STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING _____ B. WING _____	C 10/18/2018

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AUTUMN CARE OF CHESAPEAKE	715 ARGYLL ST CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/16/18 through 10/18/18. Two complaints were investigated during the survey. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long Term Care facilities. The census in this 117 certified bed facility was 107 at the time of the survey. The final survey sample consisted of 22 current Resident reviews and 4 closed record reviews.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/16/18 through 10/18/18. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 117 certified bed facility was 107 at the time of the survey. The final survey sample consisted of 22 current Resident reviews and 4 closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical	F 558	Preparation and submission of this POC	11/16/18

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

Electronically Signed | 11/06/2018

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F 558	Continued From page 1 record review, the facility staff failed to ensure call bell was in reach for 1 of 26 Residents, Resident #31. The findings include: The facility staff failed to ensure that that the call bell remained within reach for Resident # 31. Resident # 31 is a 96-year-old-female who was originally admitted to the facility on 11/20/2013 with a readmission date of 11/07/17. Diagnoses included but were not limited to muscle weakness, type 2 diabetes mellitus, chronic obstructive pulmonary disease, chronic kidney disease, and unspecified fracture of sacrum. The clinical record for Resident #31 was reviewed on 11/16/18 at approximately 3:23pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 08/14/18 coded the Resident as 15 of 15 in section C, cognitive patterns. Section G assesses functional status. In Section G0110, the facility staff documented that Resident #31 required extensive assistance with one-person physical assist for locomotion on and off the unit, dressing, and personal hygiene. The facility staff also documented that Resident #31 was totally dependent requiring assistance of two or more persons in bed mobility, transfers, and toilet use. Resident #31's CCP (comprehensive care plan) was reviewed and contained a focus area for "At risk for falls related to: History of fall with fracture, generalized muscle weakness and anxiety," has interventions that included but were not limited to, "Maintain safe environment and transfer with	F 558	is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. 1. Call bell was placed in reach for resident #31 once notified. 2. All residents have the potential to be effected by this practice. 3. DON or Designee will in-service all departments on call bells in reach while residents are in their rooms. 4. Unit Mangers or Designee will randomly audit residents daily to insure call bells are in reach for the next three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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F 558	Continued From page 2 hoyer (lift) and two staff." On 10/16/18 at approximately 11:40am, the surveyor observed Resident # 31 setting in wheel chair in the middle of room. The call bell was observed hanging off the top of the left side of the bed touching the floor and was not within reach of Resident # 31. On 10/17/18 at approximately 9:12 am, the surveyor observed Resident # 31 watching television setting in wheel chair with bedside table positioned in the front of Resident #31. The call bell was clipped to the other end of the call bell cord next to the wall. Resident #31 was facing away from the area the call bell was located a few feet away. Call bell was not within the reach of Resident #31. On 10/17/18 at approximately 2:00pm, the surveyor observed Resident #31 setting in wheel chair in the middle of room with the call bell on top of the left side of the bed. Call bell was not within the reach of Resident #31. On 10/18/18 at approximately 3:08pm, the administrative staff was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 10/18/18.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to	F 578		11/16/18

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F 578	Continued From page 3 formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 578	1. DNR was corrected for resident #8	

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F 578	Continued From page 4 review, the facility staff failed to ensure an accurate DDNR (durable do not resuscitate) order for 1 of 26 Residents Resident #8. The findings included: The facility staff failed to ensure the Residents DDNR was complete. Section's 1 and 2 had been left blank. The clinical record review revealed that Resident #8 had been admitted to the facility 08/13/13. Diagnoses included, but were not limited to, Alzheimer's disease, hypothyroidism, nutritional deficiency, chronic pain syndrome, hypertension, and heart failure. Section C (cognitive patterns) of the Residents significant change MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/06/18 had been coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making. Section O (special treatments, procedures, and programs) had been coded to indicate the Resident was receiving hospice services. The Residents clinical record included a DDNR order form from the Virginia Department of Health. This form was dated 06/07/11 and read in part. Under section 1 "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision... 2. The patient is INCAPABLE of making an informed decision..."	F 578	during the survey. 2. A 100% audit of every resident that has chosen DNR was audited to insure a properly completed form is on file with no further deficient practice noted. 3. DON or designee will in-service social services, medical records, and licensed nursing staff on completion and accuracy of DNR forms. 4. DON or designee will randomly audit new DNR forms to insure accuracy and completeness weekly for three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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F 578	Continued From page 5 Neither box had been checked. Section 2 read, "If you checked 2 above, check A, B, or C below..." All three boxes had been left blank. The Residents authorized representative had signed this form. The administrative team were notified of the inaccurate DDNR during a meeting with the survey team on 10/17/18 at 3:20 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582		11/16/18

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F 582	Continued From page 6 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide advance notice of end of coverage in regards to medicare benefits for 1 of 26 Residents, Resident #74.	F 582	1. An ABN was completed for this resident. 2. A 100% audit of all residents discharged from skilled services within the last three months has been completed to	

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F 582	Continued From page 7 The findings included: The facility failed to provide Resident #74 advance notice that the medicare part A services were ending. The clinical record review revealed that Resident #74 had been readmitted to the facility 03/23/18. Diagnoses included, but were not limited to, muscle weakness, nutritional deficiency, major depressive disorder, chronic pain, anxiety disorder, glaucoma, and bipolar disorder. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/27/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Resident #74 was one of three residents chosen for the task beneficiary protection notification review. The facility provided the surveyor with two forms regarding this task and this resident: 1. SNFABN (skilled nursing facility advance beneficiary notice of non-coverage). 2. Notice of medicare non-coverage. Both of these forms gave the date of 04/13/18 as the day the resident's medicare covered days would end. Both of these forms had been signed by the POA (power of attorney) on 04/13/18 indicating no advance notice had been given. On 10/16/18 at 2:58 p.m., the surveyor interviewed the SW (social worker) regarding this resident's notice of medicare non-coverage and	F 582	insure an ABN was completed timely with no further deficiencies noted. 3. Administrator or designee will in-service Social Work on completing an ABN timely. 4. Administrator will audit all residents discharging from skilled services for a completed ABN weekly for three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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F 582	Continued From page 8 SNFABN. During this interview, the SW verbalized to the surveyor that no advance notice had been given to this resident and the SW that provided these notices to the resident was no longer employed at the facility. The facility policy/procedure titled "Medicare Cut Letter Policy" read in part, "...For Residents who will remain in the facility for any length of time following their last Medicare covered day and have days remaining in their benefit period, the Social Worker, or Designee, will notify the Resident/Authorized Representative when the resident is approaching the end of coverage but no later than 2 days prior to the last covered Medicare Part A day, and issue both the following Notices in the order indicated...Notice of Medicare Provider Non-Coverage CMS-10123...Skilled Nursing Facility Advance Beneficiary notice CMS-10055..." The administrative team were notified of the above issue during a meeting with the survey team on 10/17/18 at 3:20 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 582		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete a	F 641	1. Discharge MDS was completed for resident #2	11/16/18

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F 641	Continued From page 9 discharge MDS (minimum data set) assessment for 1 of 26 Residents, Resident #2. The findings included: The facility failed to complete a discharge MDS assessment. The Resident had been discharged from the facility on 06/29/18. The record review revealed that Resident #2 had been admitted to the facility on 01/24/18, readmitted on 02/26/18, and discharged on 06/29/18. Diagnoses included, but were not limited to, muscle weakness, dysphagia, depressive disorder, heart failure, and hypertension. Section C (cognitive patterns) of the Residents quarterly MDS assessment with an ARD (assessment reference date) of 05/21/18 included a BIMS (brief interview for mental status) summary score of 12 out of a possible 15 points. Resident #2 was flagged in the long-term care survey process as having an overdue MDS assessment. A review of the EHR (electronic health record) revealed that this Resident had been discharged from the facility on 06/29/18. However, the surveyor was unable to locate a discharge MDS assessment. On 10/18/18 at 10:50 a.m., MDS nurse #1 and the surveyor reviewed the Residents EHR. After reviewing the EHR MDS nurse #1 verbalized to the surveyor that a discharge assessment had not been completed on this Resident but one would be completed today.	F 641	2. A 100% audit of all residents discharged from the facility within the last 60 days was completed with no further deficiencies noted. 3. Administrator or designee will in-service MDS coordinators on completing a discharge MDS timely. 4. Administrator or designee will audit all residents discharging from skilled services weekly for a timely competed discharge MDS for three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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F 641	Continued From page 10 The administrative team of the facility was made aware of the missing MDS assessment during a meeting with the survey team on 10/18/18 at 3:08 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 641		
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 the level of services provided by a nursing facility;	F 645		11/16/18

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F 645	Continued From page 11	F 645		

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 described in 435.1010 of this chapter.

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F 645	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility failed to complete a level 1 PASARR (preadmission screening and annual resident review) for 1 of 26 Residents, Resident #74. The findings included: The facility failed to ensure a level 1 PASARR was completed. A PASARR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care. The clinical record review revealed that Resident #74 had been readmitted to the facility 03/23/18. Diagnoses included, but were not limited to, muscle weakness, nutritional deficiency, major depressive disorder, chronic pain, anxiety disorder, glaucoma, and bipolar disorder. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/27/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. During the clinical record review, the surveyor was unable to locate a PASARR in the Residents EHR (electronic health record). On 10/16/18 at 4:43 p.m., the surveyor interviewed the SW (social worker) concerning the missing PASARR. The SW reviewed the EHR with the surveyor and then stated she would see if she could find anything in the previous SW's	F 645	1. PASARR was completed for resident #74 2. A 100% audit of all residents was completed to insure a completed PASARR level 1 is on file with no further deficiencies noted. 3. Administrator or designee will in-service social services on having a PASARR level 1 on file for every admitting resident. 4. Administrator or designee will audit all residents admitted to the facility weekly for a completed PASARR level 1 for the next three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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F 645	Continued From page 13 office. On 10/16/18 at 4:49 p.m., the SW approached the surveyor and stated she was unable to locate the missing PASARR. The administrative team were notified of the missing PASARR during a meeting with the survey team on 10/17/18 at 3:20 p.m. No further information regarding the missing PASARR was provided to the survey team prior to the exit conference.	F 645		
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	F 656		11/16/18

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F 656	Continued From page 14 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for 2 of 26 residents (Resident #33 and Resident #66). The findings included: 1. The facility staff failed to develop a care plan for comfort care for Resident #33. The clinical record of Resident #33 was reviewed 10/16/18 through 10/18/18. Resident #33 was admitted to the facility on 9/29/11 with diagnoses, that included but not limited to hypomagnesia, insomnia, chronic pain syndrome, dry eye syndrome, hypertension, chronic diastolic heart failure, lymphedema, acute frontal sinusitis, gastroesophageal reflux disease, urinary tract infection, left knee hemarthosis, right elbow	F 656	1. Care plan was updated to include comfort care for resident #33. The care plan for resident #66 was updated to include dementia and the use of anti-psychotic medication including symptoms and behaviors. 2. A 100% audit of care plans was completed for current residents receiving comfort care and/or anti-psychotic medications to insure accuracy of care plan. 3. MDS coordinator or designee will in-service licensed nursing staff on revising and accuracy of care plans to include comfort measures and the use of anti-psychotic medications.	

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F 656	Continued From page 15 contracture, major depressive disorder, nutritional deficiency, and dysthymic disorder. Resident #33's significant change in minimum data set (MDS) with an assessment reference date (ARD) of 8/16/18 assessed the resident with a BIMS (brief interview for mental status) as 12 out of 15 in Section C. The October 2018 physician orders were reviewed. The physician ordered Resident #33 to have comfort care on 10/6/18. The surveyor reviewed the current comprehensive care plan that was not dated. The surveyor was unable to locate a care plan for comfort care. The surveyor informed licensed practical nurse#3/minimum data set nurse of the above concern on 10/18/18 at 1:44 p.m. L.P.N.#3/MDS nurse stated the floor nurses were responsible for the day-to-day update of the care plan and should have updated the care plan to include comfort care. L.P.N. #3/MDS stated the comprehensive care plan for the admission, annual, and significant changes were the responsibility of the MDS nurses. The surveyor informed the administrative staff of the above concern on 10/18/18 at 3:08 p.m. No further information was provided prior to the exit conference on 10/18/18. 2. Resident #66 was admitted to the facility on 5/3/18 with diagnoses including muscle weakness, dysphagia, dementia in other diseases classified elsewhere without behavioral disturbance, cerebral infarction due to embolism of other cerebral artery, type II diabetes mellitus without complications, essential primary	F 656	4. MDS or designee will audit residents with new orders for comfort care and/or anti-psychotic medications weekly for three months to insure accuracy of care plan. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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F 656	Continued From page 16	F 656		

hypertension, other specified anxiety disorders, major depressive disorders, insomnia, and chest pain. On the quarterly minimum data set assessment with assessment reference date 9/17/18, the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting care. The resident's medication assessment was coded under Medications received (N0410 A) as receiving anti-psychotic medications 7 of the 7 days prior to the assessment. Under Anti-psychotic Medication Review (0450), the resident was coded as not receiving anti-psychotic medications since admission or the prior assessment.

The resident's comprehensive care plan did not list dementia as a problem. No interventions under other care areas addressed symptoms of the resident's dementia. The comprehensive care plan did not address the resident's use of anti-psychotic medication or the symptoms and behaviors to be addressed by the anti-psychotic medication.

The surveyor asked the director of nursing for documentation of the symptoms for which the anti-psychotic Seroquel 100 milligram daily for anxiety with behaviors was being used along with documentation of the need for the anti-psychotic medication for anxiety rather than an anxiolytic medication.

Seroquel 100 mg daily was ordered 9/5/18 for anxiety with behaviors. There was no documentation of behavior symptoms. This was reportedly an increase to the prior dose after a gradual dose reduction attempt started 8/27/18. On 9/13/18, an administrative order for

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non-pharmacologic intervention codes for anxiety with behaviors was entered. No interventions were documented. An order to monitor for side effects associated with Seroquel documented no side effects.

Review of physician notes, psychiatric evaluations, and nursing progress notes revealed no documentation of the symptoms for which the resident was being treated with anti-psychotic medication. A nursing note dated 8/27/18 15:13 "Resident continues to holler "help, help". When staff asks resident what he needs his response varies: Can you move my covers, can you straighten my leg, can you pull me up. In no case after yelling "help, help" is the resident in any danger of falling off bed, no bleeding, no distress. Both he and his mother are very impatient when it comes to ADL(activity of daily living) care." The next note on 8/28/18 18:54 " Resident turns light on shortly after receiving dinner tray staff feeding other residents and passing out trays when staff answers light resident state he is wet needing to be changed CNA told resident she would be back after taking cart to kitchen resident turns light back on before CNA can take cart to kitchen and come back." A note dated 9/2/18 18:39 "Resident put on light at 1630 and 1715 stating he was wet CNA in both times resident was dry". No other notes concerning behavior or symptoms were documented before 9/5/18 17:09 "FNP (family nurse practitioner) made aware that since Seroquel dosage change, resident has been experiencing increased anxiety and agitation. New orders received to restart previous dosage." The surveyor inferred that the behaviors for which the resident was being treated with an anti-psychotic medication were ringing the call bell when not bleeding or in danger of falling, and

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F 656	Continued From page 18 requesting help during meal times. No other behaviors or symptoms were documented by nursing or medical staff. The resident was hospitalized after the initial brief contact on 10/16/18, so the surveyor was unable to complete the resident interview and assess for the use of chemical restraint for staff convenience. The administrator, director of nursing and assistant director of nursing were notified of the concern during a summary meeting on 10/18/18.	F 656		
F 657 SS=C	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 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	F 657		11/16/18

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F 657	Continued From page 19 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 staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure that comprehensive care plans were prepared, reviewed and revised by an interdisciplinary team that included the necessary members. The findings included: The facility staff failed to ensure that all facility residents care plans were prepared by an interdisciplinary team that included nursing assistants. On 10/16/18 at 4:40 pm, the surveyor observed a "Care Plan Conference Summary" sheet in the clinical record for Resident # 89. The surveyor observed several signatures documented under the "Attendees of Care Plan Conference" section. The surveyor did not observe a documented signature of a certified nursing assistant. On 10/16/18 at 5:03 pm, the surveyor interviewed unit manager RN # 1 (registered nurse). The surveyor asked RN # 1 if she could identify the titles of the persons listed as attending the care plan conference. RN # 1 identified the attendees as the social worker, dietary, herself RN #1, activity director, and Resident # 89's daughter. The surveyor asked RN # 1 how certified nursing assistant staff was involved in the care planning process. RN # 1 stated,"CNAs (certified nursing	F 657	1. The care plan team has been modified to include a CNA. 2. Any resident having a care plan is at risk of this practice. 3. MDS coordinator or designee will in-service IDT on who needs to participate in a residents care plan. MDS coordinator or designee will in-service CNA's on their role during a care plan. 4. MDS coordinator or designee will audit completed care plans weekly for three months to insure a CNA provided input. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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assistants) don't come to the care plan meetings."

On 10/16/18 at 5:16 pm, the surveyor spoke with the facility social worker. The surveyor asked the social workers if certified nursing assistants participated in the care plan meetings. The social worker stated, "No." The social worker asked the surveyor why she was inquiring about certified nursing assistants participating in the care planning process. The surveyor informed the social worker that the interdisciplinary team must include a certified nursing assistant with responsibility for the resident. The social worker stated, "I was not aware CNAs had to attend."

The facility policy on "Care Plan," contained documentation that included but was not limited to:
..."Policy: An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis." The "Procedure" includes documentation that includes but is not limited to: E) The Interdisciplinary Care Planning Team may consist of:
4. CNA assigned to the resident." ...

On 10/17/18 at 4:30 pm, the administrative team was made aware of the findings as stated above. The surveyors asked the administrative team if certified nursing assistants have ever participated in the care planning process. The facility administrator informed the survey team that nursing assistants participating in the care planning process had not been the facility practice and the facility had already made efforts to initiate changes to include nursing assistants in the care planning process.

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F 657	Continued From page 21 No further information was provided to the survey team prior to the exit conference on 10/18/18.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to provide mouth care to 1 of 26 residents (Resident #59). The findings included: The facility staff failed to provide mouth care to Resident #59. The clinical record of Resident #59 was reviewed 10/16/18 through 10/18/18. Resident #59 was admitted to the facility 8/12/17 and readmitted 4/2/18 with diagnoses that included but not limited to metabolic encephalopathy, severe sepsis with shock, dysphagia, neuromuscular dysfunction of the bladder, hypertension, atherosclerotic heart disease, obsessive compulsive personality disorder, rhabdomyolysis, end stage renal disease, anxiety disorder, mental disorder, repeated falls, hyperkalemia, urinary tract infection, Parkinson's disease, and major depressive disorder. Resident #59's quarterly minimum data set (MDS) assessment with an assessment	F 677	1. Oral care was given to resident #59 on 10/16/18. 2. Any resident requiring assistance with oral care has the potential to be effected by this practice. 3. DON or designee will in-service nursing staff on providing oral care to residents requiring assistance including documentation in the medical record when provided. 4. Unit Manager or designee will randomly audit residents requiring assistance with oral care daily for three months. Unit Manager or designee will audit daily all residents requiring assistance with oral care to insure documentation is included in the medical record for one month then randomly for two months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	11/16/18

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reference date (ARD) of 9/12/18 assessed the resident with a BIMS (brief interview for mental status) as 9/15. Section G Functional Status was marked that the resident was totally dependent on 2 persons for personal hygiene, which includes brushing teeth. Section L was not coded with any broken or loosely fitting dentures, mouth or facial pain, discomfort or difficulty chewing.

Resident #59's current comprehensive care plan had the focus area that read "Resident #59 has self-care deficit. Requires assist with all levels of care. Date initiated: 04/03/2018 Revision on: 09/21/2018. Interventions: Assist with activities of daily living, dressing, grooming, toileting, feeding, oral care."

The surveyor interviewed Resident #59 on 10/16/18 at 5:12 p.m. During the interview, Resident #59 was asked how often staff brush his teeth. Resident #59 stated his teeth had not been brushed in ages. The surveyor checked the bathroom for toothpaste and toothbrush but found none. With the resident's permission, the surveyor checked the dresser drawers. The surveyor was unable to locate toothpaste but did find a toothbrush still in the packaging. The surveyor asked certified nursing assistant #1 the location of Resident #59's toothbrush and toothpaste. C.N.A. #1 was unable to locate a toothbrush or toothpaste and stated, "This was the first day she had been assigned to Resident #59."

The surveyor interviewed Resident #59's nurse licensed practical nurse #2 on 10/16/18 at 5:15 p.m. L.P.N. #2 stated staff should be doing mouth care twice per day.

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F 677	Continued From page 23 The surveyor requested the activities of daily living for mouth care records for September 2018 and October 2018 from the corporate registered nurse on 10/17/18. The surveyor reviewed the October 2018 ADL records for mouth care. The staff had failed to provide mouth care on the evening shift 10/1/18 through 10/5/18 and on 10/12/18 on day shift. The surveyor informed the administrative staff of this concern in the end of the day meeting on 10/17/18 at 3:20 p.m. No further information was provided prior to the exit conference on 10/18/18.	F 677		
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 staff interview, resident interview, facility document review, and clinical record review, it was determined that facility staff failed to follow physician's orders for 1 of 25 Residents in the survey sample, Resident # 90. The findings included:	F 684	1. Resident #90 was reassured by the unit manager her treatment will be completed as ordered. 2. To identify other residents that have the potential to be affected the facility completed a 100% audit of current residents during survey to ensure those	11/16/18

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F 684	Continued From page 24 The facility staff failed to follow physician's orders for dressing changes twice a day for Resident # 90. Resident # 90 was an 85-year-old female who was originally admitted to the facility on 5/26/17 with a readmission date of 3/5/18. Diagnoses included but were not limited to: osteoarthritis, cellulitis of right lower limb, hypertension, and non-pressure chronic ulcer of right lower leg. The clinical record for Resident # 90 was reviewed on 10/17/18 at 9:51 am. The most recent MDS assessment (minimum data set) was a quarterly assessment with an ARD date (assessment reference date) of 9/28/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 90 had a BIMS score (brief interview for mental status) of 12 out of 15 which indicated that Resident # 90's cognitive status was moderately impaired. Section M of the MDS assesses skin conditions. In Section M1030, the facility staff documented that Resident # 90 had 1 venous or arterial ulcer. In Section M1200, the facility staff documented that Resident # 90 had received ointment/medications and nonsurgical dressings during the lookback period for the 9/28/18 ARD. The plan of care for Resident # 90 was reviewed and revised on 8/28/18. The facility staff documented a focus area for Resident # 90 as "Resident # 90 has impaired skin integrity related to vascular wound to right lower extremity and 8/28/18 surgical to right thigh." Interventions included but were not limited to: "Administer treatments as ordered."	F 684	residents with treatments were completed and documented per physician's order. There were no negative findings. 3. a. DON or designee will in-service licensed nursing staff on following physician orders to include but not limited to medicine administration and treatment orders. b. Unit Manager or designee will educate resident on how to lodge a grievance and encourage her to share her concerns. 4. a. Unit Manager or designee will audit random residents daily (M-F) to insure physician orders have been carried out through chart review (MAR's and TAR's) and by direct observation of residents for three months. b. Unit Manager or designee will audit resident #90's treatment daily to ensure treatment is completed as ordered for one month and then random weekly for two months. c. Social Worker or designee will provide education/information on sharing grievances to all residents who are alert and oriented and to the RP's of other residents. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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The physician signed the current order for Resident # 90 on 9/23/18. Orders included but were not limited to: "Cleanse right lower leg with wound cleanser, liberally apply barrier cream to periwound-apply the barrier cream to the edges of the wound bed follow with 0.125% Dakin's moistened 4x4 gauze directly to wound bed and cover with ABD (abdominal) pad wrap with Kerlix BID (twice daily) and as needed."

On 10/17/18 at 8:54 am, the surveyor conducted an interview with Resident # 90. During the interview Resident # 90 stated, "The doctor says they want my leg done twice a day and they don't do it." "I talked to the head nurse and she says it's written down that they are doing it but they are not." So I have started writing down when they do it, but they don't know I'm doing it." Resident # 90 also stated, they came in at 5:30 this morning and did my dressing. Resident # 90 provided the surveyor with a handwritten note that contained the following documentation:

"Leg
10/9/18 at Dr. (doctor) office
10/10/18-3:45 pm
10/11/18-4pm
10/12/18-6:30pm
10/13/18-11:30 am
10/14/18-11am
10/15/18-4:30pm
10/16/18-10:45am
10/17/18-5:30am/Doc (doctor)

On 10/17/18 at 9:15 am, the surveyor reviewed the October 2018 treatment administration record for Resident # 90. The surveyor observed that there was no documentation that the treatment Resident # 90's right lower leg was completed on

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the night shift on 10/5/18. The surveyor also reviewed the treatment administration record for the dates that Resident # 90 had presented to the surveyor on the handwritten note. The surveyor noted that the documentation in the clinical record reflected that the treatment had been completed twice a day as ordered by the physician from 10/9/18 through 10/16/18. The surveyor reviewed the progress notes for Resident # 90 and did not locate any documentation that Resident # 90 had a doctor's appointment on 10/9/18.

On 10/17/18 at 9:37 am, the surveyor spoke with the unit manager RN # 1 (registered nurse). The surveyor asked RN #1 if Resident # 90 had gone out for a doctor's appointment on 10/9/18. RN # 1 looked at her calendar and confirmed that Resident # 90 did go out of the facility to a doctor's appointment on 10/9/18.

On 10/17/18 at 9:42 am, the surveyor spoke with unit manager RN # 1 (registered nurse) in the presence of the survey team and made her aware of Resident # 90's concerns that the treatment to her right lower leg was not being completed twice a day as ordered by the physician. The surveyor asked RN # 1 if Resident # 90 had reported to her that her treatments had not been done twice a day as ordered by the physician. RN # 1 stated that Resident # 90 had not reported to her that her treatments had not been done twice a day as ordered.

On 10/17/18 at 4:50 pm, the surveyor interviewed RN # 2. RN # 2 documented that she had completed Resident # 90's treatment to her right lower leg on the day/evening shift on 10/9/18. The surveyor asked RN # 2 if she was responsible for taking care of Resident # 90 on 10/9/18. RN # 2

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F 684	Continued From page 27 stated that she did care for Resident # 90 on 10/9/18. The surveyor asked RN # 2 if she had completed a treatment to Resident # 90's right lower leg on 10/9/18. RN # 2 stated that she did not do the dressing because Resident # 90 went to the doctor and they did the dressing there. The surveyor reviewed the treatment administration record along with RN # 2. The surveyor showed RN # 2 that the documentation on the treatment administration record for 10/9/18 reflects that she completed the dressing to Resident # 90's right lower leg, even though she stated that she had not done the treatment. The facility policy on "General Dose Preparation and Medication Administration" contained documentation that included but was not limited to: ..."6.1 Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN (as needed) medications, application sight) on appropriate forms." ... On 10/18/18 at 3:15 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 10/18/18.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		11/16/18

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F 686	Continued From page 28 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide appropriate treatments for pressure ulcers for 3 of 26 residents (Resident #33, Resident #56 and Resident #97). The findings included: 1. The facility staff failed to provide treatment and services, consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from forming for Resident #33. The clinical record of Resident #33 was reviewed 10/16/18 through 10/18/18. Resident #33 was admitted to the facility on 9/29/11 with diagnoses, that included but not limited to hypomagnesia, insomnia, chronic pain syndrome, dry eye syndrome, hypertension, chronic diastolic heart failure, lymphedema, acute frontal sinusitis, gastroesophageal reflux disease, urinary tract infection, left knee hemarthosis, right elbow contracture, major depressive disorder, nutritional deficiency, and dysthymic disorder. Resident #33's significant change in minimum	F 686	1. The nurse cited with the deficient practice was immediately educated and a competency was observed with no other issues noted. Resident #97 discharged during survey. Resident # 56 had a biweekly skin check completed 10/19/18 which was accurate to the skin integrity issues noted. 2. a. To identify other residents that have the potential to be affected the facility completed a 100% audit of current residents during survey to ensure those residents with treatments were completed and documented per physician's order. There were no negative findings. b. A 100% audit of current residents was done at time of survey to ensure most recent biweekly skin check was complete and accurate. Corrections will be made as needed. 3. DON or designee will in-service licensed nursing staff on professional standards of practice related to healing, treatment, and prevention of infection related to wounds. Licensed nursing staff will provide return demonstration of	

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F 686	Continued From page 29 data set (MDS) with an assessment reference date (ARD) of 8/16/18 assessed the resident with a BIMS (brief interview for mental status) as 12 out of 15 in Section C. Section M Skin Conditions assessed the resident was at risk for the development of pressure ulcers and that there was at least one unhealed pressure ulcer at a stage 1 or higher. Resident #33 was coded to have one stage 3 pressure ulcer and one unable to stage (UTS) pressure ulcer with slough and/or eschar. Skin and ulcer treatments marked were a pressure-reducing device for bed, application of nonsurgical dressings and application of ointments/medications. Resident #33's current comprehensive care plan was reviewed 10/16/18 through 10/18/18. Resident #33 had the focus area that read "At risk for skin integrity/t (related to) hx (history) of gluteal healing and reopening, assistance with bed mobility, disease progression, and incontinent of bowels-8/6/18 Open area to sacrum. Interventions: 8/6/18 Treatment to sacrum daily. Low air loss mattress, off load in bed, inspect skin during routine daily care, and treatment as ordered. Resident #33's current wound care orders dated 10/4/18 read to cleanse wound with ¼ strength Dakin's solution daily. Apply Santyl and Bactroban ointment and Dakin's moistened kerlix to wound bed daily. Cover with dry dressing daily. The surveyor observed wound care on 10/18/18 at 10:55 a.m. with licensed practical nurse #2. L.P.N. #2 had already prepared the over the bed table stating the table had been cleaned with Sani-wipes, a barrier had been placed, and supplies had been placed on the table (gauze, a	F 686	providing wound treatment to DON or designee. DON or designee will in-service licensed nursing staff on completing and accuracy of bi-weekly skin checks. DON or designee will in-service licensed nursing staff on following physician orders to include treatments to prevent skin breakdown. 4. a. Unit Manager or designee will audit random residents daily (M – F) to insure physician orders have been carried out through chart review (MAR's and TAR's) and by direct observation of residents for three months. b. unit manager or designee will audit admission orders to ensure all orders are transcribed accurately. c. DON or designee will randomly audit biweekly skin checks done weekly for completion and accuracy for three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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tube of santyl ointment, Dakin's solution bottle and a tube of Bactroban ointment). L.P.N. #2 washed hands, donned gloves, and unfastened brief. Resident #33 was observed with bunny boots on both heels. L.P.N. #2 removed the old dressing and placed the dressing in a red bag and removed the gloves. L.P.N. #2 washed hands and donned gloves. The sacral wound was cleaned with quarter strength Dakin's solution. L.P.N. #2 removed scissors from the uniform pocket and placed them on the over the bed table. L.P.N. #2 then used the scissors to cut the kerlix and placed the scissors back on the table. L.P.N. #2 did not change gloves or wash hands after cleaning the wound. L.P.N. #2 did not clean the scissors before the kerlix was cut to be used for packing Resident #33's sacral wound. L.P.N. #2 moistened the gauze with Dakin's solution and applied Bactroban and Santyl on the moistened gauze. L.P.N. #2 then packed the wound with gauze. L.P.N. #2 removed gloves and washed hands. L.P.N. #2 donned gloves and applied border dressing, dated tape and then applied to dressing. All supplies were removed from table. L.P.N. #2 placed scissors back into uniform pocket without cleaning them. L.P.N. #2 discarded bag in trash can in bathroom, removed gloves, washed hands and cleaned table with sani-cloth. Resident #33 was repositioned to back.

The surveyor requested the facility policy on dressing changes from the director of nursing on 10/18/18 at 12:00 noon.

The director of nursing (DON) informed the surveyor 10/18/18 at 12:29 p.m. that the facility did not have a policy for dressing changes. When asked if scissors should be cleaned before

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use and if the nurse should change gloves, wash hands and apply new gloves after cleaning a pressure ulcer, the DON stated she would expect scissors to be cleaned before use and gloves changed and hands washed after cleaning a wound.

The surveyor informed the administrative staff of the above concern during the end of the day meeting on 10/18/18 at 3:20 p.m.

No further information was provided prior to the exit conference on 10/18/18.

2. The facility staff failed to ensure skin checks had accurate documentation for Resident #56.

The clinical record of Resident #56 was reviewed 10/16/18 through 10/18/18. Resident #56 was admitted to the facility 5/15/18 with diagnoses that included but not limited to dysphagia, symbolic dysfunctions, chronic atrial fibrillation, hypertension, atherosclerotic heart disease, acute on chronic systolic heart failure, nutritional anemia, pneumothorax, gastroesophageal reflux disease, dementia without behavioral disturbances, transient ischemic attacks, gout, restlessness and agitation, urine retention, left heel pressure ulcer, sacral pressure ulcer, and left femur fracture.

Resident #56's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/11/18 assessed the resident with a BIMS (brief interview for mental status) as 9 out of 15. Section M Skin Conditions was marked that the resident was at risk for the development of pressure ulcers and the resident did have one or more currently that are greater

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than stage 1. Resident #56 was marked to have 1 unstageable-deep tissue injury pressure ulcer.

Resident #56's comprehensive care plan identified a focus area that read "Resident #56 has impaired skin integrity to sacrum and (L) (left) heel. Interventions: 7/25/18 Monitor skin integrity. Administer medications and treatments as ordered. Assess and document the status of the area (healing vs declining)."

The surveyor reviewed the October 2018 Bi-Weekly Skin Checks. The 10/10/18, 10/13/18, and 10/16/18 skin assessments read that the resident had current skin issues but there was nothing marked on the picture diagram or under the site/description of the skin issues.

The surveyor informed the director of nursing of the above concern and shown the skin assessments for October 2018. The DON stated the documentation on the skin assessments was missing and documentation should be done.

The surveyor requested the skin assessments for 10/10/18, 10/13/18, and 10/16/18 on 10/18/18 at 10:30 a.m.

The surveyor informed the administrative staff of the above concern during the end of the day meeting on 10/18/18 at 3:20 p.m.
The surveyor reviewed the facility policy titled "Pressure Ulcer Policy Wound Management" on 10/18/18. The policy read in part "Monitoring: 1. Should evaluate and document when there are identified changes. 3. Twice weekly, on bath/shower days, the nursing assistant will look at the resident's skin and place the identified area on the shower sheet. The nursing assistant will

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report any reddened and/or areas of concern to the licensed nurse. 4. The licensed nurses will complete a head to toe body review twice a week as well. This head to toe body review is in addition to the nursing assistant's skin review."

No further information was provided prior to the exit conference on 10/18/18.

3. The facility staff failed to follow the physician's orders for the Magic Butt Paste bid (twice a day) for prevention to Resident #97's sacral pressure ulcer.

The clinical record of Resident #97 was reviewed 10/16/18 through 10/18/18. Resident #97 was admitted to the facility on 3/9/18 for respite care. Diagnoses included but were not limited to chronic obstructive pulmonary disease, psoriasis, major depressive disorder, gastro-esophageal reflux disease, nausea with vomiting, constipation, and chronic pain syndrome.

An entry minimum data set (MDS) assessment was completed on 3/9/18 and a discharge MDS with an assessment reference date (ARD) of 3/11/18 was completed 3/11/18. Section C Summary Score assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #97 required extensive support for bed mobility, transfers, and locomotion on and off the unit. Resident #97 was totally dependent on staff for dressing, toilet use, and personal hygiene. Resident #97 was assessed to be incontinent of bladder occasionally and bowel frequently.

Resident #97's initial care plan identified self-care deficits and staff to assist with activities of daily living, dressing, grooming, toileting, feeding, and

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oral care. Also identified on the care plan was at risk for impaired skin integrity, fragile skin and impaired mobility. Interventions: inspect skin during routine care daily, lotion to skin as needed, pressure reduction devices if needed, treatments per order, and turn and repositions per specific routine and/or as needed. Resident has history of diagnosis of depression and or anxiety, difficulty sleeping/insomnia. Interventions: Medications as ordered by physician and provide a calm, reassuring and non-threatening environment.

The hospice communication note dated 3/9/18 read "Resident has a small stage 2 pressure injury to his sacrum. Orders to keep area clean and dry, cover with Magic Butt Paste twice daily."

The admission skin check and weekly wound assessment completed 3/9/18 at 12:50 p.m. read the resident does have current skin issues. Resident has an area on sacrum that measures 1 cm (centimeter) x 1 cm, tx (treatment) in place. Treatment: Butt Paste to sacrum bid (twice a day).

The bi-weekly skin check completed 3/9/18 at 8:50 p.m. read the resident does have current skin issues on sacrum with treatment in place.

Resident #97's March 2018 admission orders included Magic Butt Paste two times a day for Preventive-start date 3/9/18.

The surveyor reviewed Resident #97's clinical record and was unable to locate any documentation that the twice a day treatment ordered by the physician had been done. There were no treatment administration records for

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F 686	Continued From page 35 March 2018 or documentation in the progress notes that the treatment to the sacral pressure ulcer had been completed. No further information was provided prior to the exit conference on 10/18/18.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to ensure a hazard free environment for 1 of 26 residents (Resident #28). The findings included: The facility staff failed to follow the physician order for bilateral floor mats for Resident #28. The clinical record of Resident #28 was reviewed 10/16/18 through 10/18/18. Resident #28 was admitted to the facility 9/7/16 and readmitted 8/13/18 with diagnoses that included but not limited to symbolic dysfunction, dysphagia, right shoulder contracture, major depressive disorder, Type 2 diabetes mellitus, seizures, iron deficiency anemia, urine retention, anxiety disorder, moderate protein calorie malnutrition, peripheral	F 689	1. Resident #28 has been reassessed and no longer needs fall mats. The order has been discontinued. 2. A 100% audit of residents requiring fall mats was completed to insure appropriateness and use. 3. DON or designee will in-service nursing staff on appropriateness and use of fall mats as an intervention for residents at risk for falls. 4. Unit Manager or designee will randomly audit residents requiring fall mats to insure appropriate use for three months. The results of the audits will be forwarded to the facility QAPI committee for further	11/16/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 36 vascular disease, gastroesophageal reflux disease, bradycardia, diabetic neuropathy, chronic pain syndrome, paraplegia, acute renal failure, gastritis, bacteremia, hyperkalemia, insomnia, and hypertension. Resident #28's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/10/18 assessed the resident with a BIMS (brief interview for mental status) as 15 out of 15. Section J1800 Health Conditions/Falls assessed that the resident did not have any falls since admission, reentry, or prior assessment. Resident #28's current comprehensive care plan identified a focus area that the resident was at risk for falls r/t (related to) paraplegia and hx (history) of seizures. Date initiated: 08/14/2018 revision on: 08/15/2018. Interventions: Bil (bilateral) floor mats, maintain call light within reach. Educate resident to use call light, maintain needed items within reach, PT (physical therapy)/OT (occupational therapy)/SLP (speech/language pathologist) evaluation. The surveyor observed Resident #28 during the initial tour on 10/16/18 beginning at 9:10 a.m. Resident #28 was in bed. The surveyor did not observe any mats placed on either side of the bed. The surveyor interviewed Resident #28 on 10/16/18 at 10:53 a.m. The surveyor asked if the resident had had any recent falls and the resident stated it had been over a year since he had fallen. The surveyor observed Resident #28 on 10/17/18 at 10:50 a.m. The resident was in bed. There	F 689	review and recommendations. 5. 11/16/18	

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F 689	Continued From page 37 were no mats on either side of the bed. The surveyor interviewed certified nursing assistant #1 on 10/17/18 at 10:50 a.m. C.N.A. #1 stated the resident does not have floor mats. The surveyor reviewed Resident #28's October 2018 physician orders. The resident has an order for bil (bilateral) mats at bedside ordered to start 8/15/18. The surveyor informed the administrative staff of the above concern in the end of the day meeting on 10/17/18 at 3:20 p.m. The assistant director of nursing informed the surveyor on 10/18/18 at 11:52 a.m. that the order for the mats had been discontinued. When asked where the staff document the placement of the mats, the ADON stated they don't document the placement of the mats on the medication records or the treatment records. No further information was provided prior to the exit conference on 10/18/18.	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		11/16/18

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F 690	Continued From page 38 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide appropriate treatment and services for care of residents with a clinically justified indwelling catheter for 5 of 26 residents (Resident # 28, Resident #33, Resident #59, Resident #36, and Resident #35). The findings included: 1. The facility staff failed to ensure the indwelling Foley catheter was anchored and failed to obtain a physician order for the size of the catheter and the balloon for the indwelling Foley catheter for	F 690	1. Indwelling catheters were anchored for residents #28, 35, and 36. Physician orders were clarified to include size and balloon for residents #28 and 33. Catheter bag is not in contact with the floor for residents #33 and 59. Catheter tubing was positioned properly for resident #36. 2. A 100% audit of current residents with indwelling catheters was completed to insure physician orders include size and balloon, tubing is anchored, drainage bag is not on the floor, and the tubing allows for proper drainage.	

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F 690	Continued From page 39 Resident #28. The clinical record of Resident #28 was reviewed 10/16/18 through 10/18/18. Resident #28 was admitted to the facility 9/7/16 and readmitted 8/13/18 with diagnoses that included but not limited to symbolic dysfunction, dysphagia, right shoulder contracture, major depressive disorder, Type 2 diabetes mellitus, seizures, iron deficiency anemia, urine retention, anxiety disorder, moderate protein calorie malnutrition, peripheral vascular disease, gastroesophageal reflux disease, bradycardia, diabetic neuropathy, chronic pain syndrome, paraplegia, acute renal failure, gastritis, bacteremia, hyperkalemia, insomnia, and hypertension. Resident #28's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/10/18 assessed the resident with a BIMS (brief interview for mental status) as 15 out of 15. Section H Bladder and Bowel was coded for the presence of an indwelling catheter. The current comprehensive care plan for Resident #28 identified the focus area that read "Resident requires suprapubic r/t (related to) paraplegia and neurogenic bladder. Date initiated: 08/14/2018 Revision on: 08/15/2018. Interventions: Catheter care every shift, maintain drainage bag below bladder and provide privacy, change catheter and drainage system as indicated by the physician." The surveyor observed Resident #28 during the initial tour of the facility beginning at 9:10 a.m. on 10/16/18. Resident #28 was observed in bed. The surveyor observed a Foley drainage bag	F 690	3. DON or designee will in-service licensed nursing staff on proper care of indwelling catheters to include physician orders (include size and balloon), tubing is anchored, drainage bag is not on the floor, and the tubing allows for proper drainage. 4. Unit Manager or designee will audit residents with indwelling catheters daily for one month and then randomly for two months to insure physician orders include size and balloon, tubing is anchored, drainage bag is not on the floor, and the tubing allows for proper drainage. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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hooked to the left side of the bed and asked the resident if the tubing was secure with a band. The resident stated "No."

The surveyor and the unit manager registered nurse #1 checked Resident #28's thigh for the presence of a leg band. R.N. #1 stated the tubing was not anchored and stated she would get one. R.N. #1 was asked to check the size of the current catheter. R.N. #1 stated the size was 16 Fr (French) with a 10 cc (cubic centimeter) balloon.

The surveyor reviewed the October 2018 physician orders. There were no physician orders for the size of the catheter or the balloon. Resident #28 had physician orders to anchor catheter tubing and check placement every shift, catheter care every shift, maintain drainage bag below bladder and provide privacy bag, change catheter prn (as needed) for protocol change as needed-all orders dated 8/13/18. The surveyor informed the unit manager R.N. #1 of these concerns on 10/16/18 at the conclusion of the initial tour.

The surveyor requested the facility policy on Foley catheters from the director of nursing on 10/16/18 at 1:30 p.m. The surveyor reviewed the facility policy titled "Catheter Care Urinary Male-Female" on 10/16/18. The policy read in part "18. Secure catheter utilizing a leg band."

The surveyor informed the administrative staff of the above concern on 10/17/18 at 3:20 p.m.

No further information was provided prior to the exit conference on 10/18/18.

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F 690	Continued From page 41	F 690		

2. The facility staff failed to ensure the indwelling Foley catheter bag was not touching the floor and the facility staff failed to follow the physician order for the size of the catheter and balloon for Resident #33.

The clinical record of Resident #33 was reviewed 10/16/18 through 10/18/18. Resident #33 was admitted to the facility on 9/29/11 with diagnoses, that included but not limited to hypomagnesia, insomnia, chronic pain syndrome, dry eye syndrome, hypertension, chronic diastolic heart failure, lymphedema, acute frontal sinusitis, gastroesophageal reflux disease, urinary tract infection, left knee hemarthosis, right elbow contracture, major depressive disorder, nutritional deficiency, and dysthymic disorder.

Resident #33's significant change in minimum data set (MDS) with an assessment reference date (ARD) of 8/16/18 assessed the resident with a BIMS (brief interview for mental status) as 12 out of 15 in Section C. Section H Bladder and Bowel was coded for an indwelling catheter.

Resident #33's current comprehensive care plan was reviewed 10/16/18 through 10/18/18. Resident #33 had the focus area that read "Resident #33 has indwelling catheter for wound healing. Interventions: Indwelling cath (catheter) per order. Cath care per physician's orders."

During the initial tour on 10/16/18 beginning at 9:10 a.m., the surveyor observed Resident #33 in bed. The surveyor observed the bed to be in a low position with the indwelling Foley catheter drainage bag touching the floor.

The surveyor observed Resident #33 still in bed

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with the Foley catheter drainage bag touching the floor at 9:47 a.m.

The surveyor and the unit manager registered nurse #1checked the Foley catheter drainage bag on 10/16/18 at 9:47 a.m. The indwelling Foley catheter was not anchored and was still touching the floor. The unit manager R.N. #2 stated she would have to figure out what to do with the catheter bag with the bed in the lowest position. The surveyor asked the unit manager R.N. #2 if indwelling Foley catheters were to be anchored. R.N. #2 stated yes.

Resident #33's clinical record was reviewed for catheter size and frequency of Foley changes. The Foley catheter order dated 8/11/18 read "Foley catheter 14 Fr (French) continuous drainage for wound healing every shift for monitoring." A balloon size for the indwelling Foley catheter was not included in the physician order.

The surveyor and the unit manager checked the size of the catheter with the resident's permission on 10/17/18 at 11:11 a.m. The size of Resident #33's indwelling Foley catheter was a 16 Fr with a 30 cc (cubic centimeter) balloon. The 8/11/18 Foley catheter order was for 14 French and a balloon size had not been ordered by the physician.

The surveyor requested the facility policy on Foley catheters from the director of nursing on 10/16/18 at 1:30 p.m. The surveyor reviewed the facility policy titled "Catheter Care Urinary Male-Female" on 10/16/18. The policy read in part "18. Secure catheter utilizing a leg band."

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The surveyor informed the administrative staff of the above concern with the placement of the indwelling Foley catheter drainage bag, the indwelling Foley catheter not anchored, the physician order did not include the balloon size for the Foley catheter, and no physician order for the 14 Fr catheter the resident currently had in the end of the day meeting on 10/17/18 at 3:20 p.m.

No further information was provided prior to the exit conference on 10/18/18.

3. The facility staff failed to ensure Resident #59's indwelling Foley catheter care was not touching the floor.

The clinical record of Resident #59 was reviewed 10/16/18 through 10/18/18. Resident #59 was admitted to the facility 8/12/17 and readmitted 4/2/18 with diagnoses that included but not limited to metabolic encephalopathy, severe sepsis with shock, dysphagia, neuromuscular dysfunction of the bladder, hypertension, atherosclerotic heart disease, obsessive compulsive personality disorder, rhabdomyolysis, end stage renal disease, anxiety disorder, mental disorder, repeated falls, hyperkalemia, urinary tract infection, Parkinson's disease, and major depressive disorder.

Resident #59's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/12/18 assessed the resident with a BIMS (brief interview for mental status) as 9/15. Section H Bladder and Bowel was coded for the presence of an indwelling catheter. The current comprehensive care plan had the focus area that read "Resident #59 has

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nephrostomy tube and Foley catheter. At risk for UTI (urinary tract infection). Date initiated: 04/03/2018 Revision on: 09/21/2018. Interventions: Staff to position catheter bag and tubing below the level of the bladder and away from entrance room door. Privacy bag in place."

The surveyor observed Resident #59 during the initial tour on 10/16/18 at 10:02 a.m. Resident #59 was lying in bed. The surveyor observed an indwelling Foley catheter drainage bag on the floor along with the tubing. The surveyor requested the unit manager registered nurse #1. The unit manager registered nurse #1 was asked if the Foley drainage bag should be touching the floor. R.N. #1 stated no, got a pair of gloves and hooked the drainage bag to the bed frame.

The surveyor informed the administrative staff of the above observation during the end of the day meeting on 10/17/18 at 3:20 p.m. The surveyor asked if the Foley drainage bag should be touching the floor. The director of nurses stated no. The surveyor requested the facility policy for placement of Foley catheter drainage bags.

No further information was provided prior to the exit conference on 10/18/18.
4. The facility staff failed to ensure that catheter tubing was positioned to prevent the backflow of urine into the bladder and failed to ensure that the catheter was secured for Resident # 36.

Resident # 36 was an 88-year-old-female who was originally admitted to the facility on 8/10/17 with a readmission date of 5/17/18. Diagnoses included but were not limited to: Stage 4 pressure ulcer, dementia, anxiety disorder, and hypertension.

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The clinical record for Resident # 36 was reviewed on 10/17/18 at 9:09 am. The most recent MDS assessment (minimum data set) was a quarterly assessment with an ARD date (assessment reference date) of 8/20/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 36 had a BIMS score (brief interview for mental status) of 0 out of 15, which indicated that Resident # 36's cognitive status was severely impaired. Section H of the MDS assesses bladder and bowel. In Section H0100, the facility staff documented that Resident # 36 had an indwelling catheter.

The current plan of care for Resident # 36 was initiated on 5/17/18. The facility staff documented a focus area for Resident # 36 as "Resident # 36 requires urinary catheter to promote wound healing." Interventions included but were not limited to: "Foley securement devise as ordered," and "Maintain drainage bag below the bladder level."

Resident # 36 had current orders that were initiated on 5/17/18 that included but were not limited to: "Anchor catheter tubing and check placement every shift," and "Maintain catheter drainage bag below the level of the bladder every shift."

On 10/18/18 at 11:10 am, the surveyor observed wound care of Resident # 39. During the wound care observation the surveyor observed that the Resident # 36's Foley catheter was not secured, and that the catheter tubing was positioned over a bed bolster on the right side of Resident # 36 promoting the flow of urine back into the bladder.

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The surveyor asked LPN # 1 (licensed practical nurse) if the Foley catheter for Resident # 36 should be secured. LPN # 1 stated, "I will get one and get it on her." "I probably came off during ADL care." (Activities of daily living) The surveyor asked LPN # 1 if Resident # 36's catheter tubing should be positioned over the bed bolster. LPN # 1 repositioned Resident # 36's catheter tubing to run along the side of the bed bolster.

The facility policy on "Catheter Care Urinary Male-Female" contained documentation that included but was not limited to:
... "18. Secure catheter utilizing a leg band.
19. Check drainage tubing and bag to insure that the catheter is draining properly." ...

On 10/18/18 at 3:15 pm, the administrative team was made aware of the findings as stated above.

No further information regarding this issue was provided to the survey team prior to the exit conference on 10/18/18.
5. For Resident #35 the facility staff failed to ensure Foley catheter tubing was anchored.

Resident #35 was admitted to the facility on 08/31/17. Diagnoses included but not limited to unspecified dementia with behavioral disturbance, heart failure, pressure ulcer of sacral region, and encounter for palliative care.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 08/17/18 coded the Resident 00 of 15 in section C, cognitive patterns.

Resident #35's CCP (comprehensive care plan) was reviewed and contained a focus area of

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F 690	Continued From page 47 "requires urinary catheter related to wound on sacrum". Interventions included but were not limited to, maintain drainage bag below the bladder level, and change catheter and draining system as indicated by the physician. Resident #35's clinical record was reviewed on 10/17/18. It contained a physician's order summary which read in part, "Anchor catheter tubing and check placement every shift". Resident #35 was observed by the surveyor on 10/16/18 at approximately 11:02 am. Resident was resting in bed. Surveyor asked if Resident's catheter was anchored, LPN (licensed practical nurse) #1 checked Resident #35. Catheter tubing was not anchored and was positioned in Resident's groin area. Surveyor asked LPN #1 if Foley catheter should be anchored, and LPN #1 stated that she would have to check the Resident's orders and left the room. LPN#1 reentered the room with a StatLock foley catheter stabilization device. LPN#1 proceeded to apply device to the Resident's left thigh and stabilized catheter. The concern of the Foley catheter not being anchored was discussed with the administrative team during a meeting on 10/17/18 at approximately 3:18 pm. The surveyor requested a policy on catheter care at this time. The administrator provided the surveyor with said policy titled "Catheter Care Urinary Male-Female" on 10/17/18. This policy read in part "18. Secure catheter utilizing a leg band". No further information was provided prior to exit.	F 690		
F 694	Parenteral/IV Fluids	F 694		11/16/18

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F 694 SS=D	Continued From page 48 CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to obtain orders in regards to PICC line dressing changes for 1 of 26 Residents in the survey sample, Resident # 100. The findings included: The facility staff failed to ensure that Resident # 100 had orders for PICC (peripherally inserted central catheter) line dressing changes. Resident # 100 was a 66-year-old-female who was admitted to the facility on 10/9/18. Diagnoses included but were not limited to: MRSA (methicillin-resistant staphylococcus aureus), Parkinson's disease, schizophrenia, and muscle weakness. The clinical record for Resident # 100 was reviewed on 10/16/18 at 11:22 am. During the time of the survey, there was no completed MDS assessment (minimum data set) for Resident # 100. The plan of care for Resident # 100 was reviewed and revised on 10/16/18. The facility staff documented a focus area for Resident # 100 as, "Resident # 100 is on antibiotic therapy related to	F 694	1. Order for PICC line dressing change was obtained for resident #100. 2. A 100% audit of current residents with PICC lines was completed to insure orders for dressing changes were obtained. 3. DON or designee will in-service licensed nursing staff on obtaining orders for PICC line dressing changes. 4. Unit Manager or designee will audit for three months all new residents with PICC lines to insure orders for dressing changes are obtained and followed. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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F 694	Continued From page 49	F 694		

MRSA to left elbow." Interventions included but were not limited to: "Administer the full course of antibiotics as prescribed by the physician."

The current orders for Resident # 100 were initiated by the physician on 10/9/18. Orders included but were not limited to: "Admit to (facility's name withheld) under the care of (Physician's name withheld) for skilled services. Diagnosis of left elbow MRSA, scoliosis, spinal cord stimulator, IV ABT (intravenous antibiotics) via inguinal PICC." The surveyor did not locate any orders for dressing changes to the PICC line site in the clinical record.

On 10/16/18 at 1:01 pm, the surveyor interviewed LPN # 2 (licensed practical nurse). The surveyor asked LPN # 2 how often residents that have PICC lines in the facility have dressing changes. LPN # 2 stated that PICC line dressings are changed every 7 days." LPN # 2 reviewed the clinical record along with the surveyor and agreed that Resident # 100 did not have orders for dressing changes to her PICC line site. LPN # 2 stated, "I will get that taken care of."

The facility policy on "Short Peripheral Catheter Dressing Change" contained documentation that included but was not limited to:
... "Considerations:
3. Licensed nurses caring for patients receiving infusion therapies are expected to follow infection control and safety compliance procedures."

On 10/17/18 at 4:00 pm, the administrative team was made aware of the findings as stated above.

No further information regarding this issue was provided to the survey team prior to the exit

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F 694	Continued From page 50 conference on 10/18/18.	F 694		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide non-pharmacological interventions in regards to pain management for 3 of 26 Residents in the survey sample, Resident #100, Resident #90, and Resident #21. The findings included: 1. The facility staff failed to provided non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident # 100. Resident # 100 was a 66-year-old-female who was admitted to the facility on 10/9/18. Diagnoses included but were not limited to: MRSA (methicillin-resistant staphylococcus aureus), Parkinson's disease, schizophrenia, and muscle weakness. The clinical record for Resident # 100 was reviewed on 10/16/18 at 11:22 am. During the time of the survey, there was no completed MDS assessment (minimum data set) for Resident # 100.	F 697	1. Unit Manager educated resident #100, 90, and 21 regarding non-pharmacological interventions for pain control prior to administration of pain medication. Unit Manager and the resident #100, 90, and 21 identified the non-pharmacological interventions which were effective in the past. 2. To identify other residents that have the potential to be affected the facility completed 100% audit of current residents during survey receiving pain medications to ensure appropriate nonpharmacological interventions are care planned. 3. DON or designee will in-service licensed nursing staff on administering pain medication to include offering non-pharmacological interventions prior to PRN pain medication administering and documenting these interventions. 4. a. DON or designee will audit residents receiving PRN pain medications daily (M – F) for one month and then randomly for	11/16/18

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F 697	Continued From page 51 The current plan of care for Resident # 100 was reviewed and revised on 10/15.18. The facility staff documented a focus area for Resident # 100 as" "Resident # 100 has impaired skin integrity related to skin tears, right shin, right distal shin and left elbow incision." Interventions included but were not limited to: "Administer medications as ordered." Resident # 100 had current orders that were initiated by the physician on 10/9/18. Orders included but were not limited to: "Percocet 5-325 mg (milligram) Give 1 tablet by mouth every 4 hours as needed for pain or fever." On 10/16/18 at 12:17 pm, the surveyor reviewed the medication administration record for Resident # 100. The surveyor noted that Resident # 100 had received physician ordered prn (as needed) Percocet 5-325 mg on the following dates and times: 10/12/18 at 8:45 am 10/13/18 at 8:27 am 10/13/18 at 4:02 pm 10/14/18 at 8:35 am 10/15/18 at 8:24 am 10/15/18 at 9:50 pm 10/16/18 at 6:14 am The surveyor further reviewed the medication administration record and the nurse's notes and did not locate any documentation of non-pharmacological interventions attempted prior to the administration of the PRN Percocet 5-325 mg. On 10/16/18 at 1:17 pm, the surveyor spoke with unit manager RN # 1 (registered nurse) regarding	F 697	two months to insure non-pharmacological interventions were attempted and documented prior to administering PRN pain medication. b. Residents identified with chronic or acute pain will have non-pharmacological interventions discussed and the nursing staff were made aware of these interventions via the care plan. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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F 697	Continued From page 52	F 697		

non-pharmacological interventions for Resident # 100. RN # 1 reviewed the clinical record for Resident # 100 along with the surveyor and RN # 1 agreed that there were no non-pharmacological interventions documented prior to the administration of pain medication for Resident # 100. RN # 1 stated, "I will take care of it."

The facility policy on "Pain Management and Pain Protocol" included documentation that included but was not limited to:
..."Procedure
A pain evaluation will occur on admission to the facility, at each quarterly review, whenever significant change in condition and with any onset of new pain.
5. The information on the pain flow record will identify:
g. Non pharmacological interventions will be attempted prior to the administration of PRN pain medications." ...

On 10/17/18 at 4:00 pm, the administrative team was made aware of the findings as stated above.

No further information regarding this issue was presented to the survey team prior to the exit conference on 10/18/18.

2. The facility staff failed to provide non-pharmacological interventions prior to the administration of PRN (as needed) pain medications for Resident # 90.

Resident # 90 was an 85-year-old female who was originally admitted to the facility on 5/26/17 with a readmission date of 3/5/18. Diagnoses included but were not limited to: osteoarthritis, cellulitis of right lower limb, hypertension, and

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F 697	Continued From page 53	F 697		

non-pressure chronic ulcer of right lower leg.

The clinical record for Resident # 90 was reviewed on 10/17/18 at 9:51 am. The most recent MDS assessment (minimum data set) was a quarterly assessment with an ARD date (assessment reference date) of 9/28/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 90 had a BIMS score (brief interview for mental status) of 12 out of 15, which indicated that Resident # 90's cognitive status was moderately impaired. Section J of the MDS assesses health conditions.

In Section J0100, the facility staff documented that Resident # 90 was offered or had received PRN pain medication during the lookback period for the 9/28/18 ARD. The facility staff also documented in Section J0100 that Resident # 90 had not received non medication intervention for pain during the lookback period for the 9/28/18 ARD.

The current plan of care for Resident # 90 was reviewed and revised on 8/28/18. The facility staff documented a focus are for Resident # 90 as, "Resident # 90 has acute/chronic pain r/t (related to) depression, wound, hx (history) of diverticulitis, GERD, (gastroesophageal reflux disease) sciatica, osteoarthritis, DVT (deep vein thrombosis), dorsalgia, gout." Interventions included but were not limited to: "Assess/record/report to nurse resident complaints of pain or requests for pain treatment."

Resident # 90 had current orders that were initiated by the physician on 3/24/18. Orders

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included but were not limited to: "Oxycodone 10-325 mg (milligram) Give 1 tablet by mouth every 4 hours as needed for pain."

On 10/17/18 at 9:55 am, the surveyor reviewed Resident # 90's medication administration record for October 2018. The surveyor noted that Resident # 90 had been administered Oxycodone 10-325 mg per the physician's PRN (as needed) order on the following dates:
10/1/18 at 9:13 am
10/1/18 at 4:30 pm
10/1/18 at 10:00pm
10/2/18 at 8:25 am
10/2/18 at 5:18 pm
10/2/18 at 10:07 pm
10/5/18 at 4:10 am
10/5/18 at 8:42 am
10/5/18 at 5:25 am
10/6/16 at 12:00 am
10/6/18 at 5:00 am
10/6/18 at 10:25 am
10/6/18 at 5:04 pm
10/7/18 at 2:27 am
10/7/18 at 9:45 am
10/7/18 at 4:47 pm
10/7/18 at 10:00 pm
10/8/18 at 2:00 am
10/8/18 at 6:00 am
10/8/18 at 4:33 pm
10/10/18 at 11:04 am
10/10/18 at 5:22 pm
10/10/18 at 9:30 pm
10/11/18 at 9:15 am
10/11/18 at 5:00 pm
10/12/18 at 2:41 pm
10/13/18 at 3:50 pm
10/15/18 at 9:34 am
10/15/18 at 10:34 pm

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F 697	Continued From page 55 10/16/18 at 9:24 am 10/16/18 at 4:30 pm 10/16/18 at 10:36 pm 10/17/18 at 3:07 am 10/17/18 at 9:47 am The surveyor reviewed the medication administration record and the nurse's notes and did not locate any documented non-pharmacological interventions for pain management prior to PRN medication administration. On 10/17/18 at 10:50 am, the surveyor spoke with unit manager RN # 1(registered nurse) regarding the documentation of non-pharmacological interventions prior to the PRN administration of physician ordered Oxycodone 10-325 mg. RN # 1 reviewed the clinical record along with the surveyor and agreed that there were no documented non-pharmacological interventions prior to the PRN administration of Oxycodone 10-325 mg for Resident # 90. The facility policy on "Pain Management and Pain Protocol" included documentation that included but was not limited to: ..."Procedure A pain evaluation will occur on admission to the facility, at each quarterly review, whenever significant change in condition and with any onset of new pain. 5. The information on the pain flow record will identify: g. Non pharmacological interventions will be attempted prior to the administration of PRN pain medications." ...	F 697		

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F 697	Continued From page 56	F 697		

On 10/17/18 at 4:00 pm, the administrative team was made aware of the findings as stated above.

No further information regarding this issue was presented to the survey team prior to the exit conference on 10/18/18.

3. The facility staff failed to offer non-pharmacological interventions for pain management to Resident #21.

The clinical record of Resident #21 was reviewed 10/16/18 through 10/18/18. Resident #21 was admitted to the facility 9/20/17 and readmitted 10/12/17 with diagnoses that included but not limited to Type 2 diabetes mellitus, symbolic dysfunction, dysphagia, repeated falls, cardiomyopathy, cerebellar stroke syndrome, alcohol-induced chronic pancreatitis, chronic pain syndrome, anemia, transient ischemic attacks, gastric diverticulum, altered mental status, Barrett's esophagus without dysplasia, hypertension, hemiplegia affecting left dormant side, bipolar disorder, anxiety disorder, atrial fibrillation, acute respiratory infection, viral hepatitis without hepatic coma, and cerebral infarction due to embolism.

Resident #21's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 8/7/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Section J Health Conditions was coded for the use of prn (whenever needed) medications and without the use of non-medication intervention for pain. Pain frequency was assessed to be occasionally and rated at 4 out of 10. A pain assessment by staff was not indicated (Section J0700).

The current comprehensive care plan identified

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F 697	Continued From page 57	F 697		

Resident #21 to be at risk for pain and discomfort r/t (related to) dx (diagnosis) of chronic pain syndrome. Interventions: Administer pain medication as ordered. Monitor for pain. Assess for pain q (every) shift. Eliminate or reduce causative factors. Staff to attempt non-pharmacological interventions.

The October 2018 physician's order were reviewed. Resident #21 had orders for Percocet tablet 5-325 mg (milligrams) 1 tablet every 4 hours as needed for pain-start date 9/8/18. The October 2018 electronic medication administration records were reviewed. Resident #21 received Percocet 5-325 mg thirty-nine times in October 2018. Of the 39 times administered, Percocet was administered eight times (8) with a pain rating of zero (0).

The surveyor interviewed licensed practical nurse #1 on 10/17/18 at 12:26 p.m. where non-pharmacological interventions were offered prior to the administration of pain medication. The surveyor did not receive a response to the question.

The surveyor requested the September and October progress notes from the corporate registered nurse on 10/18/18 at 12:57 p.m.

The surveyor was not provided any October 2018 progress notes.

The surveyor reviewed the facility policy titled "Pain Management and Pain Control" on 10/18/18. The policy read in part "3. Non pharmacological intervention will be attempted prior to the administration of prn pain medications. When it is determined the

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F 697	Continued From page 58 resident's pain will need pharmacologic interventions: a. Documentation of administration of medications will be located on the Medication Administration Record. B. The response of the medication (s) will be identified on the pain flow record for effectiveness of the response of the medication on the back of the MAR." The surveyor informed the administrative staff that Resident #21 received pain medication without attempting non-pharmacological interventions initially and failed to identify specific non-pharmacological interventions on the care plan for pain in the end of the day meeting on 10/18/18 at 3:08 p.m. No further information was provided prior to the exit conference on 10/18/18.	F 697		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Facility staff failed to address the resident's dementia and its treatment with antipsychotic medications in the plan of care for 1 of 26 residents in the survey sample (Resident #66). The findings included: Resident #66 was admitted to the facility on 5/3/18 with diagnoses including muscle weakness, dysphagia, dementia in other diseases	F 744	1. Resident #66 care plan was updated to include dementia and the use of anti-psychotic meds including symptoms and behaviors. 2. 100% audit of care plans for residents with dementia and/or anti-psychotic meds to identify other residents who may have this deficient practice.	11/16/18

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F 744	Continued From page 59 classified elsewhere without behavioral disturbance, cerebral infarction due to embolism of other cerebral artery, type II diabetes mellitus without complications, essential primary hypertension, other specified anxiety disorders, major depressive disorders, insomnia, and chest pain. On the quarterly minimum data set assessment with assessment reference date 9/17/18, the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting care. The resident's medication assessment was coded under Medications received (N0410 A) as receiving anti-psychotic medications 7 of the 7 days prior to the assessment. Under Anti-psychotic Medication Review (0450), the resident was coded as not receiving anti-psychotic medications since admission or the prior assessment. The resident's comprehensive care plan did not list dementia as a problem. No interventions under other care areas addressed symptoms of the resident's dementia. The comprehensive care plan did not address the resident's use of anti-psychotic medication or the symptoms and behaviors to be addressed by the anti-psychotic medication. The surveyor asked the director of nursing for documentation of the symptoms for which the anti-psychotic Seroquel 100 milligram daily for anxiety with behaviors was being used along with documentation of the need for the anti-psychotic medication for anxiety rather than an anxiolytic medication. Seroquel 100 mg daily was ordered 9/5/18 for anxiety with behaviors. There was no	F 744	3. DON or designee will in-service licensed nursing staff and MDS staff on providing a comprehensive care plan to include diagnosis impacting care and anti-psychotic medication. 4. MDS coordinator or designee will audit care plans due weekly for three months to insure care plans are comprehensive and address appropriate diagnosis and medications. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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F 744	Continued From page 60	F 744		

documentation of behavior symptoms. This was reportedly an increase to the prior dose after a gradual dose reduction attempt started 8/27/18. On 9/13/18, an administrative order for non-pharmacologic intervention codes for anxiety with behaviors was entered. No interventions were documented. An order to monitor for side effects associated with Seroquel documented no side effects.

Review of physician notes, psychiatric evaluations, and nursing progress notes revealed no documentation of the symptoms for which the resident was being treated with anti-psychotic medication. A nursing note dated 8/27/18 15:13 "Resident continues to holler "help, help". When staff asks resident what he needs his response varies: Can you move my covers, can you straighten my leg, can you pull me up. In no case after yelling "help, help" is the resident in any danger of falling off bed, no bleeding, no distress. Both he and his mother are very impatient when it comes to ADL(activity of daily living) care." The next note on 8/28/18 18:54 " Resident turns light on shortly after receiving dinner tray staff feeding other residents and passing out trays when staff answers light resident state he is wet needing to be changed CNA told resident she would be back after taking cart to kitchen resident turns light back on before CNA can take cart to kitchen and come back." A note dated 9/2/18 18:39 "Resident put on light at 1630 and 1715 stating he was wet CNA in both times resident was dry". No other notes concerning behavior or symptoms were documented before 9/5/18 17:09 "FNP (family nurse practitioner) made aware that since Seroquel dosage change, resident has been experiencing increased anxiety and agitation. New orders received to restart previous dosage."

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F 744	Continued From page 61 The surveyor inferred that the behaviors for which the resident was being treated with an anti-psychotic medication were ringing the call bell when not bleeding or in danger of falling, and requesting help during meal times. No other behaviors or symptoms were documented by nursing or medical staff. The resident was hospitalized after the initial brief contact on 10/16/18, so the surveyor was unable to complete the resident interview and assess for the use of chemical restraint for staff convenience. The administrator, director of nursing and assistant director of nursing were notified of the concern during a summary meeting on 10/18/18.	F 744		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		11/16/18

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F 755	Continued From page 62 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure medications were available for administration for 4 of 26 Residents, Residents #74, #249, #21, and #43. The findings included: 1. For Resident #74, the facility staff failed to ensure the Residents exelon patch, lubricant eye night ointment, and nexium were available for administration. The clinical record review revealed that Resident #74 had been readmitted to the facility 03/23/18. Diagnoses included, but were not limited to, muscle weakness, nutritional deficiency, major depressive disorder, chronic pain, anxiety disorder, glaucoma, and bipolar disorder. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of	F 755	1. Medication cited as not administered or available for residents #74, 249, and 43 have been obtained and are available to be administered. 2. To identify other residents that have the potential to be affected the facility completed a 100% audit of current residents during survey to ensure medications were available. There were no negative findings. 3. DON or designee will in-service licensed nursing staff on policy concerning medication shortage/unavailable medications to include ordering medication timely and monitoring OTC medication to ensure they are available. 4. DON or designee will audit med pass each shift for medications not administered and/or medications not available to insure policy is followed for three months.	

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F 755	Continued From page 63 09/27/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. A review of the resident's eMARs (electronic medication administration records) revealed that the facility staff had coded the resident's lubricant eye ointment and nexium with a 16 on 09/26/18 and the resident's exelon patch with a 16 on 09/27/18. Per the preprinted code on the eMARs a 16 meant "Hold/See Nurses Notes." A review of the resident's nursing entries for these dates revealed that the nursing staff had documented the following for the lubricant eye ointment "...none available" and for the nexium "...none available awaiting pharmacy." The surveyor was unable to find a note that referenced the exelon patch. A review of the stat box list revealed that these medications would not have been available in the stat box for administration. On 10/18/18 at 8:20 a.m., the DON (director of nursing) provided the surveyor with a copy of a policy titled "7.0 Medication Shortages/Unavailable Medications." This policy read in part, " ...Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy ...If the next available delivery causes delay or a missed dose in the resident's medication schedule, facility nurse should obtain the medication from the emergency Medication Supply to administer the dose. If the medication is not available in the Emergency Medication Supply, facility staff should notify	F 755	The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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pharmacy and arrange for an emergency delivery ...If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions ..."

The administrative staff were made aware that the Residents medications were not available for administration during a meeting with the survey team on 10/17/18 at 3:20 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #249, the facility failed to ensure the resident's lyrica and adderall were available for administration.

The clinical record review revealed that Resident #249 had been admitted to the facility 10/05/18. Diagnoses included, but were not limited to, attention deficit hyperactivity disorder (ADHD), hypertension, depression, diabetes, and neuropathy.

There was no completed MDS assessment for this Resident. The resident was alert and orientated.

The Residents POS (physician order summary) included physicians orders for-adderall 30 mg 1 tab by mouth two times a day for ADHD and lyrica 100 mg two times a day for neuropathy.

A review of the Residents eMARs (electronic medication administration records) for 10/2018 revealed that for the medication adderall the facility nursing staff had documented a "19" on 10/12, 10/13, and 10/14 at 9:00 a.m. and 9:00

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p.m. For 9:00 p.m. on 10/12 and 10/13 the nursing staff had indicated that they had administered this medication.

For the medication lyrica, the nursing staff had documented a "19" on 10/06, 10/07, and 10/08 at 9:00 a.m. and 9:00 p.m.

Per the preprinted codes on the eMARs a 19 meant "Other/See Nurses Notes."

A review of the resident's progress notes indicated that for the medication adderall the nursing staff had documented the following.
10/12-"Adderall Tablet 30 MG...pharmacy notified."
10/13-"Adderall Tablet...hard scripted refaxed to pharmacy."
10/14-"Adderall Tablet...on order."
10/14-"Adderall Tablet...hard script refaxed to pharmacy."

For the medication lyrica the facility nursing staff had documented the following.
10/06-"Lyrica Capsule 100 MG...no script on file. must wait for dr. on Monday per oncall doctor."
10/06-"Lyrica Capsule 100 MG...Not available."
10/07-"Lyrica Capsule...Not available."
10/08-"Lyrica Capsule 100 MG Give 1 capsule by mouth two times a day for neuropathy."
10/08-"Lyrica Capsule 100 MG...in route from RX."

On 10/17/18 at 6:05 a.m., the surveyor interviewed LPN (licensed practical nurse) #3 via phone regarding the medication adderall. LPN #3 verbalized to the surveyor that she had not administered the adderall and she had marked that she had in error as the medication was not

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available. LPN #3 stated she had called the pharmacy regarding the medication and that sometimes it takes forever for the pharmacy to send us some stuff.

A review of the stat box list revealed that these medications would not have been available in the stat box for administration.

On 10/18/18 at 8:20 a.m., the DON (director of nursing) provided the surveyor with a copy of a policy titled "7.0 Medication Shortages/Unavailable Medications." This policy read in part, " ...Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy ...If the next available delivery causes delay or a missed dose in the resident's medication schedule, facility nurse should obtain the medication from the emergency Medication Supply to administer the dose. If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery ...If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions ..."

The administrative staff were made aware that the Residents medications were not available for administration during a meeting with the survey team on 10/17/18 at 3:20 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. The facility staff failed to ensure Resident # 21's insulin (Basaglar) was available for

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administration.

The clinical record of Resident #21 was reviewed 10/16/18 through 10/18/18. Resident #21 was admitted to the facility 9/20/17 and readmitted 10/12/17 with diagnoses that included but not limited to Type 2 diabetes mellitus, symbolic dysfunction, dysphagia, repeated falls, cardiomyopathy, cerebellar stroke syndrome, alcohol-induced chronic pancreatitis, chronic pain syndrome, anemia, transient ischemic attacks, gastric diverticulum, altered mental status, Barrett's esophagus without dysplasia, hypertension, hemiplegia affecting left dormant side, bipolar disorder, anxiety disorder, atrial fibrillation, acute respiratory infection, viral hepatitis without hepatic coma, and cerebral infarction due to embolism.

Resident #21's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 8/7/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

Resident #21's current comprehensive care plan had the focus area that read "Resident #21 is at risk for hypo/hyperglycemia episodes r/t (related to): DM (diabetes mellitus). Requires daily insulin, requires sliding scale insulin. Interventions: Medication as ordered."

The September 2018 physician orders were reviewed. Resident #21 had orders for Basaglar KwikPen Solution Pen-Injector 100 unit/ml (milliliter) Inject 35 units subcutaneously at bedtime for DM.

The surveyor reviewed the September 2018 electronic medication administration records

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(eMAR). On 9/30/18, the box for the administration of the Basaglar had "19." The legend read "19=Other/See Nurse Notes."

The surveyor reviewed the September 2018 progress notes. The 9/30/18 progress note read Basaglar not available from pharmacy.

The surveyor informed the administrative staff that the insulin Basaglar was not available for administration on 9/30/18 in the end of the day meeting on 10/18/18 at 3:08 p.m. and requested the product information sheet for Basaglar, the facility policy on obtaining medications from the pharmacy, and the September 2018 progress notes.

The surveyor reviewed the facility policy titled "Medication Shortages/Unavailable Medications" on 10/18/18. The policy read in part "1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. 2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility should notify pharmacy and arrange for an emergency delivery. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions."

The product information sheet for Insulin Glargine Solution for Injection (Trade Names Basaglar, Lantus, Lantus SoloStar, Toujeo Max SoloStar, and Toujeo SoloStar) was reviewed 10/18/18.

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Insulin Glargine is a human-made form of insulin. This drug lowers the amount of sugar in your blood. It is a long-acting insulin that is usually given once a day. This medicine is for injection under the skin. Use this medicine at the same time each day. It is important not to miss a dose. Your health care professional or doctor should discuss a plan for missed doses with you. If you do miss a dose, follow their plan. Do not take double doses.

No further information was provided prior to the exit conference on 10/18/18.

4. For Resident #43 the facility staff failed to ensure the medication Klonopin was available for administration for three consecutive doses.

Resident #43 was admitted to the facility on 08/22/17. Diagnoses included but not limited to dementia, major depressive disorder, Alzheimer's disease, schizoaffective disorder, and heart failure.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 08/28/18 coded the Resident as 00 of 15 in section C, cognitive patterns. This is a quarterly MDS.

Resident #43's CCP (comprehensive care plan) was reviewed and contained a focus area for "Resident is on antianxiety therapy," has interventions that included but were not limited to, "Administer antianxiety med as prescribed by the physician."

Resident #43's clinical record was reviewed on 10/17/18. It contained a POS (physician's order summary) for the month of September which read

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in part "KlonoPIN tablet 0.5mg (milligrams) give 0.5 mg by mouth two times a day for anxiety *hold for sedation*". The Resident's eMAR (electronic medication administration record) for the month of September was reviewed and contained an entry which read in part, "KlonoPIN tablet 0.5mg (ClonazePAM) give 0.5 mg by mouth two times a day for anxiety * hold for sedation *". This entry was coded "19" on 09/05/18 at 1700, 09/06/18 at 0900, and 09/06/18 at 1700 which is the equivalent of "medication unavailable". Resident #43's progress notes were reviewed and contained medication administration notes for 09/05/18 at 1644, 09/06/18 at 0853, and 09/06/18 at 1754 which read in part "KlonoPIN tablet 0.5mg give 0.5 mg by mouth two times a day for anxiety *hold for sedation * Awaiting medication from pharmacy".

The surveyor requested and was provided with a copy of facility policy entitled "Medication Shortages/Unavailable Medications", which read in part "Procedure: 1. Upon discovery that Facility has an inadequate supply of a medication to administer to a Resident, Facility staff should immediately initiate action to obtain the medication form pharmacy. If the medication shortage is discovered at the time of medication administration, facility staff should immediately take the action specified in Section 2 ...of this policy, as applicable. 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available causes delay or a missed dose in the Resident's medication schedule, facility nurse should obtain the

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F 755	Continued From page 71 medication form the Emergency Medication Supply to administer the dose. 2.3If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery.4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions ". The surveyor requested and was provided with a list of medications located in the facility stat box on 10/18/18 at approximately 0820. The medication Klonopin was unavailable in the stat box. The surveyor reviewed Resident #43's progress notes and could not locate a note related to nursing staff contacting the pharmacy and/or the attending physician. The surveyor spoke with the administrative team on 10/17/18 at approximately 1518 regarding the concern of Resident #43's medications not being available for administration. No further information was provided prior to exit.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		11/16/18

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F 756	Continued From page 72 §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. (i) Irregularities include, but are not limited to, any 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 staff interview and clinical record review the facility staff failed to follow up on pharmacy recommendations for 1 of 26 Residents, Resident #35. Findings included: For Resident #35, the facility failed to provide	F 756	1. Pharmacy recommendations for resident #35 was reviewed by Nurse Practitioner. 2. 100% audit of September pharmacy recommendations for current residents completed to insure NP or MD are aware and appropriate action taken.	

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F 756	Continued From page 73 evidence that the attending nurse practitioner had reviewed a pharmacy recommendation dated 08/23/18. Resident #35 was admitted to the facility on 08/31/17. Diagnoses included but not limited to unspecified dementia with behavioral disturbance, heart failure, pressure ulcer of sacral region, and encounter for palliative care. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 08/17/18 coded the Resident 00 of 15 in section C, cognitive patterns. The DON (director of nursing) provided the surveyor with a copy of a pharmacy recommendation dated 08/23/18. The attending nurse practitioner that it was addressed to had not signed the recommendation. On 10/18/18 at approximately 2:30pm, the DON (director of nursing) verbalized to the surveyor that a pharmacy review was completed in August and the recommendation provided could possibly be in medical records signed. The DON stated the Resident was placed on hospice in August, so she didn't know. The facility was unable to provide any evidence to the surveyor that the attending nurse practitioner had reviewed the recommendation. The administrative staff were notified of the issue regarding the pharmacy recommendation during a meeting with the survey team on 10/18/18 at approximately 3:08pm. No further information regarding this issue was	F 756	3. DON or designee will establish a protocol including time frames for follow up on pharmacy recommendations and in-service unit managers on protocol. 4. DON or designee will audit pharmacy recommendations monthly to insure protocol is followed for three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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F 756	Continued From page 74 provided to the survey team prior to the exit conference.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 26 residents was free of an unnecessary medication (Resident #33). The findings included: The facility staff failed to follow the physician ordered parameters for the administration of	F 757	1. No correction to be made for resident #33. Nurses assigned to resident #33 were in-serviced on obtaining BP immediately prior to administrating the medication. BP was obtained just prior to the second dose on 10/18 and subsequent days to ensure parameters were followed.	11/16/18

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F 757	Continued From page 75 Metoprolol for Resident #33. The clinical record of Resident #33 was reviewed 10/16/18 through 10/18/18. Resident #33 was admitted to the facility on 9/29/11 with diagnoses, that included but not limited to hypomagnesia, insomnia, chronic pain syndrome, dry eye syndrome, hypertension, chronic diastolic heart failure, lymphedema, acute frontal sinusitis, gastroesophageal reflux disease, urinary tract infections, left knee hemarthosis, right elbow contracture, major depressive disorder, nutritional deficiency, and dysthymic disorder. Resident #33's significant change in minimum data set (MDS) with an assessment reference date (ARD) of 8/16/18 assessed the resident with a BIMS (brief interview for mental status) as 12 out of 15 in Section C. Resident #33's current comprehensive care plan had the focus area that read "Resident #33 is at risk for altered cardiac/resp (respiratory) status r/t (related to) dx (diagnosis) HTN (hypertension), CHF (congestive heart failure). Interventions: VS (vital signs) as ordered and prn (as needed), notify MD (medical doctor) of any abnormalities." Resident #33's October 2018 physician orders included the following physician order that read "Metoprolol Succinate ER (extended release) Tablet Extended Release 24 Hour Give 25 mg (milligrams) by mouth one time a day for HTN Give 12.5 mg (1/2/tab) *DO NOT CRUSH* Hold if systolic is less than 100/diastolic is less than 60. Start Date: 6/26/2016." The surveyor reviewed the October 2018 electronic medication records (eMARs). The	F 757	2. 100% audit of current residents receiving blood pressure medications with parameters to identify other residents with the potential for this practice. 3. DON or designee will in-service licensed nursing staff on following MD orders relating to obtaining blood pressure/pulse prior to administration of medication with parameters. 4. Unit Manager or designee will audit MAR daily (M-F) for three months to insure blood pressure is obtained immediately prior to administration of medication. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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administration boxes for 10/6/18, 10/7/18, 10/11/18, 10/12/18, and 10/16/18 did not have a recorded blood pressure.

The surveyor reviewed the October 2018 Weights and Vitals Summary.

On 10/6/18, blood pressures were obtained at 2:44 a.m., 2:47 a.m., and 8:22 p.m. None of the blood pressures obtained were prior to the administration of Metoprolol.

On 10/7/18, blood pressures were obtained at 00:57 a.m., 4:51 a.m., and 5:42 p.m. None of the blood pressures were obtained prior to the administration of Metoprolol.

On 10/11/18, blood pressures were obtained at 00:52 a.m., 1:47 a.m., and 10:59 p.m. None of the blood pressures were obtained prior to the administration of the medication.

On 10/12/18, blood pressures were obtained at 1:55 a.m., 2:55 a.m., and 2:59 p.m. None of the blood pressures were obtained prior to the medication administration.

On 10/16/18, blood pressures were obtained at 1:08 a.m. and 11:21 p.m. None of the blood pressures were obtained prior to the administration.

The surveyor informed the corporate registered nurse of the above concern with obtaining the blood pressure prior to administering Resident #33's Metoprolol on 10/17/18 at 11:21 a.m. The surveyor requested the October 2018 eMARs, the October progress notes and the October vital signs.

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F 757	Continued From page 77 The surveyor discussed the vital signs and the administration of the medication with the assistant director of nursing on 10/18/18 at 10:30 a.m. The ADON was asked if the vital signs obtained would be an accurate blood pressure on which to administer the medication Metoprolol since all were obtained greater than 2 hours prior to administration. The ADON stated the blood pressures should have been obtained a little closer to the time the medications were administered. The surveyor informed the administrative staff of the above concern during the end of the day meeting on 10/17/18 at 3:20 p.m. No further information was provided prior to the exit conference on 10/18/18.	F 757		
F 758 SS=E	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	F 758		11/16/18

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F 758	Continued From page 78 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 9 of 26 Residents were free of unnecessary medications. Residents #66, #89, #90, #100, #21, #28, #33, #59, #42. The findings included:	F 758	1. Behavior monitoring flow sheets were initiated for residents #89, 90, 100, 21, 28, 33, 59, and 42. Care plan updated to address dementia and use of anti-psychotic medication for resident #66. 2. 100% audit of current residents	

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F 758	Continued From page 79 1. For Resident #66, staff failed to ensure the resident received an anti-psychotic medication only to treat specific conditions and symptoms as documented in the clinical record. Resident #66 was admitted to the facility on 5/3/18 with diagnoses including muscle weakness, dysphagia, dementia in other diseases classified elsewhere without behavioral disturbance, cerebral infarction due to embolism of other cerebral artery, type II diabetes mellitus without complications, essential primary hypertension, other specified anxiety disorders, major depressive disorders, insomnia, and chest pain. On the quarterly minimum data set assessment with assessment reference date 9/17/18, the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting care. The resident's medication assessment was coded under Medications received (N0410 A) as receiving anti-psychotic medications 7 of the 7 days prior to the assessment. Under Anti-psychotic Medication Review (0450), the resident was coded as not receiving anti-psychotic medications since admission or the prior assessment. The resident's comprehensive care plan did not list dementia as a problem. No interventions under other care areas addressed symptoms of the resident's dementia. The comprehensive care plan did not address the resident's use of anti-psychotic medication or the symptoms and behaviors to be addressed by the anti-psychotic medication. The surveyor asked the director of nursing for	F 758	receiving anti-psychotic, anti-anxiety, or anti-depressant medication to identify any resident without a behavior monitoring flow sheet. 3. DON or designee will in-service licensed nursing staff on anti-psychotic, anti-anxiety, and anti-depressant medication to include identifying behaviors or symptoms, behavior monitoring flow sheets, non-pharmalogical interventions, assessing effectiveness of medication, and documentation. 4. DON or designee will audit anti-psychotic, anti-anxiety, or anti-depressant medication administration daily to insure behavior monitoring flow sheet, effectiveness, and non-pharmalogic interventions were documented for three months. DON or designee will audit new admissions daily (Monday-Friday) to insure behavior flow sheets are initiated as indicated for three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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documentation of the symptoms for which the anti-psychotic Seroquel 100 milligram daily for anxiety with behaviors was being used along with documentation of the need for the anti-psychotic medication for anxiety rather than an anxiolytic medication.

Seroquel 100 mg daily was ordered 9/5/18 for anxiety with behaviors. There was no documentation of behavior symptoms. This was reportedly an increase to the prior dose after a gradual dose reduction attempt started 8/27/18. On 9/13/18, an administrative order for non-pharmacologic intervention codes for anxiety with behaviors was entered. No interventions were documented. An order to monitor for side effects associated with Seroquel documented no side effects.

Review of physician notes, psychiatric evaluations, and nursing progress notes revealed no documentation of the symptoms for which the resident was being treated with anti-psychotic medication. A nursing note dated 8/27/18 15:13 "Resident continues to holler "help, help". When staff asks resident what he needs his response varies: Can you move my covers, can you straighten my leg, can you pull me up. In no case after yelling "help, help" is the resident in any danger of falling off bed, no bleeding, no distress. Both he and his mother are very impatient when it comes to ADL(activity of daily living) care." The next note on 8/28/18 18:54 " Resident turns light on shortly after receiving dinner tray staff feeding other residents and passing out trays when staff answers light resident state he is wet needing to be changed CNA told resident she would be back after taking cart to kitchen resident turns light back on before CNA can take cart to kitchen and

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come back." A note dated 9/2/18 18:39 "Resident put on light at 1630 and 1715 stating he was wet CNA in both times resident was dry". No other notes concerning behavior or symptoms were documented before 9/5/18 17:09 "FNP (family nurse practitioner) made aware that since Seroquel dosage change, resident has been experiencing increased anxiety and agitation. New orders received to restart previous dosage." The surveyor inferred that the behaviors for which the resident was being treated with an anti-psychotic medication were ringing the call bell when not bleeding or in danger of falling, and requesting help during meal times. No other behaviors or symptoms were documented by nursing or medical staff.

The resident was hospitalized after the initial brief contact on 10/16/18, so the surveyor was unable to complete the resident interview and assess for the use of chemical restraint for staff convenience.

The administrator, director of nursing and assistant director of nursing were notified of the concern during a summary meeting on 10/18/18.
2. The facility staff failed to monitor effectiveness and identify target behaviors associated with the use of Risperdal for Resident # 89.

Resident # 89 was an 82-year-old-female who was admitted to the facility on 5/15/18. Diagnoses included but were not limited to: schizoaffective disorder, hypertension, bipolar disorder, and hypothyroidism.

The clinical record for Resident # 89 was reviewed on 10/16/18 at 4:14 pm. The most recent MDS assessment (minimum data set) was

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a quarterly assessment with an ARD date (assessment reference date) of 9/24/18. Section C of the MDS assesses cognitive patterns. In section C0500, the facility staff documented that Resident # 89 had a BIMS score (brief interview for mental status) of 10 out of 15, which indicated that Resident # 89's cognitive status was moderately impaired. Section N of the MDS assesses medications. In Section N0410, the facility staff documented that Resident # 89 received an antipsychotic medication for 7 days during the look back period for the 9/24/18 ARD.

The plan of care for Resident # 89 was reviewed and revised on 7/31/18. The facility staff documented a focus area for Resident # 89 as " Resident # 89 uses psychotropic medications related to bipolar and schizoaffective disorder." Interventions included but were not limited to: "Administer medications as ordered. Monitor/document for side effects and effectiveness." The surveyor did not locate any documented target behaviors associated with the use of Risperdal on the plan of care for Resident # 89.

Resident # 89 had a current order that was signed by the physician on 10/9/18 for "Risperdal tablet 0.5 mg (milligram) Give 0.5 mg by mouth one time a day for schizoaffective disorder." The surveyor reviewed the medication administration record for Resident # 89 and did not locate any documentation of monitoring target behaviors or effectiveness for the physician ordered Risperdal.

On 10/16/18 at 4:33 pm, the surveyor interviewed CNA # 1 (certified nursing assistant). The surveyor asked CNA # 1 if Resident # 89 displayed any abnormal behaviors. CNA # 1

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stated, "No she is sweet as pie."

On 10/16/18 at 4:35 pm, the surveyor interviewed unit manager RN # 1 and asked if Resident # 89 displayed any abnormal behaviors. RN # 1 stated, "She is sweet as pie." The surveyor asked RN # 1 what behaviors Resident # 89 displayed to warrant the administration of Risperdal. RN # 1 stated that Resident # 89 had been admitted on the medication and that she was not aware of what behaviors Resident # 89 displayed to warrant the use of Risperdal. RN # 1 reviewed the clinical record for Resident # 89 along with the surveyor and agreed that there were no documented target behaviors or monitoring for effectiveness for the physician ordered Risperdal for Resident # 89.

The facility policy on "Psychotropic Medication Documentation and Review" contained documentation that included but was not limited to:
... "Procedure
A. Residents receiving psychotropic medication will have a behavior /Intervention Monthly Flow Record (BFR) (Form 4.11) initiated on admission or whenever psychotropic meds are ordered.
a. Each psychotropic medication will be entered on BFR.
b. Resident specific behaviors related to medication use will be entered on BFR.
B. Nurses will document on the following every shift:
a. Number of behavior episodes
d. any side effect(s) observed." ...

On 10/17/18 at 4:00 pm, the administrative team was made aware of the findings as stated above.

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No further information regarding this issue was provided to the survey team prior to the exit conference on 10/18/18.

3. The facility staff failed to monitor physician ordered Duloxetine for effectiveness for Resident # 90.

Resident # 90 was an 85-year-old female who was originally admitted to the facility on 5/26/17 with a readmission date of 3/5/18. Diagnoses included but were not limited to osteoarthritis, cellulitis of right lower limb, major depressive disorder, and non-pressure chronic ulcer of right lower leg.

The clinical record for Resident # 90 was reviewed on 10/17/18 at 9:51 am. The most recent MDS assessment (minimum data set) was a quarterly assessment with an ARD date (assessment reference date) of 9/28/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 90 had a BIMS score (brief interview for mental status) of 12 out of 15 which indicated that Resident # 90's cognitive status was moderately impaired. Section N of the MDS assesses medications. In Section N0141, the facility staff documented that Resident # 90 had received antidepressant medication for 7 days during the look back period for the 9/28/18 ARD.

The plan of care for Resident # 90 was reviewed and revised on 8/28/18. The facility staff documented a focus area for Resident # 90 as, "Resident # 90 uses psychotropic medications r/t (related to) dx (diagnosis) of depression." Interventions included but were not limited to: "Administer medications as ordered.

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Monitor/document for side effects and effectiveness."

Resident # 90 had current orders that were initiated by the physician on 3/5/18. Orders included but were not limited to: "Duloxetine 30 mg (milligram) Give 1 capsule by mouth one time a day related to major depressive disorder."

On 10/17/18 at 9:55 am, the surveyor reviewed Resident # 90's medication administration record for October 2018. The surveyor did not locate any monitoring for effectiveness for the physician ordered Duloxetine.

On 10/18/18 at 12:25 pm, the surveyor spoke with unit manager RN # 1 (registered nurse) and made her aware that there was no monitoring for effectiveness for the physician ordered Duloxetine for Resident # 90. RN # 1 stated that she would get it taken care of.

The facility policy on "Psychotropic Medication Documentation and Review" contained documentation that included but was not limited to:
... "Procedure
C. Residents receiving psychotropic medication will have a behavior /Intervention Monthly Flow Record (BFR) (Form 4.11) initiated on admission or whenever psychotropic meds are ordered.
c. Each psychotropic medication will be entered on BFR.
d. Resident specific behaviors related to medication use will be entered on BFR.
D. Nurses will document on the following every shift:
b. Number of behavior episodes
d. any side effect(s) observed." ...

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F 758	Continued From page 86 On 10/18/18 at 3:00 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 10/18/18. 4. The facility staff failed to monitor physician ordered Seroquel for effectiveness for Resident # 100. Resident # 100 was a 66-year-old-female who was admitted to the facility on 10/9/18. Diagnoses included but were not limited to: MRSA (methicillin-resistant staphylococcus aureus), Parkinson's disease, schizophrenia, and muscle weakness. The clinical record for Resident # 100 was reviewed on 10/16/18 at 11:22 am. During the time of the survey, there was no completed MDS assessment (minimum data set) for Resident # 100. The plan of care for Resident # 100 was reviewed and revised on 10/16/18. The facility staff documented a focus area for Resident # 100 as. "Resident # 100 uses psychotropic medications r/t (related to) schizoaffective disorder." Interventions included but were not limited to: "Administer medications as ordered. Monitor/document for side effects and effectiveness." Resident # 100 had current orders that were initiated by the physician on 10/10/18. Orders included but were not limited to: "Seroquel tablet 25 mg (milligram) Give 1 tablet by mouth two times a day for paranoid schizophrenia."	F 758		

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F 758	Continued From page 87 On 10/16/18 at 12:17 pm, the surveyor reviewed the medication administration record and nurse's notes for Resident # 100. The surveyor did not locate any documentation of monitoring for effectiveness for the physician ordered Seroquel for Resident # 100. On 10/16/18 at 12:48 pm, the surveyor interviewed LPN # 2 (licensed practical nurse). The surveyor asked LPN # 2 where the nursing staff documented the effectiveness of psychotropic medications. LPN # 2 stated, "We have a behavior grid and we document the behaviors on there." LPN # 2 reviewed the clinical record for the behavior grid and LPN # 2 stated, "She doesn't have one." The facility policy on "Psychotropic Medication Documentation and Review" contained documentation that included but was not limited to: ... "Procedure E. Residents receiving psychotropic medication will have a behavior /Intervention Monthly Flow Record (BFR) (Form 4.11) initiated on admission or whenever psychotropic meds are ordered. e. Each psychotropic medication will be entered on BFR. f. Resident specific behaviors related to medication use will be entered on BFR. F. Nurses will document on the following every shift: c. Number of behavior episodes d. any side effect(s) observed." ... On 10/17/18 at 4:00 pm, the administrative team was made aware of the findings as stated above.	F 758		

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No further information regarding this issue was provided to the survey team prior to the exit conference on 10/18/18.
5. The facility staff failed to identify and monitor resident specific targeted behaviors, identify non-pharmacological interventions, and monitor for effectiveness associated with the use of Abilify and Cymbalta for Resident #21.

The clinical record of Resident #21 was reviewed 10/16/18 through 10/18/18. Resident #21 was admitted to the facility 9/20/17 and readmitted 10/12/17 with diagnoses that included but not limited to Type 2 diabetes mellitus, symbolic dysfunction, dysphagia, repeated falls, cardiomyopathy, cerebellar stroke syndrome, alcohol-induced chronic pancreatitis, chronic pain syndrome, anemia, transient ischemic attacks, gastric diverticulum, altered mental status, Barrett's esophagus without dysplasia, hypertension, hemiplegia affecting left dormant side, bipolar disorder, anxiety disorder, atrial fibrillation, acute respiratory infection, viral hepatitis without hepatic coma, and cerebral infarction due to embolism.

Resident #21's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 8/7/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #21 was assessed to have inattention continuously present, no psychosis, and no behaviors that affected others.

Resident #21's current comprehensive care plan had the focus area that read the resident was at risk for adverse effects r/t (related to) psychoactive medication use: antidepressant for depression; antipsychotic for mood stabilizer.

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Interventions: Monitor for side effects: sedation, hypotension, EPS (extrapyramidal symptoms), anticholinergic sx (symptoms), H/A (headache), insomnia, anorexia, constipation. Monitor for effectiveness of medications, Report changes in behavior or mood state, report to physician any negative outcomes associated with use of psychoactive drug.

Resident #21's October 2018 physician orders included orders for Abilify 5 mg (milligrams) in the morning for mood disorder and Cymbalta delayed release capsule 60 mg in the morning for depression and pain.

The surveyor reviewed the October 2018 electronic medication administration records (eMARS) but was unable to locate any targeted behaviors the staff were monitoring for Abilify and Cymbalta. There were no completed behavior monitoring records.
The current comprehensive care plan did not include targeted behaviors for the use of Abilify and Cymbalta.

The surveyor informed the corporate registered nurse of the above concern with monitoring of Abilify and Cymbalta on 10/17/18 12:07 PM. The surveyor requested the October 2018 eMARS.

The surveyor informed the administrative staff of the above concern on 10/17/18 at 3:20 p.m. in the end of the day meeting.

The surveyor reviewed the facility policy titled "Psychotropic Medication Documentation and Review" on 10/18/18. The policy read in part "A. Residents receiving psychotropic medication will have a Behavior/Intervention Monthly Flow

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Record (BFR) (Form 4.11) initiated on admission or whenever psychotropic meds are ordered."

No further information was provided prior to the exit conference on 10/18/18.

6. The facility staff failed to identify and monitor resident specific targeted behaviors, identify non-pharmacological interventions, and monitor for effectiveness associated with the use of Elavil for Resident #28.

The clinical record of Resident #28 was reviewed 10/16/18 through 10/18/18. Resident #28 was admitted to the facility 9/7/16 and readmitted 8/13/18 with diagnoses that included but not limited to symbolic dysfunction, dysphagia, right shoulder contracture, major depressive disorder, Type 2 diabetes mellitus, seizures, iron deficiency anemia, urine retention, anxiety disorder, moderate protein calorie malnutrition, peripheral vascular disease, gastroesophageal reflux disease, bradycardia, diabetic neuropathy, chronic pain syndrome, paraplegia, acute renal failure, gastritis, bacteremia, hyperkalemia, insomnia, and hypertension.

Resident #28's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/10/18 assessed the resident with a BIMS (brief interview for mental status) as 15 out of 15. Resident #28 was assessed without any signs or symptoms of delirium, psychosis or behaviors that affected others.

Resident #28's current comprehensive care plan was reviewed and a care plan had not been developed for psychotropic medication.

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The October 2018 physician orders were reviewed. Resident #28 had orders for Elavil 25 mg (milligrams) (Amitriptyline HCL) 1 tablet by mouth at bedtime for antidepressant Start Date 8/13/18.

The surveyor reviewed the October 2018 electronic medication administration records (eMARS) and the October 2018 behavior monitoring records but found no evidence monitoring of Elavil had been done, no targeted behaviors identified or a care plan been developed for the use of the antidepressant.

The surveyor informed the unit manager registered nurse #1 on 10/17/18 10:33 AM. R.N. #1 stated the nurses were not monitoring antidepressants use. The unit manager R.N. #1 stated she was not aware antidepressants needed to be monitored.

The surveyor informed the administrative staff of the above concern during the end of the day meeting on 10/17/18 at 3:20 p.m.

The surveyor reviewed the facility policy titled "Psychotropic Medication Documentation and Review" on 10/18/18. The policy read in part "A. Residents receiving psychotropic medication will have a Behavior/Intervention Monthly Flow Record (BFR) (Form 4.11) initiated on admission or whenever psychotropic meds are ordered."

No further information was provided prior to the exit conference on 10/18/18.

7. The facility staff failed to identify targeted behaviors for Zoloft and failed to monitor the behavior of Resident #33.

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The clinical record of Resident #33 was reviewed 10/16/18 through 10/18/18. Resident #33 was admitted to the facility on 9/29/11 with diagnoses, that included but not limited to hypomagnesia, insomnia, chronic pain syndrome, dry eye syndrome, hypertension, chronic diastolic heart failure, lymphedema, acute frontal sinusitis, gastroesophageal reflux disease, urinary tract infection, left knee hemarthosis, right elbow contracture, major depressive disorder, nutritional deficiency, and dysthymic disorder.

Resident #33's significant change in minimum data set (MDS) with an assessment reference date (ARD) of 8/16/18 assessed the resident with a BIMS (brief interview for mental status) as 12 out of 15 in Section C. Resident #33 was assessed without signs or symptoms of delirium, psychosis, or behaviors that affected others.

Resident #33's current comprehensive care plan identified that the resident was at risk for adverse effects r/t (related to) psychoactive medication use: Depression, insomnia. At risk for falls and over sedation. Interventions: Monitor for effectiveness of medications, Report changes in behavior or mood state, report to physician any negative outcomes associated with use of psychoactive drug.

Resident #33's October 2018 physician's orders were reviewed. The physician order dated 9/28/18 read "Zoloft tablet 100 mg (Sertraline HCL) 1 tablet by mouth one time a day for depression."

The surveyor reviewed the October 2018 electronic medication administration records

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(eMARS) but was unable to locate any behavior monitoring of Zoloft-no identified targeted behaviors and no side effect monitoring.

The surveyor informed the administrative staff of the concern with Resident #33's Zoloft monitoring in the end of the day meeting on 10/18/18 at 3:08 p.m.

No further information was provided prior to the exit conference on 10/18/18.

8. The facility staff failed to ensure the antidepressant medication Fluvoxamine used to treat specific symptoms or behaviors associated with a diagnosis requiring treatment by an antidepressant medication and to ensure monitoring of the symptoms for which the antidepressant medication was ordered for Resident #59. Resident # 59's clinical record did not document the symptoms which the antidepressant medication was to address. There was no ongoing behavior monitoring of a resident receiving antidepressant medications.

The clinical record of Resident #59 was reviewed 10/16/18 through 10/18/18. Resident #59 was admitted to the facility 8/12/17 and readmitted 4/2/18 with diagnoses that included but not limited to metabolic encephalopathy, severe sepsis with shock, dysphagia, neuromuscular dysfunction of the bladder, hypertension, atherosclerotic heart disease, obsessive compulsive personality disorder, rhabdomyolysis, end stage renal disease, anxiety disorder, mental disorder, repeated falls, hyperkalemia, urinary tract infection, Parkinson's disease, and major depressive disorder.

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Resident #59's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/12/18 assessed the resident with a BIMS (brief interview for mental status) as 9/15. Resident #59 was assessed to have hallucinations, but no signs or symptoms of delirium or psychosis.

Resident #59's current comprehensive care plan identified the resident to be at risk for adverse effects r/t (related to) psychoactive medication use: antidepressant and antipsychotic Date initiated: 07/17/2018 Revision on: 09/21/2018. Interventions: Monitor for effectiveness of medications, Report changes in behavior or mood state, report to physician any negative outcomes associated with use of psychoactive drug.

Resident #59's October physician orders were reviewed. Resident #59 had an order for Fluvoxamine Maleate 100 mg tablet Give 200 mg by mouth in the evening related to Obsessive-Compulsive Disorder."

FLUVOXAMINE is an antidepressant. It is used to treat obsessive-compulsive disorder.

The surveyor reviewed the October 2018 electronic medication administration record but was unable to locate any behavior monitoring of Fluvoxamine-no identified targeted behaviors and no side effect monitoring.

The surveyor informed the administrative staff of the concern with Resident #59's Fluvoxamine monitoring in the end of the day meeting on 10/17/18 at 3:20 p.m.

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No further information was provided prior to the exit conference on 10/18/18.
9. For Resident #42, the facility staff failed to monitor the Residents prozac.

The clinical record review revealed that Resident #42 had been admitted to the facility 05/20/16. Diagnoses included, but were not limited to, depressive disorder, anxiety disorder, chronic pain, gastro-esophageal reflux disease, and hypertension.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/24/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section N (medications) was coded to indicate the Resident had received antidepressant medication.

The Residents comprehensive care plan included the focus area is on antidepressant therapy. Interventions were administer antidepressant med as prescribed by the physician and refer to psych services.

The Residents current POS (physician order summary) included an order for prozac 40 mg one time a day.

During the clinical record review, the surveyor was unable to locate any information that the facility were offering and/or providing any behavioral interventions or monitoring for any side effects of this medication until after the survey team began asking questions regarding other Residents in the survey sample.

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F 758	Continued From page 96 On 10/18/18, the facility provided the surveyor with a copy of the Residents behavior monitoring and side effect monitoring forms for the medication prozac. These forms revealed that the facility began using these forms on night shift on 10/16/18. The administrative staff were notified of the above during a meeting with the survey team on 10/18/18 at 3:08 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and during a medication pass and pour observation, the facility staff failed to ensure a medication error rate of less than 5%. There were 2 errors in 28 opportunities for a medication error rate of 7.14%. These errors effected Resident #101. The findings included: The facility nursing staff failed to administer the Residents miralax and eye drops. The record review revealed that Resident #101	F 759	1. Eye drops for resident #10 were discontinued by MD. Medication was administrated as ordered daily after 10/17. 2. To identify other residents that have the potential to be affected the facility completed a 100% audit of current residents during survey to ensure medications were available. There were no negative findings. 3. DON or designee will in-service licensed nursing staff on medication pass to include policy regarding when	11/16/18

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F 759	Continued From page 97 had been admitted to the facility 10/15/18. Diagnoses included, but were not limited to, diabetes, blindness left eye, transient ischemic attack and cerebral infarcon without residual deficits, and acute appendicitis. There was no completed MDS (minimum data set) assessment completed on this Resident. The Resident was alert and orientated. On 10/17/18 beginning at approximately 7:53 a.m., the surveyor observed LPN (licensed practical nurse) #2 prepare and administer the following medications amlodipine, carvedilol, furosemide, lisinopril, cipro, iron, aspirin, thera tab vitamin, and a PPD to Resident #101. After observing the medication administration the surveyor reconciled the Residents medications using the Residents EHR (electronic health record). The Residents orders included two medications the surveyor did not observe being administered miralax and carboxymethylcellulose eye drops. The surveyor approached LPN #2 and asked about the missing medications. LPN #2 stated that she did not recall the Resident receiving miralax. However, after checking the EHR LPN #2 stated when she finished him up she would administer the miralax. In regards to the Resident's eye drops LPN #2 stated she would put an order in for them. On 10/18/18 at 8:20 a.m., the DON (director of nursing) provided the surveyor with a cop of a policy titled "7.0 Medication Shortages/Unavailable Medications." This policy read in part, "...Upon discovery that facility has an	F 759	medications are not available and checking that all medications are given. 4. Unit Manager or designee will audit med pass on four nurses a week for three months to include all shifts to ensure medications are administrated as ordered. If any medications are noted as unavailable, the nurse will follow the policy and procedure. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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F 759	Continued From page 98 inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy...If the next available delivery causes delay or a missed dose in the resident's medication schedule, facility nurse should obtain the medication from the emergency Medication Supply to administer the dose. If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery...If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions..." A review of the stat box list revelaed that these medications were not available at the facility for administration. The administrative team was notified of the medication errors during a meeting with the survey team on 10/17/18 at 3:20 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 2 of 26 Residents were free of significant medication errors. Residents #72 and #21	F 760	1. Basaglar insulin was obtained for resident #21. Lisinopril as discontinued by the MD for resident #72, BP□s have been monitored daily and no parameters	11/16/18

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F 760	Continued From page 99 Findings included: 1. For Resident #72 the facility staff failed to administer blood pressure medication as ordered by the physician. Resident #72 was admitted to the facility on 08/01/17. Diagnoses included but not limited to hypertension, diabetes mellitus, depression, cerebral infarction due to embolism, and chronic kidney disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/26/18 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #72's CCP (comprehensive care plan) was reviewed and contained a focus area for "Resident has altered cardiac status," has interventions that included but were not limited to, "Administer medications as directed by the physician." Resident #72's clinical record was reviewed on 10/17/18. It contained a POS (physician's order summary) which read in part: "Coreg Tablet 12.5 MG (milligrams) (Carvedilol) Give 12.5 mg by mouth two times a day for CVA (cerebral vascular accident), take with meals; Norvasc Tablet 10 MG (AmLODIPine Besylate) Give 10mg by mouth one time a day for CVA; Prinivil Tablet 20 MG (Lisinopril) Give 20mg by mouth one time a day for HTN (hypertension)". Resident #72's eMAR (electronic medication administration record) for the month of September 2018 were reviewed and contained an	F 760	ordered. 2. To identify other residents that have the potential to be affected the facility completed a 100% audit of current residents during survey receiving insulin and or blood pressure medication for administration accuracy including blood sugars and or BP as ordered. There were no negative findings. 3. DON or designee will in-service licensed nursing staff on medication pass to include administering insulin, blood pressure medication, meds not available, and completing med pass. 4. a. Unit Manager or designee will audit MAR daily (M-F) for three months, to insure med pass is complete and any medication not administered or charted as not available has a progress note showing follow up according to policy. b. Unit Manager or designee will audit BP medications daily (M-F) to ensure any resident with medication held related to BP has follow up including notification of MD documented. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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entry which read in part, "Norvasc Tablet 10 MG (AmLODIPine Besylate) Give 10mg by mouth one time a day for CVA ". This entry was coded "16" on 09/07/18 at 0900, 09/19/18 at 0900, and 09/20/18 at 0900 which is the equivalent of "see progress notes". This entry was also coded "7" on 09/08/18 at 0900, 09/09/18 at 0900, 09/12/18 at 0900 and 09/21/18 at 0900 which is the equivalent of "vitals outside of parameters". EMAR for the month of September 2018 also contained an entry which read in part, "Prinivil Tablet 20 MG (Lisinopril) Give 20mg by mouth one time a day for HTN". This entry was coded "16" on 09/07/18 at 0900, and 09/20/18 at 0900 which is the equivalent of "see progress notes". This entry was also coded "7" on 09/08/18 at 0900, 09/09/18 at 0900, 09/12/18 at 0900, 09/23/18 at 0900, and 09/26/18 at 0900 which is the equivalent of "vitals outside of parameters". EMAR for the month of September 2018 also contained an entry which read in part, "Coreg Tablet 12.5 MG (Carvedilol) Give 12.5 mg by mouth two times a day for CVA, take with meals". This entry was coded "16" on 09/19/18 at 0830, 09/20/18 at 0830, and 09/25/18 at 0830 which is the equivalent of "see progress notes".

Resident #72's progress notes were reviewed and contained medication administration notes for: 09/07/18 at 1053, which read in part "bp (blood pressure) 82/49", 09/08/18 at 1046 "bp low 99/57", 09/09/18 at 1121 "bp 89/57", 09/12/18 at 1140 "87/48", 09/19/18 at 1112 " ...90/56 ...", 09/19/18 at 1114 " ...90/56 ...", 09/20/18 at 1140 " ...104/56 ...", 09/20/18 at 1140 " ...104/56 ...", 09/20/18 at 1142 " ...104/56 ...", and 09/25/18 at 1107 " ...102/72 ...".

The surveyor reviewed Resident #72's physician's

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orders and could not locate an order stating to hold the following medications for vitals outside of parameters: Coreg Tablet 12.5 MG, Norvasc Tablet 10 MG, and Prinivil Tablet 20 MG.

The surveyor spoke with the administrative team on 10/17/18 at approximately 3:18pm regarding Resident #72's medications being held for vitals outside of parameters without a physician's order.

No further information was provided prior to exit.
2. The facility staff failed to ensure Resident # 21's insulin (Basaglar) was administered as ordered.

The clinical record of Resident #21 was reviewed 10/16/18 through 10/18/18. Resident #21 was admitted to the facility 9/20/17 and readmitted 10/12/17 with diagnoses that included but not limited to Type 2 diabetes mellitus, symbolic dysfunction, dysphagia, repeated falls, cardiomyopathy, cerebellar stroke syndrome, alcohol-induced chronic pancreatitis, chronic pain syndrome, anemia, transient ischemic attacks, gastric diverticulum, altered mental status, Barrett's esophagus without dysplasia, hypertension, hemiplegia affecting left dormant side, bipolar disorder, anxiety disorder, atrial fibrillation, acute respiratory infection, viral hepatitis without hepatic coma, and cerebral infarction due to embolism.

Resident #21's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 8/7/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

Resident #21's current comprehensive care plan had the focus area that read "Resident #21 is at

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risk for hypo/hyperglycemia episodes r/t (related to): DM (diabetes mellitus). Requires daily insulin, requires sliding scale insulin. Interventions: Medication as ordered."

The September 2018 physician orders were reviewed. Resident #21 had orders for Basaglar KwikPen Solution Pen-Injector 100 unit/ml (milliliter) Inject 35 units subcutaneously at bedtime for DM.

The surveyor reviewed the September 2018 electronic medication administration records (eMAR). The box for the administration of Basaglar on 9/4/18 at 2100 (9:00 p.m.) was blank and on 9/30/18, the box for the administration of the Basaglar had "19." The legend read "19=Other/See Nurse Notes."

The surveyor reviewed the September 2018 progress notes. There was not a progress note written for 9/4/18 explaining the reason Basaglar had not been administered. The 9/30/18 progress note read Basaglar not available from pharmacy.

The surveyor informed the administrative staff that the insulin Basaglar was not available for administration on 9/30/18 in the end of the day meeting on 10/18/18 at 3:08 p.m. and requested the product information sheet for Basaglar, the facility policy on obtaining medications from the pharmacy, the facility policy on medication administration and the September 2018 progress notes.

The surveyor reviewed the facility policy titled "Medication Shortages/Unavailable Medications" on 10/18/18. The policy read in part "1. Upon

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discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. 2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility should notify pharmacy and arrange for an emergency delivery. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions."

The surveyor reviewed the facility policy titled "6.0 General Dose Preparation and Medication Administration." The policy read in part "6. After medication administration, facility should take all measures required by facility policy and applicable law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, prn (whenever needed) medications, application sight) on appropriate forms."

The product information sheet for Insulin Glargine Solution for Injection (Trade Names Basaglar, Lantus, Lantus SoloStar, Toujeo Max SoloStar, and Toujeo SoloStar) was reviewed 10/18/18. Insulin Glargine is a human-made form of insulin. This drug lowers the amount of sugar in your blood. It is a long-acting insulin that is usually given once a day. This medicine is for injection under the skin. Use this medicine at the same time each day. It is important not to miss a dose.

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F 760	Continued From page 104 Your health care professional or doctor should discuss a plan for missed doses with you. If you do miss a dose, follow their plan. Do not take double doses. No further information was provided prior to the exit conference on 10/18/18.	F 760		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain physician ordered laboratory tests for 3 of 26 residents (Resident #21, Resident #33, and Resident #56). The findings included: 1. The facility staff failed to obtain a physician ordered urinalysis, culture, and sensitivity for Resident #21. The clinical record of Resident #21 was reviewed 10/16/18 through 10/18/18. Resident #21 was admitted to the facility 9/20/17 and readmitted 10/12/17 with diagnoses that included but not limited to Type 2 diabetes mellitus, symbolic dysfunction, dysphagia, repeated falls,	F 770	1. The labs were obtained for resident #33 on 10/15/18 and MD made aware of results. Resident #56 discharged on 10/21 so no urine obtained. 2. 100% audit of current residents to insure labs/urinalysis ordered in the last three months were obtained and results in medical record to identify any other resident with this issue. 3. DON or designee will in-service licensed nursing staff on lab services to include obtaining and writing orders, follow up to insure lab/urinalysis was obtained and receiving of lab results.	11/16/18

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F 770	Continued From page 105 cardiomyopathy, cerebellar stroke syndrome, alcohol-induced chronic pancreatitis, chronic pain syndrome, anemia, transient ischemic attacks, gastric diverticulum, altered mental status, Barrett's esophagus without dysplasia, hypertension, hemiplegia affecting left dormant side, bipolar disorder, anxiety disorder, atrial fibrillation, acute respiratory infection, viral hepatitis without hepatic coma, and cerebral infarction due to embolism. Resident #21's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 8/7/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Section H Bowel and Bladder assessed the resident to be frequently incontinent of both. The clinical record of Resident #21 had a physician order dated 8/19/18 that read "Obtain a UA C&S (urinalysis, culture and sensitivity) resend, one time only for routine monitoring for 1 day re/obtain UA C&S." The surveyor reviewed the laboratory section of the electronic clinical record. On the lab results report dated 8/20/18, the following was written "8/21/18 09:35 Problem Test 8/20/18 No DOB (date of birth) on UC (urine container) >UA/C*S. Resolution: RN #2 notified." The urinalysis was never re-obtained. The surveyor informed the unit manager registered nurse #1 on 10/17/18 at 1:45 p.m. The unit manager R.N. #1 stated she was unable to locate the results of the UA C&S ordered to be resent. The surveyor informed the administrative staff of	F 770	4. Unit Manager or designee will audit labs obtained/ordered daily (M-F) to ensure order is in the medical record, labs drawn/urine obtained, and results received for three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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the above concern in the end of the day meeting on 10/17/18 at 3:20 p.m.

No further information was provided prior to the exit conference on 10/18/18.

2. The facility staff failed to obtain physician ordered laboratory tests for Resident #33. The staff failed to obtain an albumin level, CBC (complete blood count) and a BMP (basic metabolic panel) for Resident #33.

The clinical record of Resident #33 was reviewed 10/16/18 through 10/18/18. Resident #33 was admitted to the facility on 9/29/11 with diagnoses, that included but not limited to hypomagnesia, insomnia, chronic pain syndrome, dry eye syndrome, hypertension, chronic diastolic heart failure, lymphedema, acute frontal sinusitis, gastroesophageal reflux disease, urinary tract infection, left knee hemarthosis, right elbow contracture, major depressive disorder, nutritional deficiency, and dysthymic disorder.

Resident #33's significant change in minimum data set (MDS) with an assessment reference date (ARD) of 8/16/18 assessed the resident with a BIMS (brief interview for mental status) as 12 out of 15 in Section C. Section H Bladder and Bowel was coded for an indwelling catheter.

Resident #33's current comprehensive care plan was reviewed 10/16/18 through 10/18/18. Resident #33 had the focus area that read "Resident #33 has indwelling catheter for wound healing. Interventions: Indwelling cath (catheter) per order. Cath care per physician's orders." Resident #33's October 2018 physician orders were reviewed. The physician ordered a

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pre-albumin level on 10/1/18. A review of the laboratory results did not reveal the pre-albumin level had been obtained.

Resident #33 also had a physician order dated 10/8/18 to obtain a CBC and a BMP. After reviewing the laboratory section of the clinical record, the surveyor was unable to locate those results and informed the unit manager registered nurse #1 of the concerns listed above.

The unit manager registered nurse #1 informed the surveyor on 10/17/18 at 1:19 p.m. that the pre-albumin was entered incorrectly into the computer. R.N. #1 stated the order was "just sitting there" with no direction on when to obtain the lab. R.N. #1 stated the contracting laboratory was contacted and the pre-albumin was not done. R.N. #1 also stated the CBC and BMP were not obtained and had no reason why they weren't.

The surveyor informed the administrative staff of the physician ordered laboratory tests that were not obtained on 10/17/18 at 3:20 p.m.

No further information was provided prior to the exit conference on 10/18/18.

3. The facility staff failed to obtain urinalysis' ordered 8/7/18 and 9/5/18 for Resident #56.

The clinical record of Resident #56 was reviewed 10/16/18 through 10/18/18. Resident #56 was admitted to the facility 5/15/18 with diagnoses that included but not limited to dysphagia, symbolic dysfunctions, chronic atrial fibrillation, hypertension, atherosclerotic heart disease, acute on chronic systolic heart failure, nutritional anemia, pneumothorax, gastroesophageal reflux

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disease, dementia without behavioral disturbances, transient ischemic attacks, gout, restlessness and agitation, urine retention, left heel pressure ulcer, sacral pressure ulcer, and left femur fracture.

Resident #56's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/11/18 assessed the resident with a BIMS (brief interview for mental status) as 9 out of 15. Section H Bladder and Bowel assessed the resident to be incontinent of bowel and bladder always.

Resident #56's current comprehensive care plan had the focus area for urinary incontinence and inability to control urination r/t (related to) cognitive deficit, prostate cancer. Goal: No infection through next review. Interventions: Note any changes in amount, frequency, color or odor. Report any abnormalities to nursing/MD (medical doctor).

Resident #56 had an order dated 8/7/18 and 9/5/18 for a UA/C&S (urinalysis, culture and sensitivity). The surveyor was unable to locate the results of the UA/C&S ordered 8/7/18 and 9/5/18 when the clinical record was reviewed 10/17/18 at 7:54 a.m.

The surveyor informed the unit manager registered nurse #1 of the missing laboratory results on 10/17/18 at 9:21 a.m.

The unit manager stated the staff were unable to obtain the UA/C&S on 8/8/18 due to an obstruction. R.N. #1 stated the staff failed to document the reason why the UA/C&S was not obtained and the staff did not document the

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F 770	Continued From page 109 physician was notified. The unit manager R.N. #1 provided the surveyor with a progress note dated 9/6/18 at 5:53 a.m. The progress note read "UA (urinalysis) attempted x1 on resident with no success, when writer went to try again resident was already up and dressed in wheelchair. Will pass on to oncoming nurse to try to attempt." On 10/17/18 at 1:17 p.m., the unit manager R.N. #1 stated the UA/C&S ordered 9/5/18 was not obtained and she stated she would expect the staff to notify the MD and document physician notification if the UA/C&S was not obtained. The surveyor informed the administrative staff of the concern with the failure to obtain Resident #56's two physician ordered urinalysis, cultures and sensitivies in the end of the day meeting on 10/17/18 at 3:20 p.m. No further information was provided prior to the exit conference.	F 770		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for	F 773		11/16/18

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F 773	Continued From page 110 notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician order prior to obtaining laboratory tests for 1 of 26 residents (Resident #59). The findings included: The facility staff failed to obtain a physician order before the CBC (complete blood count) and BMP (basic metabolic panel) were obtained on 9/18/18 for Resident #59. The clinical record of Resident #59 was reviewed 10/16/18 through 10/18/18. Resident #59 was admitted to the facility 8/12/17 and readmitted 4/2/18 with diagnoses that included but not limited to metabolic encephalopathy, severe sepsis with shock, dysphagia, neuromuscular dysfunction of the bladder, hypertension, atherosclerotic heart disease, obsessive compulsive personality disorder, rhabdomyolysis, end stage renal disease, anxiety disorder, mental disorder, repeated falls, hyperkalemia, urinary tract infection, Parkinson's disease, and major depressive disorder. Resident #59's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/12/18 assessed the resident with a BIMS (brief interview for mental status) as 9/15. The surveyor reviewed the laboratory section of the clinical record and located the results of a CBC and BMP obtained 9/18/18. The surveyor	F 773	1. Oder for BMP and CBC for resident #59 was found in the electronic medical record and was electronically dated for 9/17/18. 2. 100% audit of current residents labs to insure order is in place. 3. DON or designee will in-service licensed nursing staff on lab services to include obtaining and writing orders, follow up to insure lab/urinalysis was obtained and receiving of lab results. 4. Unit Manager or designee will audit labs obtained daily (Monday – Friday) to ensure order is in the medical record, labs drawn/urine obtained, and results received for three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 111 was unable to locate a physician order for the laboratory tests. The surveyor informed the administrative staff of the laboratory tests obtained for Resident #59 without a physician order in the end of the day meeting on 10/18/18 at 3:08 p.m. No further information was provided prior to the exit conference on 10/18/18.	F 773		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential 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	F 842		11/16/18

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	495256	A. BUILDING _____ B. WING _____	C 10/18/2018

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F 842	Continued From page 112	F 842		

representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

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

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

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F 842	Continued From page 113 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 3 of 26 Residents, Residents #21, #31, and #249. The findings included: 1. The facility staff failed to ensure the physician's orders for PROM (passive range of motion) were entered into the computer accurately for Resident #21. The clinical record of Resident #21 was reviewed 10/16/18 through 10/18/18. Resident #21 was admitted to the facility 9/20/17 and readmitted 10/12/17 with diagnoses that included but not limited to Type 2 diabetes mellitus, symbolic dysfunction, dysphagia, repeated falls, cardiomyopathy, cerebellar stroke syndrome, alcohol-induced chronic pancreatitis, chronic pain syndrome, anemia, transient ischemic attacks, gastric diverticulum, altered mental status, Barrett's esophagus without dysplasia, hypertension, hemiplegia affecting left dormant side, bipolar disorder, anxiety disorder, atrial fibrillation, acute respiratory infection, viral hepatitis without hepatic coma, and cerebral infarction due to embolism. Resident #21's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 8/7/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #21's October 2018 physician orders read PROM upper and lower extremities: 15 reps (repetitions) Order date: 6/22/2018.	F 842	1. Resident #31 and #249 had all cited medications administered for the remaining of October 2018. Order for AROM clarified for resident #21. 2. a. To identify other residents that have the potential to be affected the facility completed a 100% audit of current residents during survey with restorative orders to insure the order is accurate. b. To identify other residents that have the potential to be affected the facility completed a 100% audit of current residents during survey receiving insulin and or blood pressure medication for administration accuracy including blood sugars and or BP as ordered. There were no negative findings. 3. DON or designee will in-service licensed nursing staff on auditing orders for accuracy and documentation of medication administration accurately to include documentation such as blood sugar or BP. 4. DON or designee will audit new orders for three months for accuracy. Unit Manager or designee will audit MAR□s daily (M-F) for accuracy and completeness for three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 11/16/18	

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The surveyor reviewed the current comprehensive care plan read "Resident #21 is on restorative program for stand pivot transfer. Interventions: Stand-by assist with transfers, limited assist, use gait belt at all times, skills practice 6/7 days a week, skills practice twice a day." A second care plan read "Resident #21 is on restorative for AROM (active range of motion) capable of performing 15 reps decreased ROM (range of motion). Interventions: Skills practice: qd (everyday), Passive ROM, Complete 15 repetitions to each extremity below: hands, fingers, elbow, shoulder, neck, knees, legs, feet."

The quarterly MDS with ARD of 8/7/18 was reviewed. Section O Special Treatments, Procedures, and Programs and specifically Section O0500 Restorative Nursing Programs was coded that the resident received 7 days of range of motion (active) during the look back period and 6 days of transfers during the look back period. PROM had not been coded that the resident received any during the look back period or that the physician ordered had been followed for PROM.

The surveyor informed the assistant director of nursing (ADON) of the above concern on 10/18/18 at 1:19 p.m. The ADON stated Resident #21 was receiving AROM and the order for PROM was "operator error."

The surveyor informed the administrative staff of the documentation concerns between PROM ordered for Resident #21 and AROM performed and charted in the end of the day meeting on 10/18/18 at 3:08 p.m.

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No further information was provided prior to the exit conference on 10/18/18.

2. For Resident #31, facility staff failed to document administration of medication in the clinical record.

Resident # 31 is a 96-year-old-female who was originally admitted to the facility on 11/20/2013 with a readmission date of 11/07/17. Diagnoses included but were not limited to muscle weakness, type 2 diabetes mellitus, chronic obstructive pulmonary disease, chronic kidney disease, and unspecified fracture of sacrum.

The clinical record for Resident #31 was reviewed on 11/16/18 at approximately 3:23pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 08/14/18 coded the Resident as 15 of 15 in section C, cognitive patterns.

Resident #31's CCP (comprehensive care plan) was reviewed and contained a focus area for; "At risk for impaired skin integrity related to impaired mobility, diabetes mellitus, and edema. History of bilateral lower extremities weeping. Resident is noncompliant with thrombo-embolic deterrent hose," has interventions that included but were not limited to, "Administer medication as ordered and administer treatments as ordered."

During clinical record review, the surveyor noted blanks in the medication administration record on 09/01 and 09/14/18 for administration of Levothyroxine Sodium Tablet 75 microgram by mouth in the morning related to hypothyroidism, and the 06:00 dose of Clonidine Hydrochloride

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0.1 milligrams by mouth every six hours related to hypertension. There were blanks on the medication administration record on 09/01, 09/04, and 09/14 for the 0630 dose of Novolog Flex Pen solution pen-injector 100 units per milliliter (Insulin Aspart) Inject per sliding scale subcutaneously before meals and at bedtime: If blood sugar 201-250 give 2 units; 251-300 give 4 units; 301-350 give 6 units; 351-400 give 8 units; 401-499 give10 units; for diabetes mellitus type 2, call MD (medical doctor) for BS (blood sugar) less than 60 or greater than 450.

The surveyor reported the concern to the director of nursing, assistant director of nursing, regional director of clinical services, and administrator during meeting on 10/17/18 at approximately 3:18 pm.

No further information was provided prior to exit.
3. For Resident #249, the facility nursing staff failed to document that they had administered the Residents prilosec, insulin, and the results of the Residents blood sugar and documented they had administered the Residents adderall when it was not available at the facility for administration.

The clinical record review revealed that Resident #249 had been admitted to the facility 10/05/18. Diagnoses included, but were not limited to, attention deficit hyperactivity disorder (ADHD), hypertension, depression, diabetes, and neuropathy.

There was no completed MDS assessment for this Resident. The Resident was alert and orientated.

When reviewing the Residents eMARs (electronic

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F 842	Continued From page 117 medication administration records) for 10/2018 the surveyor observed "holes" where the nursing staff had failed to document they had administered the following medications. Prilosec on 10/14 at 6:00 a.m. Blood sugars at 6:00 a.m. on 10/06 and 10/14 and for any insulin if required. On 10/12 and 10/13 at 9:00 p.m., LPN (licensed practical nurse) #3 had documented that she had administered the Residents adderall. When this medication was not available at the facility for administration. On 10/17/18 at 6:05 a.m., the surveyor interviewed LPN #3 via phone regarding the adderall medication. LPN #3 verbalized to the surveyor that she had not administered the adderall and she had marked that she had in error, as the medication was not available. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 842		