STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495211	A. BUILDING _____ B. WING _____	C 05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTHCARE CENTER	8111 TISWELL DRIVE ALEXANDRIA, VA 22306

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/22/18 through 5/24/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5-22-18 through 5-24-18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated The census in this 130 certified bed facility was 100 at the time of the survey. The survey sample consisted of 31 current Resident reviews (Residents #15, 19, 76, 142, 33, 11, 13, 50, 1, 193, 56, 26, 192, 7, 75, 194, 144, 8, 88, 55, 6, 62, 2, 72, 54, 68, 66, 37, 31, 90, and 83) and 4 closed record reviews (Residents #92, 71, 60, and 195).	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's	F 644		7/6/18

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

Electronically Signed | 06/13/2018

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

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F 644	Continued From page 1 assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on Clinical Record Review and Staff Interview, facility staff failed to refer a resident with a diagnosed mental illness for a level II PASARR screening for 1 resident, Resident #75, in a sample of 35 residents. For Resident #75, the facility failed to refer him for a level II PASARR. The Findings included: Resident #75 was admitted on 5/2/18. His most recent Minimum Data Set (MDS) Assessment was a Medicare-15 Day Assessment with an Assessment Reference Date (ARD) of 5/16/18. Resident #75's diagnoses included Unspecified Psychoses, Schizoaffective Disorder Bipolar Type, Hypertension, and Cellulitis of the Left Lower Extremity. Resident #75 was totally dependent on 1 staff member for bathing, required extensive assistance of 1 staff member for transfers, dressing, hygiene, bed mobility, and toileting, and setup assistance for eating. On 5/22/18, a review of Resident #75's record was conducted. Resident #75 was noted to have diagnoses including "schizoaffective disorder, bipolar type". No PASARR was found in the Electronic Health Record (EHR). Facility staff	F 644	Corrective measure for resident affected by deficient practice: Resident # 75 was admitted to facility for sub-acute rehabilitation and was actively treated by community psychiatric provider before and during SNF stay. Resident achieved goals and successfully transitioned back to the community on 6-6-18. Resident suffered no adverse effects from presence in facility and assimilated well with resident population. Identify other residents with potential to be affected: Facility to perform 100% audit of all PASARRs. Measures implemented to assure deficient practice does not recur: Social Services Director or designee to reconcile all PASARR forms with active medication list and diagnosis list to assure discrepancies are addressed timely and appropriately. PASARR reconciliation to be performed prior to the initial Care Plan meeting to allow for discussion with the patient and/ or representative. Residents identified as having a qualifying	

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F 644	Continued From page 2 were asked to locate Resident #75's PASARR. On 5/23/18, facility staff provided this surveyor with a document entitled "VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES MI/MR SUPPLEMENT LEVEL I". For the question titled "2. DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS?" the box "no" is marked with a check. For the question titled "5. RECOMMENDATION", option "b. No referral for Level II is needed because individual:" is checked. None of the sub-options to this item are selected. On 5/24/18 at 10:12a.m., an interview was conducted with Employee G, the Director of Social Services. Employee G was asked to review the PASARR document for Resident #75 provided to surveyors, and to describe what it meant. Employee G stated that the form indicated that Resident #75 did not have a significant mental illness and was not in need of a level II PASARR. Resident #75's diagnoses of "Unspecified Psychosis" and "Schizoaffective Disorder Bipolar Type" were read to Employee G. She was asked whether these diagnoses constituted significant mental illness. Employee G replied yes. Employee G was asked whether the PASARR form for Resident #75 appeared accurate and complete. She replied no. Employee G was asked why Resident #75 was not referred for a Level II Screening despite his diagnoses. She replied that Resident #75 saw his own Psychiatrist outside the facility, and it was thought that a Level II referral was unnecessary. Employee G was asked whether Resident #75's	F 644	MI/MR/ IDD diagnosis or related condition will be referred to “Ascend Management” for level II Screening. Additionally, psychiatric evaluation to be ordered to assure patient’s psychosocial needs met. Monitoring of corrective measures: Admissions Director or designee will scrub all admission records to assure PASARR received and report findings to administrator weekly x4 and report to QA committee monthly x 3. Social Service Director or designee to report PASARR audit findings to QA committee monthly x 3.	

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F 644	Continued From page 3 outside Psychiatrist was qualified to perform a Level II PASARR screening. She replied that she did not know. The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 5/24/18. The Administrator stated, "we have to own it" and indicated they would be auditing residents' PASARRs. No further documents were provided.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires	F 645		7/6/18

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F 645	Continued From page 4	F 645		

the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as

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F 645	Continued From page 5 described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on Clinical Record Review and Staff Interview, facility staff failed to ensure a Pre-admission Screening and Resident Review (PASARR) was completed prior to admission for 2 residents (#75 and #8) in a sample of 35 residents. 1. For Resident #75, facility staff failed to ensure a Preadmission Screening and Resident Review (PASARR) was accurate. 2. For Resident #8, the Preadmission Screening and Resident Review (PASARR) was not completed prior to admission to the facility. The Findings included: 1. Resident #75 was admitted on 5/2/18. His most recent Minimum Data Set (MDS) Assessment was a Medicare-15 Day Assessment with an Assessment Reference Date (ARD) of 5/16/18. Resident #75's diagnoses included Unspecified Psychoses, Schizoaffective Disorder Bipolar Type, Hypertension, and Cellulitis of the Left Lower Extremity. Resident #75 was totally dependent on 1 staff member for bathing, required extensive assistance of 1 staff member for transfers, dressing, hygiene, bed mobility, and toileting, and setup assistance for eating. On 5/22/18, a review of Resident #75's record was conducted. Resident #75 was noted to have diagnoses including "schizoaffective disorder, bipolar type". No PASARR was found in the Electronic Health Record (EHR). Facility staff were asked to locate Resident #75's PASARR.	F 645	Corrective measure for resident affected by deficient practice: Resident # 75 was admitted to facility for subacute rehabilitation and was actively treated by community psychiatric provider before and during SNF stay. Resident achieved goals and successfully transitioned back to the community on 6-6-18. Resident suffered no adverse effects from presence in facility and assimilated well with resident population. Resident # 8 PASARR was recovered from the hospital record and filed to her active chart on 5-24-18. Identify other residents with potential to be affected: Facility to perform 100% audit of all PASARRs. Measures implemented to assure deficient practice does not recur: Admissions Director or designee will scrub all admission records to assure PASARR received and report findings to administrator weekly x4 and report to QA committee monthly x 3. Social Services Director or designee to reconcile all PASARR forms with active medication list and diagnosis list to assure discrepancies are addressed timely and appropriately. PASARR reconciliation to be performed prior to the initial Care Plan meeting to allow for discussion with the patient and/ or representative. Residents identified as having a qualifying	

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F 645	Continued From page 6 On 5/23/18, facility staff provided this surveyor with a document entitled "VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES MI/MR SUPPLEMENT LEVEL I". For the question titled "2. DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS?" the box "no" is marked with a check. For the question titled "5. RECOMMENDATION", option "b. No referral for Level II is needed because individual:" is checked. None of the sub-options to this item are selected. On 5/24/18 at 10:12a.m., an interview was conducted with Employee G, the Director of Social Services. Employee G was asked to review the PASARR document for Resident #75 provided to surveyors, and to describe what it meant. Employee G stated that the form indicated that Resident #75 did not have a significant mental illness and was not in need of a level II PASARR. Resident #75's diagnoses of "Unspecified Psychosis" and "Schizoaffective Disorder Bipolar Type" were read to Employee G. She was asked whether these diagnoses constituted significant mental illness. Employee G replied yes. Employee G was asked whether the PASARR form for Resident #75 appeared accurate and complete. She replied no. The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 5/24/18. The Administrator stated, "we have to own it" and indicated they would be auditing residents' PASARRs. No further documents were provided.	F 645	MI/MR/ IDD diagnosis or related condition will be referred to “Ascend Management” for level II Screening. Additionally, psychiatric evaluation to be order to assure patient’s psychosocial needs are met. Monitoring of corrective measures: Admissions Director or designee will scrub all admission records to assure PASARR received and report findings to administrator weekly x4, monthly x3, and report to QA committee monthly x 4. Social Service Director or designee to report PASARR audit findings to QA committee monthly x 3.	

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2. For Resident #8, the Preadmission Screening and Resident Review (PASARR) was not completed prior to admission to the facility.

Resident #8, an 67 year old, was admitted to the facility on 10/13/17. Diagnoses included seizures, anxiety, depression, and psychotic disorder other than schizophrenia.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 2/14/18. Resident #8 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living.

Upon review of Resident #8's clinical record, the PASARR could not be located. The Administrator and Director of Nursing (DON) were asked to provide the PASARR on 5/23/18 at 5:15 p.m. The following morning, the form titled "Psychotropic Medication Evaluation" was provided. The form included all the psychotropic medications ordered for Resident #8.

A meeting was held with the Administrator and DON on 5/24/18 around 11:00 a.m. They were notified that survey team was provided the Psychotropic Medication Evaluation form instead of the PASARR. The PASARR was again requested.

A PASARR Level I dated 5/24/18 was provided. The Administrator stated that they had to get the PASARR from the hospital because it was not in the facility.

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		7/6/18

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F 656	Continued From page 9 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility record review, and clinical record review, the facility staff failed to devise, and implement a comprehensive care plan for three Residents (Resident #76, 62, and 54) in a survey sample of 35 Residents. 1. Resident #76's care plan did not address his dementia or behaviors. 2. Resident #62's care plan did not address anxious behaviors. 3. For Resident #54, the facility failed to include targeted behaviors and non-pharmacological interventions for the use of Ativan. The findings included: 1. Resident #76's care plan did not address his dementia or behaviors. Resident # 76 was admitted to the facility on 4/17/18. Diagnoses for Resident #76 included but not limited to dementia, carotid endarterectomy with stent placement and legal blindness. Resident #76's Minimum Data Set (an assessment protocol) was a quarterly assessment with an Assessment Reference Date of 5/9/18 coded Resident #76 with a BIMS (brief interview of mental status) score of "14" out of a possible 15, or no cognitive impairment. Resident #76 required extensive assistance for his ADL's (activities of daily living such as bed	F 656	Corrective measure for resident affected by deficient practice: Resident #76 Behavior Care Plan was updated to include interventions and targeted behavior on 5-24-18. Resident #76 Dementia Care Plan initiated on 6-6-2018 to include targeted behaviors and non-pharmacological interventions. Resident #62 Antianxiety medication (Ativan) order discontinued on 5-23-2018 due to non-use exceeding 30 days pursuant to consultant pharmacist recommendation. Care Plan Focus Antianxiety med use was resolved on 5-23-2018 and patient discharged to the community 6-6-2018. Resident #54 Antianxiety medication (Ativan) order discontinued on 5-23-2018 due to non-use exceeding 30 days pursuant to consultant pharmacist recommendation. Care Plan Focus Antianxiety med use was resolved 6-6-2018. Behavior Care Plan updated on 6-6-2018 to reflect the targeted behavior with non-pharmacological interventions. Identify other residents with potential to be affected: Facility to perform 100% audit of all resident Care Plans by the compliance date. Facility to review all mood and behavior	

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F 656	Continued From page 10 mobility and toileting) of one to two staff members. The resident was legally blind. On 5/22/18 at 9:30 AM, Resident #76 was observed in his room, being fed by staff. Review of the clinical record revealed the resident was currently taking Zyprexa (antipsychotic used for hallucinations, psychosis) 2.5 mg (milligrams) twice daily for psychosis. Review of the care plan dated 5/14/18 revealed the following problem: "The resident uses antipsychotic medication related to unspecified psychosis." There were no targeted behaviors addressed on the plan of care for behaviors, nor were there any non pharmacological interventions included. On 05/24/18 at 08:40 AM: An interview with RN (registered nurse) A concerning Resident #76. She stated, "He doesn't show any behaviors with me. He is blind and will yell out, but once he knows where he is, he will calm down." On 05/24/18 at 10:20 AM: An interview with MDS coordinators regarding care plan for Resident #76's behaviors. MDS Coordinator (Employee B) stated, "He is legally blind. He will be in bed, calling out. He will hear people out in the hall outside the room, it is not hallucinations." She went on to state that should be included in the care plan. MDS coordinator (other A) stated regarding dementia care planning for Resident #76, "The resident should be checked for pain or hunger if there are behaviors with dementia." 2. Resident #62's care plan did not address anxious behaviors.	F 656	episodes in Daily Clinical meeting and assure Care Plan is updated to include non-pharmacological interventions for each focus. Measures implemented to assure deficient practice does not recur: Staff education of all licensed nurses to attempt non-pharmacological interventions and monitor efficacy prior to med administration for episodic behavior, mood, and anxiety. Director of Nursing or designee to audit 10% of Care Plans monthly to assure all conditions, diagnosis, medications, and goals addressed with targeted non-pharmacological interventions x 3 months, and quarterly x 4. Any deficient care plans to be updated immediately and findings reported to QA committee monthly x 3.	

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F 656	Continued From page 11	F 656		

Resident # 62 was admitted to the facility on 4/17/18. Diagnoses for Resident #62 included but not limited to dementia, atrial fibrillation, high blood pressure and anxiety. Resident #62's Minimum Data Set (an assessment protocol) was an admission assessment with an Assessment Reference Date of 3/28/18 coded Resident #62 with a BIMS (brief interview of mental status) score of "7" out of a possible 15, or moderate cognitive impairment. Resident #62 required extensive assistance for her ADL's (activities of daily living such as bed mobility and toileting) of one to two staff members.

On 5/22/18 at 9:00 AM, Resident #62 was observed in her bed on oxygen at 2 liters per minute. She had a sling on her right arm.

Review of the clinical record revealed Resident #62 was on Ativan (an antianxiety medication) one mg tablet every 24 hours for anxiety. Review of the care plan dated 4/2/18 revealed the following: "The resident uses antianxiety medication for anxiety disorder. There were no non pharmacological interventions to attempt prior to administration of the medication on the care plan.

On 05/24/18 at 10:20 AM: An interview with MDS coordinator (other A) stated for Resident #62's anxiety, "When she was readmitted, she wanted to go back home, but there are no issues now and that should have been addressed in the care plan."

On 5/24/18 at approximately 11:30 AM, the DON (director of nursing) was notified of above findings.

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3. For Resident #54, the facility failed to include targeted behaviors and non-pharmacological interventions for the use of Ativan.

Resident #54, an 92 year old, was admitted to the facility on 1/23/18. Diagnoses included reflux, hypertension, dementia, anxiety, and osteoarthritis.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/25/18. Resident #54 was coded with a Brief Interview of Mental Status score of 3 indicating moderate cognitive impairment and required extensive assistance with activities of daily living.

On 5/23/18 at 9:00 a.m., Resident #54 was observed in her room, dressed and seated in her wheel chair. The breakfast meal tray was on the table in front of her. Resident #54 consumed most of the meal. She was pleasant but confused during the conversation.

Resident #54's physician orders were reviewed. Included was an order dated 3/19/18 for Ativan tablet 0.5 milligram by mouth every 8 hours as needed for anxiety.

According to the 2018 Medication Administration Records (MAR), the Ativan was administered on the following occasions: 3/26/18, 3/27/18, 4/13/18, 4/20/18, 4/22/18, 4/25/18, 5/1/18, 5/7/18, and 5/9/18.

The care plan was reviewed. Included was the

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F 656	Continued From page 13 "focus" dated 4/19/18 "The resident uses, anti-anxiety medication (ativan) r/t (related to) Anxiety disorder." The "interventions" included psych consult as needed, give anti-anxiety medications ordered by physician, monitor side effects/ effectiveness, monitor mood as needed. The care plan did not indicate the targeted behaviors to indicate use. The care plan did not indicate non-pharmacological interventions to be used before administering the medication. On 5/23/18 at 5:00 p.m., the Director of Nursing, Administrator and Corporate staff were asked to provide the target behaviors and non-pharmacological interventions to support the use of the PRN ativan. They were asked again to provide the information at the end of day meeting on 5/24/18. No further information was provided.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		7/6/18

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F 657	Continued From page 14 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation and clinical record review, the facility staff failed to revise the care plan for 1 Resident (Resident #193) in a survey sample of 35 Residents. For Resident #193, the facility staff failed to include the diagnosis of Methicillin-Resistant Staphylococcus Aureus (MRSA) on the care plan and failed to identify the correct location of the infected wound. The findings included: Resident #193, a 73 year old, was re-admitted to the facility on 5/17/18. Diagnoses included hypertension, diabetes, reflux, dislocation of right hip prosthesis, and MRSA infection of right hip wound. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/4/18. Resident #193 was coded with a Brief Interview of Mental Status score of 14 indicating no cognitive impairment	F 657	Corrective measure for resident affected by deficient practice: Resident #193 Care plan for infection (MRSA) was updated to reflect the correct site (“R” hip) and type of infection (MRSA) on 6-6-2018 Identify other residents with potential to be affected: Facility performed 100% audit of all patients with active infection diagnosis. Any deficient areas addressed with specific focus, goal, and interventions. Measures implemented to assure deficient practice does not recur: All new admission Care Plans will be reviewed in the Daily Clinical Meeting and assigned necessary revision and/ or updates to the appropriate clinical team member. All areas requiring clarification, correction, addition, or resolution will be completed and validated in the daily clinical stand down meeting. Patients with	

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F 657	Continued From page 15 and required extensive assistance with activities of daily living. Resident #193 was re-admitted to the facility on 5/17/18. The History and Physical was signed by the Nurse Practitioner (NP) on 5/20/18. Section "1. Present Illness" read " 73 yo f back for skilled nursing post recent hosp. was sent for rt (right) hip dislocation and new drainage Seen by orthopedics reduction done with I and D (incision and drainage) of area Seen by ID (infectious disease) started on vancomycin PICC line placed on 5/17 and discharge back here with further ABX (antibiotics)" Section C, Physical Examination was reviewed. The section "1. Assessment" read ""Right Prosthetic Hip Dislocation; new onset drainage s/p 5/3: wash out, extraction of sinus, closure on IV (intravenous) vanco (antibiotic) for MRSA infection right hip, in association with hardware. dose adjusted due to high troughs and CKD (chronic kidney disease). Vancomycin 500 mg (milligram) IV q 48 hours. follow trough continue 6 week course (thru 6/14/18) Will need suppressive ABX indefinitely for chronic PO suppressive therapy weekly labs, fax to (doctor name)" Resident #193's care plan was reviewed. Included was a Focus initiated on 8/1/17 and revised on 5/23/18 "The resident is on, IV Medications vancomycin r/t (related to) left hip wound infection". The care plan did not indicate that MRSA was present in the wound. In addition, the incorrect hip was documented in the care plan. The right hip had the infected wound rather than the left.	F 657	ABT therapeutic interventions will have appropriate ABT Care Plan that reflects ABT stop date. Staff development educator or designee to educate all licensed staff to accurately document resident condition, focus, and goal in the Care Plan. Education will focus on deficient practice to include staff cognizance of residents with active infection and identifying type, location, and therapeutic and treatment intervention. Monitoring of corrective measures: ADON or designee to audit 10% care plans monthly x3, and finally quarterly x 4. Findings to be resolved immediately and reported to QA committee through the audit period. Consistent trends in deficient Care Plans to be reported to Administrator for process development and correction.	

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F 657	Continued From page 16 Resident #193's right hip wound was observed on 5/24/18. No further information was provided.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed for 2 residents (Resident #54 and 193) of 35 residents in the survey sample to ensure the highest practicable level of well being. 1. For Resident #54 the facility staff failed to ensure a bowel protocol was in place to manage constipation. 2. For Resident #193, the facility staff failed to start an antibiotic to treat a Methicillin-Resistant Staphylococcus Aureus (MRSA) infection of the right hip wound until 6 days after return to the facility. The findings included: 1. For Resident #54 the facility staff failed to ensure a bowel protocol was in place to manage	F 684	Corrective measures for residents affected: Resident #54 bowel record form 1-23-2018 was recovered from Medical Records and reviewed by ADON and Administrator on 6-6-2018. Bowel record reflects that resident #54 did not go without BM for over 3 days during the review period. Resident #54 also had an order for house medication entered on 1-23-18 that was pre-approved by facility Medical Director. The house medication order was entered on the day of admission 1-23-2018. All house orders include medication and treatment for constipation, including Ducolax and fleet enema. On 3-19-2018 bowel assessment was completed on 6-6-2018 the bowel regimen care plan was reviewed and intervention was	7/6/18

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F 684	Continued From page 17 constipation. Resident #54, an 92 year old, was admitted to the facility on 1/23/18. Diagnoses included reflux, hypertension, dementia, anxiety, and osteoarthritis. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/25/18. Resident #54 was coded with a Brief Interview of Mental Status score of 3 indicating significant cognitive impairment and required extensive assistance with activities of daily living. The following nursing note dated 2/14/18 was reviewed "During therapy, resident present with lethargy and was unable to participate as per therapist. Resident was brought back to her room and was assessed by this writer. Vital signs were measured and the following were noted: blood pressure 172/95 mmHg (millimeters of mercury), Heart rate 84 beats per minutes, temperature of 96.3 degrees Fahrenheit, respiration rate of 19 breaths per minute, and oxygen saturation of 95% on room air. MD (doctor) was notified of resident's clinical situation. MD (doctor) was also notified of absent bowel movement for the resident for 3 days. New orders were given to administer Dulcolax suppository 10 mg (milligram) x 1 now and as needed every 24 hours for constipation; Clonidine 0.1 mg (milligram) every eight hours as needed for systolic blood pressure equal or greater than 170; and UA C&S (urine culture) in AM (morning). Clonidine 0.1 mg and Dulcolax suppository 10 mg were administered as ordered. Incoming shift will reassess resident. Resident's guardian was notified or resident's clinical condition."	F 684	updated to include dietary interventions such as prune juice. Resident #193 admitted 5-17-2018 from hospital without IV Vancomycin on the active discharge medication list. Upon investigation, the IV Vancomycin was placed on hold prior to discharge accounting for its absence on the active D/C medication list. On 5-21-2018 patient's chart was reviewed including D/C med lists and attending nurse was delegated to contact the ID (Infectious Disease) Doctor to ask regarding the PICC line and medication order. On 5-22-2018 the ID Doctor was successfully contacted and orders were faxed for Vancomycin 500mg Q48 hours until 6-14-2018 On 5-23-2018 prior to the administration of this ABT, Vanco trough was drawn and the result was within therapeutic level. On 5-23-2018 IV Vacomycin 500mg was administered. Based on the ordered frequency, the medication was not delayed for 6 days. Identification of other residents with potential to be affected by this deficient practice: Facility to perform 100% audit of all active residents to assure House Orders entered. Systemic changes to assure deficient practice does not recur: The facility does not accept the allegation of deficient practice relative to resident #54. However, as a best practice will include dietary interventions such as	

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F 684	Continued From page 18 The care plan was reviewed. Included was the focus dated 1/23/18 "Resident is at risk for constipation as related to immobility, inadequate fluid intake, medication side effect". Interventions included bowel medication regime as ordered by doctor, dietary interventions, encourage fluids." Resident #54's medication were reviewed. Prior to 2/14/18, there were no bowel medications ordered to manage constipation. There were no dietary interventions such as the use of prune juice ordered. At the end of day meeting on 5/23/18, the Administrator, Director of Nursing (DON) and corporate staff were asked to provide the bowel movement record for the month of February 2018. The following morning on 5/24/18, the DON stated that she had looked at the bowel record but forgot to bring it with her to speak to the survey team. The bowel record was requested again at the end of day meeting on 5/24/18. At this time, the facility administration explained that they did not have access to the bowel record because they recently purchased the facility on 3/1/18 and they could not access the requested document dated 2/14/18 from the previous owner. On 5/24/18 at 12:15 p.m. the DON was asked if a resident had the problem of constipation would the resident be on a scheduled medication for the issue. She stated that there should be some kind of intervention in place, either a medication or a dietary intervention such as prune juice. When asked what types of conditions would cause constipation, the DON stated decreased mobility or narcotic use.	F 684	prune juice (if not contraindicated) on all residents with a constipation Care Plan focus. Facility clinical leadership, including Director of Nursing, Asst. Director of Nursing, and SDC to reconcile all admission orders with Hospital H&P, Medication List, and Nursing Admission Report in Daily Clinical meeting. Director of Nursing or designee will educate all Nursing Supervisors to review admission discharge medication list with hospital H&P and nursing new admission report form. Night shift Supervisor will be responsible for reconciling all orders or ensuring a full reconciliation of all patients orders are performed daily during 24 hour chart check. Monitoring of corrective measures: QA director or designee will audit all 24 hour chart check logs monthly x3 months and report findings to QA committee.	

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No further information was provided.

2. For Resident #193, the facility staff failed to start an antibiotic to treat a Methicillin-Resistant Staphylococcus Aureus (MRSA) infection of the right hip wound until 6 days after return to the facility.

Resident #193, a 73 year old, was re-admitted to the facility on 5/17/18. Diagnoses included hypertension, diabetes, reflux, dislocation of right hip prosthesis, and MRSA infection of right hip wound.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/4/18. Resident #193 was coded with a Brief Interview of Mental Status score of 14 indicating no cognitive impairment and required extensive assistance with activities of daily living.

On 5/1/18, Resident #193 was discharged to the hospital. The Medical Discharge Summary" completed by the physician on 5/5/18 read "Patient readmitted to long term care after hospitalization for anemia and guaiac positive stools. She had been non ambulatory following multiple surgeries right hip after fracture repair and prosthesis with revisions. She had been table (sic) but noted to have drainage from old right hip incision. Xray showed probable chronic dislocation and she was transferred to hospital for recurrent hip prosthesis infection."

The hospital "Discharge Note" read "Principal Problem: Infection". The Discharge Note also

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included a "Patient Active Problem List" which included the following diagnoses related to infection:
Cellulitis of drainage site, post-operative, initial encounter
Deep incisional surgical site infection, initial encounter
Post op infection
Wound infection
Acute osteomyelitis of left foot
Osteomyelitis
Infection

The section "Hospital Course" read "Seen by ID (Infectious Disease) started on vancomycin with daily vancomycin level check and redosing based on vancomycin level" and "PICC (peripherally inserted central catheter) line placed and discharge to SNF (skilled nursing facility) with antibiotics per ID (Infectious Disease).

"Discharge Instructions" read "Follow-up with PCP (primary care doctor), orthopedics and ID (infectious disease)"

An order for antibiotics was not included in the hospital discharge orders.

Resident #193 was re-admitted to the facility on 5/17/18. The History and Physical was signed by the Nurse Practitioner (NP) on 5/20/18. Section "1. Present Illness" read " 73 yo f back for skilled nursing post recent hosp. was sent for rt (right) hip dislocation and new drainage Seen by orthopedics reduction done with I and D (incision and drainage) of area Seen by ID (infectious disease) started on vancomycin PICC line placed on 5/17 and discharge back here with further ABX (antibiotics)"

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Section C, Physical Examination was reviewed. The section "1. Assessment" read ""Right Prosthetic Hip Dislocation; new onset drainage s/p 5/3: wash out, extraction of sinus, closure on IV (intravenous) vanco (antibiotic) for MRSA infection right hip, in association with hardware. dose adjusted due to high troughs and CKD (chronic kidney disease). Vancomycin 500 mg (milligram) IV q 48 hours. follow trough continue 6 week course (thru 6/14/18) Will need suppressive ABX indefinitely for chronic PO suppressive therapy weekly labs, fax to (doctor name)"

The following nursing note was written on 5/21/18, 6:54 p.m. "Spoke with daughter (name) regarding resident doctor's appointment with infection disease doctor because of resident has a PICC line on left upper arm but not using for med pass, per daughter (name), when resident discharged from hospital they told her, she should continues with ABT (antibiotic)"

A Skilled nursing note dated 5/22/18, 11:13 a.m. read "New order received from Infection Disease. (name) Start Vancomycin 500 mg (milligram) IV q48hrs for MRSA (R) hip until 6/14/18." "Yes, patient is on ABT therapy. patient will start vancomycin 500 mg IV for MRSA infection on the (R) hip on 5/23/18".

The May 2018 Medication Administration Record (MAR) was reviewed. According to the MAR, no antibiotic was administered to Resident #193 until 5/23/18 when the Vancomycin was started.

On 5/24/18 at 9:35 a.m., it was reviewed with the DON that Resident #193 was discharged from

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F 684	Continued From page 22 the hospital to the facility for PICC line care and antibiotic administration. It was reviewed that the antibiotic was not started until 6 days after Resident #193 was discharged from the hospital. The DON stated that she understood. The DON stated that (nurse practitioner) should have picked up that there was no antibiotic order when the skilled nursing facility admitting orders were written. The DON stated that the physician approached her on 5/22/18 to address the fact that Resident #193 was not started on an antibiotic. The DON was informed that the survey team wanted to observe the wound care for the right hip. When asked if Resident #193 had MRSA, the DON stated that she needed to check. Resident #193's care plan was reviewed. Included was a Focus initiated on 8/1/17 and revised on 5/23/18 "The resident is on, IV Medications vancomycin r/t (related to) left hip wound infection". The care plan did not indicate that MRSA was present in the wound. In addition, the incorrect hip was documented in the care plan. The right hip had the infected wound.	F 684		
F 711 SS=D	Complaint Deficiency Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress	F 711		7/6/18

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F 711	Continued From page 23 notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed for 1 residents (Resident #193) of 35 residents in the survey sample to ensure the physician reviewed medications and treatments at each visit. For Resident #193, the facility staff failed to start an antibiotic to treat a Methicillin-Resistant Staphylococcus Aureus (MRSA) infection of the right hip wound until 6 days after return to the facility. The findings included: Resident #193, a 73 year old, was re-admitted to the facility on 5/17/18. Diagnoses included hypertension, diabetes, reflux, dislocation of right hip prosthesis, and MRSA infection of right hip wound. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/4/18. Resident #193 was coded with a Brief Interview of Mental Status score of 14 indicating no cognitive impairment and required extensive assistance with activities of daily living. On 5/1/18, Resident #193 was discharged to the hospital. The Medical Discharge Summary"	F 711	Corrective measures for resident affected: Resident #193 admitted 5-17-2018 from hospital without IV Vancomycin on the active discharge medication list. Upon investigation, the IV Vancomycin was placed on hold prior to discharge accounting for its absence on the active D/C medication list. On 5-21-2018 patient's chart was reviewed including D/C med lists and attending nurse was delegated to contact the ID (Infectious Disease) Doctor to ask regarding the PICC line and medication order. On 5-22-2018 the ID Doctor was successfully contacted and orders were faxed for Vancomycin 500mg Q48 hours until 6-14-2018 On 5-23-2018 prior to the administration of this ABT, Vanco trough was drawn and the result was within therapeutic level. On 5-23-2018 IV Vancomycin 500mg was administered. Identification of other residents with potential to be affected by this deficient practice: QA Director perform audit of last 30 day admissions H&P and med list to assure no other residents affected.	

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F 711	Continued From page 24 completed by the physician on 5/5/18 read "Patient readmitted to long term care after hospitalization for anemia and guiac positive stools. She had been non ambulatory following multiple surgeries right hip after fracture repair and prosthesis with revisions. She had been table (sic) but noted to have drainage from old right hip incision. Xray showed probable chronic dislocation and she was transferred to hospital for recurrent hip prosthesis infection." The hospital "Discharge Note" read "Principal Problem: Infection". The Discharge Note also included a "Patient Active Problem List" which included the following diagnoses related to infection: Cellulitis of drainage site, post-operative, initial encounter Deep incisional surgical site infection, initial encounter Post op infection Wound infection Acute osteomyelitis of left foot Osteomyelitis Infection The section "Hospital Course" read "Seen by ID (Infectious Disease) started on vancomycin with daily vancomycin level check and redosing based on vancomycin level" and "PICC (peripherally inserted central catheter) line placed and discharge to SNF (skilled nursing facility) with antibiotics per ID (Infectious Disease). "Discharge Instructions" read "Follow-up with PCP (primary care doctor), orthopedics and ID (infectious disease)" An order for antibiotics was not included in the	F 711	Measures implemented to assure deficient practice does not recur: Medical Director to educate/ in-service all facility physicians to review hospital H&P, medication list, and orders upon initial visit to assure necessary treatment and medications not missed. Facility clinical leadership, including Director of Nursing, Asst. Director of Nursing, and SDC to reconcile all admission orders with Hospital H&P, Medication List, and Nursing Admission Report in Daily Clinical meeting. Director of Nursing or designee will educate all Nursing Supervisors to review admission hospital discharge medication list with hospital H&P and nursing new admission report form. Night shift Supervisor will be responsible for reconciling all orders or ensuring a full reconciliation of all patients orders are performed daily during 24 hour chart check. Monitoring of corrective measures: QA director or designee will audit all 24 hour chart check logs monthly x3 and report findings to QA committee. Assistant Director of Nursing or designee to audit 10% charts monthly x3. Findings to be reported to administrator and QA committee monthly.	

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F 711	Continued From page 25	F 711		

hospital discharge orders.

Resident #193 was re-admitted to the facility on 5/17/18. The History and Physical "Effective Date" was 5/18/18 and it was signed by the Nurse Practitioner (NP) on 5/20/18. Section "1. Present Illness" read " 73 yo f back for skilled nursing post recent hosp. was sent for rt (right) hip dislocation and new drainage Seen by orthopedics reduction done with I and D (incision and drainage) of area Seen by ID (infectious disease) started on vancomycin PICC line placed on 5/17 and discharge back here with further ABX (antibiotics)"

Section C, Physical Examination was reviewed. The section "1. Assessment" read ""Right Prosthetic Hip Dislocation; new onset drainage s/p 5/3: wash out, extraction of sinus, closure on IV (intravenous) vanco (antibiotic) for MRSA infection right hip, in association with hardware. dose adjusted due to high troughs and CKD (chronic kidney disease). Vancomycin 500 mg (milligram) IV q 48 hours. follow trough continue 6 week course (thru 6/14/18) Will need suppressive ABX indefinitely for chronic PO suppressive therapy weekly labs, fax to (doctor name)"

The following nursing note was written on 5/21/18, 6:54 p.m. "Spoke with daughter (name) regarding resident doctor's appointment with infection disease doctor because of resident has a PICC line on left upper arm but not using for med pass, per daughter (name), when resident discharged from hospital they told her, she should continues with ABT (antibiotic)"

A Skilled nursing note dated 5/22/18, 11:13 a.m.

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read "New order received from Infection Disease. (name) Start Vancomycin 500 mg (milligram) IV q48hrs for MRSA (R) hip until 6/14/18." "Yes, patient is on ABT therapy. patient will start vancomycin 500 mg IV for MRSA infection on the (R) hip on 5/23/18".

The May 2018 Medication Administration Record (MAR) was reviewed. According to the MAR, no antibiotic was administered to Resident #193 until 5/23/18 when the Vancomycin was started.

On 5/24/18 at 9:35 a.m., it was reviewed with the DON that Resident #193 was discharged from the hospital to the facility for PICC line care and antibiotic administration. It was reviewed that the antibiotic was not started until 6 days after Resident #193 was discharged from the hospital. The DON stated that she understood. The DON stated that (nurse practitioner) should have picked up that there was no antibiotic order when the skilled nursing facility admitting orders were written. The DON stated that the physician approached her on 5/22/18 to address the fact that Resident #193 was not started on an antibiotic. The DON was informed that the survey team wanted to observe the wound care for the right hip. When asked if Resident #193 had MRSA, the DON stated that she needed to check.

Resident #193's care plan was reviewed. Included was a Focus initiated on 8/1/17 and revised on 5/23/18 "The resident is on, IV Medications vancomycin r/t (related to) left hip wound infection". The care plan did not indicate that MRSA was present in the wound. In addition, the incorrect hip was documented in the care plan. The right hip had the infected wound.

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F 758	Continued From page 27	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		7/6/18

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F 758	Continued From page 28 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed for 1 resident (Resident #54) of 35 residents in the survey sample to ensure resident was free from psychotropic medications. Resident #54 had a current order for PRN ativan that was originally ordered on 3/19/18, an excess of 14 days. In addition, there were not targeted behaviors documented or non-pharmacological interventions indicated. The findings included: Resident #54, an 92 year old, was admitted to the facility on 1/23/18. Diagnoses included reflux, hypertension, dementia, anxiety, and osteoarthritis. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/25/18. Resident #54 was coded with a Brief Interview of Mental Status score of 3 indicating significant cognitive impairment and required extensive assistance with activities of daily living.	F 758	Corrective measure for resident affected by deficient practice: Resident #54 Antianxiety medication (Ativan) order discontinued on 5-23-2018 due to non-use exceeding 30 days pursuant to consultant pharmacist recommendation. Care Plan Focus-Antianxiety med use- was resolved 6-6-2018. Behavior Care Plan updated on 6-6-2018 to reflect the targeted behavior with non-pharmacological interventions. Identification of other residents with potential to be affected by this deficient practice: Facility to perform 100% audit of care plans for residents with current psychotropic, antianxiety, hypnotic, or antidepressant medication order. Measures implemented to assure deficient practice does not recur: Staff Development Coordinator to educate all licensed nurses to attempt non-pharmacological intervention prior to administration of PRN medications.	

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F 758	Continued From page 29 On 5/23/18 at 9:00 a.m., Resident #54 was observed in her room, dressed and seated in her wheel chair. The breakfast meal tray was on the table in front of her. Resident #54 consumed most of the meal. She was pleasant but confused during the conversation. Resident #54's physician orders were reviewed. Included was an order dated 3/19/18 for Ativan tablet 0.5 milligram by mouth every 8 hours as needed for anxiety. According to the 2018 Medication Administration Records (MAR), the Ativan was administered on the following occasions: 3/26/18, 3/27/18, 4/13/18, 4/20/18, 4/22/18, 4/25/18, 5/1/18, 5/7/18, and 5/9/18. The care plan was reviewed. Included was the "focus" dated 4/19/18 "The resident uses, anti-anxiety medication (ativan) r/t (related to) Anxiety disorder." The "interventions" included psych consult as needed, give anti-anxiety medications ordered by physician, monitor side effects/ effectiveness, monitor mood as needed. The care plan did not indicate the targeted behaviors to indicate use. The care plan did not indicate non-pharmacological interventions to be used before administering the medication. On 5/23/18 at 5:00 p.m., the Director of Nursing, Administrator and Corporate staff were asked to provide the target behaviors and non-pharmacological interventions to support the use of the PRN ativan. They were asked again to provide the information at the end of day meeting on 5/24/18.	F 758	PRN antianxiety, hypnotics, antipsychotic, and antidepressant medication to be discontinued within 14 days and refer to psych practitioner. Medical Director to educate all physicians and physician extenders on standard for ordering PRN meds in this drug class. Monitoring of corrective actions: QA Director or designee to audit psychotropic drug list weekly to assure PRN orders have stop dates. Audit to be performed weekly x 3 months and reported to QA committee. Pharmacy and Therapeutic committee to review all patient with antipsychotic, antianxiety, anti-depressant, and hypnotics monthly to assure orders accurate, complete, and indicated.	

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F 758	Continued From page 30 No further information was provided.	F 758		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §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 and Staff Interview, facility staff failed to hold prepared hot foods at a safe temperature. Pureed toast was observed at 114 degrees Fahrenheit and Oatmeal was observed at 124 degrees Fahrenheit. On 5/22/18 at 7:29 a.m., a tour of the kitchen was conducted with Employee F. Employee F was observed taking the temperature of foods on the steam table prior to preparation of resident meal	F 812	Corrective action: Oatmeal and Pureed bread were heated to the proper hot holding temperature, all staff was in serviced on hot holding temperatures on 5/22/18. Maintenance cut pvc pipe to accomplish an adequate 4 inch gap between it and the drain. Identification of other residents with potential to be affected by this deficient practice:	7/6/18

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F 812	Continued From page 31 trays. Upon testing the temperature of the pureed toast, Employee F verbalized the temperature as 114 degrees Fahrenheit. When asked what temperature hot foods should be held at, Employee F stated "we aim for 160 or above". When the temperature of oatmeal was tested, Employee F verbalized the temperature reading as 124 degrees Fahrenheit. Employee F stated "its gotta be like 160-165". The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 5/23/18. No further information was provided.	F 812	Daily food temperature checks by cooks and inspection from Food service director or designee. Measures implemented to assure deficient practice does not recur: Staff in-serviced on 5-22-18, all temperature logs are reviewed daily to ensure compliance by the Account Manager or Assistant Manager, Manager to oversee tray line 2 meals per day 5 days a week to ensure accurate time temperature control. Monitoring of corrective measures: Facility Dietary Management to follow up daily on temperature logs and oversee staff taking temperatures to ensure they are recording accurate temperatures, Non-compliance is to be reported to the District Manager, Temp Log findings to be reported during QA meetings.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		7/6/18

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must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(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.

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F 842	Continued From page 33 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed for 1 residents (Resident #54) of 35 residents in the survey sample to ensure a complete medical record was available. For Resident #54 the facility staff failed to ensure the February 2018 bowel movement record was available. The findings included: Resident #54, an 92 year old, was admitted to the facility on 1/23/18. Diagnoses included reflux, hypertension, dementia, anxiety, and osteoarthritis. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/25/18. Resident #54 was coded with a Brief Interview of Mental Status score of 3 indicating significant cognitive impairment and required extensive assistance with activities of daily living.	F 842	Corrective measures for residents affected by this deficient practice: Resident #54 bowel record form 1-23-2018 was recovered from Medical Records and reviewed by ADON and Administrator on 6-6-2018. Bowel record reflects that resident #54 did not go without BM for over 3 days during the review period. Resident #54 also had an order for house medication entered on 1-23-18 that was pre-approved by facility Medical Director. The house medication order was entered on the day of admission 1-23-2018. All house orders include medication and treatment for constipation, including Ducolax and fleet enema. On 3-19-2018 bowel assessment was completed. On 6-6-2018 the bowel regimen care plan was reviewed and intervention was updated to include dietary interventions such as prune juice. Identification of other residents with potential to be affected by this deficient	

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F 842	Continued From page 34 The following nursing note dated 2/14/18 was reviewed "During therapy, resident present with lethargy and was unable to participate as per therapist. Resident was brought back to her room and was assessed by this writer. Vital signs were measured and the following were noted: blood pressure 172/95 mmHg (millimeters of mercury), Heart rate 84 beats per minutes, temperature of 96.3 degrees Fahrenheit, respiration rate of 19 breaths per minute, and oxygen saturation of 95% on room air. MD (doctor) was notified of resident's clinical situation. MD (doctor) was also notified of absent bowel movement for the resident for 3 days. New orders were given to administer Dulcolax suppository 10 mg (milligram) x 1 now and as needed every 24 hours for constipation; Clonidine 0.1 mg (milligram) every eight hours as needed for systolic blood pressure equal or greater than 170; and UA C&S (urine culture) in AM (morning). Clonidine 0.1 mg and Dulcolax suppository 10 mg were administered as ordered. Incoming shift will reassess resident. Resident's guardian was notified or resident's clinical condition." At the end of day meeting on 5/23/18, the Administrator, Director of Nursing (DON) and corporate staff were asked to provide the bowel movement record for the month of February 2018. The following morning on 5/24/18, the DON stated that she had looked at the bowel record but forgot to bring it with her to speak to the survey team. The bowel record was requested again at the end of day meeting on 5/24/18. At this time, the facility administration explained that they did not have access to the bowel record because they recently purchased the facility on 3/1/18 and they could not access the requested document dated 2/14/18 from the	F 842	practice: Facility to perform 100% audit of all active residents to assure House Orders entered. Measures implemented to assure deficient practice does not recur: The facility does not accept the allegation of deficient practice relative to resident #54. However, as a best practice will include dietary interventions such as prune juice (if not contraindicated) on all residents with a constipation Care Plan focus. Monitoring of corrective measures: Assistant Director of Nursing or designee to audit 10% charts monthly x3. Findings to be reported to administrator and QA committee monthly.	

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F 842	Continued From page 35 previous owner. No further information was provided.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and 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	F 880		7/6/18

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F 880	Continued From page 36 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to implement an effective infection control program for 2 residents (Resident #193 and 54) of 35 residents in the survey sample and failed to ensure that the ice machine plumbing had an air gap to prevent	F 880	Corrective measures for residents affected by this deficient practice: Resident #193 admitted 5-17-2018 from hospital without IV Vancomycin on the active discharge medication list. Upon investigation, the IV Vancomycin was	

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F 880	Continued From page 37 the backflow of contaminated water. 1. For Resident #193, the facility staff failed to start an antibiotic to treat a Methicillin-Resistant Staphylococcus Aureus (MRSA) infection of right hip wound. 2. Resident #193 had MRSA in the hip wound. Wound care was observed with the treatment nurse's arms and shirt coming in contact with the bed surface. 3. Resident #54's unused wound care items were placed (in a Ziploc bag) on the resident's bed and then unused items were placed back into the treatment cart. 4. The drain coming from the ice machine was in direct contact with the floor drain. The findings included: 1. For Resident #193, the facility staff failed to start an antibiotic to treat a Methicillin-Resistant Staphylococcus Aureus (MRSA) infection of right hip wound. Resident #193, a 73 year old, was re-admitted to the facility on 5/17/18. Diagnoses included hypertension, diabetes, reflux, dislocation of right hip prosthesis, and MRSA infection of right hip wound. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/4/18. Resident #193 was coded with a Brief Interview of Mental Status score of 14 indicating no cognitive impairment and required extensive assistance with activities	F 880	placed on hold prior to discharge accounting for its absence on the active D/C medication list. On 5-21-2018 patient□s chart was reviewed including D/C med lists and attending nurse was delegated to contact the ID (Infectious Disease) Doctor to ask regarding the PICC line and medication order. On 5-22-2018 the ID Doctor was successfully contacted and orders were faxed for Vancomycin 500mg Q48 hours until 6-14-2018 On 5-23-2018 prior to the administration of this ABT, Vanco trough was drawn and the result was within therapeutic level. On 5-23-2018 IV Vancomycin 500mg was administered. Infection control nurse to monitor wound care weekly x4week and monthly x3 months and quarterly x4. Upon discovery of the infection control breach for resident #54 the facility sanitized the wound treatment cart and re-stocked with new supply to prevent the potential spread of infectious pathogens. Upon discovery of the inadequate air gap, the facility administrator and Maintenance director inspected the machine and corrected the gap immediately. All other air gaps were inspected for proper 4 inch clearance. None found deficient. Identification of other residents with potential to be affected by this deficient practice: Inspection of all drains performed to assure existence of proper air gap. Infection control surveillance measures in place for prevention/ mitigation and tracking and trending infections in each	

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F 880	Continued From page 38 of daily living. On 5/1/18, Resident #193 was discharged to the hospital. The Medical Discharge Summary" completed by the physician on 5/5/18 read "Patient readmitted to long term care after hospitalization for anemia and guaiac positive stools. She had been non ambulatory following multiple surgeries right hip after fracture repair and prosthesis with revisions. She had been table (sic) but noted to have drainage from old right hip incision. Xray showed probable chronic dislocation and she was transferred to hospital for recurrent hip prosthesis infection." The hospital "Discharge Note" read "Principal Problem: Infection". The Discharge Note also included a "Patient Active Problem List" which included the following diagnoses related to infection: Cellulitis of drainage site, post-operative, initial encounter Deep incisional surgical site infection, initial encounter Post op infection Wound infection Acute osteomyelitis of left foot Osteomyelitis Infection The section "Hospital Course" read "Seen by ID (Infectious Disease) started on vancomycin with daily vancomycin level check and redosing based on vancomycin level" and "PICC (peripherally inserted central catheter) line placed and discharge to SNF (skilled nursing facility) with antibiotics per ID (Infectious Disease). "Discharge Instructions" read "Follow-up with	F 880	care area. Systemic changes to assure deficient practice does not recur: Facility developed a policy with the input from the medical director to assure proper precautions observed during wound care to include maintaining un-used supplies in the patient room and discarding used supplies and materials in biohazard bags before exiting patient room. Biohazard bags to be sealed before removal and discarded in designated biohazard receptacles in soiled utility room. Initiate order to don isolation protective equipment during treatment or ADL care for any patient with MRSA and doff in biohazard bag before exiting patient area. Staff Development coordinator educating all staff on new infection control prevention measure. Central supply purchased necessary receptacles and additional supplies added to PAR level. Monitoring of corrective measures: Infection Control nurse or designee to inspect wound treatments twice weekly x 4 weeks to assure stringent infection control practices observed. Infection control nurse to round with wound team once per week x 3 months and report infection control findings to QA committee through the review period.	

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PCP (primary care doctor), orthopedics and ID (infectious disease)"

An order for antibiotics was not included in the hospital discharge orders.

Resident #193 was re-admitted to the facility on 5/17/18. The History and Physical was signed by the Nurse Practitioner (NP) on 5/20/18. Section "1. Present Illness" read " 73 yo f back for skilled nursing post recent hosp. was sent for rt (right) hip dislocation and new drainage Seen by orthopedics reduction done with I and D (incision and drainage) of area Seen by ID (infectious disease) started on vancomycin PICC line placed on 5/17 and discharge back here with further ABX (antibiotics)"

Section C, Physical Examination was reviewed. The section "1. Assessment" read ""Right Prosthetic Hip Dislocation; new onset drainage s/p 5/3: wash out, extraction of sinus, closure on IV (intravenous) vanco (antibiotic) for MRSA infection right hip, in association with hardware. dose adjusted due to high troughs and CKD (chronic kidney disease). Vancomycin 500 mg (milligram) IV q 48 hours. follow trough continue 6 week course (thru 6/14/18) Will need suppressive ABX indefinitely for chronic PO suppressive therapy weekly labs, fax to (doctor name)"

The following nursing note was written on 5/21/18, 6:54 p.m. "Spoke with daughter (name) regarding resident doctor's appointment with infection disease doctor because of resident has a PICC line on left upper arm but not using for med pass, per daughter (name), when resident discharged from hospital they told her, she should

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continues with ABT (antibiotic)"

A Skilled nursing note dated 5/22/18, 11:13 a.m. read "New order received from Infection Disease. (name) Start Vancomycin 500 mg (milligram) IV q48hrs for MRSA (R) hip until 6/14/18." "Yes, patient is on ABT therapy. patient will start vancomycin 500 mg IV for MRSA infection on the (R) hip on 5/23/18".

The May 2018 Medication Administration Record (MAR) was reviewed. According to the MAR, no antibiotic was administered to Resident #193 until 5/23/18 when the Vancomycin was started.

On 5/24/18 at 9:35 a.m., it was reviewed with the DON that Resident #193 was discharged from the hospital to the facility for PICC line care and antibiotic administration. It was reviewed that the antibiotic was not started until 6 days after Resident #193 was discharged from the hospital. The DON stated that she understood. The DON stated that (nurse practitioner) should have picked up that there was no antibiotic order when the skilled nursing facility admitting orders were written. The DON stated that the physician approached her on 5/22/18 to address the fact that Resident #193 was not started on an antibiotic. The DON was informed that the survey team wanted to observe the wound care for the right hip. When asked if Resident #193 had MRSA, the DON stated that she needed to check.

Resident #193's care plan was reviewed. Included was a Focus initiated on 8/1/17 and revised on 5/23/18 "The resident is on, IV Medications vancomycin r/t (related to) left hip wound infection". The care plan did not indicate that MRSA was present in the wound. In addition,

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the incorrect hip was documented in the care plan. The right hip had the infected wound.

2. Resident #193 had MRSA in the hip wound. Wound care was observed with the treatment nurse's arms and shirt coming in contact with the bed surface.

05/24/18 10:55 AM Resident # 193: An observation of the resident's hip wound and heels with the ADON (assistant director of nursing) was conducted. Resident #193 denied pain, stating, "Not now." The right hip incision was clean with sutures approximating, no redness or drainage evident. The ADON was asked if the resident had MRSA (methicillin resistant staph aureus) in the hip wound. The ADON stated, "They did not say if she has MRSA." During the treatment of cleaning and dressing of the wound, the ADON's arms and front of the shirt were observed to be touching the bed surface as the resident was not wearing a gown.

On 5/24/18 at approximately 9:30 AM, the DON (director of nursing) was notified of above findings.

3. Resident #54's unused wound care items were placed (in a Ziploc bag) on the resident's bed and then unused items were placed back into the treatment cart.

Resident # 54 was admitted to the facility on 1/23/18. Diagnoses for Resident #54 included but not limited to dementia, anemia, high blood pressure and muscle weakness. Resident #54's Minimum Data Set (an assessment protocol) was

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a quarterly assessment with an Assessment Reference Date of 4/25/18 coded Resident #54 with a BIMS (brief interview of mental status) score of "3" out of a possible 15, or severe cognitive impairment. Resident #54 required extensive assistance for her ADL's (activities of daily living such as bed mobility and toileting) of one to two staff members.

05/23/18 8:55 AM Resident # 54: Observed wound care to left and right feet, "arterial insufficiency" per the wound care physician. Packet (Ziploc) bag containing 4 x 4's, normal saline and Qtips placed on the resident's bed. Areas are black with dry eschar. The areas were cleansed with normal saline, Skin prep spray was applied to blackened areas, Betadine applied to toe on left foot. Resident was uncomfortable during the treatment; had been medicated at 6:00 AM with Tylenol 500 mg 2 tablets. After the treatment, the nurse (ADON- assistant director of nursing) placed the Ziploc bag containing unused items back into the treatment cart.

On 05/24/18 at 09:11 AM The Infection Control program was reviewed with the Quality and Compliance Educator. The Educator was questioned regarding the observation of the wound care done for Resident #54. The Educator stated, "I would have only taken in items that were needed and trash items not used in the treatment."

Review of the facility's infection control/wound care policy did not address discarding un-used items after the treatment was completed.

On 5/24/18 at approximately 9:30 AM, the DON (director of nursing) was notified of above

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findings.

4. The drain coming from the ice machine was in direct contact with the floor drain.

On 5/22/18 at 7:29 a.m., a tour of the kitchen was conducted with Employee F. After touring the kitchen, Employee F showed this surveyor two ice machines. Employee F described one ice machine as the "therapy ice machine", located in an alcove off the ground level dining room. It was found to have no air gap between the machine drain and the floor drain. The machine drain was observed to be in contact with the floor surface, and the opening of the machine drain was in contact with the grate over the opening of the floor drain.

On 5/24/18, an interview was conducted with Employee D, the Head of Maintenance. Employee D was asked to describe the purpose of an Air Gap on an ice machine. He stated that the purpose is to prevent waste water from flowing back up into the ice machine from the floor drain. When asked how big an Air Gap should be, Employee D stated "4 inches".

The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 5/24/18. No further information was provided.