised a minimum of quarterly and as needed to reflect the response to care and changing needs and goals." An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, interim director of nursing, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. No further information was provided prior to the end of the survey process. 2. The facility staff failed to review and revise the comprehensive care plan when Resident #56's code status changed from a full code to a do not resuscitate. Resident #56 was admitted to the facility 12/21/12 with diagnoses that included, but were not limited to; dementia, a gastrostomy (a tube to deliver feeding directly into the stomach), peripheral vascular disease (poor circulation to the legs), high blood pressure, depression, difficulty swallowing, anemia (low red blood cell count), an irregular heartbeat, and difficulty speaking. Resident #56's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/13/2017 coded Resident #56 as being unable to answer the questions on the BIMS (brief interview for mental status) and the staff assessment coded Resident #56 as being severely impaired to make decisions regarding task of daily life. Resident #56 was coded as being dependent with activities of daily living.	F 657		

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F 657	Continued From page 155 A review of Resident # 56's clinical record revealed, in part, a physician's order form dated December 2017 with the following documentation, "1/3/17 YES - ATTEMPT CPR (cardiopulmonary resuscitation). 1/3/17 NO - DO NOT ATTEMPT CPR." A review of Resident #56's comprehensive care plan dated 1/3/17 revealed, in part, the following documentation; "Focus: Resident is Full Code. Date Initiated: 11/14/17. Created on 9/29/2017." Further review of Resident #56's clinical record revealed, in part, a "Resident / Patient Health Care Instructions" form dated 10/30/17 documenting; "Part C. Code Status. No, do not attempt CPR; allow death to occur naturally (DNR [do not resuscitate])." Signed and dated on 10/30/17 by Resident #56's RP (responsible party), a nurse and physician. Further review of Resident #56's clinical record revealed, in part, a Durable Do No Resuscitate Order signed and dated by Resident #56's physician and RP on 10/30/17. On 12/7/17 at 12:30 p.m. an interview was conducted with ASM (administrative staff member) #2, the interim director of nursing (DON). ASM #2 was asked who was responsible for updating the comprehensive care plans. ASM #2 stated the care plans were updated by the MDS coordinator or herself. ASM #2 was asked when a care plan would be updated, ASM #2 stated "Anytime there is a change in condition, a change in therapies or a change in preferences." ASM #2 was asked whether or not Resident #56's care plan should have been reviewed and revised	F 657		

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F 657	Continued From page 156 when the RP and physician signed a durable do not resuscitate and changed Resident #56's status from a full code to a DNR. ASM #2 stated it should have been updated to reflect the correct code status. ASM #2 was asked who was responsible at that time, 10/30/17, for reviewing and revising the care plan. ASM #2 stated the nurse who took the order was responsible. The nurse that signed the documentation on 10/30/17 was not available for interview. An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim DON, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. No further information was provided prior to the end of the survey process. 3. The facility staff failed to review and revise Resident #72's care plan following the 9/27/17, 10/2/17 and 10/11/17 falls. Resident #72 was admitted to the facility on 8/9/16 with diagnoses that included but were not limited to: depression, arthritis and irregular heartbeat. Review of the most recent MDS (minimum data set) a significant change assessment with an ARD (assessment reference date) of 11/6/17 coded the resident as scoring a 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact to make daily decisions. Resident #72 was coded as requiring assistance from staff for all activities of daily living.	F 657		

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F 657	Continued From page 157 Review of Resident #72's clinical record and fall investigation forms documented the resident fell on 922/17, 10/2/17 and 10/11/17. Interventions to prevent future falls were documented on the fall investigation forms. Review of the resident's falls care plan initiated on 8/9/16 and updated on 11/22/17 did not evidence documentation regarding the falls or the recommended interventions documented on the fall investigation forms. An interview was conducted on 12/07/17 at 10:00 a.m. with RN (registered nurse) #2, staff educator. When asked who uses the care plan, RN #2 stated, "Nurses and nurse managers and on the tablets the CNAs (certified nursing assistants) have the plan." When asked why residents had a care plan, RN #2 stated, "So we can have plans specific to each patient and have guidelines for their care." When asked when a care plan would be reviewed and revised, RN #2 stated, "New orders, changes in condition, acute illness, ADLs (activities of daily living), falls, they even get updated for wound issues as well." When asked why the care plans were updated, RN #2 stated, "So that we know what proper interventions to use, not just the nurses but the nurse's aides." RN #2 was asked to review Resident #72's care plan. When asked if there were updates for the resident's falls on 922/17, 10/2/17 and 10/11/17, RN #2 stated, "No updates" When asked if there should be an update, RN #2 stated, "With each fall yeah." An interview was conducted on 12/17/17 at 2:30 p.m. with ASM (administrative staff member) #2, the interim director of nursing. When asked why	F 657		

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F 657	Continued From page 158 residents had care plans, ASM #2 stated, "To provide care for the residents." When asked when care plans would be reviewed and revised, ASM #2 stated, "Any change in condition." When asked if care plans would be updated after a resident fall, ASM #2 stated yes. On 12/7/17 at 4:45 p.m. ASM (administrative staff member) #1, the executive director and ASM #2, the interim director of nursing were made aware of the findings. No further information was provided prior to exit. 4. The facility staff failed to review and revise Resident #62's care plan following the 4/4/17, 4/16/17, 9/9/17 and 10/2/17 falls. Resident #62 was admitted to the facility on 1/24/17 with diagnoses that included but were not limited to: seizures, schizophrenia, high blood pressure, falls and difficulty swallowing. Review of the most recent MDS, a quarterly assessment, with an ARD of 10/18/17 coded Resident #62 as rarely to never being understood or to understand and as having short and long term memory problems. The resident was coded as requiring assistance from staff for all activities of daily living. Review of Resident #62's clinical record and fall investigation forms documented that the resident had fallen on 4/4/17, 4/16/17, 9/9/17 and 10/2/17. Interventions to prevent future falls were documented on the fall investigation forms for each fall.	F 657		

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F 657	Continued From page 159 Review of the resident's fall care plan initiated on 1/30/17 and revised on 5/3/17 did not evidence documentation of the falls or the interventions recommended on the fall investigation forms. An interview was conducted on 12/07/17 at 10:00 a.m. with RN (registered nurse) #2, staff educator. When asked who uses the care plan, RN #2 stated, "Nurses and nurse managers and on the tablets the CNAs (certified nursing assistants) have the plan." When asked why residents had a care plan, RN #2 stated, "So we can have plans specific to each patient and have guidelines for their care." When asked when a care plan would be reviewed and revised, RN #2 stated, "New orders, changes in condition, acute illness, ADLs (activities of daily living), falls, they even get updated for wound issues as well." When asked why the care plans were updated, RN #2 stated, "So that we know what proper interventions to use, not just the nurses but the nurse's aides." RN #2 was asked to review Resident #72's care plan. When asked if there was any documentation of or updates for Resident #62's falls on 4/4/17, 4/16/17, 9/9/17 and 10/2/17, RN #2 stated, "No and no updates" When asked if falls should be on the care plan and if there should be an update, RN #2 stated, "With each fall yeah." An interview was conducted on 12/17/17 at 2:30 p.m. with ASM (administrative staff member) #2, the interim director of nursing. When asked why residents had care plans, ASM #2 stated, "To provide care for the residents." When asked when care plans would be reviewed and revised, ASM #2 stated, "Any change in condition." When asked if care plans would be updated after a resident fall, ASM #2 stated yes.	F 657		

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F 657	Continued From page 160 On 12/7/17 at 4:45 p.m. ASM (administrative staff member) #1, the executive director and ASM #2, the interim director of nursing were made aware of the findings. No further information was provided prior to exit. 5. The facility staff failed to revise the care plan after Resident #19 was discharged from occupational therapy with recommendations for a BRODA chair. Resident #19 was admitted to the facility on 8/25/16 with diagnoses that included but were not limited to anemia, high blood pressure, diabetes mellitus, post stroke with aphasia (difficulty speaking), hemiplegia (paralysis on one side of the body), and Parkinson's Disease. Resident #19's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/20/17. Resident #19 was coded as being cognitively intact in the ability to make daily life decisions scoring 12 out of 15 on the BIMS (brief interview for mental status) exam. Resident #12 was coded as requiring extensive assistance from one staff member with dressing, toileting, and personal hygiene; extensive assistance from two or more staff with bed mobility and limited assistance with bathing. A "7" was coded for "Transfers: How the resident moves between surfaces including to or from bed, chair, wheelchair, standing positon, (excludes to and from bath/toilet)," indicating that the activity only occurred once or twice during the seven day look back period. Review of Resident #19's clinical record revealed	F 657		

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F 657	Continued From page 161	F 657		

that Resident #19 was discharged from occupational therapy on 10/13/17. The following was documented: "Baseline: 9/14/17: Bedbound. Poor positioning with Geri chair for feeding. Impulsive with self-feeding. 10/11/2017: Borrowed tilt in space [1] in repair status. Initiated letter of medical necessity for pt. (patient) to obtain personalized tilt in space. Currently training broda chair with good success...Caregivers inconsistent with seating and positioning schedule ensuring patient is up in broad (sic) chair for lunch...Discharge (10/13/17) Goal met with highest level available with BRODA [2] chair. 20" Tilt to space order submitted. Discharge recommendations: Caregiver support, Equipment recommended upon discharge: All equipment provided by facility as patient is a LTC (long term care) resident."

Review of Resident #19's comprehensive care plan dated 9/2/2016 failed to reveal an intervention for the BRODA chair.

Review of Resident #19's ADL (activities of daily living) task list failed to reveal an intervention or special instructions for the use of a BRODA chair.

On 12/06/17 at 1:40 p.m., an interview was conducted with CNA #8. When asked how CNAs would know the needs of each resident, CNA #8 stated that CNAs can look on the ADL tracker on their tablet. CNA #8 stated that she was not familiar with Resident # 19.

On 12/07/17 at 09:12 a.m., an interview was conducted with OSM (other staff member) #7, the Director of Therapy. OSM #7 stated that Resident #19 was awaiting a specialized chair but the therapy department had issued her a BRODA

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F 657	Continued From page 162 chair for the meantime. On 12/07/17 at 09:20 AM, an interview was conducted with LPN (licensed practical nurse) #2, Resident #19's nurse. When asked the purpose of the care plan, LPN #2 stated that the purpose of the care plan is to tell nursing the needs of each resident. When asked if Resident #19 required a specialized chair, LPN #2 stated, "I'm not aware of that. I would expect to see that on her care plan. Is it a Geri chair? I don't know if she needs a specialized chair." When asked who was responsible for updating the care plan, LPN #2 stated that the MDS nurses were responsible for updating the care plan. LPN #2 confirmed that she could not find an intervention for the BRODA chair. On 12/07/17 at 09:55 a.m., CNA #8 was observed working with Resident #19 that day. When asked if Resident #19 required a specialized chair, CNA #8 stated that she wasn't sure. On 12/07/17 at 09:56 a.m., an interview was conducted with RN (registered nurse) #4. When asked how nurses would know the needs of each resident, RN #4 stated nurses can look at the care plan. When asked if Resident #19 needed a specialized chair, RN #4 stated Resident #19 used a BRODA chair and therapy was assessing her for a new chair. When asked how CNAs would know that Resident #19 needed to use a BRODA chair rather than a regular wheelchair, RN #4 stated that Resident #19 had her name labeled on the chair. RN #4 also stated CNAs would receive this information in a verbal report or they would find a resource to ask. When asked who was responsible for updating the care plan, RN #4 stated that the nurses on the floor or	F 657		

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F 657	Continued From page 163 unit managers can update the care plan for any changes. When asked if her unit (cardinal) unit had a unit manager, RN #4 stated, "No." When asked if Resident #19's BRODA chair should be on her care plan, RN #4 stated that she wouldn't think so. When asked if therapy ever updates the care plan, RN #4 stated that she didn't know about therapy. On 12/07/17 at 8:22 a.m. an interview was conducted with RN (registered nurse) #7, the MDS nurse. RN #7 stated she updates the care plan quarterly, annually and with any significant change. RN #7 stated the floor nurses are responsible for updating the care plan after any episodic issue such as falls etc. When asked if a specialty chair should be placed on the care plan once recommended by therapy, RN #7 stated, "If it is an intervention for therapy, I would update." When asked the purpose of the care plan, RN #7 stated the care plan served as a guide to determine the resident's needs. When asked if it was important to ensure the care plan was accurate, RN #7 stated, "Yes, it's important." RN #7 stated the therapy department does not update the care plans. On 12/07/17 at 4:45 p.m., ASM #1, the executive director, ASM #2, the interim DON (Director of Nursing) and ASM #3, the clinical quality specialist were made aware of the above concerns. No further information was presented prior to exit. [1] Tilt to Space wheelchair "helps to facilitate feeding and respiratory function, reduce pressure beneath the pelvis, and improve visual alignment	F 657		

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F 686	Continued From page 233	F 686		

administration record) revealed that nursing was not documenting that the heel boots to Resident #19's feet were in place. The order was written on the TAR as an FYI (For Your Information).

Review of the ADLs (activities of daily living) tracker revealed an instruction for soft heels to Resident #19's heels.

On 12/06/17 at 11:30 a.m. an interview was conducted with LPN (licensed practical nurse) #8. When asked how CNAs (certified nursing assitant) would know what skin preventive measures to put into place for each resident, LPN #8 stated when the nurse puts the skin intervention on the care plan and places it into the computer, the nursing aides should be able to see/view this intervention under the ADLs (activities of daily living) section of the computer.

On 12/06/17 at 1:40 p.m., an interview was conducted with CNA #8. When asked how CNAs would know the needs of each resident, CNA #8 stated that CNAs can look on the ADL tracker on their tablet. CNA #8 stated that she was not familiar with Resident # 19 and could not determine what she needed in place for skin preventive measures.

On 12/06/17 at 2:10 p.m., an interview with CNA #10, Resident #19's CNA. When asked how CNAs would know what skin preventive measures to put into place for each resident, CNA #10 stated that she would look in the residents' closet and instructions for anything to be put into place should be listed in the closet. When asked what skin preventive measures should be put into place for Resident # 19, CNA #10 stated that she does not normally work with

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F 686	Continued From page 232 or more staff with bed mobility and limited assistance with bathing. On 12/04/17 at 11:46 a.m. an observation was made of Resident #19. Resident #19 was sleeping in bed. A soft heel boot was observed in her chair. On 12/04/17 at 12:23 p.m. an observation was made of Resident #19. Resident #19 was lying in bed. A CNA (certified nursing assistant) entered her room to deliver her lunch tray. A soft heel boot was observed on the chair beside her bed. On 12/06/17 at 09:03 a.m., an observation was made of Resident #19. She was lying in bed asleep. One soft heel boot was observed on the chair next to her bed. On 12/06/17 10:37 a.m., an observation was made of Resident #19. She was lying in bed. She did not have a soft heel boot in place to her right foot. Resident #19 stated her heel boot had not been on her right foot. The heel boot was observed in the chair next to her bed. Review of Resident #19's POS (physician order sheet) dated 12/4/17 documented the following order: "Soft heel boots when in bed for skin integrity." This order was initiated on 8/25/16. Review of Resident #19's comprehensive skin care plan dated 9/22/16 documented the following: "Resident is at risk for skin breakdown as evidenced by incontinence, limited mobility, moisture/excessive perspiration...Interventions: Soft heel boots as ordered." Review of the December 2017 TAR (Treatment	F 686		

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F 686	Continued From page 231 information was obtained from the website: https://www.santyl.com/ (3) Silicone dressing is a specialized type of dressing containing silicone. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/27802960 (4) Medi honey is a specialized medical honey used to treat wounds. This information was obtained from the website: http://outside-us.dermasciences.com/medihoney (5) Allevyn dressing is a foam dressing. This information was obtained from the website: http://www.smith-nephew.com/key-products/advanced-wound-management/allevyn/allevyn-adhesive/ 2. The facility staff failed to implement pressure prevention measures and ensure Resident #19's right heel boot was in place to her right heel while she was in bed. Resident #19 was admitted to the facility on 8/25/16 with diagnoses that included but were not limited to: anemia, high blood pressure, diabetes mellitus, post stroke with aphasia (difficulty speaking), hemiplegia (paralysis on one side of the body), and Parkinson's Disease. Resident #19's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/20/17. Resident #19 was coded as being cognitively intact in the ability to make daily life decisions scoring 12 out of 15 on the BIMS (brief interview for mental status) exam. Resident #12 was coded as requiring extensive assistance from one staff member with dressing, toileting, and personal hygiene; extensive assistance from two	F 686		

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F 686	Continued From page 230 eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions." This information was obtained from the website: http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/ (2) "SANTYL Ointment is an FDA (Federal Drug Administration)-approved prescription medicine that removes dead tissue from wounds so they can start to heal. Proper wound care management is important to help remove nonliving tissue from your wound properly..." This	F 686		

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F 686	Continued From page 229 present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or	F 686		

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F 686	Continued From page 228 (http://www.npuap.org/resources/educational-and-clinical-resources/pressure-injury-staging-illustrations/). The updated staging system includes the following definitions: Pressure Injury: A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not	F 686		

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F 686	Continued From page 227 pre-admission information to plan for patient's needs prior to admission. 2. Complete comprehensive evaluation of the patient upon admission/re-admission to the Center. 3. Identify patient's skin integrity status and need for prevention intervention or treatment modalities through review of all appropriate assessment information. 3.1 Include all patients who have newly identified skin impairments on the Center's 24-Hour Summary Report. 3.2 Perform skin inspection on admission/re-admission and weekly. Document on Treatment Administration Record (TAR) or in (name of computer program). 3.3 Perform wound observations and measurements and complete Skin Integrity Report upon initial identification of altered skin integrity, weekly, and with anticipated decline of wound. 3.4 Perform daily monitoring of wounds or dressings for presence of complications or declines and document. 4. Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated...4.7 Implement Special Wound Care treatments/techniques, as indicated and ordered...Review care plan weekly and revise as indicated..." No further information was presented prior to exit. (1) "Pressure injuries are staged to indicate the extent of tissue damage. The stages were revised based on questions received by NPUAP (National Pressure Ulcer Advisory Panel) from clinicians attempting to diagnose and identify the stage of pressure injuries. Schematic artwork for each of the stages of pressure injury was also revised and will be available for use at no cost through the NPUAP website in approximately 12-24 hours	F 686		

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F 686	Continued From page 226 various days. RN #1 stated, "I would assume it was not done. There is always calling the nurses to verify but typically if you don't see it, it's not done." Review of nurses' notes for the above dates that treatment was not documented on the TARs (and not completed by PT) failed to reveal documentation that treatment was implemented except on the following dates: -10/30/17- "Medications and treatments administered as ordered..." -11/6/17- "Treatment to Left buttock and Right inner calf redness continued as ordered..." -11/7/17- "Treatment to Left buttock and Right inner calf redness continued as ordered..." Also note- Resident #47 was sent to the hospital on 11/11/17 but returned the same day. On 12/6/17 at 2:18 p.m. a telephone interview was conducted with ASM (administrative staff member) #4 (the nurse practitioner who gave the verbal dressing order on 10/28/17). ASM #4 was read the verbal order and asked to clarify the type of dressing she wanted ordered. ASM #4 confirmed she wanted a silicone dressing. On 12/6/17 at 5:45 p.m. ASM #1 (the executive director), ASM #2 (the interim director of nursing) and ASM #3 (the clinical quality specialist) were made aware of the above concerns. The facility policy titled, "Skin Integrity Management" documented, "PURPOSE: To provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of all wounds. PRACTICE STANDARDS: 1. Review	F 686		

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F 686	Continued From page 225	F 686		

cleft with NS wound flush, apply santyl to wound bed and cover (with) dressing Q (every) Day & PRN (as needed)." RN #1 was asked what elements should a wound dressing order contain. RN #1 stated the order should specify the type of wound cleanser, what to apply if any medication or ointment is to be used, the dressing and the frequency of the dressing change. RN #1 was asked if the order should specify the type of dressing. RN #1 stated she was not sure if the policy specifies the exact type of dressing to be used but she has seen orders for specific dressings and orders for generalized dressings. RN #1 was asked how staff would know what type of dressing to apply if the order only documented "dressing" and did not specify the type. RN #1 stated the facility has multiple types of dry dressings and unless the physician specifies the type of dressing, the nurses use the dressing that looks applicable for the wound. RN #1 stated she would assume another nurse would use her discretion and "see what's in the cart or supply room." RN #1 was asked if the physician's order should specify the type of dressing to be used. RN #1 stated, "No. They usually say dry dressing. If they want something specific like allevyn they will say." RN #1 was asked what was to stop an unfamiliar nurse from using any type of dressing. RN #1 stated, "Nothing. There is no way to specify if they write dry dressing." RN #1 was asked how nurses evidence treatments are completed and stated the treatments are documented on the treatment record. When asked if the nurses' initials indicate the treatment was completed, RN #1 stated, "Yes. If it's not on the TAR, then sometimes it may be documented in the nurses' notes." RN #1 was asked what it meant if this surveyor could not find documentation of treatments being done on

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F 686	Continued From page 224 stage 3 ulcer- Ordered NS wound flush; Santyl ointment & silicone dressing qd." Resident #43 was transferred to the hospital on 11/15/17. Resident #43's comprehensive care plan initiated on 10/27/17 documented, "Focus: Resident is at risk for skin breakdown as evidenced by limited mobility, incontinence...Interventions: Assist resident in repositioning q 2 hrs (hours). Monitor skin for signs/symptoms of skin breakdown. Pressure redistribution surfaces to bed as per protocol, Pressure redistribution surfaces to Chair as per protocol...Focus: Resident has actual skin breakdown natal cleft related to incontinence, limited mobility...Interventions: Provide wound treatment as ordered. Skin check per policy..." The care plan failed to document information regarding the acquired pressure injuries. On 12/6/17 at 12:08 p.m. an interview was conducted with RN (registered nurse) #1. RN #1 was asked what the facility process is to ensure treatment is initiated for residents who are admitted with pressure injuries. RN #1 stated, "The admitting nurse does the skin assessment and with any impairment found the nurse contacts the provider to receive a treatment order or if the provider is in house they assess and order the treatment. The nurse documents the wound on the pressure injury tracking form and makes sure the care plan reflects the wound." RN #1 was asked how long should it take to obtain a treatment order for a new admission with a pressure injury. RN #1 stated, "As soon as the assessment is done and no later than the end of the shift." RN #1 was shown the treatment order dated 10/28/17 that documented, "Cleanse natal	F 686		

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F 686	Continued From page 223 buttock and right inner calf dated 11/5/17 remained documented as requiring medi honey and an allevyn dressing. On 11/11/17 (Saturday) and 11/12/17 (Sunday) the nurse failed to sign off treatment to the right lower buttock. On 11/11/17 the nurse signed off treatment of medi honey and an allevyn dressing to the left buttock and right inner calf. On 11/12/17 the nurse failed to sign off treatment to the left buttock and right inner calf. A nurse practitioner note signed on 11/15/17 documented, "Skin: Natal cleft IAD turned stage 3 ulcer- 4.5x3.5 cm, 100% slough, no odor, larger w/ increased slough & from 6-12 o'clock when pushed against has a very foul smelling dark red/brown/green drainage of a moderate to large amount. R. inner calfe (sic.) stage 2 turning into stage 3 ulcer- 9.5x5x0 cm w/ 90% slough, flat. L. inner calfe (sic.) stage 3 ulcer- 3x5.5 cm, 90% slough. L. sacral 2 stage 3 ulcers combined into one: 9x6 cm, 100% slough. L. heel suspected DTI- 2x4 cm, closed light red/purple bruise...Plan: 1. Wounds: Natal cleft IAD turned stage 3 ulcer- Continue NS wound flush, Santyl ointment & silicone dressg (dressing) qd, however d/t (due to) the amount of fluid obtained upon palpation obtained wound culture and am sending to the hospital for r/o (rule out) sepsis w/ evaluation for I&D (incision and drainage) of sacral wound. Report called to the ER (emergency room) charge nurse. R. inner calfe (sic) stage 2 turning into stage 3 ulcer- Continue NS wound flush, Santyl ointment & silicone dressg qd. L. sacral 2 stage 3 ulcers combined into one ulcer: Continue NS wound flush, Santyl ointment & silicone dressg qd. L. heel suspected DTI (deep tissue injury) (1)- PT to perform CPI (a treatment modality) M-F (Monday through Friday) & sure prep (protectant wipes) q shift. L. inner thigh	F 686		

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F 686	Continued From page 222 5x4 cm w/ 75% clough (sic), #2- 1cm in diameter w/ 100% slough. L. heel suspected DTI (deep tissue injury)- 3.5x8 cm, closed light red/purple bruise...Plan: 1. Wounds: Natal cleft IAD turned stage 3 ulcer- DC'd (Discontinued) previous treatment orders & changed to NS wound flush, Santyl ointment & silicone dressg (dressing) qd. R. lower buttock stage 2 ulcer- DC'd previous treatment orders & changed to NS wound flush, Santyl ointment & silicone dressg qd. R. inner calfe (sic.) stage 2 turning into stage 3 ulcer- DC'd previous treatment orders & changed to NS wound flush, Santyl ointment & silicone dressg qd. L. sacral 2 stage 3 ulcers: DC'd previous treatment orders & changed to NS wound flush, Santyl ointment & silicone dressg qd..." The note further documented for PT to treat the wounds Monday through Friday. A physician's order dated 11/8/17 documented, "(Change) tx's (treatments) to R calfe (sic), R post. (posterior) thigh, natal cleft & L sacral to NS wound flush, santyl ointment & allevyn life dsg (dressing) qd." Another physician's order dated 11/9/17 documented an order for physical therapy clarification and for physical therapy to perform ultrasound mist, santyl and an allevyn life dressing to the above pressure injuries Monday through Friday and for nursing to perform treatment with santyl Saturdays and Sundays. Review of PT notes revealed the treatments were completed as prescribed on 11/8/17, 11/9/17, 11/10/17, 11/13/17 and 11/14/17. However, the above physician's order was not transcribed onto the November 2017 TAR. The treatment order for the natal cleft dated 10/28/17 remained documented as requiring santyl and a dressing (not specified as a silicone dressing) and the treatment orders for the right lower buttock, left	F 686		

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F 686	Continued From page 221 check was performed. The following New skin injury/wound(s) were identified: Other Wound(s): Location(s): rt (right) inner calf, rt lower buttock, left buttock. The following skin injury/wound(s) were previously identified and were evaluated as follows: Other Wound(s): Location(s): Rt buttock, santyl and dressing daily. A physician's order dated 11/5/17 documented, "Cleanse new wounds to left buttock, rt lower buttock & rt inner calf (with) wound cleanser- Apply medi honey (4) & Allevyn (5) dressing daily." Resident #47's November 2017 TAR failed to reveal evidence of treatment to the right lower buttock was completed as prescribed. The section for 11/6/17 and 11/7/17 was blank. The next assessment of Resident #47's pressure injury was a progress note signed by the nurse practitioner on 11/6/17. The note documented, "Natal cleft IAD- 2.7x0.5cm, 50% slough, no odor. R. (Right) lower buttock stage 2 ulcer- 2x1 cm, granulation. R. inner calfe (sic) stage 2 ulcer- 5x3 cm. R. hip 3 new ulcers of stage 2: 1.1.5x0.5 cm, 2. 4.5 cm in diameter, & 3. 2.5x1 cm, all granulated...Plan Multiple new ulcers noted by nursing Sunday pm. Ordered NS wound flush, Medi honey gel & silicone dressings qd (every day). Wound rounds on Wednesdays." A nurse practitioner note signed on 11/8/17 documented, "Skin: Natal cleft IAD turned stage 3 ulcer- 4.5x2.5cm, 75% slough, no odor, larger w/ (with) increased slough. R. lower buttock stage 2 ulcer- 1x0.5 cm, granulation. R. inner calfe (sic) stage 2 turning into stage 3 ulcer- 8.5x4 cm w/ 40% slough, flat. R hip 3 new ulcers of stage 2 previously reported per nursing, none noted upon assessment. L (left). sacral 2 stage 3 ulcers: #1-	F 686		

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F 686	Continued From page 220	F 686		

Day & PRN." Although the date on the TAR was documented as 10/26/17, a line with an arrow was drawn to indicate the beginning of treatment on 10/28/17 and there was no physician order in the clinical record documented until 10/28/17. Also, further review of the TAR failed to reveal evidence this treatment was completed as prescribed. All sections for the dates from 10/26/17 through 10/31/17 were blank and did not contain signed initials to indicate the treatment was done except for what appeared to be a "z" documented between the dates of 10/28/17 and 10/29/17.

The next assessment of Resident #47's pressure injury was a progress note signed by the nurse practitioner on 11/1/17. The note documented, "Natal cleft IAD (incontinence associated dermatitis)- 2.7x0.5 cm (centimeters), 50% slough, no odor...Plan Natal cleft stage 3 pressure ulcer- Continue NS wound flush, Santyl ointment & silicone dressing qd."

Resident #47's November 2017 TAR documented the same above physician's order. Review of this TAR failed to reveal evidence this treatment was completed as prescribed. The section for 11/1/17 was blank; the section for either 11/2/17 or 11/3/17 was blank (there was an initial signed in between the sections) and the sections for 11/6/17 and 11/7/17 were blank. (Note- PT [physical therapy] took over treatment of wound care per physician's order on 11/8/17 and no concerns were identified).

A Braden scale for predicting pressure injury risk dated 11/2/17 documented mild risk.

A nurse's note dated 11/5/17 documented, "A skin

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F 686	Continued From page 219 as moderately impaired. Section G coded Resident #47 as being totally dependent of two or more staff with transfers, and as requiring extensive assistance of two or more staff with bed mobility, dressing and personal hygiene. Section M documented Resident #47 presented with one stage three pressure injury (1), one unstageable pressure injury with slough and/or eschar (1) and two unstageable deep tissue pressure injuries (1). Review of Resident #47's clinical record revealed a nurse's note dated 10/26/17 that documented, "A skin check was performed. The following skin injury/wound(s) were previously identified and were evaluated as follows: Pressure Area(s): Location(s) coccyx (tail bone)." The note did not document any description of the pressure injury and the clinical record failed to reveal any physician's orders for the treatment of the wound. The next assessment of Resident #47's pressure injury was a progress note signed by the nurse practitioner on 10/28/17. The note documented, "Natal cleft (crease between the buttocks) stage 3 pressure ulcer (injury) (1)- Ordered NS (normal saline) wound flush, Santyl ointment (2) & silicone dressing (3) qd (every day)." A physician's verbal order dated 10/28/17 documented, "Cleanse natal cleft with NS wound flush, apply santyl to wound bed and cover (with) dressing Q (every) Day & PRN (as needed)." The order did not specify the type of dressing. Resident #47's October 2017 TAR (treatment administration record) documented, "10/26/17- Cleanse natal cleft (with) NS wound flush, apply santyl to wound bed & cover (with) dressing Q	F 686		

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F 686	Continued From page 218 survey sample, Residents #47 and #19. 1. Resident #47 was admitted to the facility on 10/26/17 with a pressure injury. The facility staff failed to implement treatment for the wound until 10/28/17. On 10/28/17 when a treatment order was obtained, the staff failed to clarify the type of dressing that was needed. Also, the facility staff failed to implement treatment per physician's orders for the pressure injury and other acquired pressure injuries on multiple occasions until the resident was hospitalized on 11/15/17. 2. The facility staff failed to implement pressure prevention measures and ensure Resident #19's right heel boot was in place to her right heel while she was in bed. The findings include: 1. Resident #47 was admitted to the facility on 10/26/17 with a pressure injury. The facility staff failed to implement treatment for the wound until 10/28/17. On 10/28/17 when a treatment order was obtained, the staff failed to clarify the type of dressing that was needed. Also, the facility staff failed to implement treatment per physician's orders for the pressure injury and other acquired pressure injuries on multiple occasions until the resident was hospitalized on 11/15/17. Resident #47 was admitted to the facility on 10/26/17 and readmitted on 11/22/17. Resident #47's diagnoses included but were not limited to: diabetes, chronic kidney disease and adult failure to thrive. Resident #47's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 11/29/17, coded the resident's cognition	F 686	Skin Management Program, to include process upon identification of a new skin concern , obtaining treatment, carrying out the treatment order and documentation and monitoring. Education was provide to the Nursing Staff by the Nurse Practice Educator regarding Skin Management System to include prevention measures as appropriate. Skin Sweep of all current residents completed by Supervisors and Unit Managers to identify any other skin concerns. 4. Treatment/Wound Nurse will audit 24 hour report, eInteract Change of Conditions and Incident Reporting 3 X week to ensure that any new skin concerns get addressed timely with appropriate treatments. Treatment/Wound Nurse will also audit the TARs 3 X week to ensure that ordered treatments are being carried out accordingly. Unit Managers will audit residents at risk for skin breakdown 3 X week for 6 weeks and randomly thereafter to ensure that interventions are in place as appropriate. Results of these audits will be brought before the QAPI Committee monthly for review.	1/17/18

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F 684	Continued From page 217 Information obtained from https://www.radiologyinfo.org/en/info.cfm?pg=vasc_access [3] Minocycline is used to treat infections caused by bacteria including pneumonia and other respiratory tract infections; certain infections of the skin, eye, lymphatic, intestinal, genital, and urinary systems; and certain other infections that are spread by ticks, lice, mites, and infected animals. Information obtained from https://medlineplus.gov/druginfo/meds/a682101.html	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide treatment to promote the healing of pressure injuries for two of 29 residents in the	F 686	1. Resident # 47 has expired. Resident # 19 has their heel boot applied per order. 2. All residents at risk for pressure ulcers and those with pressure ulcers have potential to be affected. An audit was completed by Unit Managers of all current residents with pressure ulcers to ensure that their treatments are in place and appropriate. An audit was completed of all residents at risk for skin breakdown according to their Braden Scores, to ensure that interventions are in place as appropriate. 3. Education was provided to the Licensed Nursing Staff by the Nurse Practice Educator on the	

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F 684	Continued From page 216 [1] MRSA stands for methicillin-resistant Staphylococcus aureus. It causes a staph infection that is resistant to several common antibiotics. There are two types of infection. Hospital-associated MRSA happens to people in health care settings. Community-associated MRSA happens to people who have close skin-to-skin contact with others, such as athletes involved in football and wrestling. Infection control is key to stopping MRSA in hospitals. To prevent community-associated MRSA *Practice good hygiene *Keep cuts and scrapes clean and covered with a bandage until healed *Avoid contact with other people's wounds or bandages *Avoid sharing personal items, such as towels, washcloths, razors, or clothes *Wash soiled sheets, towels, and clothes in hot water with bleach and dry in a hot dryer If a wound appears to be infected, see a health care provider. Treatments may include draining the infection and antibiotics. Information obtained from https://medlineplus.gov/mrsa.html [2] PICC stands for peripherally inserted central catheter. A long catheter that extends from an arm or leg vein into the largest vein (superior vena cava or inferior vena cava) near the heart and typically provides central IV access for several weeks. Unlike a standard intravenous catheter (IV) which is for short term use, a PICC is more durable and does not easily become blocked or infected. It may remain in place for several months so that blood can be repeatedly drawn or medication and nutrients can be routinely injected into the patient's bloodstream.	F 684		

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F 684	Continued From page 215 A review of the clinical record revealed the "Discharge Medication List" from the hospital, undated, which documented an order for Minocycline [3] 100 mg (milligrams) twice daily by mouth. A review of the admission orders revealed this medication was also documented on the facility admission orders dated 12/4/17. A review of Resident #234's December 2017 MAR (Medication Administration Record) on 12/7/17 at 04:00 p.m., revealed that the Minocycline was not administered until 9:00 p.m. on 12/6/17. The resident had missed 4 doses of the medication since admission. A review of the pharmacy delivery manifest revealed that the Minocycline was filled on 12/4/17 but was not delivered to the facility until 12/5/17 at 5:48 p.m. (See F755). The resident went over 24 hours without the medication after it was delivered and therefore missed 2 doses after the medication arrived that should have been administered since the medication was available. A review of the facility policy "Medication Shortages/Drugs Not Available" did not document ensuring administration of the medication once it has been delivered. On 12/8/17 at 10:14 a.m., ASM #2 (Administrative Staff Member - the director of nursing) and ASM #3 (the corporate Clinical Quality Specialist) were made aware of the findings; and on 12/8/17 at 10:50 a.m., ASM #1 (the Administrator), was made aware of the findings. No further information was provided by the end of the survey.	F 684		

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F 684	Continued From page 214 (1) Gabapentin us used to treat seizures and nerve pain. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b11dbff5-ceee-4a63-a093-f6efebdc2f6f (2) Advair diskus is used to treat asthma. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=4eeb5f6a-593f-4a9e-9692-adefa2caf8fc 4. The facility staff failed to administer a physician-ordered medication that was available for Resident #234. Resident #234 was admitted to the facility on 12/4/17 with the diagnoses of but not limited to: MRSA (methicillin-resistant Staphylococcus aureus) [1] in a wound, Chronic Obstructive Pulmonary Disease, chronic back pain, scoliosis, opiate addiction, chronic pain syndrome, and aortic valve endocarditis. An MDS (minimum data set) assessment had not yet been completed. A review of the admission nursing assessment dated 12/4/17 documented the resident as being cognitively intact. The resident was documented as being able to participate in activities of daily living. The resident was also documented as having a PICC (peripherally inserted central catheter) [2] line and requiring oxygen therapy. On 12/07/17 at 03:30 p.m., LPN #7 (Licensed Practical Nurse) reported to the survey team that Resident # 234 was a new admission on 12/4/17 and that a physician-ordered medication had not been available for administration since admission.	F 684		

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F 684	Continued From page 213 stated once a resident is readmitted to the facility, she writes out the medication orders and faxes the orders to the pharmacy. LPN #4 stated the pharmacy usually delivers the medications by the night of admission but this depends on what time the medication list is faxed to the pharmacy. LPN #4 stated she also uses the Omni cell but the Omni cell does not contain all medications. LPN #4 stated if scheduled medications aren't in the Omni cell and haven't been delivered by the pharmacy then she calls the physician. On 12/7/17 at 2:23 p.m. ASM (administrative staff member) #1 (the executive director), ASM #2 (the interim director of nursing) and ASM #3 (the clinical quality specialist) were made aware of the above concern. The facility policy titled, "Medication Shortages/Drugs Not Available" documented, "When medication orders are not received or unavailable, the licensed nurse will immediately initiate action in cooperation with the attending physician and the pharmacy provider. All medication orders unavailable to the patient will be managed with urgency...If a medication shortage is discovered during normal pharmacy hours: 2.1 A licensed nurse calls the pharmacy and speaks to a registered pharmacist to determine the status of the order. If not ordered, place the order or re-order to be sent with the next scheduled delivery. 2.2. If the next available delivery causes delay or missed dose in the patient's medication schedule, take the medication from the emergency stock supply to administer the dose..." No further information was presented prior to exit.	F 684		

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F 684	Continued From page 212	F 684		

readmission. LPN #6 stated nurses should review the MARs and make sure they match the admission medication list and physician's orders. LPN #6 stated if the medications are not available then nurses should let the supervisor know and call the pharmacy so the medications will be delivered on the next pharmacy run. LPN #6 stated the pharmacy delivers medications in the afternoon and late at night. LPN #6 stated many medications can also be obtained from the facility Omni cell (STAT box). LPN #6 was asked what is meant by circled initials on the MAR. LPN #6 stated it usually means the resident refused the medication, the medication was not in the facility or the resident was not in the facility. LPN #6 was made aware she initialed and circled medications that were supposed to be administered to Resident #83 during the evening of 11/3/17 in addition to the day shift nurse initialing and circling medications. LPN #6 stated she assumed the resident was out of the facility. LPN #6 was made aware there was no documentation to evidence Resident #83 was out of the facility on 11/3/17. LPN #6 stated there could have been an order to hold medications because the resident may have been scheduled to go out for a procedure. LPN #6 was made aware there was no order to hold medications. LPN #6 stated, "I'm not sure. Those are the only things I remember."

On 12/7/17 at 11:24 a.m. an interview was conducted with LPN #4 (the nurse responsible for administering the 9:00 a.m. and 1:00 p.m. medications to Resident #83 on 11/3/17). LPN #4 was asked what is done with a resident's medications if the resident is sent to the hospital. LPN #4 stated she waits to see if the resident is admitted to the hospital and once admitted, she returns the medications to the pharmacy. LPN #4

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F 684	Continued From page 211 facility until 11/3/17 at 11:18 p.m.; however, review of the facility STAT (immediate) box (a box containing various medications that can be accessed if a resident's medications have not been delivered) inventory list revealed gabapentin and Advair diskus were available and could be administered per the prescribed order. Further review of Resident #83's clinical record (including nurses' notes and a leave of absence form) failed to reveal Resident #83 was out of the facility on 11/3/17. Note- LPN (licensed practical nurse) #4 did document "LOA" (leave of absence) under a medication that was scheduled at 9:00 a.m.; however, an interview with that nurse on 12/8/17 at 9:07 a.m. revealed she accidentally wrote "LOA." LPN #4 confirmed Resident #83 was in the facility on 11/3/17. Resident #83's comprehensive care plan revised on 11/6/17 documented, "Focus: Resident exhibits or is at risk for alterations in comfort...Interventions: Medicate resident as ordered for pain...Focus: Resident exhibits or is at risk for respiratory complications related to Asthma...Interventions: Administer aerosol as ordered/indicated..." On 12/4/17 at approximately 2:14 p.m. an interview was conducted with Resident #83. The resident stated she did not get her medications for 24 hours after coming back from hospital. On 12/7/17 at 10:23 a.m. a telephone interview was conducted with LPN #6 (the nurse responsible for administering the 9:00 p.m. dose of Advair diskus to Resident #83 on 11/3/17). LPN #6 was asked what should be done to ensure residents receive their medications upon	F 684		

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F 684	Continued From page 210 following website: https://medlineplus.gov/pulmonaryfibrosis.html. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; pages 281 and 285. 3. The facility staff failed to administer Resident #83's medications per physician's orders on 11/3/17. Resident #83 was admitted to the facility on 9/24/17 and readmitted on 11/2/17. Resident #83's diagnoses included but were not limited to: pain in the right knee, muscle weakness and high blood pressure. Resident #83's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 11/28/17, coded the resident as cognitively intact. Review of Resident #83's clinical record revealed the following readmission orders dated 11/2/17: -gabapentin (1) 600 mg (milligrams) three times a day -Advair diskus (2) 250 micrograms/50 micrograms- one puff twice daily Review of Resident #83's November 2017 MAR (medication administration record) revealed the resident was not administered the scheduled doses of gabapentin on 11/3/17 at 9:00 a.m. and 1:00 p.m. and was not administered the scheduled doses of Advair diskus on 11/3/17 at 9:00 a.m. and 9:00 p.m. as evidenced by the nurses circling their initials on the MAR. The back of the MAR documented "11/3/17 9AM NO AM Meds given. NP (Nurse practitioner) aware." A pharmacy manifest dated 11/3/17 revealed the above medications were not delivered to the	F 684		

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F 684	Continued From page 209 not documented it's not done." An interview was conducted with LPN #3 on 12/7/17 at 10:28 a.m. Resident #184's December 2017 MAR was reviewed with the 12/1/17 physician order for the Accuchecks. When asked what the blanks on the MAR for the scheduled Accucheck times meant, LPN #4 stated, "It's not done. If it's not documented, it's not done." Administrative staff member (ASM) #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, clinical quality specialist, were made aware of the above concern on 12/7/17 at 4:45 p.m. On 12/7/17 at 3:00 p.m. ASM #3 informed this surveyor the facility did not have a policy on following physician orders. When asked what professional standard of practice the facility uses, ASM #3 stated they follow their policies. 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." 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 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55. (3) This information was obtained from the	F 684		

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F 684	Continued From page 208 "device/cast/splint" in place. The physician order dated 12/1/17 documented, "Accucheks (finger stick blood sugars) AC (before meals) and HS (bedtime) X (times) 1 week." Review of Resident #184's December 2017 MAR (medication administration record) documented, "Accuchek AC & HS X 1 week." The MAR failed to evidence documentation of the blood sugar readings on the following dates and times: 12/1/17 at 9:00 p.m. 12/2/17 at 7:30 a.m., 11:30 a.m. and 4:30 p.m. 12/3/17 at 11:30 a.m. and 4:30 p.m. 12/4/17 at 4:30 p.m. and 9:00 p.m. 12/5/17 at 7:30 a.m., 11:30 a.m. and 9:00 p.m. 12/6/17 at 7:30 a.m. Review of the nurse's notes failed to evidence documentation of accucheks or blood sugar readings for the above dates. The comprehensive care plan dated, 12/6/17, documented in part, "The resident has a diagnosis of diabetes. At risk for hypoglycemia/hyperglycemia (too low and too high blood sugars) (4)." The "Interventions" documented in part, "Labs (laboratory tests) as ordered and report results to MD (medical doctor). Assess and record blood glucose (sugar) levels." On 12/7/17 at 10:25 a.m. an interview was conducted with LPN (licensed practical nurse) #4. The 12/1/17 physician order and Resident #184's December 2017 MAR was reviewed with LPN #4. When asked what the blanks for the scheduled Accucheck times meant, LPN #4 stated, "If it's	F 684		

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F 684	Continued From page 207 https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c8ecbd7a-0e22-4fc7-a503-faa58c1b6f3f (2) Glucagon -- Glucagon is an effective therapy for treating severe hypoglycemia. This information was obtained (3) This information was obtained from the website: https://www.mayoclinic.org/diseases-conditions/hypoglycemia/symptoms-causes/syc-20373685 2. The facility staff failed to follow the physician's order for obtaining finger stick blood sugars for Resident #184. Resident #184 was admitted to the facility on 11/30/17 with diagnoses that included, but were not limited to: fracture of the left humerus, chronic obstructive pulmonary disease (general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (2)), pulmonary fibrosis (pulmonary fibrosis is a condition in which the tissue deep in your lungs becomes scarred over time. This tissue gets thick and stiff. That makes it hard for you to catch your breath, and your blood may not get enough oxygen (3)), diabetes and high blood pressure. There was no completed MDS (minimum data set) assessment as of the dates of the survey. The Initial Nursing Assessment, dated 11/30/17, documented the resident was alert and oriented to person, place and time. The form documented the resident had functional limitation in range of motion in his left arm and had a	F 684		

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F 684	Continued From page 206 medication. Review of the Humalog manufacturer's prescribing information documented, "DOSAGE AND ADMINISTRATION. 2.2 Subcutaneous injection: Administer HUMALOG (trademark) U (units)- 100 or U - 200 by subcutaneous injection within 15 minutes before a meal or immediately after a meal. 2.3 Dosage Information. Individualize and adjust the dosage of HUMALOG based on route of administration, the individual's metabolic needs, blood glucose monitoring results and glycemic control goal. Risk Factors for Hypoglycemia. Other factors which may increase the risk of hypoglycemia include changes in meal pattern (e.g. macronutrient content or timing of meals) ...Patient with renal (kidney) or hepatic (liver) impairment may be at higher risk of hypoglycemia. WARNINGS AND PRECAUTIONS. Hypoglycemia: May be life-threatening. Monitor blood glucose and increase monitoring frequency with changes to insulin dosage, use of glucose lowering medication, meal pattern..." On 12/7/17 at 1:50 p.m. ASM #1, the executive director, ASM #2, the interim director of nursing and ASM #3, the corporate quality specialist were made aware of the concern for harm. ASM #3 stated, "I'm not going to fight it. We deserve it". No further information was provided prior to exit. References: (1) Humalog insulin -- HUMALOG is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from:	F 684		

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F 684	Continued From page 205 not see the cart, "I would definitely be looking for it and I would be checking on the resident because I gave him 24 units that acts so quickly." An additional interview was conducted on 12/7/17 at 12:34 p.m. with LPN (licensed practical nurse) #2, the nurse who gave Resident #286 the insulin on 12/4/17 at 4:30 p.m. When asked the process staff followed when they had a diabetic resident receiving short acting insulin, LPN #2 stated, "That particular day I was giving him his insulin. His partner was there and was giving him crackers and he had juice there. This was about 5:00 o'clock and since dinner comes around 5:30 p.m. I gave him his insulin and then I went to give my other medications. Then I was called to help another nurse and then around at 7:00 (p.m.) I was told his blood sugar had dropped to 42*." When asked who gave the resident the glucagon (2), LPN #2 stated, "(Name of LPN #4). LPN #2 stated, "I have learned from this. I would never do this again." An interview was conducted on 12/7/17 at approximately 2:20 p.m. with OSM (other staff member) #10, a pharmacist. When Resident #286's Humalog insulin order was reviewed with the pharmacist, OSM #10 stated, "Yeah, that is problem. You can't be giving insulin no matter what the blood sugar is. If they go a long time without eating they are at risk for having a low blood sugar." An interview was conducted on 12/7/17 at 2:30 p.m. with LPN #4, the nurse who administered the glucagon injection to Resident #286. When asked how she had administered the medication, LPN #4 stated, "Subq (subcutaneously)." When asked where she had documented it LPN #4 stated she had forgotten to document the	F 684		

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F 684	Continued From page 204 the physician and received an order for glucagon (2) to be given to Resident #286 either intramuscularly or subcutaneously (RN #2 had written the order on the palm of her hand and showed it to this writer)." Further review of Resident #286's physician's orders dated 11/18/17 documented, "Hypoglecemic (sic) protocol standing orders for hypoglycemic (low blood sugar) protocol." Review of the hypoglycemic protocol documented, "TREATMENT Symptomatic Unconscious. Perform fingerstick blood glucose measurement. If less than 70 or physician ordered low parameter immediately administer Glucagon 1 mg (milligram) IM (intramuscularly). DOCUMENTATION Glucagon administration on MAR (if indicated)." An interview was conducted on 12/7/17 at 10:20 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked what the process CNAs follow when dinner trays are delivered and the resident was asleep, ASM #2 stated, "I would expect the CNA to say 'your tray's here' and shake them to wake them up." When asked what the CNA should do if the resident could not be aroused, ASM #2 stated she should tell the nurse. When asked the process staff follow when a medication is ordered to be given with meals, ASM #2 stated, "First of all I would give it as close to the meal time as possible, within 15 minutes at the most if I was anticipating the tray would be on time." When asked if the blood sugar was 454 and the insulin was given what would be the staff expectation, ASM #2 stated, "I would keep an eye out for the (food) cart." When asked what staff should do if they did	F 684		

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F 684	Continued From page 203 4:30 p.m. and she had given Resident #286 24 units of Humalog insulin. When asked if she had notified the physician of the resident's blood sugar reading, LPN #2 stated, she did not call the doctor. Review of Resident #286's physician orders dated 11/18/17, signed by the physician on 11/18/17, documented in part the following: "Fingerstick blood sugar AC (before meals) & HS (bedtime) Call MD (medical doctor) < (less than) 70 - > (greater than) 400." The physician's orders further documented in part: "Humalog 24 units SQ w (with)/lunch and w/dinner- DM (diabetes mellitus)." LPN #2 was shown the physicians orders and stated that (order to notify MD of blood sugar greater than 400) was not documented on the MAR (medication administration record). When asked if she should have called the physician, LPN #2 stated yes. Resident #286's December 2017 MAR was reviewed with LPN #2. The December 2017 MAR documented in part the following: "Start: 11/15/17 (incorrect date) Accuchecks (sic.) AC (before meals) & HS (bedtime) call MD/NP (nurse practitioner) if BS (blood sugar) < 70 > 400." LPN #2 stated she did not see this order; it was her first day working at the facility. LPN #2 stated she had not yet documented Resident #286's blood sugar reading and the insulin administered on the MAR, but she had documented it on a slip of paper. At this time a copy of this paper was requested and provided. Review of LPN #2's paper revealed in part the following: Resident #286's name, and "BS (blood sugar) 454." (A later review of the December 2017 MAR revealed that the 12/4/17 blood sugar of 454 had been documented.). On 12/4/17 at approximately 7:15 p.m., RN (registered nurse) #2, the staff educator called	F 684		

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F 684	Continued From page 202 42*. LPN #2 was asked when the resident had last had his blood sugar checked. LPN #2 stated it was last checked around 4:30 p.m. and was 452, and at that time 24 units of Humalog insulin was administered. LPN #2 was asked the last time Resident #286 had eaten. LPN #2 stated, around 4:30 p.m. The visitor stated that the same thing (a low blood sugar episode) had occurred on 12/1/17. *Hypoglycemia is a condition characterized by an abnormally low level of blood sugar (glucose), your body's main energy source. Immediate treatment of hypoglycemia involves quick steps to get your blood sugar level back into a normal range - about 70 to 110 milligrams per deciliter, or mg/dL (3.9 to 6.1 millimoles per liter, or mmol/L) - either with high-sugar foods or medications. (3) On 12/4/17 at 7:35 p.m. an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 was asked if she remembered delivering the resident's meal tray around 7:05 p.m. CNA #1 stated, "He (Resident #286) was sleeping and his friend was in there with him and had been trying to wake him up for an hour and a half. I told him I would let the nurse know, she said she would be on the way." CNA #1 stated that by the time she was coming out of the resident's room the nurse was coming back to the room. When asked what she did when she saw someone who "didn't look right" the CNA stated she would tell the nurse. An interview was conducted on 12/4/17 at approximately 7:40 p.m. with LPN (licensed practical nurse) #2, the nurse who administered insulin to Resident #286 at 4:30 p.m. LPN #2 stated Resident #286's blood sugar was 454 at	F 684		

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F 684	Continued From page 201 1. Resident #286 was admitted to the facility on 2/15/17 and readmitted on 11/18/17 with diagnoses that included but were not limited to diabetes, stroke, high blood pressure, heart disease, prostate cancer and arthritis. Resident # 286's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/25/17, coded Resident # 286 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively for making daily decisions. Resident # 286 was coded as requiring extensive assistance to being totally dependent of one staff member for activities of daily living and supervision of one staff member for eating. An observation was made on 12/4/17 at approximately 7:10 p.m. of Resident #286 by another surveyor. The surveyor observed the CNA (certified nursing assistant) #1 prepare Resident #286's dinner tray. The resident was sleeping at the time and the CNA did not attempt to wake the resident. On 12/4/17 at 7:15 p.m. Resident #286 was observed lying in his bed, eyes closed, somnolent with snoring respirations. The resident's food tray was set up on a bed side table over the bed. A visitor at the bedside stated he could not wake him (Resident #286) up, he didn't know what was wrong with him. The visitor further stated the resident's (Resident #286's) gown was "soaking wet." At this time LPN (licensed practical nurse) #2 was alerted to the situation, a blood glucometer check was conducted at the bedside by the nurse and the resident's blood sugar was	F 684		

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F 684	Continued From page 200 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure treatment and care in accordance with professional standards to maintain the highest level of well-being for four of 29 residents in the survey sample, Residents #286, #83, #184 and #234. 1. The facility staff failed to prevent Resident 286 from having a profound low blood sugar episode requiring an injection of glucagon (2) to be administered to revive the resident. On 12/4/17 facility staff failed to follow the physician's order to administer, humalog insulin (a rapid acting human insulin (1)) with meals and failed to monitor and reassess the resident to ensure the resident ate within the manufacturer's recommended time frame of 15 minutes after the insulin was administered. The Humalog insulin was given between 4:30 p.m. and 5:00 p.m. and the resident's dinner tray was not delivered until 7:10 p.m. 2. The facility staff failed to follow the physician's order for obtaining finger stick blood sugars for Resident #184. 3. The facility staff failed to administer Resident #83's medications per physician's orders on 11/3/17. 4. The facility staff failed to administer a physician-ordered medication that was available for Resident #234. The findings include:	F 684	residents with these orders to ensure that the orders have been followed correctly and to identify any hypoglycemic episodes during the last 30 days. An audit was completed of the MARs for current residents for the last 30 days to identify any omissions in administration. 3. Education was provided to the nursing staff by the Nurse Practice Educator related to diabetic management, and ensuring that residents receive their meal or a snack after administration of insulin. Education was also provided to the Licensed Nursing Staff by the Nurse Practice Educator related to medication administration and documentation, and also included the process for obtaining medications from the back up box as appropriate. 4. Unit Managers will audit /monitor Insulin Dependent Diabetic Residents 5 times per week for six weeks and then randomly thereafter, to ensure that residents have eaten post insulin administration and no adverse effects are noted. Unit Managers will also audit MARs 3 Xweek for 6 weeks, and then randomly thereafter, for omissions in medication administration. Results of these audits will be brought before the QAPI Committee monthly for review.	1/17/18

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F 677	Continued From page 199 the shift assigned and then it is passed on to the next shift. It is documented in the shower book." LPN #2 was asked what it meant if the shower book is blank. LPN #2 stated, "If it wasn't documented then it was not done." On 12/7/17 at 12:30 an interview was conducted with ASM (administrative staff member) #2, the interim director of nursing (DON). ASM #2 was asked how often residents were to be showered, ASM #2 stated the residents were on a twice weekly schedule. When asked where the staff documented the baths/showers provided ASM #2 stated in the computer or on the shower/bath log sheets. An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. A facility policy was requested at this time. No further information was provided prior to the end of the survey process.	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684	1. Resident # 286 is no longer in the facility. Resident # 184 has been discharged from the facility. Residents #83 and #234 are receiving medications per order. 2. All residents with orders for insulin and blood glucose monitoring have potential to be affected. An audit was completed by Unit Managers of all	

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F 677	Continued From page 198 #8 stated, "Showers are given twice a week. The schedules depend on the room. Showers are documented in the shower book. Nursing aides sign off if baths and showers are given. Bed baths should be given every day. They document in their tablet for ADLS. If it is not documented, it was not done." On 12/07/17 at 09:33 a.m., an interview was conducted with CNA (certified nursing assistant) #15. When asked where resident showers are documented, CNA #15 stated each unit has a shower book. CNA #15 stated the shower sheets have a date documented on the top of the sheet and all room numbers listed for residents who receive showers on that assigned day. CNA #15 stated once a shower is completed, the CNAs should be signing off next to the room number of the residents who received a shower. CNA #15 stated if there is no signature next to the room number, it doesn't necessarily mean the shower was not completed. CNA #15 stated the nursing aide could have forgot to document. CNA #15 stated if a resident refuses a shower, she will tell the nurse. When asked if she has ever missed a resident shower, CNA #15 stated, "Yes, sometimes I can't get to people." When asked if a resident should have to miss their shower, CNA #15 stated they shouldn't. CNA #15 stated she was not familiar with Resident #19. On 12/07/17 at 09:40 a.m. an interview was conducted with LPN (licensed practical nurse) #2, a floor nurse. LPN #2 was asked how she ensured that residents were being bathed. LPN #2 stated, "Through the shower book. If they don't get their shower in the morning, then they should give the shower later in the day on the next shift. The aides may not get their showers on	F 677		

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F 677	Continued From page 197	F 677		

mental status) and the staff assessment coded Resident #56 as being severely impaired to make decisions regarding task of daily life. Resident #56 was coded as being dependent with activities of daily living. Under Section G, Functional Status, Bathing, Resident #56 was coded as an "8 Activity itself did not occur."

A review of the unit bathing sheets revealed, in part, that Resident #56 had last been bathed on 11/29/17.

A review of Resident #56's bathing documentation revealed, in part that Resident #56 had been bathed on the following dates between 11/1/17 and 12/6/17; 11/18/17 at 18:48 (6:48 p.m.), 11/23/17 at 14:56 (2:56 p.m.), 11/29/17 at 14:59 (2:59 p.m.).

A review of Resident #56's comprehensive care plan dated 1/3/17 revealed, in part, the following documentation; "Focus: Resident requires assistance / is dependent for ADL (activities of daily living) care in (bathing, grooming, dressing, eating, bed mobility, transfer, locomotion, toileting) due to cognitive loss/ dementia, chronic disease compromising functional ability. Date Initiated: 11/15/17. Created on: 12/24/12. Goal: Resident's ADL care needs will be anticipated and met in order to maintain the highest practicable level of functioning and physical well-being x 90 days. Interventions: Personal hygiene." There was no documentation regarding refusals for bathing by Resident #56 or by the residents RP (responsible party).

On 12/06/17 at 11:33 a.m. an interview was conducted with LPN (licensed practical nurse) #8. When asked how often showers are given, LPN

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F 677	Continued From page 196 down. CNA #8 also stated she will also clean finger nails if she visibly sees them dirty. When asked if Resident # 64's fingernails were clean, she stated she was not sure. This writer asked CNA #8 to observe Resident # 64's fingernails. Upon observation, CNA #8 was asked what she observed. CNA #8 stated it appeared that old food was underneath the resident's fingernails. CNA #8 stated she rarely works with Resident #64 and his regular CNA left early that day. When asked if his fingernails appeared long, CNA #8 stated they did not appear long to her. On 12/07/17 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the interim DON (Director of Nursing) and ASM #3, the clinical quality specialist were made aware of the above concerns. No further information was presented prior to exit. 2. The facility staff failed to provide bathing assistance to Resident #56, who was coded as being dependent with activities of daily living. Resident #56 was admitted to the facility 12/21/12 with diagnoses that included, but were not limited to; dementia, a gastrostomy (a tube to deliver feeding directly into the stomach), peripheral vascular disease (poor circulation to the legs), high blood pressure, depression, difficulty swallowing, anemia (low red blood cell count), an irregular heartbeat, and difficulty speaking. Resident #56's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/13/2017 coded Resident #56 as being unable to answer the questions on the BIMS (brief interview for	F 677		

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F 677	Continued From page 195 On 12/05/17 02:10 p.m. an observation was made of Resident #64. All fingernails appeared to have black and yellow debris that was thick underneath the nails. His fingernails appeared to be long. On 12/06/17 at 10:09 a.m. an observation was made of Resident #64. All fingernails appeared to have black and yellow debris that was thick underneath the nails. His fingernails appeared to be long. On 12/06/17 at 11:33 a.m., an interview was conducted with LPN (licensed practical nurse) #8. When asked who was responsible for providing nail care, LPN #8 stated sometimes the activity department will have a manicure day and nurses will send the residents to get manicures. LPN #8 stated, "Nurses should be checking if nails are long or dirty. Both the CNAs and nurses are responsible for ensuring nails are clean." On 12/06/17 at 1:20 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated CNAs and Nurses are responsible for ensuring fingernails are cleaned and trimmed. RN #1 stated the nurses will cut fingernails if the resident is diabetic. On 12/06/17 at 1:40 p.m., an interview was conducted with CNA (certified nursing assistant) # 8, Resident #64's CNA. CNA #8 stated CNAs were responsible for doing showers and documenting any new areas on a skin sheet. CNA #8 also stated nail care would be documented on this sheet because nails were cleaned with showers. CNA#8 stated they will take a wooden stick and clean out underneath the nails. If the nails are too long, she will file them	F 677		

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F 677	Continued From page 194 the interim DON (Director of Nursing) and ASM #3, the clinical quality specialist were made aware of the above concerns. Facility policy titled, "Activities of Daily Living" documents in part, the following: "Based on the comprehensive assessment of a patient and consistent with the patient's needs and choices, the Center must provide necessary care and services to ensure that a patient's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. Activities of daily living include: Hygiene-bathing, dressing, grooming, and oral care; Mobility; transfer and ambulation, including walking; elimination-toileting, dining-eating including meals and snacks; communication-including speech, language, and other functional communication systems." No further information was provided prior to exit. 1b. The facility staff failed to ensure Resident #64 fingernails were free from debris. On 12/04/17 at 05:09 p.m. an observation was made of Resident #64. All his fingernails appeared to be long. All fingernails to both hands appeared to be dirty with black and yellow debris underneath his nails. On 12/04/17 at 05:09 p.m., an interview was conducted with Resident #64. Resident #64 stated staff have not cleaned or cut his nails since he has been at the facility. Resident #64 had stated his nails were longer than how he keeps them.	F 677		

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F 677	Continued From page 193	F 677		

#15. When asked where resident showers are documented, CNA #15 stated that each unit has a shower book. CNA #15 stated that the shower sheets have a date documented on the top of the sheet and all room numbers listed for residents who receive showers on that assigned day. CNA #15 stated that once a shower is completed, the CNAs should be signing off next to the room number of the residents who received a shower. CNA #15 stated if there is no signature next to the room number, it doesn't necessarily mean the shower was not completed. CNA #15 stated the nursing aide could have forgot to document. CNA #15 stated if a resident refuses a shower, she will tell the nurse. When asked if she has ever missed a resident shower, CNA #15 stated, "Yes, sometimes I can't get to people." When asked if a resident should have to miss their shower, CNA #15 stated that they shouldn't. CNA #15 stated that she was not familiar with Resident #64.

On 12/07/17 at 09:38 a.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked how nurses ensure residents are receiving showers, LPN #2 stated that she would check the shower book. LPN #2 stated if a resident misses their shower on a shift, the shower would be passed on to the next shift. LPN #2 stated a resident may not get a shower on their scheduled shower day. LPN #2 stated when the resident finally receives a shower, it will be documented in the shower book. When asked what blanks meant on the shower logs in the shower book, LPN #2 stated that if the shower was not documented then it wasn't done.

On 12/07/17 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2,

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F 677	Continued From page 192 Further review of the shower sheets failed to evidence Resident #64 had received showers since his admission to the facility. Review of Resident #64's comprehensive care plan for ADL (activity daily living) dated 10/9/17, documented the following: "Resident is at risk for decreased ability to perform ADLS in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion...interventions...Resident get a shower 2x a week, Resident needs assist with adls (sic)." On 12/06/17 at 1:40 p.m., an interview was conducted with CNA (certified nursing assistant) # 8, Resident #64's CNA. CNA #8 stated that CNAs were responsible for doing showers and documenting any new areas on a skin sheet. CNA #8 also stated that nail care would be documented on this sheet because nails were cleaned with showers. CNA #8 could not determine when Resident # 64 had a shower last. CNA #8 stated that she rarely worked with him and that his CNA left early that day. On 12/06/17 at 11:33 a.m. an interview was conducted with LPN (licensed practical nurse) #8. When asked how often showers are given, LPN #8 stated, "Showers are given twice a week. The schedules depend on the room. Showers are documented in the shower book. Nursing aides sign off if baths and showers are given. Bed baths should be given every day. They document in their tablet for ADLS. If it is not documented, it was not done." On 12/07/17 at 09:33 a.m., an interview was conducted with CNA (certified nursing assistant)	F 677		

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F 677	Continued From page 191 was coded as requiring extensive assistance from two or more staff with personal hygiene. Resident #64 was admitted to the facility on 10/05/17 with diagnoses that included but were not limited to atrial fibrillation, heart failure, high blood pressure, renal insufficiency, high cholesterol, thyroid disorder, and post stroke. Resident #64's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 10/12/17. Resident #64 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (brief interview for mental status) exam. Resident #64 was coded as requiring extensive assistance from two or more staff with bed mobility, transfers, toileting, and personal hygiene. An "8/8" was coded under the area of "Bathing" indicating that bathing had not occurred over the seven-day look-back period. On 12/04/17 at 04:31 p.m., an interview was conducted with Resident #64. Resident #64 had stated he does not receive showers at the facility. Resident #64 stated he could only recall one time that he had a shower. Resident #64 stated sometimes staff will wash him with a wash cloth before they dress him every morning. Review of Resident #64's ADL (activity of daily living) records dated 10/2017 through 12/2017 failed to evidence Resident #64 had received a shower. The only bed bath documented was on 11/7/17. Review of the shower sheets dated October 2017 through December 2017 revealed Resident #64's shower days were on Thursdays and Mondays.	F 677	procedure for providing nail care on shower days. 4. The Director of Nursing/designee will audit shower schedule and fingernails 2 times a week for 6 weeks and then randomly thereafter to ensure ADL care is provided. Results of audits will be brought to the Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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F 658	Continued From page 190 information was obtained from the website: http://www.smith-nephew.com/key-products/advanced-wound-management/allevyn/allevyn-adhesive/	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide assistance with ADLS (activities of daily living) for two residents who were coded as being dependent or requiring extensive assistance (Resident # 64 and 56), in the survey sample of 29 residents. 1a. The facility staff failed to provide assistance with showers twice a week to Resident #64, who was coded as requiring extensive assistance from two or more staff with personal hygiene. 1b. The facility staff failed to ensure Resident #64 fingernails were free from debris. 2. The facility staff failed to provide bathing assistance to Resident #56, who was coded as being dependent with activities of daily living. The findings include 1a. The facility staff failed to provide assistance with showers twice a week to Resident #64, who	F 677	1. Resident # 64 is currently offered showers 2x weekly. Resident #64 has had nails trimmed and clean by staff during survey. Resident # 56 has been discharged from the facility. 2. All resident have the potential to be affected. The Director of Nursing/designee will revise the shower schedule, and a 100% audit of all residents nails was completed by the Unit Managers, with trimming and cleaning provided as appropriate. 3. Education was provided to nursing staff by the Nurse Practice Educator or the Nursing Supervisor related to importance of showers, ADL and nail care. Also included in this education was the documentation of showers /bathing received or refused. Education was provided to nursing staff by the Nurse Practice Educator related to policy and	

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F 658	Continued From page 189 as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue... Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury..." This information was obtained from the website: http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/ (2) "SANTYL Ointment is an FDA (Federal Drug Administration)-approved prescription medicine that removes dead tissue from wounds so they can start to heal. Proper wound care management is important to help remove nonliving tissue from your wound properly..." This information was obtained from the website: https://www.santyl.com/ (3) Silicone dressing is a specialized type of dressing containing silicone. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/27802960 (4) Allevyn dressing is a foam dressing. This	F 658		

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F 658	Continued From page 188 ordered. ASM #4 confirmed she wanted a silicone dressing. On 12/7/17 at 2:23 p.m. ASM (administrative staff member) #1 (the executive director), ASM #2 (the interim director of nursing) and ASM #3 (the clinical quality specialist) were made aware of the above concern. When asked what standard of practice the facility staff uses, ASM #3 stated the facility company has a team that develops the policies and these policies are the standards of practice the facility staff uses. On 12/7/17 at 3:00 p.m. ASM #3 stated the facility did not have a policy regarding order clarification. No further information was provided prior to exit. (1) "Pressure injuries are staged to indicate the extent of tissue damage. The stages were revised based on questions received by NPUAP (National Pressure Ulcer Advisory Panel) from clinicians attempting to diagnose and identify the stage of pressure injuries. Schematic artwork for each of the stages of pressure injury was also revised and will be available for use at no cost through the NPUAP website in approximately 12-24 hours (http://www.npuap.org/resources/educational-and-clinical-resources/pressure-injury-staging-illustrations/). The updated staging system includes the following definitions: Pressure Injury: A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs	F 658		

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F 658	Continued From page 187 was shown the treatment order dated 10/28/17 that documented, "Cleanse natal cleft with NS wound flush, apply santyl to wound bed and cover (with) dressing Q (every) Day & PRN (as needed)." RN #1 was asked what elements should a wound dressing order contain. RN #1 stated the order should specify the type of wound cleanser, what to apply if any medication or ointment is to be used, the dressing and the frequency of the dressing change. RN #1 was asked if the order should specify the type of dressing. RN #1 stated she was not sure if the policy specifies the exact type of dressing to be used but she has seen orders for specific dressings and orders for generalized dressings. RN #1 was asked how staff would know what type of dressing to apply if the order only documented "dressing" and did not specify the type. RN #1 stated the facility has multiple types of dry dressings and unless the physician specifies the type of dressing, the nurses use the dressing that looks applicable for the wound. RN #1 stated she would assume another nurse would use her discretion and "see what's in the cart or supply room." RN #1 was asked if the physician's order should specify the type of dressing to be used. RN #1 stated, "No. They usually say dry dressing. If they want something specific like allevyn (4) they will say." RN #1 was asked what was to stop an unfamiliar nurse from using any type of dressing. RN #1 stated, "Nothing. There is no way to specify if they write dry dressing." On 12/6/17 at 2:18 p.m. a telephone interview was conducted with ASM (administrative staff member) #4 (the nurse practitioner who gave the verbal dressing order on 10/28/17). ASM #4 was read her note and the verbal order and was asked to clarify the type of dressing she wanted	F 658		

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F 658	Continued From page 186 medication administration also pertain to oxygen administration." 5. The facility staff failed to clarify a physician's order for Resident #47's wound dressing on 10/28/17. Resident #47 was admitted to the facility on 10/26/17 and readmitted on 11/22/17. Resident #47's diagnoses included but were not limited to: diabetes, chronic kidney disease and adult failure to thrive. Resident #47's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 11/29/17, coded the resident's cognition as moderately impaired. Review of Resident #47's clinical record revealed a progress note signed by the nurse practitioner on 10/28/17. The note documented, "Natal cleft (crease between the buttocks) stage 3 pressure ulcer (injury) (1)- Ordered NS (normal saline) wound flush, Santyl ointment (2) & silicone dressing (3) qd (every day)." A physician's verbal order dated 10/28/17 documented, "Cleanse natal cleft with NS wound flush, apply santyl to wound bed and cover (with) dressing Q (every) Day & PRN (as needed)." The order did not specify the type of dressing. Resident #47's October 2017 TAR (treatment administration record) documented, "10/26/17- Cleanse natal cleft (with) NS wound flush, apply santyl to wound bed & cover (with) dressing Q Day & PRN." On 12/6/17 at 12:08 p.m. an interview was conducted with RN (registered nurse) #1. RN #1	F 658		

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F 658	Continued From page 185 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." Review of the facility policy: "Monthly Physician/Advanced Practice Provider" Under "POLICY ...Physician/Advanced practice provider (APP) orders will be reviewed by a licensed nurse on a monthly basis to ensure accuracy, completeness, and compliance with state and federal requirements. PURPOSE To provide a current and accurate record of physician/APP orders. PRACTICE STANDARDS ...2. The licensed nurse will review the previous month's printed orders and orders that were written in this time interval (telephone, verbal, written orders) ..." The oxygen concentrator manufacturer's user manual documented, under "NOTE: To properly read the flow meter, locate the prescribed flowrate 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..." No further information was provided prior to exit. According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, 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	F 658		

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F 658	Continued From page 184 During an interview on 12/06/17 at 03:02 p.m. with LPN # 3 when asked the process for transcription of physician orders, LPN # #3 sated when a physician order is received it is faxed to the pharmacy, then the staff receiving the order checks about 10 to 15 minutes later to make sure the pharmacy has received the order. The order would be hand written on the MAR/TAR (Medication Administration Record/Treatment Administration Record). Next month the printed MAR/TAR comes from the pharmacy and the new order would be on there. If for some reason it is not on the printed copy the nurse would hand write it again. If the order is not on the printed physician order sheet it means the order was not faxed to the pharmacy and the nurse would have to look for the order and fax it again. If the order is on the printed physicians' order sheet and not on the MAR/TAR, then there is a pharmacy issue. During the end of day interview on 12/6/17 at 5:20 p.m. this concern was again shared with ASM # 1, ASM # 2, and ASM # 3. During an interview on 12/7/17 at 10:05 a.m. with ASM # 3, a request was made to speak to the nurse that had transcribed the oxygen order. ASM # 3 stated the nurse was probably an agency nurse and was no longer at the facility, but stated that she would check. ASM # 3 stated, "The facility's standards of practice are the company's policies. The company has a team that writes and creates its own standard." Review of the facility policy: "Transcription of Orders" documented the following: under "POLICY Orders from an authorized licensed independent practitioner are transcribed by a licensed nurse. Written orders may be	F 658		

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F 658	Continued From page 183 observed to be set at 1.5 liters/minute 12/05/17 08:31 a.m. Resident # 43 oxygen set at 1.5 liters/minute 12/06/17 07:10 a.m. Resident # 43 oxygen noted to be set at 1.5 liters/minute 12/06/17 09:12 a.m. Resident # 43 oxygen set at 1.5 liters/minute During an interview on 12/6/17 at 2:07 p.m. with LPN (licensed practical nurse) # 2, LPN # 2 was asked to view the oxygen setting on Resident # 43's concentrator flow meter. LPN # 2 stated that the flow meter was set at 1.5 liters/minute (the center of the ball in the flow meter was centered on the 1.5 L/min. Line). LPN # 2 was asked to view the physician order and confirmed the physician order ordered the oxygen be set to 2 liters/minute. LPN # 2 then presented the MAR and when the MAR was reviewed there was documentation that Resident # 43's oxygen was to be set to 1 liter per minute. Documentation on the December 2017 MAR is as follows: "O2 @ 1L/min via nasal cannula Continuous" dated 9/20/17. LPN # 2 had no explanation for the discrepancy between the physician order and the MAR. LPN # 2 was asked who the Unit Manager was and stated that there was no unit manager. During an interview on 12/6/17 at 2:18 p.m. with ASM (Administrative Staff Member) # 1, the Executive Director, ASM # 2, the Interim Director of Nurses, and ASM # 3, the Clinical Quality Specialist, this observation was revealed. A request was made for the policies related to oxygen administration, monthly changeover of physician orders, and manufacturer's information for the oxygen concentrator on the setting of the flow meter.	F 658		

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F 658	Continued From page 182 glycemic control in adults and children with diabetes mellitus. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c8ecbd7a-0e22-4fc7-a503-faa58c1b6f3f 4. The facility staff failed to accurately transcribe a physician order for Resident # 43's oxygen to the MAR (Medication Administration Record). Resident # 43 was admitted to the facility on 7/8/17 and readmitted on 9/19/17 with diagnoses that included but were not limited to: anemia, congestive heart failure, hypertension, diabetes, hyperlipidemia, anxiety, and depression. Resident # 43's most recent MDS (minimum data set) assessment, a Quarterly Assessment, with an ARD (assessment reference date) of 10/15/17 coded Resident # 43 as understood by others and as able to understand others. Resident # 43 was coded as being cognitively intact for making daily decisions, scoring 15 out of 15 on the BIMS (brief interview for mental status). Review of a physician order dated 9/20/17 and most recently signed by the physician on 12/4/17 documented, "OXYGEN 2L/MIN VIA NASAL CANNULA CONTINUOUS." Review of the December 2017 MAR is as follows: "O2 @ 1L/min via nasal cannula Continuous" dated 9/20/17. The following observations sere made of Resident # 43's oxygen: 12/04/17 11:59 a.m. Resident # 43 oxygen set at 1.5 liters/minute 12/04/17 05:48 p.m. Resident # 43 oxygen	F 658		

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F 658	Continued From page 181 then what the order says and I follow the process to fill out the MAR and TAR (treatment administration record)." When asked who clarified an order when needed, LPN #5 stated, "I normally call the physician who wrote it and I do a clarification." The Humalog insulin order for Resident #286 was reviewed with LPN #5. LPN #5 stated, "Hmm. Humalog, that's a short acting insulin and that's a very high dose. I personally am going to call the MD (medical doctor)." When made aware that the staff stated he had taken off the order, LPN #5 stated, "I don't actually remember taking off that order." A request was made on 12/7/17 at 8:30 a.m. of ASM (administrative staff member) #2. the interim director of nursing for a copy of the facility's policy on clarifying physician orders. On 12/7/17 at 10:05 a.m. ASM (administrative staff member) #3, the corporate clinical specialist stated, "The facility's standards of practice are the company's policies. The company has a team that writes and creates its own standard." On 12/7/17 at 3:00 p.m. ASM #3 stated the facility did not have a policy regarding order clarification. On 12/7/17 at 4:45 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the interim 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) Humalog insulin -- HUMALOG is a rapid acting human insulin analog indicated to improve	F 658		

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F 658	Continued From page 180 Review of the physician's orders dated 11/18/17 documented, "Humalog 20 units sq (subcutaneously) Q (every) AM -- DM (diabetes). Humalog 24 units sq w (with)/ Lunch and w/dinner -- DM." Review of the December 2017 MAR (medication administration record) documented, "Humalog 20 units sq Q AM." It was documented that the resident had received the insulin each morning. The resident's blood sugars ranged from 121 to 238. It was documented that the resident had received the insulin on 12/3/17 and 12/4/17 at lunch. The resident's blood sugars ranged from 99 to 314. It was documented that the resident had received the insulin on 12/2/17, 12/3/17 and 12/4/17 at dinner. The residents blood sugar ranged from 79 to 454. An interview was conducted on 12/7/17 at approximately 2:20 p.m. with OSM (other staff member) #10, a pharmacist. When asked who clarified physician's orders, OSM #10 stated, "If it's a clinical question, the pharmacist calls." When Resident #286's Humalog insulin order was reviewed with the pharmacist, OSM #10 stated, "Yeah, that is problem. You can't be giving insulin no matter what the blood sugar is. If they go a long time without eating they are at risk for having a low blood sugar." OSM #10 was not able to state whether the pharmacist had attempted to clarify the order with the physician. A telephone interview was conducted on 12/7/17 at 4:16 p.m. with LPN (licensed practical nurse) #5, the nurse who took off the Humalog insulin orders for Resident #286. When asked about the process staff follow when taking off orders, LPN #5 stated, "I look at the time it was written and	F 658		

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F 658	Continued From page 179 No further information was provided prior to the end of the survey process. [1] This information was obtained from the following website; http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/. [2] This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2686636/ 3. The facility staff failed to clarify the physician's 11/18/17 order for Humalog insulin (a rapid acting human insulin (1)) 20 units to be administered at breakfast and Humalog 24 units to be administered with lunch and dinner for Resident #286 regardless of the resident's blood sugar. Resident #286 was admitted to the facility on 2/15/17 and readmitted on 11/18/17 with diagnoses that included but were not limited to diabetes, stroke, high blood pressure, heart disease, prostate cancer and arthritis. Resident # 286's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/25/17, coded Resident # 286 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively for making daily decisions. Resident # 286 was coded as requiring extensive assistance to being totally dependent of one staff member for activities of daily living and supervision of one staff member for eating.	F 658		

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F 658	Continued From page 178 unable to determine. When asked who completed the treatments between 12/2 - 12/5/17, LPN #12 stated the treatments were signed off as being completed by an LPN who was no longer with the facility. LPN #12 was asked what had the staff been using to follow the prescribed order. LPN #12 stated, "The staff have been using another resident's Medihoney." On 12/7/17 at 12:30 p.m. an interview was conducted with ASM (administrative staff member) #2, the interim director of nursing (DON). ASM #2 was asked what process the nursing staff followed if they do not have a prescribed treatment/medication to administer as ordered. ASM #2 stated, "They should call the pharmacy and have them process the order." ASM #2 was asked if it was appropriate to use another resident's treatment/medication. ASM #2 stated "No." ASM #2 was asked if she was aware Resident # 56 did not have Medihoney available to administer to her wound between 11/29/17 and 12/6/17. ASM #2 stated that she had not been made aware of that. ASM #2 was asked to provide a policy regarding obtaining medications/treatments from the pharmacy. On 12/7/17 at 3:00 p.m. ASM #3 was asked what professional standard of practice the facility uses, ASM #3 stated they follow their policies. A policy was not provided for the use of another resident's medications. An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim DON, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns.	F 658		

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F 658	Continued From page 177 On 12/6/17 at 12:30 p.m. LPN (licensed practical nurse) #12 approached this writer and stated she was ready to provide wound care for Resident # 56. As LPN #12 gathered her supplies she stated Resident #56's Medihoney had not arrived from the pharmacy. LPN #12 was asked when the Medihoney was ordered. LPN #12 stated, "It was ordered - I don't know - I want to say the 30th or the 1st." LPN #12 was asked what she normally did if she didn't have what she needed for a resident's treatment. LPN #12 stated, if another resident on the hall has the same prescription I will use another resident's supply until I get what I need from the pharmacy." LPN #12 was asked if anyone had contacted the pharmacy. LPN #12 stated, "Not that I know of. I don't know why the pharmacy hasn't been contacted. I didn't know anything about it yesterday because all the treatments were done when I came on shift. I assumed that her (Resident # 12's) supplies were here so I didn't question it." LPN #12 was asked what was she going to do next. LPN #12 stated, "I am going to contact the pharmacy and see if they've sent it. I know they got the order because I received a fax confirmation." At this time LPN #12 went to verify the fax order went to the pharmacy. LPN #12 was unable to locate the fax confirmation that the order was sent to the pharmacy. LPN #12 reviewed the order and stated she was the one who had signed off on the order. LPN #12 further stated, "It looks like it was not "taken off" but I remember sending it to the pharmacy it must not have gone through." When asked when the order for Medihoney was received by nursing LPN #12 stated, "On 11/29/17 the Medihoney was ordered and not received." LPN #12 was asked who did the treatment on 11/30/17. LPN #12 stated she was	F 658		

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F 658	Continued From page 176 2. The facility staff failed to obtain Resident #56's prescribed medication from the pharmacy as ordered and used another resident's medication for eight days. Resident #56 was admitted to the facility 12/21/12 with diagnoses that included, but were not limited to; dementia, a gastrostomy (a tube to deliver feeding directly into the stomach), peripheral vascular disease (poor circulation to the legs), high blood pressure, depression, difficulty swallowing, anemia (low red blood cell count), an irregular heartbeat, and difficulty speaking. Resident #56's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/13/2017 coded Resident #56 as being unable to answer the questions on the BIMS (brief interview for mental status) and the staff assessment coded Resident #56 as being severely impaired to make decisions regarding task of daily life. Resident #56 was coded as being dependent with activities of daily living. Resident #56 was also coded as receiving greater than 50% of her nutrition through tube feeding. A review of Resident #56's clinical record revealed, in part, the following orders for a stage 2 pressure ulcer on Resident #56's lower left leg; "11/28/17. Cleanse (L) outer calfe (sic) stg. (stage) 2 ulcer [1] (Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis.) NS (normal saline) wound cleanser, dry, apply Medihoney [2] (medically certified honey for use with wound healing) and then silicone dsg (dressing) qd (every day)." Signed and dated by the nurse practitioner on 11/29/17.	F 658		

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F 658	Continued From page 175 amounts being documented, how could the facility be sure the order was being followed, ASM #2 didn't have any comment. When asked if it was a standard of practice to document the amount of intake when a resident is on a physician-ordered fluid restriction, ASM #2 stated, "yes, it is." When asked what standard of practice the facility follows, ASM #2 stated she would have to find out. On 12/07/17 at 10:05 a.m., ASM #3 (the corporate Clinical Quality Specialist) stated, "The facilities standards of practice are the company's policies. The company has a team that writes and creates its own standards." She provided the facility policy, "Fluid Balance" which documented, "Intake and output will be monitored and documented as follows: ...Fluid Restriction: Monitor fluid intake; monitor output if ordered." She also provided the facility policy, titled "Fluid Restriction" which documented, "1. Verify order. Order must include volume or range of fluid permitted during 24- hour period.....4. Monitor fluid intake. Monitor output as ordered....8. Document: 8.1 Intake; 8.2 Output, if ordered; 8.3 Patient's compliance with restriction and response...." A review of the care plan revealed the fluid restriction was not added to the care plan. (See F657). On 12/7/17 at approximately 5:00 p.m., at the end-of-day meeting, ASM #1 (the Executive Director), ASM #2 and ASM #3 were made aware of the findings. No further information was provided by the end of the survey.	F 658		

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F 658	Continued From page 174 restriction and asked how she would know if the resident had too much fluids, LPN #12 went and questioned CNA #14 about the resident's fluids for the shift. Review of resident's intake with CNA #14 by LPN #12 revealed the fluid restriction had not been exceeded. On 12/7/17 at approximately 10:45 a.m., in a phone interview with LPN #13 (who took off the physician order for fluid restriction), LPN #13 stated the fluid intake amount should be documented. She stated that when she took off the order, she searched for the fluid intake monitoring form but could not find one. LPN #13 stated she then called the Nurse Practitioner (NP) who wrote the order and requested what restriction amounts did she (NP) want in place. LPN #13 stated she passed on in report to the next shift that she was unable to locate the form and what restriction amounts were to be followed. On 12/06/17 at 2:41 p.m., a request for the December 2017 fluid intake log for Resident #74, from the electronic health record (EHR) was requested. On 12/06/17 at 05:11 p.m., ASM #2 (Administrative Staff Member) the Interim Director of Nursing (DON) provided a copy of the MAR and stated this was the only evidence the facility had that the fluid restriction was being followed, there was no documentation in the EHR of fluid intakes for Resident #74. When asked how the facility can be sure the physician ordered fluid restriction was followed without the intake amount documented, ASM #2 stated the nurse's initials was the evidence the fluid restriction had been followed. When informed CNA #14 was not aware Resident #74 was on a fluid restriction and LPN #12 was not aware the CNA did not know this information, and asked without intake	F 658		

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F 658	Continued From page 173 Mental Status) exam. Resident # 74 was coded as requiring extensive care for bathing, hygiene, toileting, dressing, mobility and transfers; as independent for eating; and as frequently incontinent of bladder and occasionally incontinent of bowel. The resident was coded as having dialysis services. A review of the clinical record revealed a physician's order dated 12/1/17 for "Fluid restriction per neprho (nephrologist) at Dialysis Center. 32 Fluid oz/24H (ounces per 24 hours) ...." Observations of Resident #74 on 12/04/17 at 12:39 p.m., 12/05/17 at 07:30 a.m., 12/06/17 at 08:00 a.m., and 12/06/17 at 12:33 p.m., revealed the resident did not have fluids at the bedside. On 12/06/17 at 12:33 p.m., in an interview with CNA #14 (Certified Nursing Assistant), who worked with Resident #74, she stated the resident was not on a fluid restriction and could have what she wanted. On 12/06/17 at 03:12 p.m., a review of the MAR (Medication Administration Record) revealed the physician order for fluid restriction was transcribed to the MAR and the nurse was aware of it as evidenced by the nurse's initials next to the order for each day, including the initials of LPN #12 (Licensed Practical Nurse) on 12/6/17. However, when LPN #12 was asked how the amount of fluid intake was documented as it was not on the MAR, LPN #12 stated the CNA documents it in the computer. LPN #12 was not aware that CNA #14 did not know Resident #74 was on a fluid restriction. When informed the CNA was not aware Resident #74 was on a fluid	F 658		

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F 658	Continued From page 172 ordered and used another resident's medication for eight days. 3. The facility staff failed to clarify the physician's 11/18/17 order for humalog insulin 20 units to be administered at breakfast and humalog 24 units to be administered with lunch and dinner for Resident #286 regardless of the resident's blood sugar. 4. The facility staff failed to accurately transcribe a physician order for Resident # 43's oxygen to the MAR (Medication Administration Record). 5. The facility staff failed to clarify a physician's order for Resident #47's wound dressing on 10/28/17. The findings include: 1. The facility staff failed to monitor, document, and track the fluid intake of Resident #74 who was on physician-ordered fluid restriction. Resident # 74 was admitted to the facility on 1/13/17 and readmitted on 10/11/17 with the diagnoses of but not limited to End Stage Renal Disease (ESRD), renal dialysis, dementia with behaviors, anorexia, cerebrovascular disease, atrial fibrillation, diabetes, metabolic encephalopathy, altered mental status, depression, dysphagia, thrombosis, bipolar disorder, glaucoma and hyperparathyroidism. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/6/17. The resident was coded as being moderately impaired in ability to make daily life decisions, scoring a 7 out of a possible 15 on the BIMS (Brief Interview for	F 658	completed of all residents with oxygen orders to ensure transcribed correctly. Audit was completed of all current Treatment orders to ensure accurate and clear. 3. Education was provided to the Licensed Nursing Staff by the Nurse Practice Educator on documentation, transcribing of orders, clarifying of orders, ordering of medications and not borrowing medications from other residents. 4. Unit Managers will audit nursing documentation and Physician's orders in the Clinical Morning Meeting. Unit Managers and Wound Nurse will audit medications and treatments weekly x 6 weeks and randomly thereafter to ensure medications are available and not being borrowed from other residents. Results of these audits will be brought to the Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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F 657	Continued From page 171 can start to heal. Proper wound care management is important to help remove nonliving tissue from your wound properly..." This information was obtained from the website: https://www.santyl.com/ (3) Medi honey is a specialized medical honey used to treat wounds. This information was obtained from the website: http://outside-us.dermasciences.com/medihoney (4) Silicone dressing is a specialized type of dressing containing silicone. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/27802960	F 657		
F 658 SS=E	Services Provided Meet Professional Standards 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- (i) Meet professional standards of quality. 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 professional standards of practice for five of 29 residents in the survey sample; Residents #74, #56, #286, #43, and #47. 1. The facility staff failed to monitor, document, and track the fluid intake of Resident #74 who was on physician-ordered fluid restriction. 2. The facility staff failed to obtain Resident #56's prescribed medication from the pharmacy as	F 658	1. Resident # 74 currently has fluid restriction documented. Resident # 56 has been discharged from the facility. Resident # 286 is no longer in the facility. Resident # 43 had order corrected for her oxygen. These corrections were made by the Unit Managers. Resident # 47 has expired. 2. Audit was completed by the Unit Managers. for all residents with Fluid Restrictions to ensure that documentation was in place. House audit completed to ensure medications were available for all residents and that no borrowing of medications was occurring. Audit was completed of all residents with insulin orders to ensure they are appropriate. Audit was	

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F 657	Continued From page 170 Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions." This information was obtained from the website: http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/ (2) "SANTYL Ointment is an FDA (Federal Drug Administration)-approved prescription medicine that removes dead tissue from wounds so they	F 657		

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F 657	Continued From page 169 ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss	F 657		

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F 657	Continued From page 168 place then the care plan should reflect that. On 12/6/17 at 5:45 p.m. ASM (administrative staff member) #1 (the executive director), ASM #2 (the interim director of nursing) and ASM #3 (the clinical quality specialist) were made aware of the above concerns. No further information was presented prior to exit. "Pressure Injury: A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or	F 657		

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F 657	Continued From page 167 check was performed. The following New skin injury/wound(s) were identified: Other Wound(s): Location(s): rt (right) inner calf, rt lower buttock, left buttock. The following skin injury/wound(s) were previously identified and were evaluated as follows: Other Wound(s): Location(s): Rt buttock, santyl (2) and dressing daily. The next assessment of Resident #47's pressure injury was a progress note signed by the nurse practitioner on 11/6/17. The note documented, "Natal cleft IAD (incontinent associated dermatitis)- 2.7x0.5cm (centimeters), 50% slough, no odor. R. (Right) lower buttock stage 2 ulcer (injury) (1)- 2x1 cm, granulation. R. inner calfe (sic) stage 2 ulcer- 5x3 cm. R. hip 3 new ulcers of stage 2: 1.1.5x0.5 cm, 2. 4.5 cm in diameter, & 3. 2.5x1 cm, all granulated...Plan: Multiple new ulcers noted by nursing Sunday pm. Ordered NS (normal saline) wound flush, Medihoney gel (3) & silicone dressings (4) qd (every day). Wound rounds on Wednesdays." Review of Resident #47's comprehensive care plan failed to reveal any documentation regarding the new pressure injuries to the resident's right lower buttock, right inner calf, right hip or left buttock. On 12/6/17 at 12:08 p.m. an interview was conducted with RN (registered nurse) #1 regarding the process for updating the care plan. RN #1 stated any nurse can update the care plan but typically the unit managers do so (note- no nurse was employed as a unit manager at the facility during the time of survey). RN #1 stated if a nurse finds a new pressure injury then that nurse is supposed to update the care plan. RN #1 stated once the nurse puts the interventions in	F 657		

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F 657	Continued From page 166 stated a second check should be done during the clinical morning meetings with the nursing leadership who should review new orders and update the care plans if it had not already been done. On 12/7/17 at approximately 5:00 PM at the end-of-day meeting, ASM #1 (the executive director), ASM #2 (the interim director of nursing) and ASM #3 were made aware of the findings. No further information was provided by the end of the survey. 7. The facility staff failed to review and revise Resident #47's comprehensive care plan after the resident acquired new pressure injuries in November 2017. Resident #47 was admitted to the facility on 10/26/17 and readmitted on 11/22/17. Resident #47's diagnoses included but were not limited to: diabetes, chronic kidney disease and adult failure to thrive. Resident #47's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 11/29/17, coded the resident's cognition as moderately impaired. Section M documented Resident #47 presented with one stage three pressure injury (1), one unstageable pressure injury with slough and/or eschar (1) and two unstageable deep tissue pressure injuries (1). Review of Resident #47's clinical record revealed Resident #47 was admitted with a stage 3 pressure injury (1) to the natal cleft (crease between the buttocks). This wound was care planned on 10/30/17. A nurse's note dated 11/5/17 documented, "A skin	F 657		

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F 657	Continued From page 165 physician's order dated 12/1/17 for "Fluid restriction per neprho (nephrologist) at Dialysis Center. 32 Fluid oz/24H (ounces per 24 hours) ...." Observations of Resident # 74 on 12/04/17 at 12:39 p.m., 12/05/17 at 07:30 a.m., 12/06/17 at 08:00 a.m., and 12/06/17 at 12:33 p.m., revealed the resident did not have fluids at the bedside. A review of the comprehensive care plan dated 1/19/17, revealed the fluid restriction was not added to the care plan. On 12/7/17 at approximately 10:45 a.m., an interview was conducted with LPN #13 (Licensed Practical Nurse) who took off the physician order for Resident #74's fluid restriction. LPN #13 stated fluid restriction should be care planned. When asked who adds changes to the care plans, LPN #13 stated she thought it was the unit manager (for which there wasn't one at the time) or the supervisor. LPN #13 stated she did not know anything about adding changes to care plans; that she did not know if she was supposed to, she had never added anything to a care plan. On 12/07/17 at 09:21 a.m., in an interview with RN #7 (Registered Nurse), the MDS nurse, she stated that changes should be added to the care plan right away by whoever took off the order. RN #7 stated it is policy for nurses to update the care plan for episodic events, and that anybody can update the care plan. On 12/07/17 at 11:43 a.m., in an interview with ASM #3 (Administrative Staff Member) (the corporate Clinical Quality Specialist) she stated any nurse can update the care plan. ASM #3	F 657		

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F 657	Continued From page 164 by holding the head upright." This information was obtained from http://www.sunrisemedical.com/manual-wheelchairs/quickie/tilt-in-space-wheelchairs. [2] BRODA chair- "provides comfort and pressure redistribution to help maintain long term comfort for residents who are unable to reposition themselves." This information was obtained from https://www.brodaseating.com/conditions/. 6. The facility staff failed to revise Resident #74's comprehensive care plan to include the physician-ordered fluid restriction ordered on 12/1/17. Resident # 74 was admitted to the facility on 1/13/17 and readmitted on 10/11/17 with the diagnoses of but not limited to End Stage Renal Disease (ESRD), renal dialysis, dementia with behaviors, anorexia, cerebrovascular disease, atrial fibrillation, diabetes, metabolic encephalopathy, altered mental status, depression, dysphagia, bipolar disorder, glaucoma and hyperparathyroidism. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/6/17. Resident # 74 was coded as being moderately impaired in ability to make daily life decisions, scoring a 7 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident # 74 was coded as requiring extensive care for bathing, hygiene, toileting, dressing, mobility and transfers; as independent for eating; and as frequently incontinent of bladder and occasionally incontinent of bowel. The resident was coded as having dialysis services. A review of the clinical record revealed a	F 657		

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F 686	Continued From page 234	F 686		

Resident # 19 and she normally works on the 200 hall. This writer then followed CNA #10 into Resident # 19's room. No instructions for the heel boots could be found in Resident #19's closet. When asked what the CNA observed in Resident #19's chair, CNA #10 stated that she saw a heel boot. CNA #10 stated, "Maybe it was on and it fell off, so someone put in in the chair." CNA #10 then removed the blankets covering Resident # 19 legs. Her soft heel boot was not on her right foot. When asked if her soft heel boots should be in place, CNA #10 stated, "She should have them on, I would think." When asked where else she can look to see what residents needed in place, CNA #10 stated, "I would go to the nurse and ask."

On 12/06/17 at 2:10 p.m., observation of Resident # 19's right heel was conducted. Her skin was intact and not reddened.

12/07/17 at approximately 8:30 a.m., an interview was conducted with LPN # 9, the wound care nurse. When asked the purpose of soft heel boots, LPN #9 stated that the purpose of soft heel boots was to protect the ankles and heels from getting DTIS (Deep Tissue Injuries). When asked when it would be recommended for residents to wear soft heel boots, LPN #9 stated that if a resident was a moderate risk for skin breakdown, then they should be wearing them in bed.

On 12/07/17 at approximately 10:18 a.m., an interview was conducted with RN (registered nurse) #4, Resident #19's nurse. When asked the purpose of soft heel boots, RN #4 stated that the point of soft heel boots was to leave the heels free floating, to prevent the calf and heels from rubbing on the bed. RN #4 stated heel boots help

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F 686	Continued From page 235 to relieve pressure. RN #4 stated the nursing aids usually put soft heel boots on but the nurse should ensure that they are in place. On 12/06/17 at 5:30 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the interim DON (Director of Nursing) and ASM #3, the clinical quality specialist were made aware of the above concerns. No further information was presented prior to exit. Facility policy titled, "Skin Integrity Management" documents in part, the following: "The implementation of an individual patient's skin integrity management occurs within the care delivery process. Staff continually observes and monitors patients for changes and implements revisions to the plan of care as needed...4. Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated. 4.1 Implement pressure ulcer prevention for identified risk factors...4.3 Determine the need for heel protectors and heel lift devices and utilize per manufacturer's guidelines and/or Skin Integrity Care Delivery Process." No further information was presented prior to exit.	F 686		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including	F 687	1. Resident # 63 was seen by the podiatrist on 12/21/17 and had toenails trimmed. 2. All residents have the potential to be affected. House audit of current residents was completed by Unit Managers to determine who was in need of having their toe nails	

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F 687	Continued From page 236 to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide foot care for one of 29 residents in the survey sample, Resident #63. The facility staff failed to trim Resident #63's toenails in a timely manner. The findings include: Resident #63 was admitted to the facility on 4/2/05. Resident #63's diagnoses included but were not limited to: diabetes, low back pain and major depressive disorder. Resident #63's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/24/17, coded the resident as cognitively intact. Section G coded Resident #63 as requiring extensive assistance of one staff with bed mobility, dressing, eating and personal hygiene. Resident #63's comprehensive care plan revised on 9/24/17 documented, "Focus: The resident has a diagnosis of diabetes: Insulin Dependent...Interventions: Diabetic foot check daily. Observe feet/toes/ankles/soles/heels noting alteration in skin integrity, color, temperature, and cleanliness. Toenails for shape, length and color..."	F 687	trimmed either by nursing or by a podiatrist. A contract was obtained for a new Podiatrist who will start visiting the center on 1/11/2018. Podiatrist will be visiting center Monthly. Residents whose nails can be trimmed by nursing have had their nails trimmed. 3. Education was provided to the Nursing Staff by the Nurse Practice Educator, on the Process and Procedure for Nail Care. Nails are to be trimmed on residents shower days if appropriate, otherwise the residents name will be added to the Podiatry List. 4. Unit Managers will audit 5 residents per week for 6 weeks to ensure nails are being trimmed accordingly. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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F 687	Continued From page 237 Review of Resident #63's clinical record revealed the resident was last seen by the podiatrist on 8/9/17. On 12/4/17 at 2:40 p.m. an interview was conducted with Resident #63. Resident #63 stated she would like to get her toenails trimmed and she had told staff for the past two or three weeks that her toenails needed to be trimmed. Resident #63 was unable to state who she had told and reported she had told staff who had been in her room. When asked if she had been seen by a podiatrist, Resident #63 stated she had but it had been a long time. At this time, Resident #63's feet were sticking out of the bottom of the sheet while the resident was lying in bed. Resident #63's toenails were observed. All toenails on both feet were grown out past the resident's toes. The toenails on the great toes were the longest and were approximately one forth inch past the great toes. On 12/5/17 at 10:30 a.m. observation of Resident #63's toenails was conducted. The toenails remained the same length. On 12/6/17 at 12:05 p.m. an interview was conducted with CNA (certified nursing assistant) #6. CNA #6 was asked how staff ensures residents' toenails are cared for. CNA #6 stated diabetic residents' toenails are cared for by the podiatrist. CNA #6 stated usually if the resident is alert then the resident will ask the nurse to see the podiatrist and CNAs also let nurses know if they see the need during resident care. On 12/6/17 at 12:08 p.m. an interview was conducted with RN (registered nurse) #1. RN #1	F 687		

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F 687	Continued From page 238 was asked how staff ensures residents' toenails are cared for. RN #1 stated residents' toenails are monitored daily with patient care and if the toenails get long, grow fungus or anything out of the ordinary occurs then staff notifies the charge nurse or unit manager who puts the resident's name in the book to be seen by the podiatrist. RN #1 stated the podiatrist is supposed to come to the facility once a month. On 12/6/17 at 12:58 p.m. Resident #63's toenails were observed with RN #1. RN #1 confirmed the resident's toenails needed to be cut. RN #1 stated Resident #63 was assisted out of bed to be seen by the podiatrist one day during the previous month but then the podiatrist called and cancelled. When asked if arrangements were made for the podiatrist to schedule a make-up date, RN #1 stated the executive director was responsible for handling the podiatry arrangements. RN #1 stated she would make sure Resident #63's name was still in the book to be seen by the podiatrist. RN #1 stated the facility nurses do not trim diabetic residents' toenails. On 12/6/17 at 5:31 p.m. an interview was conducted with ASM (administrative staff member) #1 (the executive director). ASM #1 stated the podiatrist last came to the facility in August. ASM #1 stated he received communication from the facility's compliance office that the podiatrist had an issue with his licensed and the issue had cleared but the podiatrist had to be reinstated and re-credentialed. ASM #1 stated he was in communication with the podiatrist. ASM #1 stated the podiatrist was scheduled to come to the facility in October but didn't show up. ASM #1	F 687		

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F 687	Continued From page 239 stated the podiatrist was also supposed to come to the facility during the previous week but cancelled. ASM #1 stated he was in the process of pursuing another podiatrist. ASM #1 stated he communicates with Resident #63's daughter so he may see if the resident could go out of the facility to see a podiatrist. On 12/6/17 at 5:45 p.m., ASM #1, ASM #2 (the interim director of nursing) and ASM #3 (the clinical quality specialist) were made aware of the above concern. The facility policy titled, "1.2 ADL (Activities of Daily Living): Foot Care" documented, "Foot care and observations for signs of skin breakdown are provided for residents as requested or indicated. Toenail trimming must be performed by a physician or podiatrist for residents..." No further information was presented prior to exit. *"NAIL GROWTH, Fingernails grow faster than toenails - especially on your dominant hand. On average, fingernails grow 3.5 millimeters (mm) per month, while toenails grow an average of 1.6 mm per month." https://www.aad.org/media/stats/prevention-and-care/nail-care. (1.6 mm = 0.063 inches)	F 687		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689	1. The oxygen tank from Resident # 40's room was removed by Administrator and secured. Resident # 40 has since been discharged from the facility. Resident # 12 has her fall matts in place while in bed according to her order and care plan.	

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F 689	Continued From page 240 supervision and assistance devices to prevent accidents. 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 a safe environment for two of 29 residents in the survey sample, Resident's #40 and #10. This citation was originally found at a level four isolated and upon acceptance of the plan of correction, it was lowered to a level two isolated. 1. An oxygen tank was observed in Resident #40's room. The tank was unsecured. There was approximately 2000 PSI (pounds-force per square inch) reading on the gauge of the tank. It was sitting, without a stand or holder, next to the night stand with no support. The observation constituted the notification of immediate jeopardy. 2. The facility staff failed to place the fall mat down beside Resident #12's bed when she was lying in the bed. Resident #12 was observed on three separate occasions in bed without a fall mat in place as ordered by the physician and per the comprehensive care plan. The findings included: 1. Resident #40 was admitted to the facility on 8/8/17 with diagnoses that included, but were not limited to: stroke, dementia, dysphagia, (difficulty swallowing (1)), diabetes, and high blood pressure.	F 689	2. All residents have potential to be affected. House audit was completed by the Unit Managers during survey to ensure that there were no other unsecured oxygen tanks. All residents with orders for Fall Matts were reviewed to ensure that fall matts were in place per order. 3. Education was provided for all staff during survey related to Oxygen Storage. Education was provided again for facility staff post survey , by the Nurse Practice Educator , related to Oxygen Storage. Education was provided to nursing staff by the Nurse Practice Educator , related to Fall Prevention and ensuring that fall interventions are in place per order. 4. The Interdisciplinary Team will monitor for unsecured oxygen tanks on their daily rounds. Unit Managers will audit residents with orders for Fall Matts 3 X week for 6 weeks and randomly thereafter to ensure the fall matts are in place per order. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly	1/17/18

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F 689	Continued From page 241 The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/3/17, coded the resident as being severely cognitively impaired to make daily decisions. The resident was coded as requiring extensive assistance to being totally dependent of one or more staff members for all of her activities of daily living. In Section O - Special treatments, Procedures and Programs, Resident #40 was not coded as having received oxygen during the past 14-day look back period. On 12/5/17 at 9:40 a.m. an oxygen tank was observed unsecured by three surveyors. There was approximately 2000 PSI (pounds-force per square inch) reading on the gauge of the tank. It was observed sitting, without a stand or holder, next to the night stand with no support. The 12/5/17 at 9:45 a.m. A sweep of the entire facility was conducted by the survey team and there were no other unsecured oxygen tanks found in the building. On 12/5/17 at approximately 9:55 a.m. the supervisors at the Virginia Department of Health, Office of Licensure and Certification (OLC) were contacted regarding the Immediate Jeopardy for Resident #40. After a discussion, OLC Supervisors agreed with the Immediate Jeopardy assessment concerning Resident #40. The executive director, interim director of nursing and the clinical quality specialist were made aware of Immediate Jeopardy and substandard in quality of care on 12/5/17 at 10:03 a.m. Following the notification of immediate jeopardy, the executive director, interim director of nursing	F 689		

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F 689	Continued From page 242 and the clinical quality specialist were shown Resident #40's room with the unsecured oxygen tank. The executive director removed the oxygen tank out of the resident's room. The physician order dated, 8/9/17 and signed by the physician on 10/12/17, documented, "Oxygen via nasal cannula @ (at) 2 L (liters) for shortness of breath." The review of the comprehensive care plan dated 8/16/17 failed to evidence the use of oxygen. The facility policy, "Oxygen: High Pressure Cylinders" documented in part, "Cylinders must never be left standing at any time." Interviews were conducted with CNA (certified nursing assistant) #3 on 12/5/17 at 10:18 a.m. When asked how a portable oxygen tank is stored in a resident's room, CNA #3 stated, "It depends. It can be on the back of a wheelchair in a bag or in a stand." When asked if a tank can freely stand alone, CNA #3 stated, "No, they have to be in a holder." An interview was conducted with LPN (licensed practical nurse) #3 on 12/5/17 at 10:20 a.m. When asked how oxygen tanks are stored, LPN #3 stated, "We have them in the medication room." The medication room on the Reach unit was observed with four portable oxygen tanks, in a rack. When asked how a tank in a resident's room is stored, LPN #3 stated, "It has to be in a holder or on the back of a wheelchair in a holder." An interview was conducted with RN (registered nurse) #4 on 12/5/17 at 10:22 a.m. When asked how oxygen tanks are stored, RN #4 stated, "The	F 689		

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F 689	Continued From page 243 are in the medication room." The mediation room on the Cardinal unit was observed with eight tanks in a stand. When asked, how a tank in a resident's room is stored, RN #4 stated, "It has to be in a rack or on the back of the wheelchair in the pouch." When asked if a tank can stand freely, without a stand, RN #4 stated, "No." A Plan of Correction was presented on 12/5/17 at 12:42 p.m. The Plan of Correction documented the following: 1. "Oxygen cylinder removed from (Resident #40's) room by Executive Director at 10:00 a.m. on 12/05/17, and stored according to policy. 2. Education initiated by Nurse Practice Educator, all staff currently on duty were education on the policy for Oxygen Storage, on 12/5/17. No staff shall work until they have completed this education; this will be completed by the Nurse Practice Educator in person or via telephone by utilizing the facility staffing schedule to ensure all staff are educated accordingly. 3. 100% Room audit and common area audit completed by the Executive Director and Interim Director of Nursing to ensure no other improper Oxygen Storage. No other improper storage was noted. 4. Routine room rounds will be conducted daily by administrative staff to ensure that all oxygen is stored securely per policy. The Quality Assessment and Performance Improvement Committee met on 12/5/17 to discuss the findings identified by the surveyor and to review this action plan. 5. Allegation of compliance 12/5/17 at 12:30 p.m." Interviews were conducted with five staff members from varying departments on 12/5/17 between 12:55 p.m. and 1:02 p.m. All staff	F 689		

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F 689	Continued From page 244 members interviewed could verbalize their education received on the proper storage of oxygen tanks. Interviews were conducted with five staff members from varying departments on 12/5/17 between 3:06 p.m. and 3:11 p.m. All staff had received the education and could verbalize the facility policy on the storage of oxygen tanks. An interview was conducted on 12/6/17 at 6:50 a.m. with CNA #12, a 11:00 p.m. to 7:00 a.m. aide. When asked if she had received education regarding how to manage an oxygen tank, CNA #12 stated, "No. I got called (by the facility) but I didn't answer because I work night shift but I know how to take care of it." When asked how an oxygen tank was to be managed and stored, CNA #12 stated, "It has to be in a sack or a pouch." When asked why, CNA #12 stated, "If the oxygen tank falls it's like a grenade going off." Review of the staff education log did not evidence documentation that CNA #12 had received education prior to working. An interview was conducted on 12/6/17 at 6:50 a.m. with LPN #11, the night nurse. When asked how an oxygen tank was to be managed, LPN #11 stated, "Put it in a basket. It would be a torpedo if it falls." When asked if she received education that night about oxygen safety, LPN #11 stated, "I did." An interview was conducted on 12/6/17 at 6:55 a.m. with CNA #13, the night shift aide. When asked how an oxygen tank was to be stored, CNA #13 stated, "Make sure it's standing up." When asked if she received education that night before working about oxygen safety, CNA #13 stated,	F 689		

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F 689	Continued From page 245 "No. I wasn't aware." Interviews were conducted with employees of varying departments related to the storage of oxygen on 12/6/17 between 8:15 a.m. and 8:22 a.m. All staff members received the education regarding the storage of oxygen tanks and could verbalize the facility policy on the storage of oxygen tanks. On 12/6/17 at 8:45 a.m. the executive director, ASM (administrative staff member) #1, informed this surveyor they still had not reached eight staff members and had left messages for them to call the facility. He stated that if he hadn't heard from them in one hour, then he, himself would be contacting the staff members. ASM #1, the executive director stated he understood that it has to be 100% completed before the immediate jeopardy could be abated. On 12/6/17 at 10:18 a.m. the executive director informed this surveyor that only five staff members needed to be educated. One staff member was out of the country. Two of the staff members were scheduled for 11:00 p.m. to 7:00 a.m. tonight and would receive education prior to working. One staff member was to call the Nurse Practice Educator in the afternoon. and one staff member was schedule to work 12/7/17. An interview was conducted with CNA #1 on 12/6/17 at 3:00 p.m. When asked if she had received any education regarding oxygen storage, CNA #1 stated that she received education on oxygen tank storage and could verbalize the facility policy regarding the storage of oxygen tanks.	F 689		

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F 689	Continued From page 246 On 12/7/17 at 5:53 a.m. interviews were conducted with two of the staff members who were not marked as having received their education on oxygen tank storage. Both staff members could verbalize the facility policy regarding the storage of oxygen tanks and that they had received their education prior to working last night. On 12/7/17 at 8:40 a.m. final documentation was received that all staff members, other than the one staff member who was out of the country, had been educated in the storage of oxygen tanks. The Immediate Jeopardy was abated at 8:40 a.m. Guidance for safe handling of oxygen cylinders was provided by the Joint Commission at www.jointcommission.org <http://www.jointcommission.org> as follows: "It may be impractical for some organizations to have piped nonflammable medical gases, so they may provide these gases in freestanding cylinders of various sizes. All freestanding cylinders must be stored in a rack, a cart, or another enclosure to protect them. Unsecured cylinders could fall, breaking the valve and possibly resulting in a rapid release of the gas, propelling the cylinder and turning it into a dangerous projectile." The executive director was made aware of the abatement of the Immediate Jeopardy on 12/7/17 at 8:57 a.m. No further observations of oxygen tanks being stored improperly were noted. No further information was provided prior to exit.	F 689		

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F 689	Continued From page 247 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 178. 2. The facility staff failed to place the fall mat down beside Resident #12's bed when she was lying in the bed. Resident #12 was observed on three separate occasions in bed without a fall mat in place as ordered by the physician and per the comprehensive care plan. Resident #12 was admitted to the facility on 11/15/10 with a readmission on 5/5/16 with diagnoses that included, but were not limited to; dementia, osteoporosis (weakening of the bones), anemia (low red blood cells), acid reflux disease, depression, difficulty swallowing, and cognitive deficit. Resident #12's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/17/17, revealed, in part, that Resident #12 was unable to answer the questions on the BIMS (brief interview of mental status) and was coded on the staff assessment as being severely impaired to make decisions regarding tasks of daily life. Resident #12 was further coded as being dependent on staff for activities of daily living. Resident #12 was observed lying in her bed on the following dates and times: 12/04/17 at 01:15 p.m., Fall mat observed to be folded and propped against the wall at the end of Resident # 12's bed. Resident lying in bed with eyes closed.	F 689		

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F 689	Continued From page 248 12/4/17 at 02:05 p.m., Fall mat observed to be folded and propped against the wall at the end of Resident # 12's bed. Resident lying in bed with eyes closed. 12/06/17 09:17 a.m., Resident # 12 observed lying in her bed with her eyes closed. Bumper pads on either side and upper side rails up. Fall mat is folded and at the end of the bed. A review of Resident # 12's clinical record revealed, in part, the following order; "1/31/11 Fall mat at all times while in bed. 3/9/12 Pull alarm in chair." A review of Resident #12's comprehensive care plan dated 5/5/16 revealed, in part, the following documentation; "Focus: Resident is at risk for falls: Impaired mobility, history of falls and requires assistance with transfers. Date Initiated: 9/13/17. Interventions: fall mat when in bed. Date Initiated 8/24/11." On 12/07/17 at 11:44 a.m. an interview was conducted with CNA (certified nursing assistant) #14. CNA #14 was asked how she would know when a resident needs fall mats, CNA #14 stated, "It should be in the care plan." CNA #14 was asked if she looked at the care plan, CNA #14 stated that she did not. CNA #14 was asked If she didn't refer to the care plan how she knew what to do when taking care of the residents, CNA #14 stated, "The nurse lets me know." CNA #14 was asked was asked what she used to know what to do with the residents, CNA #14 stated, "I would say look at their chart, if you can find their chart." CNA #14 was asked if she knew that Resident #12 required a fall mat when in bed. CNA #14 stated that she did know. CNA #14 was informed the fall mat was observed not in place	F 689		

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F 689	Continued From page 249 on several occasions. CNA #14 stated, "From me being around her most of the time I know that it is in place. Most times it stays on her floor." On 12/7/17 at 12:30 an interview was conducted with ASM (administrative staff member) #2, the interim director of nursing (DON). ASM #2 was asked what the CNAs and nursing staff should do if there was an order for fall mats to be down when the resident was in bed. ASM #2 stated the floor mat should be down. ASM #2 was asked specifically about Resident #12's order for a fall mat. ASM #2 stated she had seen the floor mat down when she did rounds that morning. ASM #2 was made aware of the three observations (2 observations on 12/4/17 and one on 12/6/17) where Resident #12 was lying in bed, and the floor mat was folded and placed against the wall at the end of the bed. ASM #2 was asked to provide a policy for use of safety devices. A review of the facility document titled "Falls Management" did not reveal any documentation regarding the use of fall mats / safety devices for fall prevention. An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. No further information was provided prior to the end of the survey process.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		

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F 690	Continued From page 250 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to 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 and staff interview, it was determined the facility staff failed to ensure appropriate care services of a Foley Catheter to	F 690	1. Residents #284 and #286 indwelling-catheter tubing found on the floor was immediately removed and secured. Resident #286 is no longer in the facility. Resident #284 has tubing maintained in a sanitary manner. 2. All residents with indwelling catheters have the potential to be affected. A 100% audit was completed, by the Unit Managers, for all current residents with indwelling catheters to ensure the tubing was secured off the floor, with any identified deviations corrected immediately. 3. Education was provided to the nursing staff by the Nurse Practice Educator or the Nursing Supervisor related to providing foley-catheter care, including ensuring that tubing is not touching the floor. 4. The Unit Managers will audit residents with indwelling catheters 3x/week for six weeks, then randomly thereafter, to ensure tubing is secured in place and not	

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F 690	Continued From page 251 prevent infections for two of 29 residents in the survey sample; Resident # 284 and # 286. 1. The facility staff failed to maintain the indwelling urinary catheter tubing off the floor for Resident # 284. 2. The facility staff failed to maintain the indwelling urinary catheter tubing off the floor for Resident # 286. The findings include: 1. The facility staff failed to maintain the indwelling urinary catheter tubing off the floor for Resident # 284. Resident # 284 was admitted to the facility on 11/30/17 with diagnoses that included but were not limited to: atrial fibrillation, dysphagia (1), osteoporosis (2), attention of ileostomy (3) and attention to gastrostomy (feeding tube) (4). Resident # 284's most recent MDS (minimum data set), an admission assessment was not due at the time of survey. On 12/05/17 at approximately 11:25 a.m. Resident # 284 was observed dressed, in her wheelchair being pushed down the hall by her husband. Observation of the wheelchair revealed the catheter tubing dragging on the floor underneath the wheelchair. On 12/06/17 at approximately 2:10 p.m. an interview was conducted with LPN (licensed practical nurse) # 4 regarding the placement of catheter tubing. When told of the observation of Resident # 284's catheter tubing being dragged	F 690	touching the floor. Results of audits will be brought to the QAPI Committee for follow up monthly.	1/17/18

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F 690	Continued From page 252 on the floor under her wheelchair LPN # 4 stated, "The catheter tubing should always be off the floor." On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, executive director, ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit. References: (1) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (2) Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html. (3) An ileostomy (colostomy) is used to move waste out of the body. This surgery is done when the colon or rectum is not working properly. This information was obtained from the website: https://medlineplus.gov/ency/article/007378.htm. (4) A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm. 2. The facility staff failed to maintain the	F 690		

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F 690	Continued From page 253 indwelling urinary catheter tubing off the floor for Resident # 286. Resident # 286 was admitted to the facility on 02/15/17 with a readmission date of 11/18/17. Diagnosis include but were not limited to muscle weakness, prostate cancer, secondary cancer to bone, type 1(one) diabetes mellitus (1) and kidney disease. Resident # 286's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/25/17, coded Resident # 286 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact for making daily decisions. Resident # 286 was coded as requiring extensive assistance to being totally dependent of one staff member for activities of daily living and supervision of one staff member for eating. On 12/05/17 at approximately 10:53 a.m. Resident # 286 was observed lying in bed. The Foley catheter tubing was observed resting on the floor below the bed. On 12/06/17 at approximately 2:10 p.m. an interview was conducted with LPN (licensed practical nurse) # 4. When asked about the placement of a resident's catheter tubing LPN # 4 stated, "The tubing should be kept off the floor." When informed of the observation of Resident # 286's catheter tubing resting on the floor under his bed, LPN #4 stated it should have been clipped to the bed. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, executive	F 690		

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F 690	Continued From page 254 director, ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit. References: (1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §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.	F 693	1. Resident #56 no longer resides in the center. 2. All residents who receive tube feedings have potential to be affected. An audit was completed by the Unit Managers 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, to include appropriate positioning in bed while tube feed is running and following physician's order for Tube Feed administration. 4. Unit Managers will monitor/audit residents with tube feedings 3 X	

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F 693	Continued From page 255 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 a tube feeding as ordered by the physician for one of 29 residents in the survey sample, Resident #56. The facility staff left Resident #56's tube feeding running during a physician prescribed downtime of 10:00 a.m. until 2:00 p.m. The findings include; Resident #56 was admitted to the facility 12/21/12 with diagnoses that included, but were not limited to; dementia, a gastrostomy (a tube to deliver feeding directly into the stomach), peripheral vascular disease (poor circulation to the legs), high blood pressure, depression, difficulty swallowing, anemia (low red blood cell count), an irregular heartbeat, and difficulty speaking. Resident #56's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/13/2017 coded Resident #56 as being unable to answer the questions on the BIMS (brief interview for mental status) and the staff assessment coded Resident #56 as being severely impaired to make decisions regarding task of daily life. Resident #56 was coded as being dependent with activities of daily living. The following observations were made of Resident #56; 12/5/17 8:55 a.m. - Resident #56 lying on back in the bed with tube feeding infusing at 60 ml / hour.	F 693	week for 6 weeks, and randomly thereafter, to ensure that orders are followed accordingly. Results of these audits will be brought before the QAPI Committee monthly for review.	1/17/18

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F 693	Continued From page 256 Head of bed at approximately 30-degree elevation. 12/06/17 09:31 a.m. - Resident # 56 lying in bed, tube feeding infusing at 60 ml / hour. Head of bed elevated at approximately 30 degrees 12/06/17 11:36 a.m. Resident # 56 lying in bed, tube feeding running at 60 ml / hour 12/06/17 12:28 p.m. - tube feeding continues to run at 60 ml / hour. A review of Resident #56's clinical record revealed, in part, the following physician order on the physician order summary dated December 2017; "6/11/17 Jevity (a brand of tube feeding) 1.5 via gast-tube (gastric tube) at 50 ml/hr (milliliters / hour) 20 hrs/day (hours per day) - up at 2pm and down at 10 am. Flush tube with 200 ml of water every 4 hours." Further review of Resident # 56's clinical record revealed, in part, the following "Enteral Protocol" provided by the pharmacy, signed by nurse and physician on 11/20/17; "Tube feeding Jevity 1.5, 60 ml / hour 20 hours / day, downtime 10 am - 2 pm. Total volume of flush 1200 ml /24 hours; Total volume of nutrient + flush - 2400 ml /24 hours " A review of Resident # 56's comprehensive care plan dated 1/3/17 revealed, in part, the following documentation; "Focus: Resident has an enteral feeding tube to meet nutritional needs, sacral PU (pressure ulcer). Dated initiated 8/15/2017 Created on: 12/24/2012. Interventions: Aspiration precautions, Date Initiated: 7/19/2017. Check patency and placement of tube daily and before administering feedings and meds (medications). Dietary evaluation and monitoring. Formula Jevity 1.5 via pump per MD (medical	F 693		

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F 693	Continued From page 257 doctor) orders. Head of bed elevated 30-45 degrees during feeding." On 12/06/17 at 01:09 p.m. an interview was conducted with LPN (licensed practical nurse) #12, the floor nurse caring for Resident #56. LPN #12 was asked to explain Resident #56's tube feeding. LPN #12 stated, "She (Resident #56) is on Jevity 1.5 at 60 ml/ hr (she has a lot of reflux and she vomits easily), we change out the syringe every 24 hours on night shift." LPN #12 was asked what the schedule was for Resident #56's tube feeding. LPN #12 stated, "She (Resident #56) has her tube feeding off for a four-hour period during the day, from 10 am to 2 pm." LPN #12 was asked who was responsible for disconnecting the tube feeding. LPN #12 stated the nurse was responsible. LPN #12 further stated, "We disconnect her (Resident #56) from it (the tube feeding) at 10 am until 2 pm." At this time this writer and LPN #12 entered Resident #56's room and observed Resident #56's tube feeding was running. LPN #12 was asked whether or not the tube feeding was supposed to be running at this time. LPN #12 stated, " She (Resident #56) was vomiting at 7:30 a.m. this morning and so I disconnected the tube feeding for 25 minutes maybe. I then gave her (Resident #56) medications. I hooked her back up (to the tube feeding) at about 8am and it has been running since that time." LPN #12 was asked whether or not Resident #56 had received the 4 hour break as ordered. LPN #12 stated that Resident #56 had not received a four-hour break. LPN #12 was asked why Resident #56 was ordered a 4-hour break, LPN #56 stated, "I don't know. It is ordered, that's all I know. I would assume it is because of the vomiting. I need to stop it now and give her a break before 2pm."	F 693		

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F 693	Continued From page 258 On 12/07/17 at 10:24 a.m. an interview was conducted with LPN #3, a floor nurse. LPN #3 was asked to describe the process followed for a resident receiving tube feeding and how he knew what to do in regards to tube feed administration. LPN #3 stated, "We would have an order that would tell us when to put it (tube feeding) up and when to take down or if it is to be continuous. The order would also include the rate per hour for administration, and the type of tube feed. Sometimes it (the order) will list the calories or even the amount to be delivered." LPN #3 stated, "We follow the instructions provided in the order." An end of day meeting was conducted on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. A facility policy for tube feedings was requested at this time. A review of the facility policy titled, "Administration by Pump" revealed, in part, the following documentation; "7. Monitor patient tolerance to feeding. If nausea, vomiting, or diarrhea occur: 17.1 Stop feeding; 9. Disconnect feeding according to ordered schedule (e.g. (example) Bolus schedule, intermittent schedule, cyclic schedule, downtime for continuous schedule.)" No further information provided prior to the end of the survey process.	F 693		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		

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F 695	Continued From page 259 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide appropriate respiratory care services for six of 26 residents in the survey sample; Residents #234, #36, #286, #184, #9, and #43. 1. The facility staff failed to ensure a physician's order was in place prior to the administration of oxygen for Resident #234. 2. The facility staff failed to administer Resident # 36's oxygen according to the physician's orders. 3. The facility staff failed to administer Resident # 286's oxygen according to the physician's orders. 4. a. The facility staff failed to obtain a physician order for the use of oxygen for Resident #184. 4. b. The facility staff failed to administer oxygen per the physician prescribed rate for Resident #184. 4. c. The facility staff failed to store oxygen equipment and nebulizer equipment in a sanitary manner for Resident #184 5. For Resident #9, facility staff failed to maintain	F 695	1. Resident #184 has been discharged from the facility. Resident # 234 has an oxygen order in place. Resident #36 is receiving oxygen per order, Resident #286 is no longer in the facility. Resident #9 has respiratory equipment stored in a clean and sanitary manner. Resident #43 is receiving oxygen per order at the correct flow rate. These corrections were made by the Unit Managers. 2. All residents utilizing oxygen have potential to be affected. An audit was completed by the Unit Managers of all current residents utilizing oxygen to ensure that 1) orders were in place, 2) care plans in place 3) orders being followed correctly and correct flow rate administered, and 4) appropriate storage. 3. Education was provided to nursing staff by the Nurse Practice Educator on Oxygen Administration to include orders, setting flow rate, and oxygen equipment storage. 4. Unit Managers to monitor/audit residents receiving oxygen 3 x week for 6 weeks and randomly	

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F 695	Continued From page 260 oxygen equipment in a sanitary manner 6. The facility staff failed to administer oxygen at the physician's prescribed flow rate of two liters per minute for Resident # 43. The Findings include: 1. The facility staff failed to ensure a physician's order was in place prior to the administration of oxygen for Resident #234. Resident #234 was admitted to the facility on 12/4/17 with the diagnoses of but not limited to: MRSA (methicillin-resistant Staphylococcus aureus) [1] in a wound, Chronic Obstructive Pulmonary Disease, chronic back pain, scoliosis, opiate addiction, chronic pain syndrome, and aortic valve endocarditis. A MDS (minimum data set) assessment had not yet been completed. A review of the admission nursing assessment dated 12/4/17 documented the resident as being cognitively intact. The resident was documented as being able to participate in activities of daily living. The resident was also documented as having a PICC (peripherally inserted central catheter) [2] line and requiring oxygen therapy. On 12/08/17 at 09:12 a.m., Resident # 234 was observed with oxygen on at 1.75 liters/min (liters per minute) via nasal cannula. A review of the admission nursing assessment dated 12/4/17 documented Resident # 234 was on oxygen 2 liters/min. A review of the clinical record revealed there were no orders for oxygen.	F 695	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 Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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F 695	Continued From page 261 On 12/08/17 at 09:40 a.m. in an interview with RN #2 (Registered Nurse), she stated an order is required for the administration of oxygen. RN #2 stated the nurses should have recognized there was not an order in place for the oxygen when they went in the room and saw him on oxygen, and it wasn't on the MAR (Medication Administration Record). A review of the facility policy, "Oxygen Therapy Via Nasal Cannula" documented, "Oxygen therapy via nasal cannula will be administered as ordered by a physician ...Procedure: 1. Verify physician's order..." On 12/8/17 at 10:14 a.m., ASM #2 (Administrative Staff Member - the interim director of nursing) and ASM #3 (the corporate Clinical Quality Specialist) were made aware of the findings; and on 12/8/17 at 10:50 a.m., ASM #1 (the Executive), was made aware of the findings. No further information was provided by the end of the survey. [1] MRSA stands for methicillin-resistant Staphylococcus aureus. It causes a staph infection that is resistant to several common antibiotics. There are two types of infection. Hospital-associated MRSA happens to people in health care settings. Community-associated MRSA happens to people who have close skin-to-skin contact with others, such as athletes involved in football and wrestling. Infection control is key to stopping MRSA in hospitals. To prevent community-associated MRSA *Practice good hygiene *Keep cuts and scrapes clean and covered with a	F 695		

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F 695	Continued From page 262 bandage until healed *Avoid contact with other people's wounds or bandages *Avoid sharing personal items, such as towels, washcloths, razors, or clothes *Wash soiled sheets, towels, and clothes in hot water with bleach and dry in a hot dryer If a wound appears to be infected, see a health care provider. Treatments may include draining the infection and antibiotics. Information obtained from https://medlineplus.gov/mrsa.html [2] PICC stands for peripherally inserted central catheter. A long catheter that extends from an arm or leg vein into the largest vein (superior vena cava or inferior vena cava) near the heart and typically provides central IV access for several weeks. Unlike a standard intravenous catheter (IV) which is for short term use, a PICC is more durable and does not easily become blocked or infected. It may remain in place for several months so that blood can be repeatedly drawn or medication and nutrients can be routinely injected into the patient's bloodstream. Information obtained from https://www.radiologyinfo.org/en/info.cfm?pg=vasc_access 2. The facility staff failed to administer Resident # 36's oxygen according to the physician's orders. Resident # 36 was readmitted to the facility on 10/18/17 with diagnoses that included but were not limited to: pneumonia, heart failure, diabetes mellitus (1), altered mental status, high blood pressure and Parkinson's disease (2). Resident # 36's most recent MDS (minimum data set), an admission assessment with an ARD	F 695		

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F 695	Continued From page 263 (assessment reference date) of 10/18/17, coded Resident # 36 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 being moderately impaired of cognition for making daily decisions. Resident # 36 was coded as requiring extensive assistance of one staff member for activities of daily living and supervision of one staff member for eating. On 12/04/17 at approximately 11:55 a.m. Resident # 36 was observed in bed receiving oxygen by nasal cannula from an oxygen concentrator. Observation of the oxygen concentrator flow meter documented the flow rate at between one and a half liters per minute. On 12/05/17 at approximately 8:53 a.m. Resident # 36 was observed in bed eating breakfast. Resident # 36 was receiving oxygen by nasal cannula from an oxygen concentrator. Observation of the oxygen concentrator flow meter documented the flow rate at between one and one and a half liters per minute. On 12/05/17 at approximately 4:00 p.m. Resident # 36 was observed in in bed, awake. Resident # 36 was receiving oxygen by nasal cannula from the oxygen concentrator. Observation of the oxygen concentrator revealed the oxygen flow rate between one and one and a half liters per minute. On 12/06/17 at approximately 9:05 a.m. Resident # 36 was observed in bed watching television. Resident # 36 was receiving oxygen by nasal cannula from an oxygen concentrator. Observation of the oxygen concentrator flow meter documented the flow rate at one and a half liters per minute.	F 695		

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F 695	Continued From page 264 The physician's order dated 11/04/17 for Resident # 36 documented, "O2 (oxygen) at 2Lpm (two liters per minute) via (by) NC (nasal cannula)." The MAR (medication administration record) dated "Dec" (December) 2017 for Resident # 36 documented, "O2 at 2Lpm via NC." Further review of the MAR revealed Resident # 36 was receiving oxygen at two liters per minute from 12/01/17 through 12/0617 on the 11:00 p.m. to 7:00 a.m. shift, the 7:00 a.m. to 3:00 p.m. shift and on the 3:00 p.m. to 11:00 p.m. shift. The comprehensive care plan for Resident # 36 dated 10/23/17 documented, "Interventions. O2 (oxygen) as ordered. Date Initiated: 10/23/17. Created on: 10/23/17." On 12/06/17 at approximately 2:10 p.m. an interview was conducted with LPN (licensed practical nurse) # 4 regarding the oxygen flow rate for Resident # 36. When asked how to read the oxygen flow rate on an oxygen concentrator, LPN # 4 stated, "The liter line on the flow meter should pass through the middle of the float ball to indicate the liters per minute." When asked about her position to the oxygen concentrator when reading the flow rate, LPN # 4 stated, "I get down and get level with the flow meter to read it." When asked how often the resident's oxygen flow rate is checked, LPN # 4 stated, "I check it every time I go into the resident's room and it's documented on the MAR (medication administration record) each shift. When asked what the oxygen flow rate for Resident # 36's oxygen should be, LPN # 4 referred to the physician's order for Resident # 36 and stated, "It should be two liters per minute." LPN # 4 was	F 695		

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F 695	Continued From page 265 then asked to accompany this surveyor to Resident # 36's room. Upon entering the room LPN # 4 was then asked to read the oxygen flow rate on the oxygen concentrator for Resident # 36. LPN # 4 stated, "It's set at one and a half liters. It should be at two liters." LPN # 4 immediately adjusted Resident # 36's oxygen flow rate to two liters per minute. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, executive director, ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit. References: (1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (2) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. 3. The facility staff failed to administer Resident # 286's oxygen according to the physician's orders. Resident # 286 was admitted to the facility on 02/15/17 with a readmission date of 11/18/17. Diagnosis include but were not limited to muscle weakness, prostate cancer, secondary cancer to bone, type 1(one) diabetes mellitus (1) and	F 695		

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F 695	Continued From page 266 kidney disease. Resident # 286's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/25/17, coded Resident # 286 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively for making daily decisions. Resident # 286 was coded as requiring extensive assistance to being totally dependent of one staff member for activities of daily living and supervision of one staff member for eating. On 12/04/17 at approximately 11:55 a.m. Resident # 286 was observed in bed receiving oxygen by nasal cannula (2) from an oxygen concentrator. On 12/04/17 at approximately 3:25 p.m. an observation revealed Resident # 286 was in bed receiving oxygen by nasal cannula from an oxygen concentrator. Further observation of the flow meter on the oxygen concentrator revealed the flow rate was at one and a half liters per minute. On 12/05/17 at approximately 9:40 a.m. an observation revealed Resident # 286 was in bed receiving oxygen by nasal cannula from an oxygen concentrator. Further observation of the flow meter on the oxygen concentrator revealed the oxygen flow rate was set at between one and a half and two liters per minute. On 12/05/17 at approximately 4:05 p.m. an observation revealed Resident # 286 was in bed receiving oxygen by nasal cannula from an oxygen concentrator. Further observation of the	F 695		

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flow meter on the oxygen concentrator revealed the oxygen flow rate was set at one and a half liters per minute."

On 12/05/17 at approximately 10:53 a.m. an observation revealed Resident # 286 was laying bed receiving oxygen via nasal cannula from an oxygen concentrator. Further observation of the flow meter on the oxygen concentrator revealed the oxygen flow rate was set at one and a half liters per minute."

On 12/06/17 at approximately 9:08 a.m. an observation revealed Resident # 286 was laying bed eating breakfast independently receiving oxygen via nasal cannula from an oxygen concentrator. Further observation of the flow meter on the oxygen concentrator revealed the oxygen flow rate was set at between one and a half and two liters per minute.

The physician's Telephone Order dated 11/30/17 documented, "Oxygen via (by) NC (nasal cannula) at 2 (two) Li (liters). Oxygen titrate up to 3.5 (three and a half) liters via NC."

Review of the resident's comprehensive care plan dated 11/29/17 failed to evidence a care plan to address oxygen.

The MAR (medication administration record) for Resident # 286 dated "Dec (December) 2017 documented, "Oxygen via NC at 2L. May titrate up to 3.5L (three and a half liters)." Further review of the MAR revealed Resident # 286 was receiving oxygen from 12/01/17 through 12/07/17.

12/06/17 2:10 PM an interview was conducted with LPN (licensed practical nurse) # 4 regarding

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F 695	Continued From page 268	F 695		

the oxygen flow rate for Resident # 286. When asked how to read the oxygen flow rate on an oxygen concentrator, LPN # 4 stated, "The liter line on the flow meter should pass through the middle of the float ball to indicate the liters per minute." When asked about her position to the oxygen concentrator when reading the flow rate, LPN #4 stated, "I get down and get level with the flow meter to read it." When asked how often the resident's oxygen flow rate is checked, LPN # 4 stated, "I check it every time I go into the resident's room and it's documented on the MAR (medication administration record) each shift. When asked what the oxygen flow rate for Resident # 286 's oxygen should be, LPN # 4 referred to the physician's order for Resident # 286 and stated, "It should be two liters per minute." Resident # 286 was not in his room and was out with his family at the time of the interview with LPN #4 and Immediate observation of the oxygen concentrator flow meter could not be conducted. When LPN # 4 was informed of the above previous observations of Resident # 286's oxygen flow rate, LPN #4 stated, "It should have been set at two liters per minute."

On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, executive director, ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings.
No further information was obtained prior to exit.

References:

(1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/

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F 695	Continued From page 269 001214.htm. 4. a. The facility staff failed to obtain a physician order for the use of oxygen for Resident #184. Resident #184 was admitted to the facility on 11/30/17 with diagnoses that included, but were not limited to: fracture of the left humerus, chronic obstructive pulmonary disease (general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (2)), pulmonary fibrosis (pulmonary fibrosis is a condition in which the tissue deep in your lungs becomes scarred over time. This tissue gets thick and stiff. That makes it hard for you to catch your breath, and your blood may not get enough oxygen (3)), diabetes and high blood pressure. There was no completed MDS (minimum data set) assessment as of the dates of the survey. The Initial Nursing Assessment, dated 11/30/17, documented Resident #184 was alert and oriented to person, place and time. The form documented under "Respiration - regular Method: oxygen via nasal." The review of the care plan failed to evidence any documentation related to the use of oxygen for Resident #184. Observations were made of Resident #184's room on 12/04/17 at 11:45 a.m. There was an oxygen concentrator in the room with the nasal cannula tubing lying on the bed, not covered. The	F 695		

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F 695	Continued From page 270 resident was not in the room at this time. A review of the clinical record failed to evidence a physician's order for oxygen. On 12/04/17 at 4:30 p.m., Resident # 184 was observed asleep in his bed, with oxygen on via nasal cannula at 4 L/Min (liter/minute). On 12/05/17 at 8:44 a.m., Resident # 184 was sitting on side of bed eating breakfast with O2 (oxygen) at 4L/min running via nasal cannula. On 12/06/17 at 10:55 a.m. the clinical record was reviewed and a new physician order dated, 12/6/17 documented, "O2 (oxygen) @ (at) 2 L (liters) via nasal cannula." The nurse's notes dated 12/2/17 at 10:30 p.m. documented in part, "Resident continues on O2 at 4L/min with good effect." The nurse's note dated, 12/3/17 at 2:30 p.m. documented in part, "Pt (patient) on 2L (liters) O2 via N/C (nasal cannula - a tube with two prongs that go into the nostrils)." An interview was conducted with LPN (licensed practical nurse) #4 on 12/6/17 at 2:06 p.m. When asked if a physician order is required for oxygen, LPN #4 stated "Yes, Ma'am." When asked where the nurse documents checking a residents oxygen flow rate, LPN #4 stated it is documented on the MAR (medication administration record). Resident # 184's MAR was reviewed with LPN #4 and she stated, "I just noticed it today that he was on oxygen and I checked the orders and there was no order for oxygen." When asked if she has	F 695		

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F 695	Continued From page 271 taken care of him since last Thursday, LPN # 4 stated, "Yes, I took care of him Monday." When asked if she noticed this on Monday, LPN #4 stated, "Honestly, I couldn't remember if he had it Monday." LPN #4 stated, "I went in this morning and he was set at 4L/min so I went to check the chart and found no order." An interview was conducted with LPN #3 on 12/6/17 at 2:34 p.m. When asked if a physician's order is required for the use of oxygen, LPN #3 stated, "Yes, absolutely." The facility policy, "Oxygen Therapy via Nasal Cannula" documented in part, "Oxygen therapy via nasal cannula will be administered as ordered by a physician and will include correct flow rate, mode of delivery and frequency...Procedure: Verify physician's order." 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 administration." Administrative staff member (ASM) #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, were made aware of the above concern on 12/7/17 at 4:45 p.m. No further information was obtained prior to exit.	F 695		

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F 695	Continued From page 272 4.b. The facility staff failed to administer oxygen per the physician prescribed rate for Resident #184. On 12/06/17 at 10:55 a.m. the clinical record was reviewed and a new physician order dated, 12/6/17 documented, "O2 (oxygen) @ (at) 2 L (liters) via nasal cannula." On 12/06/17at 12:02 p.m., Resident # 184 observed in bed, reciving oxygen by nasal cannula connected to a concentrator. The concentrator flow rate was set at 1.5 - 2 l/min. The ball of the flow meter was observed with the top of the ball on the line for 2 and the bottom of the ball was on the line for 1.5 l/min. Resident #184 stated when he goes to therapy in the wheelchair, they put it up to 4 l/min. Since he's just resting in bed, it should be 2 liters/min but even at home he states he puts it up to 4l/min when he is up and walking around. On 12/06/17 at 1:41 p.m., Resident # 184 was observed in bed, O2 on via nasal cannula. The oxygen concentrator flow rate was set with the ball of the flow meter set between 1.5 and 2 L/min. The top of the ball was observed on the line for 2 and the bottom of the ball was on the line for 1.5 l/min. Resident # 184's care plan was reviewed and failed to evidence documentation for the use of oxygen. An interview was conducted with LPN #4 on 12/6/17 at 2:06 p.m. When asked how to read an oxygen flow rate, LPN #4 stated you check the level of glass tube and the ball. You put the ball	F 695		

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F 695	Continued From page 273 with the line passing through the middle of the ball. When asked how often the oxygen flow rate is checked by the nurse, LPN #4 stated she checks it each time she enters the room. At this time LPN #4 accompanied this surveyor into Resident #184's room to read his oxygen concentrator. LPN #4 looked at Resident #184's oxygen concentrator flow meter and stated, "It needs to be up a little bit more, the line isn't through the center of the ball." 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..." Administrative staff member (ASM) #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, were made aware of the above concern on 12/7/17 at 4:45 p.m. No further information was obtained prior to exit. 4. c. The facility staff failed to store oxygen equipment and nebulizer equipment in a sanitary manner for Resident #184. On 12/04/17 at 11:45 a.m., Resident #184's room was observed. The Oxygen (O2) tubing was observed lying on the bed. A nebulizer mask was not covered, and was sitting on nightstand. On 12/04/17 at 02:21 p.m., Resident # 184's Nebulizer mask was observed on the night stand, uncovered.	F 695		

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F 695	Continued From page 274 On 12/04/17 at 2:28 p.m., an oxygen tank with O2 tubing, not covered, had the nasal cannula just hanging and touching the floor. On 12/04/17 at 3:07 p.m., The clinical record was reviewed; there was no documented physician order for oxygen. On 12/04/17 at 4:30 p.m., Resident # 184 was observed asleep, with oxygen on via nasal cannula at 4 L/Min. On 12/05/17 at 8:44 a.m., Resident #184 was sitting on side of bed eating breakfast. O2 at 4L/min running via nasal cannula. Nebulizer mask on top of night stand, uncovered. O2 tubing on O2 tank on back of wheelchair uncovered, hanging, almost touching floor. On 12/06/17 at 10:55 a.m. Resident #184's room was observed. The nebulizer was on the top of the night stand uncovered. The oxygen tubing was located wrapped around the concentrator, uncovered. A New order was noted for 12/6/17 for Oxygen @ (at) 2L(liters)/NC (nasal cannula) with O2 saturation every shift. On 12/7/17 at 10:20 a.m., Resident #184's room was observed. The nebulizer machine mask and oxygen tubing was on the bed, uncovered. An interview was conducted with LPN (licensed practical nurse) #4 on 12/6/17 at 2:06 p.m. When asked where oxygen tubing is stored when it's not in use, LPN #4 stated that all respiratory equipment should be bagged when not in use." When asked why it should be bagged, LPN #4	F 695		

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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
F 695	Continued From page 275 stated, "For infection control purposes." The facility policy, "Respiratory Equipment Disinfection/Cleaning" did not address storing the respiratory equipment in bags 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." Administrative staff member (ASM) #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, were made aware of the above concern on 12/7/17 at 4:45 p.m. No further information was obtained prior to exit. 5. For Resident #9, facility staff failed to properly store oxygen equipment in a plastic bag and ensure it was free from touching the floor. Resident #9 was admitted to the facility on 9/14/16 and readmitted on 8/11/17 with diagnoses that included but were not limited to: pancreatic cancer, muscle weakness, pressure ulcer to the right buttock, type two diabetes, and hypothyroidism. Resident #9's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/09/17. Resident #9 was coded as being moderately impaired in cognitive function scoring 09 out of 15 on the BIMS (brief interview for mental status) exam. Resident #9 was coded as requiring extensive assistance from two or more staff members with transfers, bed mobility, and toileting, and extensive assistance from one staff member with dressing and personal hygiene.	F 695		

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F 695	Continued From page 276 On 12/04/17 at 03:21 p.m., an observation was made of Resident #9. Her oxygen tubing including the nasal cannula was uncovered sitting on top of the concentrator. Her oxygen tubing was not placed in a plastic bag. A plastic bag could not be found in her room. On 12/05/17 at 08:11 a.m., an observation was made of Resident #9. Her oxygen tubing including the nasal cannula was uncovered sitting on top of the concentrator. Her oxygen tubing was not placed in a plastic bag. A plastic bag could not be found in her room. On 12/06/17 07:58 a.m. an observation was made of Resident #9. Her oxygen tubing was observed on the floor. A plastic bag could not found in her room. Review of Resident #9's physician telephone orders revealed the following order initiated on 10/22/17, "Oxygen via nasal cannula titrate up to 5 liters to maintain oxygen sats (saturations) at or above 92 percent." On 12/06/17 at 11:32 a.m., an interview was conducted with LPN (licensed practical nurse) #8. When asked how oxygen should be stored when not in use, LPN #8 stated, "Oxygen is wrapped in plastic bags. Tubing is changed out on Saturdays. 11-7 shift does that. They change the bag as well, date and label it with the resident's name and room number." LPN #8 stated that oxygen tubing should be stored in a plastic bag to prevent infections. On 12/06/17 at 3:10 p.m., an interview was conducted with LPN #2, Resident #9's nurse.	F 695		

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F 695	Continued From page 277 When asked how oxygen tubing should be stored when not in use, LPN #2 stated, "02 (oxygen) tubing should be stored in a plastic bag with their (resident) name on it, liters of 02 (oxygen), and the date when changed. Tubing should be changed every Saturday." When asked why oxygen tubing should be stored in a plastic bag, LPN #2 stated, "Should be stored for sanitary purposes." This writer accompanied LPN #2 to Resident # 9's room. When asked what LPN #2 observed about Resident #9's oxygen tubing, LPN #2 stated the oxygen tubing was on the floor. LPN #2 also stated she could not find a plastic bag. On 12/07/17 at 12:16 p.m., an observation was made of Resident #9. Resident #9 was on 2 liters of oxygen via nasal cannula. A plastic bag was not in Resident #9's room. A date of when the tubing was changed could not be found on the tubing. On 12/06/17 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the interim DON (Director of Nursing) and ASM #2, the clinical quality specialist were made aware of the above concerns. Facility policy titled, "Respiratory Equipment Disinfection/Cleaning," did not address the above concerns. No further information was presented prior to exit. 6. The facility staff failed to administer oxygen at the physician's prescribed flow rate of two liters per minute for Resident # 43. Resident # 43 was admitted to the facility on 7/8/17 and readmitted on 9/19/17 with diagnoses	F 695		

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F 695	Continued From page 278 that included but were not limited to: anemia, congestive heart failure, hypertension, diabetes, hyperlipidemia, anxiety, and depression. Resident # 43's most recent MDS (minimum data set) assessment, a Quarterly Assessment, with an ARD (assessment reference date) of 10/15/17 coded Resident # 43 as understood by others and as able to understand others. Resident # 43 was coded as being cognitively intact for making daily decisions, scoring 15 out of 15 on the BIMS (brief interview for mental status). Review of a physician order dated 9/20/17 and most recently signed by the physician on 12/4/17 documented, "OXYGEN 2L/MIN VIA NASAL CANNULA CONTINUOUS" Review of the December 2017 MAR is as follows: "O2 @ 1L/min via nasal cannula Continuous" dated 9/20/17. Review of the care plan revealed documentation of the following: Under "Focus: Resident exhibits or is at risk for respiratory complications related to history of CHF (congestive heart failure), PNA (pneumonia) and seasonal allergies. Date Initiated 09/28/17" Under "Interventions ...O2 as ordered via nasal cannula. Date Initiated 09/28/2017" The following observations were made of Resident # 43's oxygen: - 12/04/17 11:59 a.m. Resident # 43's oxygen was observed set at 1.5 liters/minute - 12/04/17 05:48 p.m. Resident # 43's oxygen was observed set at 1.5 liters/minute - 12/05/17 08:31 a.m. Resident # 43's oxygen was observed set at 1.5 liters/minute	F 695		

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F 695	Continued From page 279 - 12/06/17 07:10 a.m. Resident # 43's oxygen observed set at set at 1.5 liters/minute - 12/06/17 09:12 a.m. Resident # 43's oxygen was observed set at 1.5 liters/minute During an interview on 12/6/17 at 2:07 p.m. with LPN (licensed practical nurse) # 2, LPN # 2 was asked to view the oxygen setting on Resident # 43's concentrator flow meter. LPN # 2 stated the flow meter was set at 1.5 liters/minute (the center of the ball in the flow meter was centered on the 1.5 L/min. line). LPN # 2 was asked to view the physician order and confirmed the physician ordered the oxygen be set to 2 liters/minute. LPN # 2 then presented the MAR and when the MAR was reviewed there was documentation that Resident # 43's oxygen was to be set to 1 liter per minute. Documentation on the December 2017 MAR is as follows: "O2 @ 1L/min via nasal cannula Continuous" dated 9/20/17. LPN # 2 had no explanation for the discrepancy between the physician order and the MAR. LPN # 2 was asked who the Unit Manager was and stated that there was no unit manager. During an interview on 12/6/17 at 2:18 p.m. with ASM (Administrative Staff Member) # 1, the Executive Director, ASM # 2, the Interim Director of Nurses, and ASM # 3, the Clinical Quality Specialist, this observation was revealed. A request was made for the policies related to oxygen administration, following physician orders, and manufacturer's information for the oxygen concentrator on the setting of the flow meter. During the end of day interview on 12/6/17 at 5:20 p.m. this concern was again shared with ASM # 1, ASM # 2, and ASM # 3 and a requested the facility policy on following physician orders.	F 695		

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F 695	Continued From page 280 During an interview on 12/7/17 at 10:05 a.m. with ASM # 3, the corporate clinical specialist, the facility policy for following physician orders was discussed. ASM # 3 stated she could find no policy specifically for following physician orders. ASM # 3 stated, "The facility's standards of practice are the company's policies. The company has a team that writes and creates its own standard." The facility policy, "Oxygen Therapy via Nasal Cannula" documented in part, "Oxygen therapy via nasal cannula will be administered as ordered by a physician and will include correct flow rate, mode of delivery and frequency...Procedure: Verify physician's order." 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..." No further information was provided prior to exit. According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."	F 695		

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F 698	Continued From page 281	F 698	1. Resident #39 now has a Physician's order that includes the name of the Dialysis Center. Resident #39 care plan was updated to include Dialysis care needs. Resident # 39 has a Dialysis Communication book that goes back and forth from facility to Dialysis Center. Resident #39 has current documentation of monitoring on the MAR. These corrections were made by the Unit Managers. The center now has a Dialysis Contract in place, initiated by the Administrator.	
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698	2. All residents on Dialysis have the potential to be affected. An audit was completed by the Unit Managers of all current residents on Dialysis to ensure that there was an appropriate physician's order, care plan, documentation of monitoring and Dialysis Communication in place. Dialysis Center Contracts are now in place.	
	§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 observation, 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 29 residents in the survey sample, Resident #39. The facility staff failed to ensure physician orders were in place for Resident #39 who was receiving dialysis and for the care of his dialysis access. The finding include: Resident #39 was admitted to the facility on 10/3/17 with diagnosis that included but were not limited to: high blood pressure, diabetes, seizure disorder, below the knee amputation, infection of the right lower leg and end stage renal failure requiring hemodialysis. Hemodialysis is a procedure used in toxic conditions and renal failure in which wastes and impurities are removed from the blood by a special machine. The blood is shunted to and from a dialyzer where, through diffusion and ultrafiltration, wastes are removed." (1) The most recent MDS (minimum data		3. The Nurse Practice Educator provided education to Licensed Nursing Staff on Dialysis Management to include orders, care plans, documentation of	

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F 698	Continued From page 282 assessment), a Medicare 60-day assessment, with an assessment reference date of 11/28/17, coded the resident as being cognitively intact to make daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis while a resident at the facility. Review of the physician's orders revealed there was no physician order for dialysis. There was no documentation of the dialysis center name, contact information, days of the week the resident was to go to dialysis and or any transportation pick up documentation. In addition, there was no documentation of what type of dialysis access Resident #39 had in place and there was nothing documented regarding its care. The December 2017 TAR (treatment administration record) documented, "Dialysis on T (Tuesday), Th (Thursday) and Sat (Saturday)." No name of the dialysis center or contact information. The December 2017 MAR (medication administration record) documented, "Observe external hemodialysis catheter every 2 hours for signs of complications. There was nothing documented on the following dates and times: 12/1/17 - 6:00 a.m. until 4:00 p.m. 12/2/17 - 8:00 a.m. until 4:00 p.m. 12/5/17 - 8:00 a.m. until 4:00 p.m. 12/6/17 - 10:00 a.m. until 4:00 p.m. There were no physician orders for the above. The nurse's notes from 11/1/17 through 12/6/17 were reviewed and failed to evidence any documentation related to the hemodialysis	F 698	monitoring on the MARs, and Dialysis Communication Forms/Books. 4. Unit Managers will audit all residents on Dialysis weekly x 6 weeks and randomly thereafter, to ensure documentation on MARs and Dialysis Communication is in place. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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F 698	Continued From page 283 access site. Review of the comprehensive care plan dated, 10/13/17, failed to evidence any documentation related to the resident being on hemodialysis. An interview was conducted with 12/6/17 at 2:25 p.m. with LPN (licensed practical nurse) #3. When asked if you need an order for dialysis, LPN #3 stated, "Yes, you need to have how many times a week." When asked where checking a dialysis access is documented, LPN #3 stated it's should be documented on the MAR. When asked how often a dialysis access check is performed, LPN #3, stated it should be checked every shift. An interview was conducted with LPN #4 on 12/6/17 at 2:40 p.m. When asked if the facility needed a physician order for dialysis, LPN #4 stated that they need orders for transportation to dialysis. When asked what type of access Resident # 39 had for dialysis, LPN #4 stated he has a catheter in his chest. When asked where staff document that Resident #39's dialysis access is checked, LPN #4 stated, "It's on the MAR." The MAR for Resident #39 was reviewed. It did document the observation of the external hemodialysis catheter every 2 hours for signs of complications, but was not consistently signed off as observed. Also documented on the MAR was "Smooth Clamps at bedside at all times." The room was checked with LPN #4 and the clamp was located on the bulletin board next to the bed. When asked the care plan should include Resident #39's dialysis care, such as, the catheter site observation, the clamp at the bedside, what to monitor for a resident on dialysis, LPN #4 stated, "Yes, I would think so."	F 698		

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F 698	Continued From page 284 Administrative staff member (ASM) #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, were made aware of the above concern on 12/7/17 at 4:45 p.m. A policy on the care for a resident receiving dialysis was requested. 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 266.	F 698		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 732	1. Facility currently has staff posting in place per regulation. 2. Nursing Supervisors and Unit Managers will ensure that the staff posting is posted according to regulations and updated accordingly each shift to reflect accurate staffing. 3. Education was provided to the nursing leadership team and the administrator by the Regional Nurse on the requirements of this regulation. 4. Director of Nursing or Administrator to monitor 5 days per week x 3 weeks then randomly thereafter to ensure posting is in place per regulation. Results of these audits will be brought before	

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F 732	Continued From page 285 residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. 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 ensure the Staff Posting was posted timely. The findings include: On 12/07/17 at 3:35 p.m., a tour of the facility revealed the daily staff posting. The posting was printed 12/7/17 at 7:53 a.m., and therefore was not posted before the beginning of the 7a.m.-3p.m. shift. As of the observation on 12/7/17 at 3:35 p.m., the census information had not been updated to include the 3p.m.-11p.m. shift census information for staffing, and in addition, any updates to the pre-printed staffing information for the 3p.m.-11p.m. shift had not been made. On 12/07/17 at 04:14 p.m., an interview was conducted with ASM #3 (Administrative Staff Member - the corporate Clinical Quality Specialist). She stated the staffing should be posted daily and updated every shift.	F 732	the Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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F 732	Continued From page 286 On 12/7/17 at approximately 5:00 p.m. at the end-of-day meeting, ASM #1 (the Administrator), ASM #2 (the Director of Nursing) and ASM #3 were made aware of the findings. On 12/08/17 at 10:14 a.m., a review of the daily staff posting was made again. The posting for this date was not printed until 8:14 a.m., after the beginning of the 7a.m.-3p.m. shift. A review of the facility policy, "Posting Staffing" documented, "3. The posting should be: ...3.2 completed on a daily basis at the beginning of each shift; and 3.3 adjusted either upward or downward if staffing changes." On 12/8/17 at 10:14 a.m., ASM #2 (Administrative Staff Member - the interim director of nursing) and ASM #3 (the corporate Clinical Quality Specialist) were made aware of the findings; and on 12/8/17 at 10:50 a.m., ASM #1 (the Executive Director), was made aware of the findings that the posting was late again, even after being notified of the concern on 12/7/17. No further information was provided by the end of the survey.	F 732		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755	1. Residents #83 and #234 are currently receiving all ordered medications. Resident #56 has been discharged from the facility. 2. All residents have potential to be affected. An audit of current residents was completed by the Unit Managers, to ensure their medications were available and	

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F 755	Continued From page 287 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure medications were available for administration as ordered by the physician for three of 29 residents in the survey sample, Residents #83, #56 and #234. 1. The facility staff failed to acquire and administer Resident #83's medications per physician's orders on 11/3/17. 2. The facility staff failed to obtain Resident #56's	F 755	administered per order. 3. Education was provided to Licensed Nursing Staff by the Nurse Practice Educator on Medication Administration to include the process for obtaining medications from pharmacy, back up pharmacy or back up box as needed. 4. Unit Managers to audit MARs 3 x week for six weeks and randomly thereafter to ensure medications are available and administrated according to order. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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F 755	Continued From page 288 prescribed Medihoney [2] (a medically certified honey used to treat wounds) to apply to her wound for a period of eight days. 3. The facility staff failed to ensure a physician-ordered medication was available for administration for Resident #234. The findings include: 1. The facility staff failed to acquire and administer Resident #83's medications per physician's orders on 11/3/17. Resident #83 was admitted to the facility on 9/24/17 and readmitted on 11/2/17. Resident #83's diagnoses included but were not limited to: pain in the right knee, muscle weakness and high blood pressure. Resident #83's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 11/28/17, coded the resident as cognitively intact. Review of Resident #83's clinical record revealed the following readmission orders dated 11/2/17: -levocetirizine (1) 5 mg daily -lyrica (2) 150 mg twice a day -bisoprolol (3) 5 mg daily -carisoprodol (4) 350 mg every night -vesicare (5) 10 mg daily Review of Resident #83's November 2017 MAR (medication administration record) revealed the resident was not administered the scheduled doses of levocetirizine, lyrica, bisoprolol and vesicare on 11/3/17 at 9:00 a.m. and was not administered the scheduled dose of carisoprodol on 11/3/17 at 9:00 p.m. as evidenced by the	F 755		

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nurses circling their initials on the MAR. The back of the MAR documented "11/3/17 9AM NO AM Meds (medications) given. NP (Nurse practitioner) aware."

A pharmacy manifest dated 11/3/17 revealed Resident #83's levocetirizine, bisoprolol, and vesicare were not delivered to the facility until 11/3/17 at 11:18 p.m. The manifest did not contain information regarding the other medications.

Review of the facility STAT (immediate) box (a box containing various medications that can be accessed if a resident's medications have not been delivered) inventory list revealed all the above medications that were not administered were not in the STAT box.

Further review of Resident #83's clinical record (including nurses' notes and a leave of absence form) failed to reveal Resident #83 was out of the facility on 11/3/17. Note LPN (licensed practical nurse) #4 did document "LOA" (leave of absence) under a medication that was scheduled at 9:00 a.m.; however, an interview with that nurse on 12/8/17 at 9:07 a.m. revealed she accidentally wrote "LOA." LPN #4 confirmed Resident #83 was in the facility on 11/3/17.

Resident #83's comprehensive care plan revised on 11/6/17 documented, "Focus: Resident exhibits or is at risk for alterations in comfort...Interventions: Medicate resident as ordered for pain...Focus: Resident exhibits or is at risk for respiratory complications related to Asthma...Interventions: Administer aerosol as ordered/indicated...Focus: Resident exhibits or is at risk for cardiovascular

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F 755	Continued From page 290 symptoms...Interventions: Administer meds (medications) as ordered..." On 12/4/17 at approximately 2:14 p.m. an interview was conducted with Resident #83. The resident stated she did not get her medications for 24 hours after coming back from hospital. On 12/7/17 at 10:23 a.m. a telephone interview was conducted with LPN (licensed practical nurse) #6 (the nurse responsible for administering the 9:00 p.m. dose of Advair diskus to Resident #83 on 11/3/17). LPN #6 was asked what should be done to ensure residents receive their medications upon readmission. LPN #6 stated nurses should review the MARs and make sure they match the admission medication list and physician's orders. LPN #6 stated if the medications are not available then nurses should let the supervisor know and call the pharmacy so the medications will be delivered on the next pharmacy run. LPN #6 stated the pharmacy delivers medications in the afternoon and late at night. LPN #6 stated many medications can also be obtained from the facility Omni cell (STAT box). LPN #6 was asked what is meant by circled initials on the MAR. LPN #6 stated it usually means the resident refused the medication, the medication was not in the facility or the resident was not in the facility. LPN #6 was made aware she initialed and circled medications that were supposed to be administered to Resident #83 during the evening of 11/3/17 in addition to the day shift nurse initialing and circling medications. LPN #6 stated she assumed the resident was out of the facility. LPN #6 was made aware there was no documentation to evidence Resident #83 was out of the facility on 11/3/17. LPN #6 stated there could have been an order to hold	F 755		

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F 755	Continued From page 291 medications because the resident may have been scheduled to go out for a procedure. LPN #6 was made aware there was no order to hold medications. LPN #6 stated, "I'm not sure. Those are the only things I remember." On 12/7/17 at 11:24 a.m. an interview was conducted with LPN #4 (the nurse responsible for administering the 9:00 a.m. and 1:00 p.m. medications to Resident #83 on 11/3/17). LPN #4 was asked what is done with a resident's medications if the resident is sent to the hospital. LPN #4 stated she waits to see if the resident is admitted to the hospital and once admitted, she returns the medications to the pharmacy. LPN #4 stated once a resident is readmitted to the facility, she writes out the medication orders and faxes the orders to the pharmacy. LPN #4 stated the pharmacy usually delivers the medications by the night of admission but this depends on what time the medication list is faxed to the pharmacy. LPN #4 stated she also uses the Omni cell but the Omni cell does not contain all medications. LPN #4 stated if scheduled medications aren't in the Omni cell and haven't been delivered by the pharmacy then she calls the physician. On 12/7/17 at 2:23 p.m. ASM (administrative staff member) #1 (the executive director), ASM #2 (the interim director of nursing) and ASM #3 (the clinical quality specialist) were made aware of the above concern. The facility policy titled, "Medication Shortages/Drugs Not Available" documented, "When medication orders are not received or unavailable, the licensed nurse will immediately initiate action in cooperation with the attending physician and the pharmacy provider. All	F 755		

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F 755	Continued From page 292 medication orders unavailable to the patient will be managed with urgency...If a medication shortage is discovered during normal pharmacy hours: 2.1 A licensed nurse calls the pharmacy and speaks to a registered pharmacist to determine the status of the order. If not ordered, place the order or re-order to be sent with the next scheduled delivery. 2.2. If the next available delivery causes delay or missed dose in the patient's medication schedule, take the medication from the emergency stock supply to administer the dose. 2.3 If medication is not available in the emergency stock supply, notify the pharmacist and arrange for an emergency delivery..." No further information was presented prior to exit. (1) levocetirizine is used to relieve symptoms of allergies. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a607056.html (2) lyrica is used to treat nerve pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a605045.html (3) bisoprolol is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a693024.html (4) carisoprodol is used to relax muscles and relieve pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682578.html	F 755		

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F 755	Continued From page 293 (5) Vesicare is used to treat overactive bladder. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a605019.html 2. The facility staff failed to obtain Resident #56's prescribed Medihoney [2] (a medically certified honey used to treat wounds) to apply to her wound for a period of eight days. Resident #56 was admitted to the facility 12/21/12 with diagnoses that included, but were not limited to; dementia, a gastrostomy (a tube to deliver feeding directly into the stomach), peripheral vascular disease (poor circulation to the legs), high blood pressure, depression, difficulty swallowing, anemia (low red blood cell count), an irregular heartbeat, and difficulty speaking. Resident #56's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/13/2017 coded Resident #56 as being unable to answer the questions on the BIMS (brief interview for mental status) and the staff assessment coded Resident #56 as being severely impaired to make decisions regarding task of daily life. Resident #56 was coded as being dependent with activities of daily living. Resident #56 was also coded as receiving greater than 50% of her nutrition through tube feeding. A review of Resident #56's clinical record revealed, in part, the following orders for a stage 2 pressure ulcer on Resident #56's lower left leg; "11/28/17. Cleanse (L) outer calfe (sic) stg. (stage) 2 ulcer [1] (Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis.) NS (normal saline) wound cleanser, dry, apply	F 755		

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Medihoney [2] (medically certified honey for use with wound healing) and then silicone dsg (dressing) qd (every day)." Signed and dated by the nurse practitioner on 11/29/17.

On 12/6/17 at 12:30 p.m. LPN (licensed practical nurse) #12 approached this writer and stated she was ready to provide wound care for Resident # 56. As LPN #12 gathered her supplies she stated Resident #56's Medihoney had not arrived from the pharmacy. LPN #12 was asked when the Medihoney was ordered. LPN #12 stated, "It was ordered - I don't know - I want to say the 30th or the 1st." LPN #12 was asked what she normally did if she didn't have what she needed for a resident's treatment. LPN #12 stated, if another resident on the hall has the same prescription I will use another resident's supply until I get what I need from the pharmacy." LPN #12 was asked if anyone had contacted the pharmacy. LPN #12 stated, "Not that I know of. I don't know why the pharmacy hasn't been contacted. I didn't know anything about it yesterday because all the treatments were done when I came on shift. I assumed that her (Resident # 12's) supplies were here so I didn't question it." LPN #12 was asked what was she going to do next. LPN #12 stated, "I am going to contact the pharmacy and see if they've sent it. I know they got the order because I received a fax confirmation." At this time LPN #12 went to verify the fax order went to the pharmacy. LPN #12 was unable to locate the fax confirmation that the order was sent to the pharmacy. LPN #12 reviewed the order and stated she was the one who had signed off on the order. LPN #12 further stated, "It looks like it was not "taken off" but I remember sending it to the pharmacy it must not have gone through." When asked when the order for Medihoney was

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received by nursing LPN #12 stated, "On 11/29/17 the Medihoney was ordered and not received." LPN #12 was asked who did the treatment on 11/30/17. LPN #12 stated she was unable to determine. When asked who completed the treatments between 12/2 - 12/5/17, LPN #12 stated the treatments were signed off as being completed by an LPN who was no longer with the facility. LPN #12 was asked what had the staff been using to follow the prescribed order. LPN #12 stated, "The staff have been using another resident's Medihoney."

On 12/7/17 at 12:30 p.m. an interview was conducted with ASM (administrative staff member) #2, the interim director of nursing (DON). ASM #2 was asked what process the nursing staff followed if they do not have a prescribed treatment/medication to administer as ordered. ASM #2 stated, "They should call the pharmacy and have them process the order." ASM #2 was asked if it was appropriate to use another resident's treatment/medication. ASM #2 stated "No." ASM #2 was asked if she was aware Resident # 56 did not have Medihoney available to administer to her wound between 11/29/17 and 12/6/17. ASM #2 stated that she had not been made aware of that. ASM #2 was asked to provide a policy regarding obtaining medications/treatments from the pharmacy.

On 12/7/17 at 3:00 p.m. ASM #3 was asked what professional standard of practice the facility uses, ASM #3 stated they follow their policies. A policy was not provided for the use of another resident's medications.

An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director,

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F 755	Continued From page 296 ASM #2, the interim DON, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. No further information was provided prior to the end of the survey process. [1] This information was obtained from the following website; http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/. [2] This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2686636/ 3. The facility staff failed to ensure a physician ordered medication was available for administration for Resident #234. Resident #234 was admitted to the facility on 12/4/17 with the diagnoses of but not limited to: MRSA (methicillin-resistant Staphylococcus aureus) [1] in a wound, Chronic Obstructive Pulmonary Disease, chronic back pain, scoliosis, opiate addiction, chronic pain syndrome, and aortic valve endocarditis. An MDS (minimum data set) assessment had not yet been completed. A review of the admission nursing assessment dated 12/4/17 documented the resident as being cognitively intact. The resident was documented as being able to participate in activities of daily living. The resident was also documented as having a PICC (peripherally inserted central catheter) [2] line and requiring oxygen therapy.	F 755		

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F 755	Continued From page 297 On 12/07/17 at 03:30 p.m., LPN #7 (Licensed Practical Nurse) reported to the survey team that Resident # 234 was a new admission on 12/4/17 and that physician-ordered medication had not been available for administration since admission. A. Theophylline [3]: A review of the clinical record revealed the "Discharge Medication List" from the hospital, undated, revealed an order for Theophylline [3] 100 mg (milligrams) by mouth twice daily. A review of the admission orders revealed this medication was also on facility admission orders. A review of the MAR (Medication Administration Record) on 12/7/17 at 04:00 p.m., revealed the Theophylline had not been administered since admission. The resident had missed 6 doses since admission. Further review of the clinical record on 12/8/17 at 8:30 a.m. revealed an order dated 12/7/17 for "Order Clarification" which documented the Theophylline 100 mg tab was not available per the pharmacy, and to start 300 mg tabs, give half tab (150 mg) by mouth twice daily. A review of the nurse's notes revealed one dated 12/7/17 at 1:50 p.m. documented, "Pt (patient) theophylline 100 mg did not get delivered from rx (pharmacy). RX was called and stated they do not carry theophylline 100mg they only carry 300mg and 400mg. A new order was written for theophylline 300mg tablet 1/2 (half) tab (tablet) PO (by mouth) BID (twice daily). MD (doctor) and pt made aware..."	F 755		

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F 755	Continued From page 298 B. Minocycline [4]: Further review of the "Discharge Medication List" from the hospital, undated, revealed an order for Minocycline [4] 100 mg (milligrams) by mouth twice daily. A review of the admission orders revealed this medication was included on facility admission orders. A review of the MAR revealed that the Minocycline was not administered until 9:00 p.m. on 12/6/17. The resident had missed 4 doses of this medication since admission. There were no nurse's notes documenting the status or notification of the Minocycline. (See F580). Two of the 4 missed doses were missed due to the medication not being delivered timely. (A review of the pharmacy delivery manifest revealed the Minocycline was filled on 12/4/17 but was not delivered to the facility until 12/5/17 at 5:48 p.m.). On 12/08/17 at 09:40 a.m. in an interview with RN #2 (Registered Nurse), she stated she wrote the admission orders but was not the one that took them off. RN #2 stated that the evening shift should have done a MAR-to-order check when the MAR's were printed. She stated that this step was probably not done as the medication did not make it to the MAR, and thus contributed to the missed doses. RN #2 stated that had this step taken place, the nurses would have realized much sooner that the Theophylline had not arrived as it was not available to administer, and order clarification would have occurred much sooner. RN #2 stated when the Theophylline did not arrive timely the nurse should have called the pharmacy to find out why it was not sent, and that would have then triggered the clarification. RN #2 stated that regarding the Minocycline, had the MAR been verified against the orders, the Minocycline would have then been added as	F 755		

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F 755	Continued From page 299 required and the resident would not have missed as many doses once it arrived. She stated the resident should not have had to go 3 to 4 days without his medications. A review of the facility policy for "Medication Shortages/Drugs Not Available" documented, "When medication orders are not received or unavailable, the licensed nurse will immediately initiate action in cooperation with the attending physician and the pharmacy provider. All medication orders unavailable to the patient will be managed with urgency." On 12/8/17 at 10:14 a.m., ASM #2 (Administrative Staff Member - the director of nursing) and ASM #3 (the corporate Clinical Quality Specialist) were made aware of the findings; and on 12/8/17 at 10:50 a.m., ASM #1 (the Executive Director), was made aware of the findings. No further information was provided by the end of the survey. [1] MRSA stands for methicillin-resistant Staphylococcus aureus. It causes a staph infection that is resistant to several common antibiotics. There are two types of infection. Hospital-associated MRSA happens to people in health care settings. Community-associated MRSA happens to people who have close skin-to-skin contact with others, such as athletes involved in football and wrestling. Infection control is key to stopping MRSA in hospitals. To prevent community-associated MRSA *Practice good hygiene *Keep cuts and scrapes clean and covered with a bandage until healed	F 755		

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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
F 755	Continued From page 300 *Avoid contact with other people's wounds or bandages *Avoid sharing personal items, such as towels, washcloths, razors, or clothes *Wash soiled sheets, towels, and clothes in hot water with bleach and dry in a hot dryer If a wound appears to be infected, see a health care provider. Treatments may include draining the infection and antibiotics. Information obtained from https://medlineplus.gov/mrsa.html [2] PICC stands for peripherally inserted central catheter. A long catheter that extends from an arm or leg vein into the largest vein (superior vena cava or inferior vena cava) near the heart and typically provides central IV access for several weeks. Unlike a standard intravenous catheter (IV) which is for short term use, a PICC is more durable and does not easily become blocked or infected. It may remain in place for several months so that blood can be repeatedly drawn or medication and nutrients can be routinely injected into the patient's bloodstream. Information obtained from https://www.radiologyinfo.org/en/info.cfm?pg=vasc_access [3] Theophylline is used to prevent and treat wheezing, shortness of breath, and chest tightness caused by asthma, chronic bronchitis, emphysema, and other lung diseases. It relaxes and opens air passages in the lungs, making it easier to breathe. Information obtained from https://medlineplus.gov/druginfo/meds/a681006.html [4] Minocycline is used to treat infections caused	F 755		

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F 755	Continued From page 301 by bacteria including pneumonia and other respiratory tract infections; certain infections of the skin, eye, lymphatic, intestinal, genital, and urinary systems; and certain other infections that are spread by ticks, lice, mites, and infected animals. Information obtained from https://medlineplus.gov/druginfo/meds/a682101.html	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761	1. The Medication Cart was secured during survey. No other carts noted to be unlocked and unattended, as noted by the Unit Managers. 1:1 Education was provided to LPN #1 and #2 regarding securing medication carts. 2. All residents have potential to be affected. Medication carts are being maintained according to policy, as evidenced by audits. 3. Education was provided by the Nurse Practice Educator to the Licensed Nursing Staff on securing the medication carts. 4. Unit Managers will monitor/audit med carts 5 x week for 6 weeks and randomly thereafter to ensure that the carts are kept secure when not attended. Results of these audits will be brought before the	

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F 761	Continued From page 302 by: Based on observation, staff interview and facility document review, the facility staff failed to ensure one of six medication carts was secured when not under direct observation, the medication cart on the Martin hallway. Facility staff failed to lock the medication cart on the Martin hallway when the cart was out of the line of sight of the nurse. The findings include: A medication administration observation was conducted on 12/05/17 at 10:45 a.m. on the Martin hallway with LPN (licensed practical nurse) #1. LPN #1 went to the medication cart where LPN #2 was standing. LPN #2 then left the cart, entered room a resident room and closed the door. LPN #1 followed LPN #2 into the room and closed the door leaving the medication cart unlocked and out of line of sight. A CNA (certified nursing assistant) was observed standing next to the cart when it was left unlocked. LPN #1 returned to the cart approximately 35 seconds later and immediately locked the cart. An interview was conducted on 12/5/17 at 12:35 p.m. with LPN #1. When asked how staff secure the medication carts, LPN #1 stated, "Lock it anytime I'm not there." When asked if she should have locked the cart earlier that morning, LPN #1 stated, "Yes I should have locked it." On 12/7/17 at 4:45 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the interim director of nursing and ASM #3, the corporate quality specialist were made aware of the findings.	F 761	Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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F 761	Continued From page 303 Review of the facility's policy titled, "Medication Administration: General" documented, "PURPOSE. To provide a safe, effective medication administration process. PRACTICE STANDARDS. 1. Maintain security of cart and keys at all times." No further information was provided prior to exit.	F 761		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. 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 obtain a physician ordered laboratory test for one of 29 residents in the survey sample, Resident #184. The facility staff failed to obtain a HgA1C (hemoglobin A1C), CBC (complete blood count) and BMP (basic metabolic panel) ordered on 12/1/17 for Resident #184.	F 773	1. Resident # 184 no longer resides at the center. 2. All residents with orders for labs have potential to be affected. An audit was completed by the Unit Managers, of all current residents with lab orders in the last 30 days to ensure that labs were obtained per order. 3. Education was provided to the Licensed Nursing Staff by the Nurse Practice Educator on the Lab Process. 4. The Clinical Nurse Management Team will review all new orders for labs in the Clinical Morning Meeting 5 days per week, to ensure that labs are added to the lab tracking form and carried out per order. Results of these audits will be brought before the Quality	

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F 773	Continued From page 304 The findings include: Resident #184 was admitted to the facility on 11/30/17 with diagnoses that included, but were not limited to: fracture of the left humerus, chronic obstructive pulmonary disease (general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (2)), pulmonary fibrosis (pulmonary fibrosis is a condition in which the tissue deep in your lungs becomes scarred over time. This tissue gets thick and stiff. That makes it hard for you to catch your breath, and your blood may not get enough oxygen (3)), diabetes and high blood pressure. There was no completed MDS (minimum data set) assessment as of the dates of the survey. The Initial Nursing Assessment, dated 11/30/17, documented Resident #184 was alert and oriented to person, place and time. The physician order dated, 12/1/17, documented, "HgA1C *, CBC**, and BMP*** in am (morning)." *HgA1c is a lab test that shows the average level of blood sugar (glucose) over the previous 3 months. It shows how well you are controlling your diabetes. Alternative Names include: Hemoglobin - glycosylated; A1C. (4) ** A complete blood count (CBC) test measures the following: The number of red blood cells (RBC count) The number of white blood cells (WBC count) (5)	F 773	Assurance and Performance Improvement Committee monthly for review.	1/17/18

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F 773	Continued From page 305 ***The basic metabolic panel (BMP) is a group of blood tests that provides information about your body's metabolism (6) Review of the clinical record failed to evidence documentation of the completed laboratory tests; HgA1C, CBC and BMP. The comprehensive care plan dated, 12/6/17, documented in part, "The resident has a diagnosis of diabetes. At risk for hypoglycemia/hyperglycemia (too low and too high blood sugars (7))." The "Interventions" documented in part, "Labs (laboratory tests) as ordered and report results to MD (medical doctor)." The December 2017 MAR (medication administration record) documented, "12/1/17 - HgA1C, CBC, BMP." A box was drawn around 12/2/17. The box was blank. An interview was conducted with LPN (licensed practical nurse) #4 on 12/6/17 at 2:06 p.m. LPN #4 was asked about the process staff follows for obtaining physician ordered laboratory tests. LPN #4 stated the nurse gets the order and puts it in the computer, in the laboratory program, and write down the acquisition number you get from the computer. Once it's submitted in the computer, you get the number and write the number on the telephone order. The lab person comes early in the morning and the labs are drawn." When asked about the process for obtaining the test results, LPN # 4 stated, "The 3-11 staff get the results and hand them out to the nurses or call the physician." When asked how you know a laboratory test documented on a residents TAR was completed, LPN #4 stated you	F 773		

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F 773	Continued From page 306	F 773		

need to check to see if it was drawn."

A copy of Resident #184's laboratory test results for the CBC, BMP and HbA1C ordered on 12/1/17 were requested from executive director, interim director of nursing and the corporate clinical quality specialist, on 12/6/17 at 5:00 p.m.

On 12/7/17 at 9:58 a.m. administrative staff member (ASM) #3, the clinical quality specialist, presented a physician order dated, 12/7/17 to obtain the above ordered laboratory tests. ASM #3 stated, "This lab (laboratory test) was missed. It has been ordered to be drawn tomorrow, 12/8/17."

An interview was conducted with LPN #3 on 12/7/17 at 10:28 a.m. When asked about the process followed for obtaining physician ordered laboratory tests, LPN #3 stated, "You take the order and put it in the laboratory program on the computer. You get the requisition number and put it on the telephone order and write it on the MAR." When asked how staff knows the lab test was done, LPN #3 stated you look at the MAR."

The facility policy, "Diagnostic Tests/Results Reporting" documented in part, "Policy: Diagnostic tests - including laboratory, radiologic pulmonary, and waived testing (finger stick glucose monitoring, hemoccult testing) will be performed as ordered...Procedure: 1. Verify the physician order for laboratory, diagnostic testing and specifics for reporting. 2. Notify diagnostic service to arrange for test. 3. Obtain report of diagnostic test. 4. Notify physician of all abnormal labs (laboratory tests). "

Administrative staff member (ASM) #1, the

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F 773	Continued From page 307 executive director, ASM #2, the interim director of nursing, and ASM #3, were made aware of the above concern on 12/7/17 at 4:45 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 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55. (3) This information was obtained from the following website: https://medlineplus.gov/pulmonaryfibrosis.html. (4) This information was obtained from the following website: http://www.nlm.nih.gov/medlineplus/ency/article/003640.htm (5) This information was obtained from the following website: http://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&query=CBC&x=24&y=17 (6) This information was obtained from the following website: http://www.nlm.nih.gov/medlineplus/ency/article/003462.htm (7) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; pages 281 and 285.	F 773		
F 803 SS=B	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of	F 803	1. Facility is currently following the planned menu for each meal. Changes to the menu are reviewed and approved by the Registered Dietician, as evidenced by audits.	

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F 803	Continued From page 308 residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility document review, it was determined that the facility staff failed to follow the menus provided to the residents. The facility staff were observed to serve items that were not on the menu during the dinner hour on 12/4/17. The findings include: A review of the facility dinner menu for 12/4/17 revealed, the following items to be served; garlic mashed potatoes, glazed pork chop, puree carrots, roasted vegetables, roasted Brussels	F 803	2. All residents have potential to be affected. Food production sheets will be in place and followed by the cooks. 3. Education provided to the Dietary Staff by the Regional Dietary Services Manager regarding regulation and process for following Posted Menus. Education provided to the facility Dietary Services Director by the Regional Dietary Services Manager regarding process for making changes to posted menu. 4. Administrator and Registered Dietician to audit meals 5 days per week to ensure menus are followed accordingly. Assigned, Weekend Managers On Duty to audit one meal on Saturday and Sunday to ensure that menus are followed. Administrator to meet with Dietary Services Director weekly to ensure that food supply meets all menu requirements. Results of these audits will be brought to the Quality Assurance and Performance Improvement Committee monthly for review.	1/17/18

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F 803	Continued From page 309 sprouts, sliced carrots, Swiss roast beef. The following items were served; glazed pork chop, roasted vegetables, garlic mashed potatoes, Swiss roast beef, ham and salads. An observation was made on 12/4/17 at 4:45 p.m. until 7:05 p.m. of the dinner preparation for service to the residents. Between 4:45 p.m. and 5:30 p.m. the food items were being placed into the steam oven to bring the food items up to the required temperatures. At 5:30 p.m. the staff began plating the foods for delivery to the residents on the floor. At 6:20 p.m. with 20 plates remaining OSM (other staff member) #2, the executive chef, stated he had run out of the roast beef and mashed potatoes. When asked what his process was when he ran out of a meal item, OSM #2 stated he would go to the alternate, pork and OSM #2 was observed making more mashed potatoes. OSM #2 began serving the sliced pork loin and ran out of the pork after plating five more plates. OSM #2 replaced the pork with sliced ham. At 6:35 p.m. the meal line had run out of the mixed vegetables. OSM #2 asked OSM #13, the director of dining services, to make some small mixed salads to replace the vegetables, the salads consisted of chopped lettuce and small tomatoes. OSM #2 was asked whether or not the residents are made aware of the changes made to the meal being served prior to sending the trays out. OSM #2 stated, "No we just need to get something out, if they don't like it they can send it back and we will do something else, but otherwise we just send them something." On 12/4/17 at 6:50 p.m. an interview was conducted with OSM #13, the dietary manager. OSM #13 was asked if any of the residents were asked about the food changes that had been	F 803		

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F 803	Continued From page 310 made because the kitchen had run out of roast beef and vegetables. OSM #13 stated she didn't think so. When asked why the kitchen had run out of beef and mixed vegetables. OSM #13 stated she did not know what had happened and would look into it. OSM #13 stated, "I don't know what happened and why carrots were not served, most of the time they (the residents) get what's on the menu." OSM #13 was asked the process for residents to choose their menus. OSM #13 stated the residents fill out their request one time per week, usually done on a Friday for the following week." OSM #13 was asked if the residents should get what they choose. OSM #13 stated the residents should get what they choose. OSM #13 further stated they should not have run out of beef because they have production charts that say how much to make. On 12/5/17 at 9:30 a.m. an interview was conducted with OSM #13. OSM #13 was asked to describe the process for changing items on the menu. OSM #13 stated, "If we know that we need to substitute food items then we write the substitute on a log which then comes to me." OSM #13 provided the log and an entry for 12/4/17 documented; "Substitute carrots for mixed vegetables." No other information was provided. A policy was requested regarding substituting menu items. An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM (administrative staff member) #1, the executive director, ASM #2, the DON, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. No further information was provided prior to the	F 803		

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F 803	Continued From page 311 end of the survey process.	F 803		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §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 the facility staff failed to store and serve food in a sanitary manner. 1a. The refrigerator and freezer were inspected during the course of the survey process and food items were observed to be open to air, opened but not dated or labeled and serving carts were observed to have dried substances on the rails. 1b. The facility staff failed to store food safely in two refrigerators in the hallway pantries.	F 812	**Kitchen** 1. Expired, undated, unlabeled, and uncovered items have been discarded. Food Service Carts have been cleaned. Coffee Machine and surrounding area have been cleaned. The Dry Food Storage area floor has been cleaned, boxes and bread removed from the floor. All of this was completed by facility Dietary Services Director. 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. 3. Education provided to dietary staff by the Regional Dietary Manager regarding the process and schedules for cleaning of the kitchen and equipment, storage of food in accordance with professional standards of food service safety.	

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F 812	Continued From page 312 The findings include; 1a. The refrigerator and freezer were inspected during the course of the survey process and food items were observed to be open to air, opened but not dated or labeled and serving carts were observed to have dried substances on the rails. On 12/4/17 at 4:45 p.m. an inspection was made of the freezer revealing, in part, a bag of frozen green beans that were not sealed and were open to air in the freezer. OSM (other staff member) #13, the dietary manager, stated the green beans should have been sealed, OSM #13 further stated, "We are cooking them for dinner." A review of the menu and observation of the dinner service verified green beans were not served for dinner. OSM #13 was unable to state how long the green beans had been left open to air. The green beans were removed by OSM #13 and given to OSM #2, the executive chef, who tied a knot in the top of the bag and returned the bag to the freezer. On 12/5/17 at 9:30 a.m. an inspection was made of the refrigerator in the kitchen. The green beans observed open to air on 12/4/17 had been placed back in the refrigerator for use with the bag tied, OSM #13 was asked if there should have been a label on the green beans. OSM #13 stated that there should have been a label and stated they had been opened on Monday for lunch. A review of the week's menus revealed, in part, the green beans were used on 12/3/17. OSM #13 removed the green beans and threw them in the trash.	F 812	4. Administrator and Registered Dietician will audit the kitchen 5 X week for 6 weeks and then 2 X per week thereafter to ensure that Kitchen is maintained in a clean and sanitary manner and that food storage is in accordance with professional standards of food service safety. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly for review. **Nursing** 1. Both Unit Refrigerators were cleaned and all unlabeled, undated and expired items were discarded by Unit Managers. 2. Director of Nursing instituted a nightly cleaning process for the Pantry Refrigerators to ensure that they are maintained in a manner that meets the professional standards for food safety and service. 3. Education was provided to the Nursing Staff by the Nurse	1/17/18

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F 812	Continued From page 313 Further inspection of the refrigerator revealed the following items; - A tub of butter that was approximately half full, no lid (open to air), no label and no date. The butter appeared opaque in some areas. - A large piece of ham wrapped in saran wrap without a label or date. - A ham sandwich with chips in a basket, no label and date and not completely sealed. All above items observed were also by OSM #13. OSM #13 stated that all items should have been covered, labeled and dated. On 12/5/17 at 9:45 a.m. an inspection of the kitchen area was conducted with OSM #19, a cook. The following areas/equipment were found unclean; - Under the coffee machines a large amount of dried coffee and grains was observed on the table under the machine. - A food delivery cart with large amount of spills in the back of the cart and used packs of sugar stuck to the bottom of the cart. - Dry food storage area - sticky floors and boxes laying on the floor, a half used pack of bread on the floor. When asked about the above listed items, OSM #19 stated, "The food carts should have been cleaned last night, but it wasn't done. A lot of food gets put into the refrigerator without labels and dates." On 12/5/17 at approximately 1:30 p.m. OSM #13 was made aware of the dry storage room, the serving carts and the table beneath the coffee	F 812	Practice Educator on maintaining the refrigerators on the units, to include labeling and dating of all items, and discarding expired and unlabeled items. Social Services to provide notification to residents and family members regarding the process of labeling and dating all food items brought into the facility. 4. Unit Managers to audit pantry refrigerators 3 X week for 6 weeks, and then randomly thereafter to ensure they are maintained in a manner that meets the professional standards of food safety and service. Results of these audits will be brought before the QAPI Committee monthly for review.	1/17/18

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F 812	Continued From page 314 machine. OSM #13 was asked who was responsible for cleaning in the kitchen. OSM #13 stated the dietary staff were supposed to be cleaning the kitchen. A review of the facility policy titled "Food Storage: Dry Goods" revealed, in part, the following documentation; "All dry goods will be appropriately stored in accordance with the FDA (food and drug administration) Food Code. 1. All items will be stored on shelves at least 6 inches above the floor." A review of the facility policy titled, "Food Storage: Cold Foods" revealed, in part, the following documentation; "5. All foods will be stored wrapped (sic) or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination." A review of the facility policy titled "Environment" revealed, in part, the following documentation; "All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. 1. The dining services director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting and ventilation. " An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. No further information was provided prior to the end of the survey process.	F 812		

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F 812	Continued From page 315 1b. The facility staff failed to store food safely in two refrigerators in the hallway pantries. The following observations were made in the refrigerators in the 200-unit pantry on 12/8/17 at approximately 8:15 a.m.: - Applesauce - no label / not dated - Opened Gatorade - no date - Container of unknown substance - no date/no label - Container of unknown substance date of 12/4/18, contents appeared spoiled - An unsecured pizza box with a have eaten slice of pizza - no date/ no label - A bag containing fast food - no date / no label - 1/2 pitcher of orange juice with no date / no label - Almost empty bottle of an energy drink - no date / no label On 12/8/17 at 8:30 a.m. LPN (licensed practical nurse) #3 was asked to accompany this writer to the Unit 200 pantry and shown the items listed above. LPN #3 was asked whether or not the items should have been labeled and dated. LPN #3 stated that they should have been. LPN #3 was asked who was supposed to manage the refrigerators in the unit pantries. LPN #3 stated he did not know. The following observations were made in the refrigerator in the 100-unit pantry on 8/8/17 at 8:30 with LPN #3: - Applesauce no label/ date - French vanilla coffee creamer - no label / no date - A half a loaf of bread - no label / date - A half pack of liverwurst opened in a zip lock	F 812		

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F 812	Continued From page 316 baggie - no date - Large foil container filled with two layers of egg salad sandwiches open to air - no label / no date - Paper plate with a half-eaten egg sandwich and a roll, no label / no date and open to air LPN #3 was asked whether or not each item listed above were appropriately / safely stored. LPN #3 stated no they were not. LPN #3 was asked whether or not opened items should have been labeled and dated, LPN #3 stated yes. LPN #3 was asked whether or not open items should have been securely covered. LPN #3 stated yes. On 12/8/17 at 8:43 a.m. an interview was conducted with RN (registered nurse) #2, the staff development coordinator, RN #2 was asked who was responsible for ensuring that food was stored appropriately in the unit pantries. RN #2 stated, "We have gone back and forth between dietary and nursing. I guess that nursing is responsible for food." RN #2 was asked whether or not the opened food should be labeled and dated. RN #2 stated it should. On 12/8/17 at 8:50 a.m. an interview was conducted with OSM (other staff member) #13, the dietary manager. OSM #13 was asked who was responsible for food in the unit pantry refrigerators. OSM #13 stated the nursing staff was responsible for food items placed in the refrigerator that did not come from the kitchen. OSM #13 was asked about the egg salad sandwiches in the 100-unit pantry refrigerator. OSM #13 stated that activities had a party so it was probably left overs. OSM #13 was asked if they should have been placed in the refrigerator uncovered. OSM #13 stated no. OSM #13 was asked whether or not the staff were trained on	F 812		

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F 812	Continued From page 317 safe food handling, OSM #13 stated she did not know. OSM #13 was asked to provide a policy on food storage in the unit refrigerators. A review of the facility policy titled "Food Brought in for Patients/Residents" revealed, in part, the following documentation; "Food items that require refrigeration must be labeled with patient's / resident's name and date the food was brought in. Food items must be stored in a closed container to prevent contamination." An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. A facility policy was requested at this time. No further information was provided prior to the end of the survey process.	F 812		
F 840 SS=E	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside	F 840	1. Resident #63 received podiatry care offsite on 12/21/17. Resident #185 discharged back to the community on 12/14/17. Contracts with the outpatient dialysis centers where residents #39 & #74 are receiving treatment were initiated and executed by the Administrator, and both residents continue to reside at the facility in stable condition.	

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F 840	Continued From page 318 resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined the facility staff failed to maintain contracts for outside resources for four of 29 residents in the survey sample, Residents #39, 185, 74 and #63. 1. The facility staff failed to maintain a contract with the dialysis center that Resident #39 was receiving treatment at, while a resident at the facility. 2. The facility staff failed to maintain a contract with the dialysis center that Resident #185 was receiving treatment at, while a resident at the facility. 3. The facility staff failed to maintain a contract with the dialysis center that Resident #74 was receiving treatment at, while a resident at the facility. 4. The facility staff failed to maintain a contract with a podiatrist who performed services in the facility for Resident #63. The findings include: 1. Resident #39 was admitted to the facility on 10/3/17 with diagnosis that included but were not limited to: high blood pressure, diabetes, seizure	F 840	2. All residents requiring hemodialysis and podiatry services have the potential for being affected. 3. Administrator secured the services of a community-based podiatrist effective 1/11/18 and a contract was executed. Administrator will ensure that contracts are executed with all outpatient dialysis centers where current residents are receiving treatment. 4. Administrator will share this information regarding Use of Outside Resources at the monthly QAPI Committee meeting for education and review purposes, and will review twice annually to ensure continued compliance.	1/17/18

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F 840	Continued From page 319 disorder, below the knee amputation, infection of the right lower leg and end stage renal failure requiring hemodialysis. Hemodialysis is a procedure used in toxic conditions and renal failure in which wastes and impurities are removed from the blood by a special machine. The blood is shunted to and from a dialyzer where, through diffusion and ultrafiltration, wastes are removed." (1) The most recent MDS (minimum data assessment), a Medicare 60-day assessment, with an assessment reference date of 11/28/17, coded the resident as being cognitively intact to make daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis while a resident at the facility. There was no physician order for dialysis. The December 2017 TAR (treatment administration record) documented, "Dialysis on T (Tuesday), Th (Thursday) and Sat (Saturday)." (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 266. 2. Resident #185 was admitted to the facility on 11/30/17 with diagnoses that included but were not limited to: below the knee amputation, shortness of breath, fall diabetes, and end stage renal disease requiring hemodialysis. There was no completed MDS (minimum data set) assessment completed as of the survey.	F 840		

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F 840	Continued From page 320 The Initial Nursing Assessment, dated 11/30/17, documented in part, the resident was alert and oriented to person, place and time. The physician order dated, 11/30/17, documented in part, "Dialysis - M (Monday) - W (Wednesday) - F (Friday)." 3. Resident # 74 was admitted to the facility on 1/13/17 and readmitted on 10/11/17 with the diagnoses of but not limited to end stage renal disease, renal dialysis, disease, atrial fibrillation, diabetes, and depression. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/6/17. The resident was coded as being moderately impaired in ability to make daily life decisions, scoring a 7 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis while a resident at the facility. A review of the clinical record revealed a physician's order dated 10/12/17 for "Dialysis TU/THU/SAT (Tuesday/Thursday/Saturday)." During the entrance conference on 12/4/17 at approximately 11:30 a.m. a request was made of the administrator for the list of residents who were receiving dialysis. A list was provided with the names of three residents. An interview was conducted with the executive director, administrative staff member (ASM) #1, on 12/7/17 at 12:20 p.m. When asked if he had	F 840		

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F 840	Continued From page 321 any contracts with the dialysis center, ASM #1 stated, "There is no individualized contract. I found a contract with one dialysis center. When asked if any of his residents go to that dialysis center, ASM #1 stated, "No. Reality is that we should have an agreement with these dialysis centers." A request was made for a list of the residents who go out of the building for dialysis and which centers they go to. On 12/8/17 the executive director presented a list with each resident listed with the dialysis centers each attend. They all attend the same company of dialysis centers but at three different locations. The executive director was made aware of the above concern on 12/7/17 at 12:23 p.m. No further information was provided prior to exit. 4. The facility staff failed to maintain a contract with a podiatrist who performed services in the facility for Resident #63. Resident #63 was admitted to the facility on 4/2/05. Resident #63's diagnoses included but were not limited to: diabetes, low back pain and major depressive disorder. Resident #63's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/24/17, coded the resident as cognitively intact. Section G coded Resident #63 as requiring extensive assistance of one staff with bed mobility, dressing, eating and personal hygiene. Resident #63's comprehensive care plan revised on 9/24/17 documented, "Focus: The resident has a diagnosis of diabetes: Insulin	F 840		

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F 840	Continued From page 322 Dependent...Interventions: Diabetic foot check daily. Observe feet/toes/ankles/soles/heels noting alteration in skin integrity, color, temperature, and cleanliness. Toenails for shape, length and color..." Review of Resident #63's clinical record revealed the resident was last seen by the podiatrist on 8/9/17. On 12/4/17 at 2:40 p.m. an interview was conducted with Resident #63. The resident stated she would like to get her toenails trimmed and she had told staff for the past two or three weeks that her toenails needed to be trimmed. Resident #63 was unable to state who she had told and reported she had told staff who had been in her room. When asked if she had been seen by a podiatrist, Resident #63 stated she had but it had been a long time. At this time, Resident #63's feet were sticking out of the bottom of the sheet while the resident was lying in bed. Resident #63's toenails were observed. All toenails on both feet were grown out past the resident's toes. The toenails on the great toes were the longest and were grown approximately one forth inch past the great toes. On 12/6/17 at 12:08 p.m. an interview was conducted with RN (registered nurse) #1. RN #1 was asked how staff ensures residents' toenails are cared for. RN #1 stated residents' toenails are monitored daily with patient care and if the toenails get long, grow fungus or anything out of the ordinary occurs then staff notifies the charge nurse or unit manager who puts the resident's name in the book to be seen by the podiatrist. RN #1 stated the podiatrist is supposed to come to the facility once a month.	F 840		

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F 840	Continued From page 323 On 12/6/17 at 12:58 p.m. Resident #63's toenails were observed with RN #1. RN #1 confirmed the resident's toenails needed to be cut. RN #1 stated Resident #63 was assisted out of bed to be seen by the podiatrist one day during the previous month but then the podiatrist called and cancelled. When asked if arrangements were made for the podiatrist to schedule a make-up date, RN #1 stated the executive director was responsible for handling the podiatry arrangements. RN #1 stated she would make sure Resident #63's name was still in the book to be seen by the podiatrist. RN #1 stated the facility nurses do not trim diabetic residents' toenails. On 12/6/17 at 5:31 p.m. an interview was conducted with ASM (administrative staff member) #1 (the executive director). ASM #1 stated the podiatrist last came to the facility in August. ASM #1 stated he received communication from the facility's compliance office that the podiatrist had an issue with his license and the issue had cleared but the podiatrist had to be reinstated and re-credentialed. ASM #1 stated he was in communication with the podiatrist. ASM #1 stated the podiatrist was scheduled to come to the facility in October but didn't show up. ASM #1 stated the podiatrist was also supposed to come to the facility during the previous week but cancelled. ASM #1 stated he was in the process of pursuing another podiatrist. ASM #1 stated he communicates with Resident #63's daughter so he may see if the resident could go out of the facility to see a podiatrist. On 12/8/17 at 7:55 a.m. another interview was	F 840		

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F 840	Continued From page 324 conducted with ASM #1. ASM #1 stated he could not produce a podiatry contract for the former podiatrist. ASM #1 stated he was working on getting a new podiatrist credentialed to see residents on a regular basis. ASM #1 stated there should have been a contract with the former podiatrist while he was performing services and he (ASM #1) was unaware of there being a contract. ASM #1 was made aware that this was a concern. No further information was presented prior to exit.	F 840		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842	1. Resident #47 has expired. Physician and Responsible Party have been notified that medication for resident #83 was not given as scheduled; this notification was documented in resident #83 medical record. Nurse has documented that Glucagon was given and documented in medical record for resident #286. Unit Managers ensured these corrections were made. Resident #286 is no longer in the facility. 2. All residents with changes of condition have potential to be affected. Audit was completed by Unit Managers by reviewing 24 Hour Report and eInteract Changes of Condition for the past	

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F 842	Continued From page 325 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; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F 842	30 days, to ensure that appropriate documentation has been completed. 3. Education was provided to the licensed nursing staff by the Nurse Practice Educator regarding Physician and Responsible party notification and medication documentation. 4. Management team will audit 24 Hour Report in morning clinical meetings 5 days per week, to ensure that appropriate notification have been completed and document. Unit Manager or Supervisor will audit the MAR's for incomplete documentation daily. Results of audits will be brought to the QAPI Committee for follow up monthly.	1/17/18

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F 842	Continued From page 326 (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 29 residents in the survey sample, Residents #47, #83 and #286. 1. The facility staff failed to document Resident #47's representative was notified when a urinary catheter was placed in the resident. 2. The facility staff failed to document an explanation why Resident #83 was not administered medication scheduled for 9:00 p.m. on 11/3/17. 3. The facility staff failed to document that Resident #286 received glucagon on 12/4/17 as ordered by the physician. The findings include: 1. The facility staff failed to document Resident #47's representative was notified when a urinary catheter was placed in the resident. Resident #47 was admitted to the facility on 10/26/17 and readmitted on 11/22/17. Resident #47's diagnoses included but were not limited to: diabetes, chronic kidney disease and adult failure to thrive. Resident #47's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 11/29/17, coded the resident's cognition as moderately impaired. Section H coded	F 842		

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F 842	Continued From page 327 Resident #47 as having an indwelling catheter (1). Review of Resident #47's clinical record revealed a physician's order dated 11/5/17 for a urinary catheter. Further review of the clinical record (including nurses' notes) failed to reveal Resident #47's representative was notified regarding the new catheter order. On 12/7/17 at 3:30 p.m. an interview was conducted with LPN (licensed practical nurse) #7 (the nurse responsible for noting the 11/5/17 catheter order). LPN #7 stated she called Resident #47's representative regarding new wounds and remembered telling her about the catheter. LPN #7 confirmed she did not document notification of the catheter. When asked if she should have documented this, LPN #7 stated, "Probably. Yes." On 12/7/17 at 4:53 p.m. ASM (administrative staff member) #1 (the executive director), ASM #2 (the interim director of nursing) and ASM #3 (the clinical quality specialist) were made aware of the above concern. The facility policy titled, "Communication of Health Status" documented, "Patient and/or health care decision maker will be provided with information regarding patient's total health status...Document: 3.1 Communications, explanations of health status and response in Nurses' Notes..." No further information was presented prior to exit. (1) "A urinary catheter is a tube placed in the body to drain and collect urine from the bladder." This	F 842		

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F 842	Continued From page 328 information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm 2. The facility staff failed to document an explanation why Resident #83 was not administered medication scheduled for 9:00 p.m. on 11/3/17. Resident #83 was admitted to the facility on 9/24/17 and readmitted on 11/2/17. Resident #83's diagnoses included but were not limited to: pain in the right knee, muscle weakness and high blood pressure. Resident #83's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 11/28/17, coded the resident as cognitively intact. Review of Resident #83's clinical record revealed the following readmission orders dated 11/2/17: -carisoprodol (1) 350 mg (milligrams) every night -Advair diskus (2) 250 micrograms/50 micrograms- one puff twice daily Review of Resident #83's November 2017 MAR (medication administration record) revealed the resident was not administered the 9:00 p.m. dose of the above medications as evidenced by the nurse circling her initials on the MAR. There was no documentation on the back of the MAR, the November 2017 treatment administration record or in the nurses' notes that Resident #83 was out of the facility or to explain why the medication was not administered. On 12/7/17 at 10:23 a.m. a telephone interview was conducted with LPN (licensed practical nurse) #6 (the nurse responsible for	F 842		

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F 842	Continued From page 329 administering the 9:00 p.m. medications to Resident #83 on 11/3/17). LPN #6 was asked what should be done to ensure residents receive their medications upon readmission. LPN #6 stated nurses should review the MARs and make sure they match the admission medication list and physician's orders. LPN #6 stated if the medications are not available then nurses should let the supervisor know and call the pharmacy so the medications will be delivered on the next pharmacy run. LPN #6 stated many medications can also be obtained from the facility Omni cell (STAT (immediate) box- a box containing various medications). LPN #6 was asked what is meant by circled initials on the MAR. LPN #6 stated it usually means the resident refused the medication, the medication was not in the facility or the resident was not in the facility. LPN #6 was made aware she initialed and circled medications that were supposed to be administered to Resident #83 during the evening of 11/3/17. LPN #6 stated she assumed the resident was out of the facility. LPN #6 was made aware there was no documentation to evidence Resident #83 was out of the facility on 11/3/17. LPN #6 stated there could have been an order to hold medications because the resident may have been scheduled to go out for a procedure. LPN #6 was made aware there was no order to hold medications. LPN #6 stated, "I'm not sure. Those are the only things I remember." When asked if she should document why a medication is not administered when she initials and circles the medication on the MAR, LPN #6 stated, "Yes." On 12/7/17 at 11:24 a.m. an interview was conducted with LPN #4 (the nurse responsible for administering the day shift medications to Resident #83 on 11/3/17). LPN #4 stated the	F 842		

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F 842	Continued From page 330 resident's medications were not available for administration during her shift so she documented this on the back of the MAR and notified the nurse practitioner. On 12/7/17 at 3:31 p.m. an interview was conducted with LPN #7. LPN #7 was asked what it meant when a medication was initialed and circled on the MAR. LPN #7 stated, "That means it wasn't given. Then I turn the MAR over and explain why it wasn't given. On 12/7/17 at 2:23 p.m. ASM (administrative staff member) #1 (the executive director), ASM #2 (the interim director of nursing) and ASM #3 (the clinical quality specialist) were made aware of the above concern. The facility policy titled, "Medication Shortages/Drugs Not Available" documented, "Document missed dose on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) with explanation in the nurses' notes..." No further information was presented prior to exit. (1) carisoprodol is used to relax muscles and relieve pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682578.html (2) Advair diskus is used to treat asthma. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=4eeb5f6a-593f-4a9e-9692-adefa2caf8fc	F 842		

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F 842	Continued From page 331 3. The facility staff failed to document that Resident #286 received glucagon for a low blood sugar of 42 on 12/4/17 as ordered by the physician. Resident #286 was admitted to the facility on 2/15/17 and readmitted on 11/18/17 with diagnoses that included but were not limited to diabetes, stroke, high blood pressure, heart disease, prostate cancer and arthritis. Resident # 286's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/25/17, coded Resident # 286 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively for making daily decisions. Resident # 286 was coded as requiring extensive assistance to being totally dependent of one staff member for activities of daily living and supervision of one staff member for eating. An observation was made of Resident #286 on 12/4/17 at approximately 7:10 p.m. when the resident's dinner tray was delivered. The resident's visitor told the staff he was unable to wake up Resident #286. The resident was lying in bed with deep snoring. LPN (licensed practical nurse) #4 checked the resident's blood sugar. The blood sugar reading was 42 (1). On 12/4/17 at approximately 7:15 p.m., RN (registered nurse) #2, the staff educator called the physician and received an order for glucagon (2) to be given to Resident #286 either intramuscularly or subcutaneously (RN #2 had written the order on the palm of her hand and showed it to this writer)."	F 842		

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F 842	Continued From page 332 Review of Resident #286's physician's orders dated 11/18/17 documented, "Hypoglecemic (sic) protocol standing orders for hypoglycemic (low blood sugar) protocol." Review of the hypoglycemic protocol documented, "TREATMENT Symptomatic Unconscious. Perform fingerstick blood glucose measurement. If less than 70 or physician ordered low parameter immediately administer Glucagon 1 mg (milligram) IM (intramuscularly). DOCUMENTATION Glucagon administration on MAR (if indicated)." Review of the December 2017 MAR (medication administration record) did not evidence that the glucagon had been administered to Resident #286 on 12/4/17. An interview was conducted on 12/07/17 at 12:34 p.m. with LPN (licensed practical nurse) #2, the nurse who gave Resident #286 the insulin on 12/4/17 at 4:30 p.m. When asked the process staff followed when they had a diabetic resident receiving short acting insulin, LPN #2 stated, "That particular day I was giving him his insulin. His partner was there and was giving him crackers and he had juice there. This was about 5:00 o'clock and since dinner comes around 5:30 p.m. I gave him the insulin and then I went to give my other medications. Then I was called to help another nurse and then around at 7:00 p.m. I was told his blood sugar had dropped to 42." When asked who gave the resident the glucagon, LPN #2 stated, "(Name of LPN #4). LPN #2 stated, "I have learned from this. I would never do this again. I will always make sure I check them."	F 842		

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F 842	Continued From page 333 On 12/7/17 at 1:50 p.m. with ASM (administrative staff member) #1, the executive director, ASM #2, the interim director of nursing and ASM #3, the corporate clinical specialist were made aware of the concern. An interview was conducted on 12/7/17 at 2:30 p.m. with LPN #4, the nurse who administered the glucagon injection to Resident #286. When asked how she had administered the medication, LPN #4 stated, "Subq (subcutaneously)." When asked where she had documented it LPN #4 stated she had forgotten to document the medication. An interview was conducted on 12/7/17 at 2:45 p.m. with ASM (administrative staff member) #2, the interim director of nursing. When asked where staff should document their medications ASM #2 stated in the MAR. No further information was obtained prior to exit. (1) Low blood sugar -- Hypoglycemia, also called low blood glucose or low blood sugar, occurs when the level of glucose in your blood drops below normal. For many people with diabetes, that means a level of 70 milligrams per deciliter (mg/dL) or less. This information was obtained from: https://www.niddk.nih.gov/health-information/diabetes/overview/preventing-problems/low-blood-glucose-hypoglycemia (2) Glucagon -- Glucagon is an effective therapy for treating severe hypoglycemia. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3180523/	F 842		

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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:	F 880	1. Resident #286 discharged to the hospital on 12/14/17 and has not returned to the facility. Resident #9 expired at the facility on 1/5/18. Resident #184 discharged to home on 12/16/17. All staff will consistently practice good hand-washing during meal service. All oxygen supplies will be stored observing appropriate infection control practices. 2. House audit completed by Administrator of all oxygen supply storage in resident rooms to ensure appropriate infection control storage in place. House audit completed by Unit Managers to ensure that oxygen supplies were stored appropriately. 3. Education was provided to 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. 4. Unit Managers and Shift Supervisors will audit staff good handwashing practice during meal time 3 times a week for 6 weeks and then randomly thereafter. Unit Managers and Shift Supervisor will perform room rounds and audit oxygen equipment 3 times a	

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F 880	Continued From page 335 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct 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, clinical record review and facility document review, it was determined the facility staff failed to maintain infection control practices during a meal observation and for three of 29 residents in the survey sample and during the dining observation. Resident #286, #9 and #184. 1. The facility staff failed to sanitize their hands after removing gloves and touching their face prior to serving residents their meal on 12/4/17 at	F 880	week for 6 weeks and then randomly thereafter to ensure safety. Results of audits will be brought to the Quality Assurance and Performance Improvement Committee for follow up monthly.	1/17/18

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F 880	Continued From page 336 12:39 p.m. during a lunch dining observation in the main dining room. 2. The facility staff failed to serve Resident # 286's lunch in a sanitary manner. 3. The facility staff failed to store Resident #9's oxygen equipment in a sanitary manner to prevent infection. 4. The facility staff failed to store oxygen equipment and nebulizer equipment in a sanitary manner to prevent infection for Resident #184. The findings include: 1. A dining observation was conducted 12/4/17 at 12:39 p.m. in the main dining room. CNA (certified nursing assistant) #10 was wearing gloves and was observed providing hand wipes to the residents. CNA #10 then removed her gloves, rubbed her chin and began delivering meals to the residents. CNA #10 did not wash her hands after removing her gloves and touching her face. RN (registered nurse) #1 was observed wearing gloves and providing hand wipes to the residents. RN #1 removed her gloves and began serving residents lunch. An interview was conducted on 12/6/17 at 12:35 p.m. with RN (registered nurse) #1. When asked when staff washed their hands, RN #2 stated, "I knew that when you asked me my name I should have washed my hands." When asked why staff wash their hands, RN #1 stated, "Infection control." An interview was conducted on 12/07/17 at 10:40	F 880		

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WOODMONT CENTER	11 DAIRY LANE FREDERICKSBURG, VA 22405

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F 880	Continued From page 337 a.m. with CNA #10. When asked when staff washed their hands, CNA #10 stated, "Before and after anything." When asked if staff were to wash their hands after removing their gloves, CNA #10 stated, "Yes." When asked what staff should do if they touch their face, CNA #10 stated, "Wash my hands." When asked why staff washed their hands, CNA #10 stated, "To keep from spreading germs." On 12/7/17 at 4:45 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the interim director of nursing and ASM #3, the corporate quality specialist were made aware of the findings. Review of the facility's policy titled, "Hand Washing" documented, "POLICY Hand washing is performed frequently and using correct hand washing technique. PURPOSE To minimize the spread of disease. PROCESS 1.2 Touching hair, ears, nose, or mouth; 1.7 When moving from one task to another. 4. Use of disposable gloves does not replace proper hand washing." No further information was provided prior to exit. 2. The facility staff failed to serve Resident # 286's lunch in a sanitary manner Resident # 286 was admitted to the facility on 02/15/17 with a readmission date of 11/18/17. Diagnosis include but were not limited to muscle weakness, prostate cancer, secondary cancer to bone, type 1(one) diabetes mellitus (1) and kidney disease. Resident # 286's most recent MDS (minimum data set), an admission assessment with an ARD	F 880		

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F 880	Continued From page 338 (assessment reference date) of 11/25/17, coded Resident # 286 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively for making daily decisions. Resident # 286 was coded as requiring extensive assistance to being totally dependent of one staff member for activities of daily living and supervision of one staff member for eating. On 12/04/17 at approximately 12:40 p.m. an observation of Resident # 286's room was conducted. CNA (certified nursing assistant) # 7 and OSM (other staff member) # 11, nursing student were observed in Resident # 286's room. CNA # 7 and OSM # 11 were observed repositioning Resident # 286 in his bed to prepare him for lunch. CNA # 7 and OSM # 11 were both wearing gloves. After Resident # 286 was pulled up in his bed CNA # 7 went to the sink in Resident # 286's room, removed her gloves and washed her hands. OSM # 11 while still wearing the same gloves, retrieved the over the bed table containing Resident # 286's lunch tray. OSM # 11 then proceeded to open containers and set up the lunch tray for Resident # 286. She then went to the sink in Resident # 286's room, removed her gloves and washed her hands. On 12/04/17 at approximately 2:55 p.m. an interview was conducted with CNA # 7 regarding the lunch observation for Resident # 286. When asked if she was aware OSM # 11 did not remove her gloves before serving the resident his lunch, CNA # 7 stated no. When asked if she was responsible for OSM # 11, CNA # 7 stated, "I'm only responsible for a student if they are assigned to me."	F 880		

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F 880	Continued From page 339 On 12/07/17 at approximately 8:20 a.m. an interview was conducted with OSM (other staff member) # 12, Assistant Professor of (Name of Community College) regarding an infection control concern of a nursing student observed by this surveyor. When asked about the student's education regarding infection control OSM # 12 stated, "The nursing students are educated about infection control practices and the use of gloves prior to their field placement." On 12/07/17 at 8:40 a.m. an interview was conducted with OSM (other staff member) # 11, nursing student from (Name of Community College) in the presence of OSM #12, Assistant Professor of (Name of Community College). When asked if she had received training regarding infection control practices and the use of gloves, OSM # 11 stated, "Yes." When asked if she recalled assisting CNA (certified nursing assistant) # 7 with Resident #286. OSM # 11 agreed that she had assisted CNA # 7 in repositioning Resident #286 for lunch in his bed while wearing gloves. When asked what she did next OSM # 11 stated she then moved the over the bed table with Resident # 286's lunch tray on it and began to open the lunch containers. OSM # 11 further stated she had not removed her gloves after repositioning Resident # 286 and before serving his lunch. OSM # 11 stated, "I should have taken off my gloves before serving (Resident # 286) his lunch." On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director, ASM # 2, the interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings.	F 880		

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F 880	Continued From page 340 No further information was obtained prior to exit. 3. The facility staff failed to store Resident #9's oxygen equipment in a sanitary manner to prevent infection. Resident #9 was admitted to the facility on 9/14/16 and readmitted on 8/11/17 with diagnoses that included but were not limited to: pancreatic cancer, muscle weakness, pressure ulcer to the right buttock, type two diabetes, and hypothyroidism. Resident #9's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/09/17. Resident #9 was coded as being moderately impaired in cognitive function scoring 09 out of 15 on the BIMS (brief interview for mental status) exam. Resident #9 was coded as requiring extensive assistance from two or more staff members with transfers, bed mobility, and toileting, and extensive assistance from one staff member with dressing and personal hygiene. On 12/04/17 at 03:21 p.m., an observation was made of Resident #9. Her oxygen tubing including the nasal cannula was uncovered sitting on top of the concentrator. Her oxygen tubing was not placed in a plastic bag. A plastic bag could not be found in her room. On 12/05/17 at 08:11 a.m., an observation was made of Resident #9. Her oxygen tubing including the nasal cannula was uncovered sitting on top of the concentrator. Her oxygen tubing was not placed in a plastic bag. A plastic bag could not be found in her room. On 12/06/17 07:58 a.m. an observation was made of Resident #9. Her oxygen tubing was observed on the floor. A plastic bag could not	F 880		

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F 880	Continued From page 341 found in her room. Review of Resident #9's physician telephone orders revealed the following order initiated on 10/22/17, "Oxygen via nasal cannula titrate up to 5 liters to maintain oxygen sats (saturations) at or above 92 percent." On 12/06/17 at 11:32 a.m., an interview was conducted with LPN (licensed practical nurse) #8. When asked how oxygen should be stored when not in use, LPN #8 stated, "Oxygen is wrapped in plastic bags. Tubing is changed out on Saturdays. 11-7 shift does that. They change the bag as well, date and label it with the resident's name and room number." LPN #8 stated that oxygen tubing should be stored in a plastic bag to prevent infections. On 12/06/17 at 3:10 p.m., an interview was conducted with LPN #2, Resident #9's nurse. When asked how oxygen tubing should be stored when not in use, LPN #2 stated, "02 (oxygen) tubing should be stored in a plastic bag with their (resident) name on it, liters of 02 (oxygen), and the date when changed. Tubing should be changed every Saturday." When asked why oxygen tubing should be stored in a plastic bag, LPN #2 stated, "Should be stored for sanitary purposes." This writer accompanied LPN #2 to Resident # 9's room. When asked what LPN #2 observed about Resident #9's oxygen tubing, LPN #2 stated the oxygen tubing was on the floor. LPN #2 also stated she could not find a plastic bag. On 12/07/17 at 12:16 p.m., an observation was made of Resident #9. Resident #9 was on 2 liters of oxygen via nasal cannula. A plastic bag was	F 880		

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F 880	Continued From page 342 not in Resident #9's room. A date of when the tubing was changed could not be found on the tubing. On 12/06/17 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the interim DON (Director of Nursing) and ASM #2, the clinical quality specialist were made aware of the above concerns. Facility policy titled, "Respiratory Equipment Disinfection/Cleaning," did not address the above concerns. No further information was presented prior to exit. 4. The facility staff failed to store oxygen equipment and nebulizer equipment in a sanitary manner to prevent infection for Resident #184. Resident #184 was admitted to the facility on 11/30/17 with diagnoses that included, but were not limited to: fracture of the left humerus, chronic obstructive pulmonary disease (general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (2), pulmonary fibrosis (pulmonary fibrosis is a condition in which the tissue deep in your lungs becomes scarred over time. This tissue gets thick and stiff. That makes it hard for you to catch your breath, and your blood may not get enough oxygen (3)), diabetes and high blood pressure. There was no completed MDS (minimum data	F 880		

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F 880	Continued From page 343 set) assessment as of the dates of the survey. The Initial Nursing Assessment, dated 11/30/17, documented the resident was alert and oriented to person, place and time. The form documented under "Respiration - regular Method: oxygen via nasal." On 12/04/17 at 11:45 a.m., Resident #184's room was observed. The Oxygen (O2) tubing was observed lying on the bed. A nebulizer mask was not covered, and was sitting on nightstand. On 12/04/17 at 02:21 p.m., Resident # 184's Nebulizer mask was observed on the night stand, uncovered. On 12/04/17 at 2:28 p.m., an oxygen tank with O2 tubing, not covered, had the nasal cannula just hanging and touching the floor. On 12/04/17 at 3:07 p.m., The clinical record was reviewed; there was no documented physician order for oxygen. On 12/04/17 at 4:30 p.m., Resident # 184 was observed asleep, with oxygen on via nasal cannula at 4 L/Min. On 12/05/17at 8:44 a.m., Resident #184 was sitting on side of bed eating breakfast. O2 at 4L/min running via nasal cannula. Nebulizer mask on top of night stand, uncovered. O2 tubing on O2 tank on back of wheelchair uncovered, hanging, almost touching floor. On 12/06/17 at 10:55 a.m. Resident #184's room was observed. The nebulizer was on the top of the night stand uncovered. The oxygen tubing	F 880		

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F 880	Continued From page 344 was located wrapped around the concentrator, uncovered. A New order was noted in the clinical record dated 12/6/17 for Oxygen @ (at) 2L(liters)/NC (nasal cannula) with O2 saturation every shift. On 12/7/17 at 10:20 a.m., Resident #184's room was observed. The nebulizer machine mask and oxygen tubing was on the bed, uncovered. An interview was conducted with LPN (licensed practical nurse) #4 on 12/6/17 at 2:06 p.m. When asked where oxygen tubing is stored when it's not in use, LPN #4 stated that all respiratory equipment should be bagged when not in use." When asked why it should be bagged, LPN #4 stated, "For infection control purposes." The facility policy, "Respiratory Equipment Disinfection/Cleaning" did not address storing the respiratory equipment in bags 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." Administrative staff member (ASM) #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, were made aware of the above concern on 12/7/17 at 4:45 p.m. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.	F 880		

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F 880	Continued From page 345 (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55. (3) This information was obtained from the following website: https://medlineplus.gov/pulmonaryfibrosis.html.	F 880		
F 947 SS=B	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility document review, it was determined the facility staff failed to provide the required in-service training for the CNAs (certified nursing assistants). The facility staff failed to provide the 12 hours of competency training for the CNAs for the last	F 947	1. Certified Nurse Aides who have not received their 12 hours of mandatory, annual training will receive the required training. 2. All residents have the potential to be affected. A 100% audit of current Certified Nurses Aides was completed by the Nurse Practice Educator, to determine who had not received the mandatory 12 hours of training. 3. The Nurse Practice Educator will schedule and track the required training monthly, with oversight by the Director of Nursing. 4. The Nurse Practice Educator will audit 2 times a week for 6 weeks, and then randomly thereafter, to ensure compliance. Results of audits will be brought to the QAPI Committee for follow up	1/17/18

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F 947	Continued From page 346 year except for CNAs who had been hired in the past year. The findings include: During the extended survey a request for evidence of the CNA competency training was requested on 12/5/17 at 5:10 p.m. from ASM (administrative staff member) #2, the interim director of nursing. A request for any education on oxygen safety for CNAs was requested at that time. On 12/6/17 at 7:20 a.m. RN (registered nurse) #2 stated, "We don't have any annual competencies done. They would be the same as the ones we do initially." A review of the CNA competencies booklet did not evidence documentation that the CNAs were educated on oxygen safety. An interview was conducted on 12/6/17 at 9:00 a.m. with ASM (administrative staff member) #1, the executive director. When asked about the CNA competencies, ASM #1 stated, "We went months and months without a nurse educator. I got one and then she left after two months. Now it's (name of RN #2.)." ASM #1 verbalized understanding of concern and the education requirement. An interview was conducted on 12/8/17 at 9:40 a.m. with ASM #2, the interim director of nursing. When asked the process for providing CNA education, ASM #1 stated, "Normally at least on an annual basis. They need to be done once a year."" When asked why the education was	F 947		

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F 947	Continued From page 347 completed, ASM #2 stated, "So we know their skills are up-to-date and up to par to meet the needs of the residents. The concern was shared at that time. No further information was provided prior to exit.	F 947		