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| **SUMMIT HEALTH & REHABILITATION CENTER** | **1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502** |

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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 08/21/18 through 08/23/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted on 08/21/18 through 08/23/18. The facility was not in compliance with 42 CFR Part 483, the Federal Long Term Care requirements. One complaint was investigated. The Life Safety Code survey/report will follow.<br><br>The census in this 120 certified bed facility was 92 at the time of the survey. The survey sample consisted of 19 current Resident reviews and three (3) closed record reviews. | F 000 | | |
| F 550 SS=B | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. | F 550 | | 10/5/18 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/05/2018

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 550 | Continued From page 1<br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and facility document review, the facility staff failed to ensure a dignified dining experience during lunch in the dining room on the second floor on 08/21/18.<br><br>During the lunch observation on 08/21/18, staff were observed feeding more than one resident at the same time.<br><br>The findings were:<br><br>A dining observation was conducted during lunch on 08/21/18 beginning at approximately 11:32 | F 550 | F550<br>1. The DON and Administrator met with C.N.A's # 1 and #2 on August 29, 2018 and reviewed our Senior Care Services Dining Room Protocol.<br>2. Observations of the second floor dining room will be conducted by the DON or designee for breakfast and lunch daily for one week. Observations will be made to ensure a pleasant dining experience based on our Dining Room protocol and to ensure that no other residents are affected/ involved. | |

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| F 550 | Continued From page 2<br>a.m. Residents were observed seated at various tables around the dining room.<br><br>CNA (certified nursing assistant) #1 was observed seated between two residents She was observed feeding both residents at the same time. She alternated between the two residents, giving one resident a few bites of food and then feeding the other resident. This continued for the entire meal. Neither of the residents being fed made any effort to feed themselves.<br><br>CNA #2 was observed at another table feeding one resident. CNA #2 stated they needed more assistance in the dining room and at 11:45 a.m., she placed a telephone call to someone requesting additional assistance. CNA #2 moved a resident who was in a geri-chair from one table to the table she (CNA #2) was sitting at. CNA #2 was then observed seated between the two residents. She used proper hand hygiene and proceeded to feeding the second resident, whom she had just moved to the table. She alternated between the two residents giving one resident a few bites of food and then feeding the other resident. Neither of the residents made any attempt to feed themselves. This continued until approximately 12:12 p.m. when another staff member arrived to assist CNA #2 with feeding the residents at the table.<br><br>Other staff members were observed walking around in the dining room, assisting various residents with lunch by bringing additional food or drinks to the table and preparing for the second lunch round which started at 12:30 p.m. for residents who were independent and did not require feeding assistance with meals. | F 550 | 3. Education will be provided to Nursing Staff by the DON or designee on the Senior Care Dining Services Protocol. With input from nursing staff, seating arrangements at the tables will be evaluated and residents placed to prevent feeding more than one resident at a time.<br>4. Additional second floor dining room observations will be conducted by the DON or designee weekly for one month. Findings of the audits/ observations will be reported to the facility QAA meetings for ongoing compliance.<br>5. All corrective action will be complete by October 05, 2018. | |

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On 08/21/18 at 12:16 p.m., CNA #1 was interviewed regarding the lunch observation. She was asked why both residents were being fed at the same time. She stated both residents required feeding assistance at each meal. She continued and stated because they have so many residents who need feeding assistance, it is normal for her to feed two residents at the same time.

On 08/21/18 at 12:24 p.m., CNA #2 was interviewed regarding the lunch observation. She was asked about the feeding of the two residents at lunch. She stated "I want them to enjoy their meals and not have cold food. That's why I moved the second resident over to the table with me so that I could feed her too." She was asked if she normally fed more than one resident at at time. She stated "Yes."

The administrator, DON (director of nursing) and the managing director of senior care services were notified of the above information during a meeting on 08/23/18 at approximately 11:15 a.m. They were asked what the expectation was regarding feeding assistance. The managing director of senior care services stated it was not the expectation for a CNA to feed more than one resident at the same time.

On 08/23/18 at approximately 11:45 a.m., the DON provided a copy of the facility's Dining Protocol (approved 03/15/2018) which documented the following: " The dining atmosphere should be pleasant, attractive, well lighted and homelike."

No further information and/or documentation was presented prior to the exit conference on

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| F 550 | Continued From page 4<br>08/23/18 at approximately 1:00 p.m. | F 550 | | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview and clinical record review, the facility staff failed to honor a bathing preference for one of 22 residents in the survey sample. Resident #48 | F 561 | F561<br>1. The assignment sheet and care plan for resident # 48 has been updated to reflect her choice in bathing preference. | 10/5/18 |

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F 561 Continued From page 5

was given a whirlpool bath against her voiced preference for a bed bath.

The findings include:

Resident #48 was admitted to the facility on 7/19/18 with diagnoses that included pneumonia, respiratory failure, COPD (chronic obstructive pulmonary disease), high blood pressure, chronic kidney disease and hyperlipidemia. The minimum data set (MDS) dated 7/19/18 assessed Resident #48 with moderately impaired cognitive skills and as totally dependent upon staff for transfers and bathing.

On 8/22/18 at 12:54 p.m., Resident #48 was interviewed about quality of life in the facility. Resident #48 stated her only issue was regarding her preference for a bed bath. Resident #48 stated she preferred a bed bath but her aides told her she had to take a shower and/or whirlpool bath twice a week. Resident #48 stated this had happened on more than one occasion. Resident #48 stated, "I know it should make you feel better but I just don't care for it [whirlpool bath]." Resident #48 stated she did not like the shower room because she did not like transfers with the mechanical lift. Resident #48 stated she was most recently denied a bed bath today (8/22/18) when the CNA (certified nurses' aide) insisted she take a whirlpool bath in the shower room instead of a bed bath.

Resident #48's plan of care (effective 8/16/18) listed the resident received hospice services and required total assistance with activities of daily living (ADL) due to decreased mobility and weakness. Interventions to maintain hygiene and proper grooming included provide/assist with ADL

F 561

2. A 100% audit/ interview of patients will be conducted by the DON or designee to determine individual choice for bathing. Care plans will be updated by the Unit Managers to address the resident□s self-determination regarding their bathing choice.
3. Education will be provided by the DON or designee to Nursing staff and Social Services staff regarding 483.10(f)-Self- determination and the right the resident has to make choices about aspects of his or her life that are significant to the resident.
4. A 10% random audit will be conducted by the DON or designee monthly for 3 months to confirm bathing preference is honored. Findings of the audits will be reported to the facility QAA committee meetings for ongoing compliance.
5. All Corrective action will be complete by October 05, 2018.

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| F 561 | Continued From page 6<br>care and oral care as needed.<br><br>On 8/22/18 at 1:05 p.m., CNA #2 caring for Resident #48 was interviewed about the resident's bath preference. CNA #2 stated, "She [Resident #48] is the type you have to encourage it [going to shower room]." CNA #2 stated she knew the resident did not prefer the whirlpool but stated, "In the end she will be better." CNA #2 stated the resident's daughter wanted her to get the whirlpool bath and stated she tried to get the resident to take the whirlpool because after she would feel better. CNA #2 stated, "If she [Resident #48] had started hollering I would have let her get a bed bath."<br><br>On 8/22/18 at 4:08 p.m., the registered nurse unit manager (RN #1) was interviewed about Resident #48's bath preference. RN #1 stated Resident #48 should get a bed bath as requested. RN #1 stated some of the families wanted the residents to get showers and be out of bed even though that was not always the residents' preference. RN #1 stated she thought the CNAs might be trying to do what the families wanted.<br><br>These findings were reviewed with the administrator and director of nursing during a meeting on 8/23/18 at 11:00 a.m. | F 561 | | |
| F 585 SS=D | Grievances<br>CFR(s): 483.10(j)(1)-(4)<br><br>§483.10(j) Grievances.<br>§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or | F 585 | | 10/5/18 |

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| F 585 | Continued From page 7 | F 585 | | |

reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey

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| F 585 | Continued From page 8<br>Agency and State Long-Term Care Ombudsman program or protection and advocacy system;<br>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;<br>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;<br>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as | F 585 | | |

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the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to resolve grievances and concerns in a timely manner for one of 22 residents in the survey sample. Resident #33 had been over three months without a satisfactory resolution to reported trust and care issues involving a nurse providing care and treatments for the resident.

The findings include:

Resident #33 was admitted to the facility on 7/18/17 with diagnoses that included diabetes, stasis ulcers, high blood pressure, peripheral venous insufficiency, obesity and vitamin deficiency. The minimum data set (MDS) dated 7/6/18 assessed Resident #33 as cognitively intact.

On 8/21/18 at 11:25 a.m., Resident #33 requested to talk with a surveyor about an ongoing issue with a nurse caring for him that was unresolved. Resident #33 stated licensed practical nurse (LPN) #2 routinely provided care and dressing changes on his legs/feet when the "regular" nurse was not working. Resident #33 stated about 3 months ago he "got word" from other staff members in the facility that LPN #2

F 585

F585
1. The facility Administrator and Social Worker met with resident # 33 on August 22, 2018 at approximately 4:00 pm to discuss his concerns about LPN #2. At the resident□s request, LPN# 2 has been re-assigned so that she will not be his caregiver. The resident stated he was satisfied with this plan.
2. On August 22 and 23, 2018, the facility Social Workers and Administrator conducted resident interviews on all four Neighborhoods with residents who were alert and able to provide feedback. Interview questions were focused on any issues the residents may have with reported trust and care issues involving nurses providing care and treatments for the individual resident. There were no issues identified
3. Education will be provided to facility staff by the Social Worker or designee on our grievance policy and our desire to have a prompt effort to resolve grievances. Our Grievance/ Concern Form has been updated to include notification of grievances by the Social Worker in the event the Social Worker is not the individual who initially receives the

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| F 585 | Continued From page 10<br>wrote in his record that his foot smelled so bad that she did not want to change his dressing. Resident #33 stated he talked to LPN #2 about any note indicating his feet smelled and LPN #2 "denied it." Resident #33 stated he did not feel LPN #2 was being honest with him so he stopped letting her change his wound dressings. Resident #33 stated he had an uncomfortable feeling when interacting with LPN #2 and did not think she was trustworthy or honest. Resident #33 stated during a tornado warning in June (2018), when he was self-propelling in his wheelchair to the designated area in the hall, LPN #2 came up behind him and pushed him in the wheelchair. Resident #33 stated his foot went down while she was pushing and his right leg went under the chair and caused knee pain. Resident #33 stated LPN #2 left the unit, did not check on him and never apologized or said she was sorry for hurting his leg. Resident #33 stated about 10 days ago, LPN #2 changed a dressing on his leg and applied an ointment with a tongue depressor instead a Q-tip. Resident #33 stated the depressor was "rough" and all the other nurses used Q-tips. Resident #33 stated the dressing she applied felt loose and when he told LPN #2 that the dressing was not going to stay on, LPN #2 "got fretted" with him and told him she knew how to care for wounds. Resident #33 stated he did not trust LPN #2, she frequently was "sarcastic" with him and he did not want her caring for him.<br><br>Resident #33 stated he had no issues with any other staff in the facility and no problems other than LPN #2. Resident #33 stated he talked to the unit manager and the director of nursing (DON) about the issue. Resident #33 stated the DON told him LPN #2 was a good nurse and offered to have a meeting with him and LPN #2. | F 585 | information.<br>4. Grievance/ Concern forms will be audited by the Administrator on a weekly basis for 1 month; then monthly for 3 months to ensure a timely resolution to the concern has occurred. Findings of the audits will be reported to the facility QAA committee meetings for ongoing compliance<br>5. All corrective action will be complete by October 05, 2018 | |

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| F 585 | Continued From page 11<br>Resident #33 stated he did not want to meet or talk to LPN #2. Resident #33 stated, "I don't want to deal with her [LPN #2]." Resident #33 stated he refused care from LPN #2 "for awhile" but had recently started letting her do dressing changes again. Resident #33 stated, "I got so mad one day I cried." Resident #33 stated he just did not trust LPN #2 and at times did not sleep at night thinking about issues with her. Resident #33 stated he had been trying to keep his cool and had been waiting for the "state" to come to report the issues and requested to file a complaint. Resident #33 stated the issues with LPN #2 had been ongoing for several months and the only thing the facility had offered were meetings with LPN #2.<br><br>Resident #33's clinical record documented a nursing note written by LPN #2 dated 5/5/18 stating, "...attempted to put new dressing on wound to heel, refused by resident, states he was told that this nurse said his foot stunk and was dirty. Resident informed that this nurse passed on in report 2 days ago that the staff members need to ensure his foot is dried well prior to putting on his socks and tubigrips since moisture can lead to further wounds, inhibit the current wound from healing and with his being a diabetic he is more at risk. This nurse apologized to resident that it was reported differently to him, that I was only trying to ensure his foot care was performed properly to prevent further damage to his feet and to encourage healing to current wound, continued to refuse."<br><br>The clinical record documented a nursing noted written by LPN #2 dated 6/25/18 stating, "Late entry for 6/23/18 During the tornado alert resident was being pushed down the hallway per | F 585 | | |

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a staff member when the resident stated his right leg went under his wheelchair. Resident stated that when his right leg went under his wheelchair that it caused a pain to his right knee. Resident now having difficulty bearing weight on his right leg and knee...Resident refused a X ray... [Physician] ordered a PT [physical therapy] consult to obtained due to resident is unable to stand..." (sic)

The clinical record documented Resident #33 refused dressing changes, wound treatments and/or restorative ambulation eight times from 5/5/18 through 8/6/18. All of the refusals involved LPN #2. The clinical record made no mention of the resident's conflict with LPN #2 or of any conversations or discussions with the resident about his concerns. Current physician orders for wound care included orders dated 8/6/18 for daily treatment of ulcers to the left lower leg and right lower leg. Treatment included cleansing of wounds with wound cleanser, application of Hydrofera Blue foam, covered with ABD pad and gauze wrap.

The resident's care plan (effective date 7/15/18 to present) documented the resident "does prefer to not have dressing changed at times" regarding care for a left heel pressure ulcer and stasis ulcers on his right leg. The care plan included no interventions to address care/treatment refusals, made no mention of any conflicts with staff members or any reference to the right knee injury of 6/23/18. The care plan listed the resident, "...may have difficulty adjusting with changes in health, social, and emotional status while in the facility." Interventions to minimize or prevent adverse reactions to changes included keeping physician informed of any significant changes,

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providing opportunity to express concerns and having meals in dining room.

Social worker notes made no mention of any resident concerns, conflicts or care refusals.

On 8/21/18 at 1:44 p.m., LPN #2 was interviewed about Resident #33. LPN #2 stated in May, she found the resident with his sock, shoe and tubigrips (protective sleeve over dressings) on his left heel wound wet. LPN #2 stated when she gave report that evening to the next shift, she reported the resident's foot/wound had been wet and had an odor. LPN #2 stated she documented the dressing change but did not refer to the resident's feet as "stinking" in the note. LPN #2 stated when she returned to work the next week, the resident accused her of saying his feet smelled bad and he refused to let her change his dressings. LPN #2 stated after that she tried to be "overly nice" but the resident did not allow her to change the dressings. LPN #2 stated she tried "tough love," telling him he had to do the dressing changes but he still refused. LPN #2 stated she told the resident he was "fighting against us" with trying to heal the wounds. LPN #2 stated the unit manager and DON were aware of the issue and of the resident's refusals. When asked how they addressed the resident's concerns, LPN #2 stated dressing changes for Resident #33 were done by another nurse on the unit if available. LPN #2 stated if she was the only nurse available, she changed the dressings if the resident allowed. LPN #2 stated Resident #33 "would prefer another nurse." Concerning the wheelchair incident, LPN #2 stated she assisted with moving residents to the designated safe area during an actual tornado warning in June 2018. LPN #2 stated while pushing

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| F 585 | Continued From page 14<br>Resident #33, the resident put down his right foot and his leg went under the wheelchair. LPN #2 stated she was the end of her shift and she left the unit immediately after moving him to the area. LPN #2 stated other staff members were in the area with Resident #33 and she did not realize he hurt his knee until she came back to work a couple of days later. LPN #2 stated this incident occurred during a real tornado warning, not a drill so there was an urgency to get residents to a safe place.<br><br>On 8/22/18 at 10:51 a.m., LPN #1 that routinely cared for Resident #33 was interviewed. LPN #1 stated LPN #2 worked on her unit when she was off. LPN #1 stated when she returned to work after days off Resident #33 was "very, very upset." LPN #1 stated Resident #33 did not trust LPN #2 and at times, he did not like the dressings she applied. LPN #1 stated she tried to diffuse the situation as much as possible and felt she was "put in the middle" when dealing with LPN #2 and Resident #33. LPN #1 stated she had reported the issue to the unit manager. LPN #1 stated the unit manager told her that Resident #33 had to let LPN #2 work on his leg wounds. LPN #1 stated she had done dressing changes at times when the resident was not assigned to her due to the conflict. LPN #1 stated to her knowledge, no administration had investigated the situation. Regarding the "stinky feet" comments, LPN #1 stated she heard in the shift change report the resident had smelly feet related to a fungus but she was not sure where that originated.<br><br>On 8/22/18 at 2:18 p.m., the registered nurse unit manager (RN #1) was interviewed about Resident #33's conflict with LPN #2. RN #1 | F 585 | | |

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| F 585 | Continued From page 15<br>stated the resident had talked with the DON and other nurses about LPN #2. RN #1 stated that nurses had reported to her that Resident #33 did not trust and was refusing care from LPN #2. RN#1 stated Resident #33 reported that LPN #2 said his feet were "stinky" and that he thought she was not honest when asked about it. RN #1 stated Resident #33 refused to let LPN #2 perform dressing changes after that incident and preferred the other nurses perform dressing changes. RN #1 stated, she did not remember exactly when but she talked with the DON and they thought he just needed some time to let things settle. RN #1 stated she had not heard anything about the conflict "for awhile." RN #1 stated there had been no formal investigation of the conflict and that LPN #2 preferred that someone else perform dressing changes for him if available. Concerning the wheelchair incident, RN #2 stated she was not here that day but LPN #2 reported she told the resident to raise his feet and she pushed him to the designated safe area during a tornado warning. RN #1 stated the resident dropped his foot while LPN #2 was pushing the wheelchair and his leg went under the chair. RN #1 stated LPN #2 left shortly after this as her shift had ended. LPN #2 stated the resident suffered a sprained knee and had therapy but was back to usual activity following the incident. LPN #2 stated this incident occurred during an actual tornado emergency and not a drill.<br><br>On 8/22/18 at 2:46 p.m., the DON was interviewed about Resident #33's concerns with LPN #2 and any attempts to resolve the issues. The DON stated that in May 2018 the resident reported he had a concern but he was going to handle it himself. The DON stated she did not | F 585 | | |

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hear anything else about it until a couple of weeks ago when he asked to talk. The DON stated the resident looked upset and said he could not deal with LPN #2 anymore. The DON stated Resident #33 reported that LPN #2 would not stop finding things wrong with him and that LPN #2 had referred to him having "stinking feet." The DON stated she talked with LPN #2 who stated she had reported there was an odor to the wound on his feet and this was verbally communicated during a shift change report. The DON stated LPN #2 told her she was just giving report and there was nothing derogatory intended by the comment. The DON stated Resident #33 also said he was upset about the dressing change with the tongue depressor. The DON stated LPN #2 used the tongue depressor to mix the cream ordered for the wound care and applied the cream with the tongue depressor because the substance was "thick." The DON stated it was not against policy to apply ointments/creams with a tongue depressor. The DON stated that at this point she offered to have a meeting with Resident #33 and LPN #2 to discuss the issues but Resident #33 refused. The DON stated, "I told him [Resident #33] that I don't think [LPN #2] meant any harm and she has his best interest at heart." The DON stated she asked the resident at this point about letting LPN #2 give him medications and perform dressing changes and the resident agreed. The DON stated she had no documentation of her conversations with Resident #33 and did not enter a formal grievance or complaint form regarding the concerns. The DON stated after the resident agreed to let LPN #2 perform the dressings again, she thought everything was ok.

On 8/22/18 at 3:08 p.m., the administrator was

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interviewed about Resident #33. The administrator stated she did not realize the resident was still upset about LPN#2.

On 8/22/18 at 3:31 p.m., the facility's social worker was interviewed about Resident #33. The social worker stated she was not aware of any issues with Resident #33 and LPN #2. The social worker stated she had talked with the resident several times and he did not mention it to her. The social worker stated no staff members had reported any issues to her regarding Resident #33. The social worker was the designated grievance officer for the facility and stated no formal grievance or concern form had been entered regarding Resident #33.

On 8/23/18 at 10:38 a.m., the administrator and DON were interviewed again about Resident #33. The DON stated there was no concern form entered regarding Resident #33's issues with LPN #2. The DON stated she had no documentation or specific dates of when she talked with the resident. The DON stated several weeks ago when Resident #33 agreed to let LPN #2 perform dressing changes, she thought everything had since been ok. When asked if anyone had followed up with the resident about the concerns, the DON stated she had checked on him but had not asked him specifically about LPN #2. The DON had no incident report or investigation regarding Resident #33's knee injury during the tornado warning in June 2018 involving LPN #2.

The facility's policy titled Grievances/Complaints (dated 3/9/18) stated, "The facility will assist residents and/or resident representatives in filing grievances or concerns when requested. Staff

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| F 585 | Continued From page 18<br>members are encouraged to assist the resident or their representative in filing a grievance and/or concern ensuring the rights of that resident. All grievances must be investigated and the disposition of the said grievance or complaint must be filed with the facility. The resident and/or representative will be notified of the grievance process on admission...The Social Worker in the facility will be the designated Grievance Officer. The Administrator will ensure timely resolution to a grievance...Any resident, resident representative, family member or appointed advocate may file a grievance or complaint regarding treatment, medical care, behavior of other residents, staff members, theft of property, etc., without fear of threat or reprisal in any form...Grievance and/or complaints may be submitted orally or in writing...The administrator or designee is assigned the responsibility of investigating grievances and concerns The Administrator or designee conducting the investigation will be careful to not violate the resident's rights during the course of the investigation...The resident, or person filing the grievance and/complaint in behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. Such report will be made orally by the administrator, or his or her designee, within 3 working days of the filing of the grievance or complaint with the facility..."<br><br>These findings were reviewed with the administrator and director of nursing during a meeting on 8/23/18 at 11:00 a.m.<br><br>This was a complaint deficiency. | F 585 | | |
| F 623 | Notice Requirements Before Transfer/Discharge | F 623 | | 10/5/18 |

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| F 623<br>SS=C | Continued From page 19<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, | F 623 | | |

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under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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| F 623 | Continued From page 21<br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident record review and staff interview the facility failed to notify the state ombudsman's office for resident discharges to hospital.<br><br>The facility did not notify the state ombudsman's office of resident discharge to the hospital<br><br>The Findings Include:<br><br>Resident #8 was admitted to the facility on 2/22/12 with a readmission 5/14/18 with diagnoses including peripheral vascular disease, renal insufficiency, and urinary tract infection.<br><br>The most recent MDS (minimum data set) was a 5 day assessment with an ARD (assessment reference date) of 5/21/18. Resident #8 was assessed with severe cognitive impairement with a score of 5. | F 623 | F623<br>1. Notification to the State Ombudsman Office regarding discharge to the hospital of Resident #8 and Resident #82 was sent by a facility Social Worker on 08/27/2018 at 10:41 a.m.<br>2. An audit of facility discharges to the hospital for the past month will be conducted by the Social Worker or designee to verify if the State Ombudsman office has been notified. Notification to the Ombudsman office will be provided if indicated.<br>3. Education will be provided to the facility Social Workers by the Administrator on the requirement to notify the State Ombudsman□s office of resident transfers/ discharge to the hospital.<br>4. A 10% audit of all discharges to the hospital will be conducted by the | |

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| F 623 | Continued From page 22<br><br>Resident # 8's medical record was reviewed on 8/23/18 and documented that Resident #8 was admitted to the hospital on 5/10/18, due to a urinary tract infection.<br><br>A closed record review of another resident that was discharged to the hospital included the following:<br><br>Resident #82 was admitted to the facility on 5/22/18 with diagnoses that include: Coronary artery disease with bypass graphs and diabetes.<br><br>The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 5/29/18. Resident #82 was assessed as being cognitively intact with a score of 15.<br><br>Resident #82's medical record was reviewed on 8/23/18 and documented via nursing note dated 6/3/18 to send Resident #82 to the hospital for an evaluation related to infection of the harvest site of the graphs for the coronary bypass. Resident # 82 did not return to the facility.<br><br>On 08/23/18 at 8:18 AM, the social worker (other staff, OS #5) was interviewed concerning notifying the State ombudsman's office regarding residents being discharged to the hospital. OS #5 verbalized that it is not the facilities practice to send notice to the ombudsman regarding discharge to the hospital and didn't know that she was supposed to notify the ombudsman's office.<br><br>On 8/23/18 at 11:00 AM, the above information was presented to the DON (director of nursing) and Administrator of not notifying Ombudsman. | F 623 | Administrator or designee monthly for 3 months to ensure notification has been provided to the State Ombudsman office. The results of these audits will be reported to the facility QAA Committee meetings to ensure ongoing compliance.<br>5. All corrective action will be completed by October 05, 2018 | |

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| F 623 | Continued From page 23<br><br>No other information was presented prior to exit conference on 8/23/18. | F 623 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document | F 656 | | 10/5/18 |

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| F 656 | Continued From page 24<br>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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and staff interview, the facility staff failed to develop a comprehensive resident centered care plan for behavior interventions for one of 22 residents in the survey sample: Resident # 18.<br><br>Findings include:<br><br>Resident # 18 was admitted to the facility 12/6/17 with diagnoses to include, but were not limited to: high blood pressure, vascular dementia, anxiety, and COPD.<br><br>The most recent MDS (minimum data set) was a quarterly review dated 6/12/18 and had Resident # 18 coded with severe cognitive impairment with a total summary score of 03 out of 15.<br><br>On 8/23/18 beginning at 8:00 a.m. the care plan was reviewed. The identified problem "(name of resident) uses psychotropic medication..." Under "Goals" was documented "(name of resident) will be on the lowest therapeutic dose by next quarterly review." "Interventions" included: "Monitor and document behavior...Encourage activities that will decrease agitated mood...Redirect resident as needed."<br><br>On 8/23/18 8:50 a.m. Registered Nurse (RN) # 2, | F 656 | F656<br>1. The comprehensive care plan for Resident # 18 was updated on 08/28/2018 to include resident centered, individualized interventions related to his behaviors<br>2. A 100% audit of resident care plans who have behaviors care planned will be conducted by the DON or designee to ensure interventions are individualized and resident centered.<br>3. Education will be provided to Nursing staff by the DON or designee regarding using individualized resident centered interventions for residents who have behaviors.<br>4. A 10% audit of resident care plans who have care behaviors will be conducted monthly for 3 months by the DON or designee to ensure interventions are individualized and resident centered. The results of these audits will be reported to the facility QAA meeting to ensure ongoing compliance.<br>5. All corrective action will be completed by October 05, 2018. | |

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| F 656 | Continued From page 25<br>who was the unit manager, was asked about the care plan for the use of psychotropic medications. The care plan did not appear individualized, as the interventions included "medicate per physician orders, redirect as needed, and encourage activities to decrease agitated mood." RN # 2 stated "Well, we talk to him about the war, we play music...we try to talk to him about what's bothering him as he has nightmares frequently." RN # 2 was asked if what nursing was doing prior to administering an antipsychotic medication should be more descriptive than to "redirect" him, and the nightmares were not mentioned on the care plan. She agreed, stating "Yes, I guess it should say what to do to try and get him calmed down and what exactly should be done to redirect him." RN # 2 was asked where the behaviors would be documented. She stated "In the nursing notes; there is not a monitoring sheet for that."<br><br>The administrator and DON (director of nursing) were informed of the above findings during a meeting with facility staff 8/23/18 beginning at 12:00 p.m.<br><br>No further information was provided prior to the exit conference. | F 656 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, | F 658 | F658 | 10/5/18 |

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| F 658 | Continued From page 26<br>facility document review, clinical record review and complaint investigation, the facility staff failed to follow professional standards of care for one of 22 residents in the survey sample.<br><br>Nursing failed to assess Resident #33's right leg/knee immediately after his leg was caught under the wheelchair causing pain. The resident was diagnosed with a sprained right knee and received two weeks of therapy for treatment of the injury. There was no documented assessment of the right knee until four days after the incident. The facility performed no review or investigation of this incident that caused a short-term decline in function for Resident #33.<br><br>The findings include:<br><br>Resident #33 was admitted to the facility on 7/18/17 with diagnoses that included diabetes, stasis ulcers, high blood pressure, peripheral venous insufficiency, obesity and vitamin deficiency. The minimum data set (MDS) dated 7/6/18 assessed Resident #33 as cognitively intact.<br><br>On 8/21/18 at 11:25 a.m., Resident #33 requested to speak with a surveyor about an ongoing issue with a nurse caring for him that was unresolved. Resident #33 stated during a tornado warning in June (2018), when he was self-propelling in his wheelchair to the designated area in the hall, licensed practical nurse (LPN) #2 came up behind him and pushed him in the wheelchair. Resident #33 stated his foot went down while she was pushing and his right leg went under the chair and caused pain in his knee. Resident #33 stated LPN #2 left the unit, did not check on him and never apologized or said she | F 658 | 1. The injury reported to the right knee of resident #33 has resolved and he is back to his baseline.<br>2. A 100% audit of any reported injuries for the past 30 days will be conducted by the DON or designee to confirm a timely assessment and investigation of the event has been completed.<br>3. Education will be provided for Licensed Nurses by the DON or designee regarding timely assessment and investigation of any injury according to professional standards of care.<br>4. A 10% audit of all reported injuries will be conducted monthly by the DON or designee for 3 months to confirm timely assessment and investigation. Results of these audits will be reported to the facility QAA committee to ensure ongoing compliance.<br>5. All corrective action will be complete by October 05, 2018 | |

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| F 658 | Continued From page 27<br>was sorry for hurting his leg. Resident #33 stated other staff members helped get his leg from under the chair and he told them he had pain in his right knee.<br><br>The clinical record documented no assessment of the resident's right leg/knee related to the wheelchair incident until 6/27/18 when the nurse practitioner (NP) entered a progress note about the injury.<br><br>Resident #33's clinical record documented a nursing noted written two days after the incident by LPN #2 dated 6/25/18 stating, "Late entry for 6/23/18 During the tornado alert resident was being pushed down the hallway per a staff member when the resident stated his right leg went under his wheelchair. Resident stated that when his right leg went under his wheelchair that it caused a pain to his right knee. Resident now having difficulty bearing weight on his right leg and knee...Resident refused a X ray...[Physician] ordered a PT [physical therapy] consult to obtained due to resident is unable to stand..." (sic)<br><br>Further review of the clinical record documented no entries on 6/23/18. There was no assessment of the resident's knee or leg at the time of the injury from 6/23/18 until 6/27/18 in a NP note. The clinical record documented on 6/24/18, "Pt. [patient] c/o [complained of] right knee 6/10 scale [pain scale 0 = no pain; 10 = worst pain] Tramadol given per md order..." There was no documented assessment related to the pain indicating the knee's appearance including skin color, presence of swelling and range of motion or function. | F 658 | | |

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| F 658 | Continued From page 28 | F 658 | | |

The resident was seen by the nurse practitioner (NP) on 6/25/18 and 6/26/18 regarding an upper respiratory infection but made no mention or assessment of the resident's knee. A NP note dated 6/27/18 documented, "He did have an incident over the weekend where his foot had been caught on the floor. They were wheeling him, I believe it was last Friday, in the wheelchair. I was notified today of this...I believe he did have some tenderness at the time. He denies any pain there, but Therapy had picked him up and noted he was having some pain. We did get an x-ray today. It looks like we had a tornado alert and he was being moved from the room. His right leg did get caught under his wheelchair, caused pain to the right knee...No acute injury and he is not having any pain today on exam. He does have positive movement...He does have a lot of edema, but he has his legs wrapped..."

A physical therapy evaluation dated 6/25/18 documented, "per medical doctor, patient is unable to stand related to knee and hip dysfunction. Upon talking to pt [patient], pt had incident on June 22, 2018 in which his right knee 'bent under wheelchair' and he had 'knife'-like sensation and was having pain since and inability to bear weight through RLE [right lower extremity] now requiring additional assistance to toilet, unable to walk." Therapy treated the resident from 6/25/18 through 7/11/18 with the resident returning to prior functioning.

On 8/21/18 at 1:44 p.m., LPN #2 was interviewed about Resident #33. Concerning the wheelchair incident, LPN #2 stated she assisted with moving residents to the designated safe area during an actual tornado warning in June 2018. LPN #2 stated while pushing Resident #33, the resident

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| F 658 | Continued From page 29<br>put down his right foot and his leg went under the wheelchair. LPN #2 stated she was the end of her shift and she left the unit immediately after moving him to the area. LPN #2 stated other staff were in the area with Resident #33 and she did not realize he hurt his knee until she came back to work a couple of days later.<br><br>On 8/22/18 at 2:46 p.m., the director of nursing (DON) was interviewed about any investigation or review of Resident #33's injury related to the wheelchair incident. After looking, the DON stated she had no investigation or incident report about Resident #33's right knee injury with the wheelchair.<br><br>On 8/22/18 at 4:05 p.m., a certified nurses' aide (CNA #1) working on Resident #33's unit on 6/23/18 during the tornado alert was interviewed. CNA #1 stated staff members were moving residents to the designated safe area due to the tornado alert/warning. CNA #1 stated LPN #2 pushed Resident #33 in the wheelchair moving him to the safe area. CNA #1 stated the resident's foot caught on the floor and he hollered out "aww." CNA #1 stated she and some of the nurses helped to get his leg straight. CNA #1 stated she was not assigned to Resident #33 that day and other staff members cared for him the rest of the shift.<br><br>On 8/23/18 at 8:00 a.m., the registered nurse unit manager (RN #1) was interviewed about the lack of assessment of Resident #33's knee/injury. RN #1 stated the nurse working at the time of the incident should have written a note and an assessment of the leg/knee. RN #1 stated LPN #2 left the unit after the incident because her shift was over but the nurse working with Resident #33 | F 658 | | |

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| F 658 | Continued From page 30<br>should have assessed the knee and entered a note. RN #1 stated the on-call physician was notified and ordered the therapy evaluation. RN #1 stated the on-call physician ordered an x-ray but the resident initially refused the x-ray.<br><br>The facility's policy titled Accidents and Incidents Investigating and Recording (dated 6/6/17) stated, "All accidents or incidents occurring on our premises must be investigated and reported to the administrator...Regardless of how minor an accident or incident may be, including injuries of an unknown source, it must be reported to the department supervisor, and an Accident or Incident Report Form must be completed on the shift that the accident or incident occurred...Render immediate assistance. Do not move the victim until he/she has been examined for possible injuries...Examine all accident/incident victims...The charge nurse and/or the department director or supervisor must conduct an immediate investigation of the accident or incident..."<br><br>The Lippincott Manual of Nursing Practice 10th edition states on page 16 concerning standards of care, "A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because the passage of time may lead to a less than accurate recollection of the specific events." Pages 16 and 17 of this reference state, "Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow | F 658 | | |

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| F 658 | Continued From page 31<br>appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record...Failure to communicate or document a significant change in a patient's condition to appropriate professional...Failure to make prompt, accurate entries in a patient's medical record..." (1)<br><br>These findings were reviewed with the administrator and director of nursing during a meeting on 8/23/18 at 11:00 a.m. The DON stated during this meeting that no incident report was entered for Resident #33's right knee injury of 6/23/18 so there had been no investigation of the incident.<br><br>(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.<br><br>This was a complaint deficiency. | F 658 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On<br>CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any | F 756 | | 10/5/18 |

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drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility staff failed to provide a clinical rationale for the use of a PRN (as needed) antipsychotic medication longer than 14 days for one of 22 residents in the survey sample: Resident # 18. Resident # 18 had a PRN order for Seroquel without a clinical rationale or evaluation.

Findings include:

Resident # 18 was admitted to the facility 12/6/17 with diagnoses to include, but were not limited to:

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1. A monthly Drug Regimen Review for resident # 18 was completed by a licensed pharmacist on August 27, 2018. The pharmacy recommendation to discontinue or reduce the PRN Seroquel was accepted by the Provider and the PRN Seroquel was discontinued.
2. A 100% audit of monthly Drug Regimen reviews for patients on PRN Antipsychotic Medication will be conducted by the DON or designee to ensure a clinical rationale or evaluation is

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high blood pressure, vascular dementia, anxiety, and COPD.

The most recent MDS (minimum data set) was a quarterly review dated 6/12/18 and had Resident # 18 coded with severe cognitive impairment with a total summary score of 03 out of 15.

On 8/23/18 beginning at 8:00 a.m. the clinical record was reviewed. The current POS (physician order summary) for August 2018 included an order carried forward for "Seroquel 50 mg tablet as needed every four hours starting 6/29/18. Notes: Dementia with behaviors/anxiety and aggression."

Also noted in the clinical record were two (2) pharmacy recommendations dated 7/8/18 and 7/20/18.

The recommendation dated 7/8/18 documented "Please review the current order for the resident's quetiapine (Seroquel) in order to comply with current CMS (Centers for Medicare and Medicaid Services) guidelines requiring attempts to discontinue psychoactive prn medications." On the recommendation form there was a box for the physican to document an appropriate diagnosis for each medication ordered. The box was blank. Beside "Physician/Prescriber Response" was written "No change- still behaviors and some psychosis."

On the recommendation dated 7/20/18 the pharmacist documented "This resident currently takes Seroquel 50 mg every four hours PRN. CMS guidelines require routine attempts to discontinue PRN orders for psychoactive medications and limits their use to 14 days.

F 756

present.
3. Education will be provided to Providers by the Administrator on documenting in the medical record a review of any identified irregularity and what, if any action has been taken to address it.
4. A 10% audit of monthly Drug Regimen reviews for patients on PRN Antipsychotic Medication will be conducted by the DON or designee for 3 months to ensure a clinical rationale or evaluation is present. The results of these audits will be reported to the facility QAA meetings to ensure ongoing compliance.
5. All corrective action will be completed by October 05, 2018.

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| F 756 | Continued From page 34<br>Please consider a trial discontinuation of this PRN medication at this time." The box for the physician to document the appropriate diagnosis was blank. For the "Physician/Prescriber Response" the physician had written "Improvement with this increased dose."<br><br>On 8/23/18 at 12:00 p.m. during a meeting with the administrator and DON (director of nursing) the above findings were discussed. The DON was asked about the responses from the physician. She stated "No, that's really not a clinical rationale for continuing the PRN dose."<br><br>No further information was provided prior to the exit conference. | F 756 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§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:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§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; | F 758 | | 10/5/18 |

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| F 758 | Continued From page 35<br><br>§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;<br><br>§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<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to ensure one of 22 residents in the survey sample was free from unnecessary medications: Resident # 18.<br><br>There was no documentation of Resident # 18's behaviors for the administration of three (3) doses of a PRN antipsychotic medication.<br><br>Findings include: | F 758 | F758<br>1. The PRN Seroquel for resident #18 was discontinued on August 30, 2018.<br>2. A 100% audit of residents receiving PRN Antipsychotic medications will be conducted by the DON or designee to ensure documentation of behaviors associated with the administration of PRN Antipsychotic medications has been done.<br>3. Education will be provided to nursing | |

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| F 758 | Continued From page 36<br><br>Resident # 18 was admitted to the facility 12/6/17 with diagnoses to include, but were not limited to: high blood pressure, vascular dementia, anxiety, and COPD.<br><br>The most recent MDS (minimum data set) was a quarterly review dated 6/12/18 and had Resident # 18 coded with severe cognitive impairment with a total summary score of 03 out of 15.<br><br>On 8/23/18 beginning at 8:00 a.m. the clinical record was reviewed. The current POS (physician order summary) for August 2018 included an order carried forward for "Seroquel 50 mg tablet as needed every four hours starting 6/29/18. Notes: Dementia with behaviors/anxiety and aggression."<br><br>The August 2018 MAR (medication administration record) was reviewed, and revealed Resident # 18 had been administered the PRN medication 8/4/18, 8/5/18, and 8/6/18. There were no nursing notes documenting any behaviors for the resident during that time. There were no nursing notes from 8/3/18 through 8/13/18.<br><br>The care plan was reviewed and included the identified problem "(name of resident) uses psychotropic medication..." Under "Goals" was documented "(name of resident) will be on the lowest therapeutic dose by next quarterly review." "Interventions" included: "Monitor and document behavior...Encourage activities that will decrease agitated mood...Redirect resident as needed."<br><br>On 8/23/18 at 8:50 a.m., Registered Nurse (RN) # 2, who was the unit manager, was asked for | F 758 | staff by the DON or designee regarding the need to document in the clinical record behaviors associated with the administration of PRN antipsychotic medication.<br>4. A 10% audit of all residents receiving PRN Antipsychotic medications will be conducted monthly for 3 months by DON or designee to ensure documentation of behaviors associated with the administration of PRN Antipsychotic medications has been done. The results of these audits will be reported to the facility QAA meetings to ensure ongoing compliance.<br>5. All corrective action will be complete by October 05, 2018. | |

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| F 758 | Continued From page 37 | F 758 | | |

assistance locating documentation of behaviors for Resident # 18, as there was no documentation on the resident from 8/3/18 through 8/13/18. RN # 2 stated she would look in a couple of places in the electronic record. She then stated "I'm not finding any nursing documentation other than what you've seen." She stated there was one more section of the electronic record to check, but she would need to contact the IT (Information Technology) people for the time frame being looked at.

On 8/23/18 at 9:30 a.m., RN # 2 informed this surveyor "I had the IT folks look for any documentation of why the PRN seroquel was given, but there was nothing located. Other than under the medication notes where it's documented to give for dementia with behaviors/anxiety and aggression, there are no notes, or any other documentation of why the medication was given." RN # 2 stated the staff who administered the Seroquel were weekend staff and not working presently in the facility.

RN # 2 was also asked about the care plan for the use of psychotropic medications. The care plan did not appear individualized, as the interventions included "medicate per physician orders, redirect as needed, and encourage activities to decrease agitated mood." RN # 2 stated "Well, we talk to him about the war, we play music...I think activities has more things to do with him on that care plan..." RN # 2 was asked if what nursing was doing prior to administering an antipsychotic medication should be more descriptive that to "redirect" she agreed, stating "Yes, I guess it should say what to do to redirect him."

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| F 758 | Continued From page 38<br>On 8/23/18 at 12:00 p.m. the administrator and DON (director of nursing) were informed of the above findings.<br><br>No further information was provided prior to the exit conference. | F 758 | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure | F 883 | | 10/5/18 |

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| F 883 | Continued From page 39<br>that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, staff interview, and facility document review, the facility staff failed to accurately assess and document the pneumococcal vaccine for one of five resident records reviewed: Resident # 18.<br><br>Resident # 18's pneumococcal immunization status was not known.<br><br>Findings include:<br><br>Resident # 18 was admitted to the facility 12/6/17 with diagnoses to include, but were not limited to: high blood pressure, vascular dementia, anxiety, | F 883 | F883<br>1. Resident #18 was assessed by the DON and it was determined that the resident had received the pneumococcal vaccine.<br>2. A 100% resident audit will be conducted by the DON or designee to confirm the pneumococcal vaccine status of each resident<br>3. A spreadsheet has been developed by the DON to track the status of the pneumococcal vaccine of residents. This will be managed by the Unit Manager of each neighborhood. The Unit Managers | |

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| F 883 | Continued From page 40<br>and COPD.<br><br>The most recent MDS (minimum data set) was a quarterly review dated 6/12/18 and had Resident # 18 coded with severe cognitive impairment with a total summary score of 03 out of 15.<br><br>On 8/23/18 beginning at 8:00 a.m. the electronic medical record (EMR) was reviewed for pneumococcal vaccine status. The information was not readily available, and the DON (director of nursing) was asked for assistance in locating the information.<br><br>On 8/23/18 at 8:45 a.m. the DON stated, "I'm still looking for his information; he was admitted during the time we would have been still giving flu shots, so I will need to dig a little deeper to see what I can find."<br><br>On 8/23/18 at 11:45 a.m. the DON informed the survey team she was unable to find a date the pneumococcal vaccine was administered. She stated "On admission, the admitting nurse is responsible for obtaining that information. He actually came to us from assisted living, so his flu shot was documented but for the pneumococcal vaccine the form they sent over has that he received the vaccine in the past, but there's no date." The DON was asked who was responsible for assuring the vaccine status for residents, both currently residing in the facility, and those newly admitted. The DON stated "The admitting nurse should get that information, or the unit manager." The DON further stated there was not an infection control nurse in the facility; since the facility was operated under the hospital the infection control nurse there kept up with tracking and trending for infections. The hospital nurse | F 883 | will be educated by the DON or designee on assessing and tracking the status of each resident□s Pneumococcal immunization status.<br>4. New admissions will be added to the resident tracking form on their respective Neighborhood to ensure pneumococcal vaccine status has been determined. The DON or designee will review the tracking forms on each neighborhood monthly for 3 months to ensure ongoing compliance.<br>5. All corrective action will be complete by October 05, 2018. | |

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| F 883 | Continued From page 41<br>did not track vaccines for the residents in the facility. The DON stated "I have a spread sheet for the influenza vaccines we give, but not the pneumococcal vaccine." The DON also stated "I can call the doctor's office to see if they have the date; but I'm not sure when they will send that information over." The DON was asked since the resident was admitted in December 2017, should that information already have been obtained? The DON nodded her head indicating "yes." She stated the policy for influenza and pneumococcal vaccines were located in the survey ready book. The policy "Senior Care Services Immunization Pneumococcal and Influenza" documented the following:<br><br>"POLICY: ....... 3. A. All patients meeting assessment criteria will receive the appropriate vaccine per standing order unless otherwise ordered by the physician......Primary care physician offices will be contacted to determine vaccine history if unknown by the patient.......If unable to determine immunization status, vaccines will be administered....B. The Long Term Care Facilities will obtain an informed consent at the time of admission and review the patient's immunization status. If the immunizations have not been given, the reason will be documented in the medical record....Completed assessment forms and immunization records will be stored in the resident's medical record."<br><br>The above findings were discussed with the administrator and DON during a meeting with facility staff 8/23/18 beginning at 12:00 p.m.<br><br>No further information was provided prior to the exit conference. | F 883 | | |

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