STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	327 HERSHBERGER RD NW ROANOKE, VA 24012

(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 11/14/18 through 11/16/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Three complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/14/18 through 11/16/18 . Three 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 253 certified bed facility was 234 residents in the facility at the time of the survey. The survey sample consisted of 35 current Resident reviews and 3 closed record reviews .	F 000		
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 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,	F 578		12/28/18

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

Electronically Signed | 12/20/2018

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F 578	Continued From page 1 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 review the facility staff failed to ensure a complete and accurate DDNR (durable do not resuscitate) form for 2 of 38 Residents, #68 and #163. The findings included: 1. For Resident #68 the facility staff failed ensure a complete and accurate DDNR form. Resident #68 was admitted to the facility on	F 578	F578 Corrective Action(s): Resident #68 has had her DDNR form reviewed by the DON and the attending physician and it has been updated and correctly completed to reflect resident #68□s code status. An Incident and Accident form was completed for this incident. Resident #163 has had his DDNR form	

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F 578	Continued From page 2 02/06/18. Diagnoses included but not limited to congestive heart failure, hypertension, diabetes mellitus, dementia, dysphagia, constipation and osteoarthritis. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/10/18 coded the Resident as 3 of 15 in Section C, cognitive patterns. This is a quarterly MDS. Resident #68's clinical record was reviewed on 11/15/18. It contained a Virginia Department of Health DDNR form dated 02/22/18, which read as follows: I further certify (must check 1 or 2): [] 1. The Patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required) [] 2. The Patient is INCAPABLE of making an informed decision about provided, withholding, or withdrawing a specific medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision , or to make a rational evaluation of the risks and benefits of alternatives to that decision. If you checked 2 above, check A, B, or C below: [] A. While capable of making an informed decision, the Patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn. [] B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging	F 578	reviewed by the DON and the attending physician and it has been updated and correctly completed to reflect resident #163□s code status. An Incident and Accident form was completed for this incident. Identification of Deficient Practice(s) & Corrective Action(s): All other residents may have been potentially affected. The Social Services Director will review all resident□s medical records to ensure the DDNR is accurately filled out. Any negative findings will result in the Social Services Director to contact all responsible parties to verify each resident□s code status and advance directives to insure that the proper status has been explained and that written notification has been placed in the medical record. Systemic Change(s); The Facility policy and procedure was reviewed and no changes are warranted at this time. The Social Services Director has been in-serviced on the proper completion of a DDNR and Advance Directives when required. The Social Services Director will discuss with each future Admission their advance directives and resuscitation status upon admission to the facility. Any/all concerns expressed will be reported to the Administrator. The Administrator & Director of Nursing will speak to those concerned or with questions about each area & follow through on all concerns to ensure proper resuscitation status is reflected in the	

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F 578	Continued From page 3 procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.) [] C. The Patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required) Sections I and II of the DDNR form had not been checked as directed. The concern of the incomplete DDNR form was discussed with the administrative team during a meeting on 11/15/18 at approximately 1515. DON (director of nursing) stated the form should be complete. No further information was provided prior to exit. 2. For Resident #163 the facility staff failed to ensure a complete and accurate DDNR form. Resident #163 was admitted to the facility on 10/11/18. Diagnoses included but not limited to coronary artery disease, congestive heart failure, hypertension, hyperlipidemia, dementia, depression, anxiety, and psychotic disorder. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/18/18 coded the Resident as 3 out of 15 in section C, cognitive patterns. This is an admission MDS. Resident #163's clinical record was reviewed on 11/15/18. It contained a Virginia Department of Health DDNR form dated 10/11/18, which read as follows: I further certify (must check 1 or 2):	F 578	medical record. Monitoring: The Social Services Director is responsible for maintaining compliance. The Social Services Director will audit all Residents medical records monthly to monitor compliance for having a current resuscitation order and/or advance directive. Any/all negative findings will be reported to the Administrator for immediate correction.	

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F 578	Continued From page 4 [] 1. The Patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required) [] 2. The Patient is INCAPABLE of making an informed decision about provided, withholding, or withdrawing a specific medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision , or to make a rational evaluation of the risks and benefits of alternatives to that decision. If you checked 2 above, check A, B, or C below: [] A. While capable of making an informed decision, the Patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn. [] B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.) [] C. The Patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required) Sections I and II of the DDNR form had not been checked as directed. The concern of the incomplete DDNR form was discussed with the administrative team during a meeting on 11/15/18 at approximately 1515. DON (director of nursing) stated the form should be	F 578		

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F 578	Continued From page 5 complete. No further information was provided prior to exit.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		12/28/18

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F 584	Continued From page 6 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to maintain a homelike environment for 1 of 38 Residents, Resident #35. The findings included: The facility failed to finish repairing and/or painting the resident's wall after fixing the drywall. The work order was over a year old and was dated 08/15/2017. The record review revealed that Resident #35 had been admitted to the facility 01/10/2017. Diagnoses included, but were not limited to, diabetes, atrial fibrillation, congestive heart failure, and gastro-esophageal reflux disease. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/23/2018 included a BIMS (brief interview for mental status) summary score of 13 out of a possible 15 points. On 11/14/2018 at 12:25 p.m., during an interview with Resident #35, the surveyor was able to visualize several areas on the Residents wall behind their recliner, nightstand, and bed where	F 584	F584 Corrective Action(s): The wall in Resident #35□s room that was found to have not been patched and painted properly was fixed on Monday, November 19, 2018 as scheduled with Resident #35 during the survey. Identification of Deficient Practice(s) and Corrective Action(s): All other resident rooms and common areas may have potentially been affected. A complete documented environmental and maintenance walkthrough of the facility will be conducted by the maintenance team to identify resident rooms and common areas at risk. All resident rooms, hallways, and common areas identified to need repairs, patching, and/or painting will be corrected by the maintenance department. Systemic Change(s): The facility□s policy & procedure for providing a safe, clean, comfortable and homelike environment has been reviewed and no changes are warranted at this time. The Administrator and/or Maintenance Director will in-service all maintenance staff on the facility policy and	

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F 584	Continued From page 7 the staff had started a repair. This wall was wallpapered. However, the patched areas were of a different substance and did not match the wallpaper. When asked what had happened to the wall Resident #35 verbalized to the surveyor that the facility staff had patched the wall but had failed to return and complete the repair job. Resident #35 stated that everyone that comes to visit me asks what is wrong with your wall and I do not have an answer. That is my biggest concern. On 11/14/2018 at 12:48 p.m., maintenance worker #1 and the administrator were shown the Residents wall. After speaking with Resident #35 maintenance worker #1 stated he would have it fixed. On 11/15/2018 at 10:21 a.m., the resident verbalized to the surveyor that she was not feeling well and the facility was going to repair her wall on Monday. The administrative staff were notified of the issues regarding the Residents wall on 11/15/2018 at 3:06 p.m., during an end of the day meeting with the survey team. On 11/16/2018 at 8:50 a.m., during a follow up interview with Resident #35, Resident #35 stated that the wall had been that way since sometime around July of last year and that they (unknown facility staff) had patched the wall and said they would be back in a couple of weeks to paint it but they never returned. Resident #35 stated she saw the man that repaired her wall in the hallway once and asked him about it and he said he was having a hard time matching up the paint. She stated she told him she did not care what color	F 584	procedure for providing and maintaining a clean, comfortable, homelike environment, to include specific education on ensuring work is sufficiently completed prior to closing out work order tickets. Monitoring: The Maintenance Director is responsible for maintaining compliance. Documented facility rounds will be completed weekly to monitor compliance. The administrator will review these rounds weekly to ensure negative findings are being corrected. Cumulative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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F 584	Continued From page 8 they painted it as long as it was painted. Resident #35 stated they just did not come back. I have had a lot of people ask me about it-it almost looks like water damage. Resident #35 then stated they are waiting until Monday to fix it because today is my shower day, I did not feel well yesterday, and over the weekend, I just figured no one would be here. Therefore, I told them Monday would be okay. The facility provided the surveyor with a copy of a work order for this room that indicated a "Drywall repair behind bed and paint" had been started on 08/15/2017. The status of this work order had been documented as being complete. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 584		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to provide services to meet professional standards of practice in regards to administrating medications and applying treatments to 4 of 38 residents in the survey sample; Resident #184, Resident #175, Resident #109, and Resident #225. The findings included:	F 658	F658 Corrective Action(s): Resident #184□s medication orders have been changed to allow for proper administration of medication prior to departure for dialysis. A Medication Error report was completed for this incident. Resident #175□s TED Hose orders were	12/28/18

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F 658	Continued From page 9 1. For Resident # 184 the facility staff failed to obtain an order to hold medications. The clinical record review revealed that Resident #184 had been admitted to the facility on 12/20/15 with a readmission date of 08/09/16. Diagnoses included, but were not limited to, hemiplegia, hemiparesis following cerebral infarction, type 2 diabetes mellitus, end stage kidney disease, hypertension, depression and constipation. The clinical record for Resident #184 was reviewed on 11/15/18 at 3:00pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 10/10/18 coded the Resident as 12 of 15 in section C, cognitive patterns. Resident #184's CCP (comprehensive care plan) was reviewed and contained a focus areas for: "Resident is receiving anticoagulant therapy and antiplatelet therapy ..."; "Resident has the potential for complications and abnormal labs related to altered cardiovascular status ...."; "Resident needs Dialysis r/t (related to) ESRD (end stage renal disease) ..."; has interventions that included but were not limited to, "Give medications per order ....", and "Supplement as ordered". Resident #184's clinical record was reviewed on 11/15/18. It contained a POS (physician's order summary) which read in part: " Dialysis 3 times a week TTS (Tuesday, Thursday, and Saturday) 6:55 AM per dialysis schedule ...; Zoloft Tablet 100 MG (milligrams) (Sertraline HCL) Give 1 tablet by mouth one time a day for mood; Zoloft	F 658	reviewed with no changes warranted at this time. RN# 1 has been properly educated on the importance of ensuring proper administration of medication/treatment orders prior to signing off in the administration record. A Medication Error report was completed for this incident. Resident #109□s TED Hose orders were reviewed with no changes warranted at this time. RN# 1 has been properly educated on the importance of ensuring proper administration of medication/treatment orders prior to signing off in the administration record. A Medication Error report was completed for this incident. Resident #225□s treatment orders were changed to properly reflect the usage of skin prep for the treatment to her toes. LPN# 1 was educated on the importance of clarifying physician orders prior to administration. A Medication Error report was completed for this incident. Identification of Deficient Practices/Corrective Action(s): Residents in the facility with dialysis orders, TED Hose orders, and skin-prep orders are affected by the facility□s medication administration program and may have been impacted. An audit has been completed for all dialysis residents to ensure that their medications are administered prior to departure for dialysis. An audit has been completed on all residents with TED Hose orders to	

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F 658	Continued From page 10 Tablet 25 MG ...Give 1 tablet by mouth one time a day for mood ...; BusPIRone HCL Tablet 7.5MG Give 7.5 mg by mouth two times a day for anxiety; Eliquis Tablet 2.5 MG (Apixaban) Give 2.5mg by mouth two times a day related to UNSPECIFIED ATRIAL FIBRILATION; PhosLo Capsule 667MG (Calcium Acetate) Give 3 capsules by mouth three times a day for ESRD (end stage renal disease) administer TID (three times a day) with meals; Plavix Tablet 75MG (Clopidogrel Bisulfate) Give 1 tablet by mouth one time per day for CAD (coronary artery disease); Renal Capsule 1 MG (B Complex-C Folic Acid) Give 1 capsule by mouth one time a day for ESRD supplement". Resident #184's eMAR (electronic medication administration record) for the month of November 2018 was reviewed and contained an entry which read in part: "Zoloft Tablet 100 MG Give 1 tablet by mouth one time a day for mood; Zoloft Tablet 25 MG Give 1 tablet by mouth one time a day for mood ...; BusPIRone HCL Tablet 7.5MG Give 7.5 mg by mouth two times a day for anxiety; Eliquis Tablet 2.5 MG Give 2.5mg by mouth two times a day related to UNSPECIFIED ATRIAL FIBRILATION; PhosLo Capsule 667MG Give 3 capsules by mouth three times a day for ESRD administer TID with meals; Plavix Tablet 75MG Give 1 tablet by mouth one time per day for CAD ; Renal Capsule 1 MG Give 1 capsule by mouth one time a day for ESRD supplement". These entries were coded "6" on 11/01/18, 11/03/18, 11/06/18, 11/08/18, 11/10/18, 11/13/18, and 11/15/18 for "AM (8am-11am)" medication administration time which is the equivalent of "medical leave of absence ". The surveyor reported the concern to the director	F 658	ensure that they have the proper treatment in place. Further, a daily checklist has been developed to double-check placement on these residents. Lastly, all treatment orders for skin prep have been reviewed to verify that the product used was named specifically. Systemic Change(s): The facility policy and procedure has been reviewed and revisions have been made; the medication block times have been deleted so that medications are given specific administration times with a grace-period one hour before and one hour after. Licensed staff will be in-serviced by the DON and/or designee on these changes to the medication administration program. The DON and/or designee will also in-service all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. Monitoring: The DON is responsible for maintaining compliance. The DON and/or designee will perform daily reviews of the Order Listing Report, which shows all new or changed orders within the past 24-hours and a 24-hour chart check, which provides a second layer of reviews for these orders. Aggregate findings of these meetings will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure,	

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F 658	Continued From page 11 of nursing, assistant director of nursing, and administrator during meeting on 11/15/18 at approximately 3:38 pm. The surveyor asked the director of nursing the following, "The medications that are being held without a physician's order, is it important for the Resident to get these medications consistently as ordered?" The director of nursing replied "yes" and voiced she would talk to the prescribing physician to clarify what medications Resident #184 is supposed to receive prior to dialysis. On 11/16/18 at 7:50 am, the surveyor was provided with an order which read in part, "May administer medications early morning due to dialysis time." The surveyor requested a standards of practice for medication administration. The facility was unable to provide surveyor with the requested document. Reference: Lippincott's Nursing Procedures, 6th Edition, page 530. "...Verify that the medication is being administrated at the proper time ..." No further information was provided prior to exit. 2. For Resident # 175 the facility staff failed to follow professional standards of nursing practice when administering medications and applying prescribed treatments. The clinical record review revealed that Resident #175 had been admitted to the facility on 11/30/14. Diagnoses included, but were not limited to, dependence on renal dialysis, type 2 diabetes mellitus, end stage kidney disease, hypertension, anxiety and depression.	F 658	and/or practice.	

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The clinical record for Resident #175 was reviewed on 11/16/18. The most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/18/18 coded the Resident as 15 of 15 in section C, cognitive patterns.

Resident #175's clinical record was reviewed on 11/16/18. It contained a POS (physician's order summary) which read in part: "Dialysis 3 times a week QOD (every other day) ...; TED (thromboembolic disease) hose as Resident allows. ON in the am, off at HS (hour of sleep); Reglan Tablet 5 MG (milligrams)...Give 1 tablet by mouth for gastroparesis ...; HydrALAZINE HCL Tablet 25 MG Give 1 tablet by mouth every 8 hours for HTN; Renvela Tablet 800 MG ...Give 1 tablet by mouth three times a day for ESRD (end stage renal disease)/binder ..."

Resident #184's eMAR (electronic medication administration record) for the month of November 2018 was reviewed and contained an entry which read in part, "Reglan Tablet 5 MG ...Give 1 tablet by mouth for gastroparesis ...; HydrALAZINE HCL Tablet 25 MG Give 1 tablet by mouth every 8 hours for HTN (hypertension); Renvela Tablet 800 MG ...Give 1 tablet by mouth three times a day for ESRD/binder". These entries were coded "6" on 11/02/18, 11/05/18, 11/07/18, 11/09/18, and 11/12/18 for "MID-D (mid-day) (2pm-5pm)" medication administration time which is the equivalent of "medical leave of absence ".

Resident #175's TAR (treatment administration record) for the month of November 2018 was reviewed and contained an entry which read in part, "TED hose as Resident allows. ON in AM,

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Off at HS ..." This entry was consistently marked as administered for the month of November at "AM" (8am-11am) administration time, including November 16th which indicated the TED hose were applied.

On 11/15/18 at 9:48am the surveyor observed Resident #175 not wearing physician ordered TED hose.

On 11/16/18 at 11:41am the surveyor observed Resident #175 not wearing physician ordered TED hose. RN#1 (registered nurse) on floor documented TED hose were applied on TAR. The surveyor asked Resident #175, "Why aren't you wearing your TED hose?" Resident #175 replied "They never put them on me. I have never wore them." The surveyor could not visibly locate TED hose in Resident#175's room.

The surveyor reported the concern to the director of nursing, and assistant director of nursing on 11/16/18 at approximately 1:00 pm.

The surveyor requested a standards of practice for medication administration and documentation. The facility was unable to provide the surveyor with the requested documentation.

Reference: Lippincott's Nursing Procedures, 6th Edition, page 530. "...Verify that the medication is being administrated at the proper time ..."

Reference: Potter-Perry Fundamentals of Nursing, 6th Edition, page 477. "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client record is a vital aspect of nursing practice. Nursing

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documentation must be accurate, comprehensive and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice."

No further information was provided prior to exit.

3. For Resident #109 the facility staff failed to follow professional standards of nursing practice when applying prescribed treatments.

The clinical record review revealed that Resident #109 had been admitted to the facility on 11/03/17. Diagnoses included, but were not limited to, spinal stenosis, heart failure, dementia, atherosclerotic heart disease, muscle weakness and osteoporosis.

The clinical record for Resident #109 was reviewed on 11/16/18. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 09/25/18 coded the Resident as 13 of 15 in section C, cognitive patterns.

Resident #109's clinical record was reviewed on 11/16/18. It contained a POS (physician's order summary) which read in part: "TED Hose on every day one time a day for circulation."

Resident #109's TAR (treatment administration record) for the month of November 2018 was reviewed and contained an entry which read in part, "TED Hose on every day one time a day for circulation" This entry was consistently marked as administered for the month of November at "AM" (8am-11am) administration time, including November 16th which indicated the TED hose were applied.

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F 658	Continued From page 15 On 11/14/18 at 12:28pm the surveyor observed Resident #109 not wearing physician ordered TED hose. On 11/16/18 11:45am Resident did not have TED hose on. RN#1 (registered nurse) documented TED hose was applied on TAR. The surveyor asked Resident #109 "Why aren't you wearing your TED hose?" Resident #109 replied "I cannot put them on without assistance". The surveyor reported the concern to the director of nursing, and assistant director of nursing on 11/16/18 at approximately 1:00 pm. On 11/16/18 at 2:05pm the surveyor spoke to unit manager about the concern and she stated, "Resident #109 will take TED hose off". The surveyor asked unit manager, "Does Resident #109 have issues putting TED hose on by herself?" The unit manager stated "Resident #109 has difficulty putting them on and she cannot manage them by herself". On 11/16/18 2:11pm. The surveyor spoke to Resident #109 and asked Resident #109, "Did staff offer to help you apply your TED hose today?" Resident #109 stated "No, they never offer". The surveyor asked Resident #109, "Did you remove your TED hose today?" Resident #109 replied, "I did not remove them today. They never offered to put them on". The surveyor requested a standards of practice for documentation. The facility was unable to provide the surveyor with the requested document.	F 658		

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Reference: Potter-Perry Fundamentals of Nursing, 6th Edition, page 477. "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice."

No further information was provided prior to exit.
4. For Resident #225 the facility staff failed to follow professional standards of practice for transcribing physician's orders.

Resident #225 was admitted to the facility on 06/26/08. Diagnoses included but not limited to Alzheimer's disease, anxiety, hypertension, dementia, bipolar disorder, glaucoma, depression, gastroesophageal reflux disease, hypothyroidism, and psychosis.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/05/18 coded the Resident as 99 in section C, cognitive patterns. This is a significant change MDS.

Resident #225's clinical record was reviewed on 11/15/18. It contained a physician's order summary for the month of November, which read in part, "Spray first two toes on left foot daily for redness one time a day for redness". Resident's eTAR (electronic treatment administration record) was reviewed and contained an entry, which read in part, "Spray first two toes on left foot daily for redness one time a day for redness". The order did not specify what to use to spray the toes.

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Surveyor spoke with LPN #1 on 11/16/18 at approximately 0845. Surveyor asked LPN #1 what she used to spray Resident's toes and she stated that she used skin prep. Surveyor then asked LPN #1 how she knew to use skin prep, and she stated, "I look at the treatment sheet". Surveyor then asked LPN #1 to review the treatment sheet with her, and LPN #1 looked at the treatment sheet and stated, "Well, it don't say what to use, does it". Surveyor again asked LPN #1 how she knew what to use, and she stated, "It's our protocol".

Surveyor spoke with DON (director of nursing) on 11/16/18 at approximately 0900. Surveyor showed the DON Resident #225's treatment sheet and DON stated there was no way to know what the treatment was supposed to be. Surveyor asked DON to provide protocol for this treatment that LPN #1 had referred to, and DON stated there was no protocol. The DON then stated to surveyor that the wound doctor usually hand wrote his orders and the nurses entered them into the computer. DON stated that it was probably a transcription error. Surveyor then requested the facility standard of practice for transcribing physician's orders.

DON provided the surveyor with a copy of the original handwritten physician's order, dated 08/23/18, which read in part "Spray first two toes on left foot with skin prep daily for redness". DON stated to the surveyor "We do not go by a prescribed standard, just the policy" and provided the surveyor with a copy of a facility policy entitled "Order Transcription". This policy read in part, "PROCEDURE: 1. Verbal telephone orders must be documented by the nurse receiving the order. The documentation occurs in two locations in the

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F 658	Continued From page 18 order entry field in the electronic medical record. 2. The order will be read back to the physician and confirmed as correct by the ordering Provider. 3. The order must contain Resident name, attending physician, the date and time it was received, complete instructions from the provider, to include dose, form route, schedule, and indication or diagnosis, and signature/title of person taking order." The concern of the facility staff failing to follow professional standards of practice for transcribing physician's orders was discussed with the administrative team during a meeting on 11/16/18 at approximately 1530 . No further information was provided prior to exit.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to provide ADL (activities of daily living) care for dependent Residents for 1 of 38 Residents, #68. The findings included: For Resident #68 the facility staff failed to provide nail care. Resident #68 was admitted to the facility on 02/06/18. Diagnoses included but not limited to	F 677	F677 Corrective Action(s): Resident #68 has had her fingernails cleaned and cut appropriately. The C.N.A.□s who were assigned to this resident on 11/14/18 and 11/15/18 have been appropriately educated. Identification of Deficient Practices/Corrective Action(s): All other residents may have potentially been affected. The DON and/or designee	12/28/18

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F 677	Continued From page 19 congestive heart failure, hypertension, diabetes mellitus, dementia, dysphagia, constipation and osteoarthritis. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/10/18 coded the Resident as 3 of 15 in Section C, cognitive patterns. Section G, functional status, coded the Resident as 3/2 in the area of personal hygiene. This is equivalent to extensive assistance, two-person physical assist. This is a quarterly MDS. Surveyor observed Resident #68 on 11/14/18 at approximately 1540. Resident's fingernails were observed to be long and ragged with brownish debris underneath. Surveyor observed Resident #68 on 11/15/18 at approximately 0935. Resident was seated at dining room table. Resident's nails remained long and ragged with brownish debris underneath. The concern of Resident #68's nails being long and ragged was discussed with the administrative staff during a meeting on 11/15/18 at approximately 1515. No further information provided prior to exit.	F 677	has completed an audit on all residents to ensure that fingernails are cut and cleaned appropriately and that proper grooming has occurred. Any/all negative findings discovered during the audit will be corrected at time of discovery. Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. The DON and/or designee will provide an in-service training to the CNA's to address the importance of providing proper grooming, to include fingernail care and facial grooming, to all residents. Monitoring: The DON is responsible for maintaining compliance. The DON and/or designee will perform grooming audits weekly to insure that proper grooming, including fingernail care and facial grooming, has occurred for specific residents. Any/all negative findings will be reported to the DON for immediate correction. Detailed findings of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in facility policy, procedure, and/or practice.	
F 684 SS=E	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	F 684		12/28/18

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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, facility document review and clinical record review, the facility staff failed to follow physician's orders for 9 of 38 residents in the survey sample (Resident's #88, #179, #80, #209, #482, #184, #175, #109 and #281).

The findings included:

1. The facility staff failed to follow physician's orders for the administration of Baclofen and Xanax for Resident #88.

Resident #88 was readmitted to the facility on 2/20/18 with the following diagnoses of, but not limited to high blood pressure, diabetes, seizure disorder, depression and Traumatic Brain Injury. On the quarterly MD (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/16/18, the resident was coded for a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #88 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and being totally dependent on 1 staff member for bathing.

The surveyor performed a clinical record review on 11/15 and 11/16/18. During this review, the surveyor noted the following physician's orders:
" Baclofen 10 mg (milligram) Give 1 tablet by mouth as needed for muscle spasms. Do not give within 2 hours of hs (bedtime) Xanax dose.
" Xanax 0.25 mg Give 1 tablet by mouth at

F684
Corrective Action(s):
Residents #88□s attending physician was notified that the facility failed to administer Baclofen and Xanax as ordered, with the appropriate time lapse between administrations of the medications, respectively. A facility Medication Error form was completed for this incident.

Resident #179□s attending physician was notified that the facility staff failed to obtain daily weights as ordered. A facility Medication Error form was completed for this incident.

Residents #80□s attending physician was notified that the facility failed to obtain finger stick Accuchecks as ordered. A facility Medication Error form was completed for this incident.

Resident #209□s attending physician was notified that the facility failed to appropriately follow sliding scale Novolog orders. A facility Medication Error form was completed for this incident.

Resident #482□s attending physician was notified that the facility staff failed to obtain daily weights as ordered. A facility Medication Error form was completed for this incident.

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F 684	Continued From page 21 bedtime. The surveyor requested a copy of the medication administration audit report for the month of November 2018 from the director of nursing (DON) on 11/16/18 at 9:15 am. After the surveyor received the report, the surveyor noted the following dates and times for the administration of Baclofen and Xanax for Resident #88: 11/1/18 Baclofen 10 mg documented as being administrated to resident at 20:26 (8:26 pm) Xanax 0.25 mg documented as being administrated to resident at 20:26. 11/2/18 Baclofen 10 mg documented as being administrated to resident at 20:20 (8:20 pm) Xanax 0.25 mg documented as being administrated to resident at 20:19 (8:19 pm). 11/15/18 Baclofen 10 mg documented as being administrated to resident at 22:19 (10:19 pm) Xanax 0.25 mg documented as being administrated to resident at 22:30 (10:30 pm). The facility policy on "Administering Medications" contained documentation that read in part, "..."Procedure ...2. Medications must be administered in accordance with the orders, including any required time frame. ..." The administrator, director of nursing (DON) and the facility's pharmacist was notified of the above documented findings on 11/16/18 at approximately 1:15 pm. The DON agreed that these two medications should not had been administrated as they had been on the above documented dates and time. The DON stated, "We have to follow physician's orders for administrating medications."	F 684	Resident #485 should have been identified as Resident #482. Resident #184□s attending physician was notified that the facility failed to administer his medications prior to departure to dialysis per the physician order. Additionally, Resident #184□s medication orders have been changed to allow for proper administration of medication prior to departure for dialysis. A facility Medication Error form was completed for this incident. Resident #175□s attending physician was notified that the facility failed to administer medications and apply TED hose per physician orders. Resident #175□s TED Hose orders were reviewed with no changes warranted at this time. A facility Medication Error form was completed for this incident. Resident #109□s attending physician was notified that the facility failed to apply TED hose per physician order. Resident #109□s TED Hose orders were reviewed with no changes warranted at this time. A facility Medication Error form was completed for this incident. Resident #281□s attending physician was notified that the facility failed to administer Sevelamer Carbonate with meals per physician order. Additionally, Resident #281□s medication orders have been changed to allow for proper administration of medication prior to departure for	

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F 684	Continued From page 22 No further information was provided to the surveyor prior to the exit conference on 11/16/18. 2. The facility staff failed to obtain physician ordered daily weights on Resident #179. Resident #179 was readmitted to the facility on 9/22/18 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/18/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #179 was also coded as requiring supervision of 1 staff member for dressing and limited assistance of 1 staff member for personal hygiene. The surveyor performed a clinical record review on 11/15 and 11/16/18. During this review, the surveyor noted the following physician order: " Daily weight one time a day for fluid retention. Order date was documented as being 10/7/18, discontinued on 10/22/18 and then reordered by the physician on 10/22/18 to restart on 10/23/18. The surveyor also reviewed the resident's MAR (Medication Administration Record for October and November 2018. There were no weights documented on the following dates: 10/7/18, 10/10/18 and 10/29/18. The surveyor notified the administrative team of the above documented findings on 11/16/18 at approximately 2 pm. No further information was provided to the surveyor prior to the exit conference on 11/16/18. 3. The facility staff failed to obtain finger stick	F 684	dialysis, with meals. A facility Medication Error form was completed for these incidents. Identification of Deficient Practices/Corrective Action(s): All other residents may have been potentially affected. The DON and Unit Managers will conduct a 100% audit of all resident□s physician orders and MAR□s over the past 30 days to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. Systemic Change(s): The facility policy and procedure has been reviewed and revisions have been made; the medication block times have been deleted so that medications are given specific administration times with a grace-period one hour before and one hour after. Licensed staff will be in-serviced by the DON and/or designee on these changes to the medication administration program. The DON and/or designee will also in-service all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. Monitoring: The DON will be responsible for	

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F 684	Continued From page 23 blood sugars as ordered by the physician for Resident #80. Resident #80 was readmitted to the facility on 10/19/15 with the following diagnoses of, but not limited to anemia, high blood pressure, heart failure and diabetes. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/12/18, the resident was coded as having their short term and long-term memory ok. The resident was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing. The surveyor conducted a clinical record review on 11/15 and 11/16/18 on Resident #80. During this review, the surveyor noted a physician ordered which stated, " ...Accuchecks AC (before meals) and HS (at bedtime) ..." The surveyor reviewed the MAR (Medication Administration Record) for October and November 2018 on Resident #80 and noted the following: No accucheck documented for the evening time on 10/5/18. No accucheck documented for the mid-D (mid-day) on 11/12/18. On 11/16/18 at 1:51 pm, the surveyor notified the facility pharmacist, administrator and director of nursing of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 11/16/18. 4. The facility staff failed to follow physician's orders for sliding scale Novolog for Resident # 209. Resident # 209 was an 87-year-old-female who was admitted to the facility on 10/24/18.	F 684	maintaining compliance. The DON, ADON and/or Unit Managers will perform daily MAR/TAR and Point-of-Care audits (ADL and non-skilled C.N.A. care) to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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Diagnoses included but were not limited to: type 2 diabetes mellitus, anemia, hypertension, and hypothyroidism.

The clinical record for Resident # 209 was reviewed on 11/14/18 at 2:13 pm. The most recent MDS (minimum data set) assessment was a 14-day scheduled assessment with an ARD (assessment reference date) of 11/7/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 209 had a BIMS score (brief interview for mental status) of 9 out of 15, which indicated that Resident # 209's cognitive status was moderately impaired. Section N of the MDS assesses medications. In Section N0350, the facility staff documented that Resident # 209 had received insulin injections for 7 days during the lookback period for the 11/7/18 ARD.

The current plan of care for Resident # 209 was reviewed and revised on 11/6/18. The facility staff documented a focus area for Resident # 209 as, "Resident # 209 has dx (diagnosis) of diabetes mellitus and is on insulin." Interventions included but were not limited to: "Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Orders may change from time secondary to labs."

Resident # 209 had orders for" Accuchecks ACHS (before meals and hour of sleep) & PRN (as needed)" that were initiated by the physician on 10/24/18 and orders that were initiated by the physician on 11/12/18 for "Novolog flex pen solution Pen-Injector 100 unit/ML (milliliter) (Insulin Aspart) Inject as per sliding scale:

If 0-64 = 0 units Hypoglycemia/notify physician

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65-199 = 0 units
200-250 = 4 units
251-300 = 6 units
301-350 = 8 units
351-400 = 10 units
401-450 = 12 units
451-500 = 15 units
501+ = 0 units Notify physician,
Subcutaneously every 6 hours as needed for Diabetes mellitus."

The surveyor reviewed Resident # 209's medication administration record for November 2018 and observed Resident # 209 did not receive Novolog per physician's order on the following dates:

11/1/18 MID-D (mid-day) BS (blood sugar) 281. There was no documented Novolog coverage. Resident # 209 should have received 6 units of Novolog.

11/2/18 MID-D BS 204. There was no documented Novolog coverage. Resident # 209 should have received 4 units of Novolog.

11/3/18 MID-D BS 310. There was no documented Novolog coverage. Resident # 209 should have received 8 units of Novolog.

11/4/18 MID-D BS 216. There was no documented Novolog coverage. Resident # 209 should have received 4 units of Novolog.

11/5/18 MID-D BS 219. There was no documented Novolog coverage. Resident # 209 should have received 4 units of Novolog.

11/8/18 MID-D BS 245. There was no

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documented Novolog coverage. Resident # 209 should have received 4 units of Novolog.

11/10/18 MID-D BS 240. There was no documented Novolog coverage. Resident # 209 should have received 4 units of Novolog.

11/11/18 MID-D BS 205. There was no documented Novolog coverage. Resident # 209 should have received 4 units of Novolog.

11/12/18 MID-D BS 202. There was no documented Novolog coverage. Resident # 209 should have received 4 units of Novolog.

11/13/18 MID-D BS 204. There was no documented Novolog coverage. Resident # 209 should have received 4 units of Novolog.

11/15/18 MID-D BS 236. There was no documented Novolog coverage. Resident # 209 should have received 4 units of Novolog.

On 11/16/18 at 12:15 pm, the surveyor spoke with the director of nursing about the accucheck orders and Novolog orders for Resident # 209. The director of nursing reviewed the accucheck orders and Novolog sliding scale orders and agreed that the orders for accuchecks achs & prn were not consistent with the orders for Novolog sliding scale every 6 hours as needed. The director of nursing also reviewed the "MID-D blood sugars on the November 2018 medication administration record and agreed that Resident # 209 did not receive insulin coverage as ordered by the physician.

On 11/16/18 at 1:51 pm, the facility pharmacist reviewed accucheck orders and Novolog sliding

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scale orders and agreed that the orders for accuchecks achs & prn were not consistent with the orders for Novolog sliding scale every 6 hours as needed. The facility pharmacist also reviewed the "MID-D blood sugars on the November 2018 medication administration record and agreed that Resident # 209 did not receive insulin coverage as ordered by the physician.

The facility policy on "Administering Medications" contained documentation that included but was not limited to:

..."Procedure
3. Medications must be administered in accordance with the orders, including any required time frame." ...

On 11/16/18 at 3:45 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 11/16/18.

5. The facility staff failed to obtain daily weights per physician's orders for Resident # 482.

Resident # 482 was an 84-year-old-male that was admitted to the facility on 11/3/18. Diagnoses included but were not limited to: heart failure, atrial fibrillation, type 2 diabetes mellitus, and hyperlipidemia.

The clinical record for Resident # 482 was reviewed on 11/15/18 at 10:20 am. During the time of the survey, there was no completed MDS (minimum data set) assessment for Resident # 482.

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The plan of care for Resident # 485 was incomplete during the time of the survey.

Resident # 482 had orders that was initiated by the physician on 11/6/18 that included but was not limited to: "Daily weights. Notify provider if 3 lb (pound) or more weight gain in 24 hrs (hours) or 5 lb or more weight gain in 1 week. One time a day for monitoring."

On 11/15/18 at 10:25 am, the surveyor reviewed the November 2018 treatment record for Resident # 482. The surveyor observed that facility staff had documented a weight of 119.4 on 11/12/18, and a weight of 119.4 on 11/14/18. The surveyor also reviewed the "Weights and Vitals" in the clinical record for Resident # 482 and observed a weight of 114 Lbs (pounds) (Standing) on 11/6/18, and 119.4 Lbs on 11/11/18.

On 11/15/18 at 2:09 pm, LPN # 1 (licensed practical nurse) reviewed the physician's orders for daily weights for Resident # 482. LPN # 1 reviewed the record along with the surveyor to review weights. LPN # 1 stated that she only saw 3 documented weights in Resident # 482's clinical record.

On 11/16/18 at 3:45 pm, the administrative team was made aware that the facility staff did not obtain daily weight per physician's orders on 11/7/18, 11/8/18, 11/9/18, 11/10/18, and 11/13/18.

No further information regarding this issue was presented to the survey team prior to the exit conference on 11/16/18.

6. For Resident # 184 the facility staff failed to administer medications as ordered by the

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physician.

The clinical record review revealed that Resident #184 had been admitted to the facility on 12/20/15 with a readmission date of 08/09/16. Diagnoses included, but were not limited to, hemiplegia, hemiparesis following cerebral infarction, type 2 diabetes mellitus, end stage kidney disease, hypertension, depression and constipation.

The clinical record for Resident #184 was reviewed on 11/15/18 at 3:00pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 10/10/18 coded the Resident as 12 of 15 in section C, cognitive patterns.

Resident #184's CCP (comprehensive care plan) was reviewed and contained a focus areas for: "Resident is receiving anticoagulant therapy and antiplatelet therapy ..."; "Resident has the potential for complications and abnormal labs related to altered cardiovascular status ...."; "Resident needs Dialysis r/t (related to) ESRD (end stage renal disease) ..."; has interventions that included but were not limited to, "Give medications per order ....", and "Supplement as ordered".

Resident #184's clinical record was reviewed on 11/15/18. It contained a POS (physician's order summary) which read in part: " Dialysis 3 times a week TTS (Tuesday, Thursday, and Saturday) 6:55 AM per dialysis schedule ...; Zoloft Tablet 100 MG (milligrams) (Sertraline HCL) Give 1 tablet by mouth one time a day for mood; Zoloft Tablet 25 MG ...Give 1 tablet by mouth one time a day for mood ...; BusPIRone HCL Tablet 7.5MG

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Give 7.5 mg by mouth two times a day for anxiety; Eliquis Tablet 2.5 MG (Apixaban) Give 2.5mg by mouth two times a day related to UNSPECIFIED ATRIAL FIBRILATION; PhosLo Capsule 667MG (Calcium Acetate) Give 3 capsules by mouth three times a day for ESRD (end stage renal disease) administer TID (three times a day) with meals; Plavix Tablet 75MG (Clopidogrel Bisulfate) Give 1 tablet by mouth one time per day for CAD (coronary artery disease); Renal Capsule 1 MG (B Complex-C Folic Acid) Give 1 capsule by mouth one time a day for ESRD supplement".

Resident #184's eMAR (electronic medication administration record) for the month of November 2018 was reviewed and contained an entry which read in part: "Zoloft Tablet 100 MG Give 1 tablet by mouth one time a day for mood; Zoloft Tablet 25 MG Give 1 tablet by mouth one time a day for mood ...; BusPIRone HCL Tablet 7.5MG Give 7.5 mg by mouth two times a day for anxiety; Eliquis Tablet 2.5 MG Give 2.5mg by mouth two times a day related to UNSPECIFIED ATRIAL FIBRILATION; PhosLo Capsule 667MG Give 3 capsules by mouth three times a day for ESRD administer TID with meals; Plavix Tablet 75MG Give 1 tablet by mouth one time per day for CAD ; Renal Capsule 1 MG Give 1 capsule by mouth one time a day for ESRD supplement". These entries were coded "6" on 11/01/18, 11/03/18, 11/06/18, 11/08/18, 11/10/18, 11/13/18, and 11/15/18 for "AM (8am-11am)" medication administration time which is the equivalent of "medical leave of absence ".

The surveyor reported the concern to the director of nursing, assistant director of nursing, and

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administrator during meeting on 11/15/18 at approximately 3:38 pm. The surveyor asked the director of nursing the following, "The medications that are being held without a physician's order, is it important for the Resident to get these medications consistently as ordered?" The director of nursing replied "yes" and voiced she would talk to the prescribing physician to clarify what medications Resident #184 is supposed to receive prior to dialysis.

On 11/16/18 at 7:50 am, the surveyor was provided with an order which read in part, "May administer medications early morning due to dialysis time."

No further information was provided prior to exit.

7. For Resident # 175 the facility staff failed to administer medications as ordered by the physician and apply physician ordered TED hose.

The clinical record review revealed that Resident #175 had been admitted to the facility on 11/30/14. Diagnoses included, but were not limited to, dependence on renal dialysis, type 2 diabetes mellitus, end stage kidney disease, hypertension, anxiety and depression.

The clinical record for Resident #175 was reviewed on 11/16/18. The most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/18/18 coded the Resident as 15 of 15 in section C, cognitive patterns.

Resident #175's clinical record was reviewed on 11/16/18. It contained a POS (physician's order summary) which read in part: "Dialysis 3 times a

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week QOD (every other day) ...; TED (thromboembolic disease) hose as Resident allows. ON in the am, off at HS (hour of sleep); Reglan Tablet 5 MG (milligrams)...Give 1 tablet by mouth for gastroparesis ...; HydrALAZINE HCL Tablet 25 MG Give 1 tablet by mouth every 8 hours for HTN; Renvela Tablet 800 MG ...Give 1 tablet by mouth three times a day for ESRD (end stage renal disease)/binder ..."

Resident #184's eMAR (electronic medication administration record) for the month of November 2018 was reviewed and contained an entry which read in part, "Reglan Tablet 5 MG ...Give 1 tablet by mouth for gastroparesis ...; HydrALAZINE HCL Tablet 25 MG Give 1 tablet by mouth every 8 hours for HTN (hypertension); Renvela Tablet 800 MG ...Give 1 tablet by mouth three times a day for ESRD/binder". These entries were coded "6" on 11/02/18, 11/05/18, 11/07/18, 11/09/18, and 11/12/18 for "MID-D (mid-day) (2pm-5pm)" medication administration time which is the equivalent of "medical leave of absence ".

Resident #175's TAR (treatment administration record) for the month of November 2018 was reviewed and contained an entry which read in part, "TED hose as Resident allows. ON in AM, Off at HS ..." This entry was consistently marked as administered for the month of November at "AM" (8am-11am) administration time, including November 16th which indicated the TED hose were applied.

On 11/15/18 at 9:48am the surveyor observed Resident #175 not wearing physician ordered TED hose.

On 11/16/18 at 11:41am the surveyor observed

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Resident #175 not wearing physician ordered TED hose. RN#1 (registered nurse) on floor documented TED hose were applied on TAR. The surveyor asked Resident #175, "Why aren't you wearing your TED hose?" Resident #175 replied "They never put them on me. I have never wore them." The surveyor could not visibly locate TED hose in Resident#175's room.

The surveyor reported the concern to the director of nursing, and assistant director of nursing on 11/16/18 at approximately 1:00 pm.

No further information was provided prior to exit.

8. For Resident #109 the facility staff failed to apply physician ordered TED hose.

The clinical record review revealed that Resident #109 had been admitted to the facility on 11/03/17. Diagnoses included, but were not limited to, spinal stenosis, heart failure, dementia, atherosclerotic heart disease, muscle weakness and osteoporosis.

The clinical record for Resident #109 was reviewed on 11/16/18. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 09/25/18 coded the Resident as 13 of 15 in section C, cognitive patterns.

Resident #109's clinical record was reviewed on 11/16/18. It contained a POS (physician's order summary) which read in part: "TED Hose on every day one time a day for circulation."

Resident #109's TAR (treatment administration record) for the month of November 2018 was

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reviewed and contained an entry which read in part, "TED Hose on every day one time a day for circulation" This entry was consistently marked as administered for the month of November at "AM" (8am-11am) administration time, including November 16th which indicated the TED hose were applied.

On 11/14/18 at 12:28pm the surveyor observed Resident #109 not wearing physician ordered TED hose.

On 11/16/18 11:45am Resident did not have TED hose on. RN#1 (registered nurse) documented TED hose was applied on TAR. The surveyor asked Resident #109 "Why aren't you wearing your TED hose?" Resident #109 replied "I cannot put them on without assistance".

The surveyor reported the concern to the director of nursing, and assistant director of nursing on 11/16/18 at approximately 1:00 pm.

On 11/16/18 at 2:05pm the surveyor spoke to unit manager about the concern and she stated, "Resident #109 will take TED hose off". The surveyor asked unit manager, "Does Resident #109 have issues putting TED hose on by herself?" The unit manager stated "Resident #109 has difficulty putting them on and she cannot manage them by herself".

On 11/16/18 2:11pm. The surveyor spoke to Resident #109 and asked Resident #109, "Did staff offer to help you apply your TED hose today?" Resident #109 stated "No, they never offer". The surveyor asked Resident #109, "Did you remove your TED hose today?" Resident #109 replied, "I did not remove them today. They

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never offered to put them on".

No further information was provided prior to exit.
9. For Resident #281 facility staff failed to administer a medication to be administered with meals with meals on days the resident received dialysis treatment.

Resident #281 was admitted to the facility on 11/8/18 with diagnoses including anemia, heart failure, hypertension, gastroesophageal reflux, end stage renal disease, urinary tract infection,Alzheimer's dementia, non-Alzheimer's dementia, altered mental status, and sarcoidosis. On the admission minimum data set assessment with assessment reference date 11/15/18, the resident scored 3/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.

Clinical record review indicated the resident received hemodialysis 3 days per week. Post dialysis assessments and fistula checks were documented after each treatment. The medication administration record for November 2018 indicated a physician order for Sevelamer Carbonate 800 milligram (Renleva Tablet give 1 tablet by mouth with meals for binder take with meals, changed to Sevelamer Carbonate .8 gram on 11/10/18). Sevelamer was held 11/8, 9, and 12 at midday. Nursing progress notes said: 11/12 held for resident in dialysis; 11/9 held for resident in dialysis; and for 11/8, the resident had not arrived yet.

11/16/18 02:19 PM Spoke with LPN#1 about Resident # 281. She acknowledged that the resident had been leaving the floor for dialysis

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F 684	Continued From page 36 and was not there at lunch time on the days the medication was held. She said the resident was eating early on those days. The surveyor asked about the omission of Sevelamer carbonate with lunch on those 2 days. She said that was because the resident was not on the floor when mid day medications were administered on those days. The surveyor explained that the order said to give with meals for binder and the purpose was for the medication to bind with food substances for elimination and would be ineffective when not administered with food. The director of nursing and administrator were notified of the concern during a summary meeting on 11/16/18. The surveyor requested copies of the the resident's medication administration record and progress notes. While writing the report, the surveyor noted the medication administration record documented a new order for Sevelamer carbonate packet 0.8 gram give 1 packet by mouth two times per day every Mon, Wed, Fri for ESRD (end state renal disease) give with meals entered with start date 11/16/2018 18:00. The surveyor checked prescribing information on the manufacturer's website [Http://www.renvela.com/about-renvela/renvela-powder]. The recommended dosing is 3 times per day, daily, with meals. Intermittent dosing was not recommended. The surveyor did not have the opportunity to discuss this new concern with the administrative team.	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	F 686		12/28/18

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F 686	Continued From page 37 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, Resident interview, clinical record review, and during the course of a complaint investigation, the facility staff failed to provide treatment and services to prevent pressure ulcers for 1 of 33 Residents in the survey sample, Resident # 15. The findings included: The facility staff failed to provide wound treatments as ordered by physician, failed to ensure prevelon boots were in place as ordered by the physician, and failed to assess and notify physician of foul wound odors for Resident # 15. Resident # 15 was an 87-year-old female who was originally admitted to the facility on 11/27/16, with a readmission date of 8/2/17. Diagnoses included but were not limited to: heart failure, hypertension, atrial fibrillation, and major depressive disorder. The clinical record for Resident # 15 was reviewed on 11/14/18 at 1:27 pm. The most	F 686	F686 Corrective Action(s): Resident #15□s attending physician was notified that the contracted hospice staff failed to follow wound treatments as ordered, that the facility staff failed to ensure Prevelon boots were in place as ordered, and that the facility failed to assess Resident #15□s wound for odor. Resident #15 has had her orders reviewed and her wound assessed to reflect current needs. Due to the resident□s declining status, it was decided a wound culture would not be appropriate at this time. The C.N.A.□s assigned to care for Resident #15 on 11/14/18 and 11/15/18 have been given disciplinary action for failure to apply the Prevelon boots. A facility Incident & Accident form was completed for this incident. Identification of Deficient Practice(s) and Corrective Action(s):	

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F 686	Continued From page 38 recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 8/10/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 15 had a BIMS (brief interview for mental status) score of 12 out of 15, which indicated that Resident # 15's cognitive status was moderately impaired. Section M of the MDS assesses skin conditions. In Section M0210 the facility staff documented that Resident # 15 had one or more Stage 1 or higher pressure ulcers during the lookback period for the 8/10/18 ARD. The current plan of care for Resident # 15 was reviewed and revised on 8/24/18. The facility staff documented a focus area for Resident # 15 as, "Resident # 15 is at risk for pressure ulcer development /skin breakdown related to decreased mobility and incontinence. She is on hospice services for Dx (diagnosis) of end stage heart disease. She has puritis and scratches self till she bleeds. She is being treated for unstageable area . This area was on admission and resolved." Interventions included but was not limited to: "Follow facility policies protocols for the prevention/treatment of skin breakdown." The current orders for Resident # 15 were signed by the physician on 10/30/18. Orders included but were not limited to: "Prevalon boots to (B) (bilateral) feet at all times while in bed as resident will allow every shift for prevention," Cleanse wound to coccyx with wound cleaner twice weekly and apply mepelix one time a day every Tue, Fri for comfort care change every Tuesday and Friday per hospice," Cleanse wound to L (left) scapula with wound cleanser twice weekly and apply mepelix one time a day every Tue, Fri for	F 686	All other residents at high risk for skin breakdown or residents with active skin breakdown may have been potentially affected. The DON, ADON and/or Unit Manager will conduct daily audits on these residents to monitor for proper application of preventative measures (i.e. Prevelon boots) and will monitor two wound treatments weekly. Any negative findings will be addressed immediately and disciplinary action taken as indicated. A facility Incident and Accident form will be completed each negative finding. Systemic Change(s): The facility Policy and Procedure for Wound Care has been reviewed and no changes are warranted at this time. The facility□s licensed nursing staff and the contracted hospice nurse will be in-serviced by the DON and/or designee on the Policy & Procedure for proper application of wound treatments per physician orders and proper notification to attending physicians if changes are noted. The C.N.A. staff will be in-serviced by the DON and/or designee on the facility□s wound care program, including the preventative benefits of pressure reducing boots. Monitoring: The DON is responsible for compliance. The DON, ADON and/or Unit Manager will conduct daily audits on residents at high-risk for skin breakdown and residents with active skin breakdown to monitor for proper application of preventative measures (i.e. Prevelon	

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F 686	Continued From page 39 comfort care change every Tuesday and Friday per hospice." "Cleanse wounds to R (right) foot twice weekly with wound cleanser, apply medihoney, dry gauze and wrap one time a day every Tue, Fri for comfort care change every Tuesday and Friday per hospice," "Cleanse wounds to L (left) foot twice weekly with wound cleanser, apply medihoney, dry gauze and wrap one time a day every Tue, Fri for comfort care change every Tuesday and Friday per hospice." On 11/14/18 at 11:55 am, the surveyor noted a foul odor upon entering Resident # 15's room. Once inside Resident # 15's room, the surveyor observed a pair of blue Prevalon boots in the recliner chair in Resident # 15's room, and a pair of while lamb's wool heel protectors on the nightstand beside Resident # 15's bed. On 11/15/18 at 8:03 am, the surveyor noted a foul odor upon entering Resident # 15's room. The surveyor observed a pair of blue Prevalon boots in the recliner chair in Resident # 15's room and a pair of white lamb's wool heel protectors on the nightstand beside Resident# 15's bed. On 11/15/18 at 8:27 am, the surveyor noted a foul odor coming from Resident # 15's room while standing outside of Resident # 15's room on the other side of the hallway. On 11/15/18 at 9:34 am, two surveyors walked the hallway near Resident # 15's room and could smell a foul odor coming from Resident # 15's room. On 11/15/18 at 10:35 am, the surveyor was in Resident # 15's room with the hospice nurse RN # 1 (registered nurse) preparing to observe	F 686	boots) and will monitor two wound treatments weekly. Any/all negative findings will be addressed at time of discovery and additional inservice training and/or disciplinary with will be administered at that time. The results of the audits will be sent to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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dressing changes for Resident # 15. The surveyor noted a foul odor in the room. The surveyor also observed 2 blue Prevalon boots in the recliner chair in Resident # 15's room and a pair of while lamb's wool heel protectors Resident # 15's nightstand. The hospice nurse RN # 1 gathered the supplies and cleaned the over bed table and assembled her supplies appropriately. Hospice nurse RN # 1 pulled down Resident # 15's bed linens. The surveyor observed Resident # 15 lying in bed contracted in a fetal position. The surveyor observed that Resident # 15 was not soiled at that time. Hospice nurse RN # 1 cleaned her scissors and cut the Kerlix wrap from Resident # 15's left foot. The surveyor observed that Resident # 15 had two red open areas to the left foot and a necrotic area below the 4th and 5th toes on her left foot. Hospice nurse RN # 1 cleaned areas appropriately and covered the areas with a non adhesive dressing and wrapped Resident # 15's foot in Kerlix. The surveyor did not observe hospice nurse RN # 1 apply physician ordered medihoney to Resident # 15's wounds on her left foot.

Hospice nurse RN # 1 assessed Resident # 15 and positioned her to change the dressing on Resident # 15's right foot. The surveyor observed that the dressing to the Residents right foot was heavily soiled with dark red drainage. Hospice nurse RN # 1 cleaned her scissors and removed the kerlix wrap from Resident # 15's right foot. Upon removing the kerlix wrap from Resident # 15's right foot, the foul odor became more profound. The surveyor observed that Resident # 15 had 2 necrotic areas with slough on the lateral aspect of the right foot and an open necrotic area to the heel and an open wound to the medial aspect of the right foot. Hospice nurse RN # 1

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cleaned the areas with wound cleanser, applied alginate to the areas on the lateral right foot, covered the areas with a non adhesive dressing and wrapped Resident # 15's foot with Kerlix. The surveyor did not observe hospice nurse RN # 1 apply physician ordered medihoney to Resident # 15's wounds on her left foot.

Hospice nurse RN # 1 turned Resident # 15 to position her to provide treatment to her sacrum. The hospice nurse RN # 1 showed the surveyor a reddened uncovered area to Resident # 15's sacrum. The surveyor asked hospice nurse RN # 1 if the area to Resident # 15's sacrum was supposed to be covered with a dressing. Hospice nurse RN # 1 stated that the area was supposed to be covered but sometimes the dressings come off when they are soiled. The surveyor asked the hospice nurse RN # 1 if the facility staff are expected to reapply or change the dressings on Resident # 15 if they are soiled. Hospice nurse RN # 1 stated, "Yes." The surveyor hospice nurse RN # 1 asked about the prevelon boots that were in Resident # 15's recliner chair. Hospice nurse RN # 1 stated, "I have seen them on her one or two times, but most of the time they are over in the chair." Hospice nurse RN # 1 stated that the prevolon boots are bulky and due to Resident # 15's contractures they cause pain at times so she brought in lambs' wool heel protectors. The surveyor observed the lamb's wool heel protectors on the nightstand. The surveyor asked hospice nurse RN # 1 if the lamb's wool heel protectors are on Resident # 15 when she comes in to visit and do Resident # 15's dressing changes. Hospice nurse RN # 1 stated, "No." The hospice nurse RN # 1 asked Resident # 15 in the presence of the surveyor if the facility staff puts the prevalon boots or lamb's wool heel protectors

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on her heels. Resident # 15 stated, "No." Hospice nurse RN # 1 asked Resident # 15 if she is requesting not to have the boots on, Resident # 15 stated, "It doesn't matter to me."

Hospice nurse RN # 1 stated that due to Resident # 15's contractures, her dressings get soiled often. Hospice nurse RN # 1 turned Resident # 15 to her right side. Once Resident # 15 was turned on her right side, the surveyor observed a large non-adhesive dressing on Resident # 15's left upper back. The surveyor observed a large amount of dark red drainage on the non-adhesive dressing on Resident # 15's left upper back. Hospice nurse RN # 1 removed the dressing to Resident # 15's left upper back and surveyor observed a large circular area with slough about the size of a fifty-cent piece on Resident # 15's left upper back. Hospice nurse RN # 1 cleaned area appropriately and covered the area with a non-adhesive dressing.

On 11/15/18 at 11:25 am, the surveyor interviewed hospice nurse RN # 1. The surveyor interviewed hospice nurse RN # 1 about the foul odor from Resident # 15's wounds. The surveyor asked hospice nurse RN # 1how long has the Resident # 15 has had the odor. Hospice nurse RN # 1 stated, "As long as I have been seeing her and that has been a little over a month." The nurse asked if the areas have been cultured to determine if there is an infection. Hospice nurse RN # 1 stated, "No."

On 11/15/18 at 11:40 am, the surveyor reviewed the clinical record for Resident # 15 and could not find any documentation of foul odor from Resident # 15's wounds. The surveyor also reviewed the November 2018 treatment

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administration record for Resident # 15 and observed that facility staff had documented that Prevalon boots were in place on Resident # 15 for 11/14/18 and 11/15/18 when the surveyor observed that the Prevalon boots were not in place on Resident # 15.

On 11/15/18 at 3:00 pm, the administrative team was made aware of the foul odor from Resident # 15's wounds and that there was no documentation found in the clinical record regarding the foul odor to Resident # 15's wounds.

On 11/16/18 at 8:20 am, the director of nursing approached the surveyor and stated that she had spoken to hospice and gotten an order to use peppermint oil in attempts to mask the odor coming from Resident # 15's wounds and that Resident # 15's plan of care had been updated. The surveyor asked the director of nursing if she had been able to locate any documentation in Resident # 15's clinical record about the foul odor to Resident # 15's wounds. The director of nursing stated, "No." The surveyor asked the director of nursing if the staff nurses care for Resident # 15's wounds. The director of nursing stated, "No." The surveyor asked the director of nursing if Resident # 15's dressings fell off or became soiled would she expect the staff nurses to replace the dressings. The director of nursing stated, "Yes."

On 11/16/18 at 3:45 pm, the administrative team was made aware of all 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 686	Continued From page 44 conference on 11/16/18. This is a complaint deficiency.	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, staff interview, and facility document review, the facility staff failed to ensure that 1 of 33 Residents in the survey sample was free of accident hazards, Resident # 2. The findings included: The facility staff failed to ensure that oxygen cylinders were appropriately stored in Resident # 2's room. Resident # 2 was a 73-year-old female who was admitted to the facility on 7/8/14 with a readmission date of 10/31/18. Diagnoses included but were not limited to: COPD (chronic obstructive pulmonary disease), chronic respiratory failure, anxiety disorder, and hypertension. The clinical record for resident # 2 was reviewed on 11/14/18 at 2:56 pm. The most recent MDS (minimum data set) assessment was a 5-day	F 689	F689 Corrective Action(s): Resident #2 shared with facility staff that these oxygen cylinders had been brought from home and that staff were not aware of their presence in her closet. Regardless, these oxygen cylinders were removed and properly secured. Identification of Deficient Practices/Corrective Action(s): All other residents with physician ordered portable oxygen may have been affected. An audit has been completed to ensure that there are no unsecured oxygen cylinders present in their room or closet space. Additionally, an audit of the oxygen storage closets has been completed to ensure oxygen cylinders are properly stored. Negative findings will be corrected at the time of discovery with disciplinary action given, as appropriate.	12/28/18

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F 689	Continued From page 45 scheduled assessment with an ARD (assessment reference date) of 11/7/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 2 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 2 was cognitively intact. Section O assesses special treatments, procedures, and programs. In Section O0100, the facility staff documented that Resident # 3 received oxygen therapy during the lookback period for the 11/7/18 ARD. The plan of care for Resident # 2 was reviewed and revised on 11/9/18. The facility staff documented a focus area for Resident # 2 as, "Resident # 2 has a dx (diagnosis) of COPD and uses O2 and nebulizer treatments." Interventions included but were not limited to: "Give oxygen therapy/neb treatments as ordered by the physician." Resident # 2 had orders that were initiated by the physician on 10/31/18 for "Oxygen continuous @ (at) 3 LPM (liters per minute) per N/C (nasal cannula) every shift for COPD. On 11/14/18 at 3:41 pm, the surveyor was in Resident # 2's room conducting a Resident interview. Resident # 2 stated that she was cold and asked the surveyor to look in her closet and see if she had a blanket in the closet. Upon opening the closet, the surveyor observed 3 empty oxygen cylinders and 2 full oxygen cylinders lying unsecured on the shelves in Resident # 2's closet. On 11/16/18 at 8:33 am, the surveyor and LPN # 2 (licensed practical nurse) went into Resident #	F 689	Systemic Change(s): The facility policy and procedure for oxygen equipment has been reviewed and no revisions are warranted at this time. The DON and/or designee will in-service all nursing staff on the oxygen equipment policy which includes directives on storage of both empty and full cylinder storage. Monitoring: The DON is responsible for maintaining compliance. The DON and/or designee will perform daily audits of the rooms of residents with physician ordered portable oxygen and oxygen storage rooms to Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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F 689	Continued From page 46 2's room and was given permission by Resident # 2 to look in her closet. Upon opening the closet, the surveyor along with LPN # 2 observed 5 oxygen cylinders lying on the shelves in the closet. The surveyor and LPN # 2 observed 3 empty cylinders and 2 full cylinders lying unsecured on the shelves in the closet. The surveyor asked LPN # 2 if this was the correct way to store oxygen cylinders. LPN # 2 stated, "No they are supposed to be secured." The facility policy on "oxygen Equipment" contained documentation that included but was not limited to: ..."Procedures: 1. Maintain proper storage, internal transportation and use of oxygen cylinders. Oxygen cylinders must be kept secure. a. Do not allow oxygen cylinder to be overturned or sustain a blow that may break off the top. b. Tanks must be in a cart or stand made for the type of tank being used or stored in a rack. 2. Oxygen storage areas must have designated "Empty" and "Full" cylinder storage areas." ... On 11/16/18 at 3:45 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 11/16/18.	F 689		
F 690 SS=D	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	F 690		12/28/18

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F 690	Continued From page 47 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and clinical record review, the facility staff failed to provide treatment to prevent urinary tract infections for 2 of 33 Residents in the survey sample, Resident # 180 and Resident # 36. 1. The findings included:	F 690	F690 Corrective Action(s): Resident #180 has had his suprapubic catheter orders reviewed and updated to included orders for the proper catheter and bulb size. Additionally, the catheter is now secured per policy and procedure to	

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F 690	Continued From page 48 The facility staff failed to ensure that Resident # 180 had orders for suprapubic catheter that included catheter and bulb size and failed to ensure that Resident # 180's suprapubic catheter was secured. Resident # 180 was a 69-year-old-male who was admitted to the facility on 10/10/18. Diagnoses included but were not limited to: end stage renal disease, hypertension, gout, and anemia. The clinical record for Resident # 180 was reviewed on 11/14/18 at 2:40 pm. The most recent MDS (minimum data set) assessment for Resident # 180 was an admission assessment with an ARD (assessment reference date) of 10/18/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 180 had a BIMS score (brief interview for mental status) of 15 out of 15 which indicated that Resident # 180 was cognitively intact. Section H of the MDS assesses bladder and bowel. In Section H0100, the facility staff documented that Resident # 180 had an indwelling catheter (including suprapubic catheter and nephrostomy tube) during the lookback period for the 10/18/18 ARD. The current plan of care for Resident # 180 was reviewed and revised on 10/31/18. The facility staff documented a focus area for Resident # 180 as "Resident # 180 has an actual alteration in bladder elimination and utilize a suprapubic catheter. The need for catheterization is related to BPH (benign prostatic hyperplasia) with obstruction." Interventions included but were not limited to: "Change cath strap 2 times a week and prn (as needed)."	F 690	prevent infection and injury. Resident #36 has had his Foley catheter orders reviewed and updated to include orders for the proper bulb and balloon size. Identification of Deficient Practice(s) and Corrective Action(s): All other residents with a suprapubic or Foley catheter may have been potentially affected. The DON and/or designee will conduct a 100% review of all residents orders with a suprapubic or Foley catheter to ensure proper orders. Residents identified will be corrected at time of discovery and a Facility Incident & Accident Form will be completed. Systemic Change(s): The facility Policy and Procedure for Foley Catheter usage and Foley Catheter Care has been reviewed and no changes are warranted at this time. The nursing staff will be in-serviced by the DON on the policy and procedures for proper Foley Catheter Orders, to include proper bulb and balloon size, and care to include the proper anchoring of catheter tubing. Monitoring: The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will conduct weekly audits of all suprapubic and Foley Catheters to ensure compliance with anchoring of tubing and to ensure orders are comprehensive. All negative findings will be corrected at time of discovery.	

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F 690	Continued From page 49 Resident # 180 had orders that were initiated by the physician on 10/10/18. Orders included but were not limited to: "Foley cath care & check cath secure placement Q (every) shift, "and "Suprapubic Foley usage for BPH/Obstructive uropathy (including French size & mL (milliliter) balloon" On 11/15/18 at 8:19am, the surveyor was in Resident # 180's room conducting a Resident interview. The surveyor asked Resident # 180 if he could show the surveyor his catheter. Resident # 180 independently stood from the bed without assistance, pulled down his pants and showed the surveyor his suprapubic catheter that had been inserted into the lower abdominal area. The surveyor observed that Resident # 180's suprapubic catheter is not secured. The surveyor asked Resident # 180 if the staff had something in place to secure his catheter. Resident # 180 stated, "That thing keeps coming off." On 11/15/18 at 4:00 pm, the surveyor reviewed the clinical record for Resident # 180 and observed that the facility staff had documented "Foley cath care & check cath secure placement Q shift" for 11/15/18 for "Day 6" (6am) and "Eve 2" (evening 2 pm). The surveyor also reviewed the clinical record for Resident # 180 and did not locate any documented orders that included the French size & mL balloon per physician's orders. On 11/16/18 at 3:45 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 of 11/16/18.	F 690	Detailed findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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F 690	Continued From page 50	F 690		

2. For Resident #36 the facility staff failed to obtain a physician's order containing Foley catheter bulb and balloon size to appropriately care and administer treatment.

The clinical record review revealed that Resident #36 had been admitted to the facility on 06/14/18 with a readmission date of 08/03/18. Diagnoses included, but were not limited to, sepsis, obstructed and reflux uropathy, type 2 diabetes mellitus, acute kidney failure, hypertension, and benign prostatic hyperplasia with lower urinary tract symptoms.

The clinical record for Resident #36 was reviewed on 11/15/18 at 3:15pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 08/22/18 coded the Resident as 15 of 15 in section C, cognitive patterns.

Resident #36's clinical record was reviewed on 11/15/18. It contained a POS (physician's order summary) which read in part: "Change foley cath (catheter), tubing Q (every) month on the 1st and PRN (as needed) for clogged tube or absence of easy drainage..." The surveyor observed that there is no catheter and bulb size documented with the order.

On 11/15/18 at 9:47am, the surveyor was given permission by Resident # 36 to look at his foley catheter. The surveyor observed a 16FR (French) with 10cc (cubic centimeter) bulb. The surveyor observed the Foley catheter was secured to Resident # 36's left leg.

LPN (licensed practical nurse) #1's progress note dated 10/11/18 at 3:02pm which read in part, "

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F 690	Continued From page 51 ...Foley catheter changed due to leaking and minimal drainage to bag. Foley changed while maintaining sterile technique ..." LPN #2's progress note dated 10/27/18 at 1:24am read in part, " .... Inserted new catheter using sterile technique. Immediately got a flow of straw colored urine draining into bag. Resident tolerated well. Secured catheter to left leg with cath secure ..." The surveyor requested and was provided with a copy of the policy entitled "Foley catheter care" on 11/16/18. The policy read in part under section 3, " To reinsert catheter: Assemble items needed, (correct size catheter and catheter kit) using sterile technique insert catheter, replace and reconnect clean drainage bag, document date and time catheter changed, note catheter and balloon size being inserted." ... The surveyor reported the concern to the director of nursing, assistant director of nursing, and administrator during meeting on 11/15/18 at approximately 3:38 pm. No further information was provided prior to exit.	F 690		
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:	F 697		12/28/18

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F 697	Continued From page 52 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 1 of 33 Residents in the survey sample, Resident # 481. 1. The findings included: The facility staff failed to provided non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident # 481. Resident # 481 was an 88-year-old female who was admitted to the facility on 11/1/18. Diagnoses included but were not limited to: type 2 diabetes mellitus, hypertension, urinary retention, and fracture of third lumbar vertebra. The clinical record for Resident # 481 was reviewed on 11/14/18 at 2:04 pm. The most recent MDS (minimum data set) assessment was a 5-day scheduled assessment with an ARD (assessment reference date) of 11/8/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 481 had a BIMS score (brief interview for mental status) of 11 out of 15 which indicated that Resident # 481's cognitive status was moderately impaired. The admission plan of care for Resident # 481 was initiated on 11/1/18. The facility staff documented a focus area for Resident # 481 as "Pain." Interventions included but were not limited to, "Non-drug interventions." Resident # 481 had current orders that were	F 697	F697 Corrective Action(s): Resident #481□s attending physician was notified that the facility failed to document non-pharmacological interventions for pain management prior to administration of pain medication. A medication error form has been completed for this incident. Identification of Deficient Practices/Corrective Action(s): All other residents receiving pain medications may have been potentially affected. The DON, ADON, and/or Unit Manager will conduct a 100% audit of all resident□s receiving pain medications to identify residents at risk for having failed to receive non-pharmacological interventions to pain prior to the administration of pain medications. Residents identified at risk will have their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. Systemic Change(s): The facility policy and procedures for pain management has been reviewed and no changes are warranted at this time. The DON and/or designee will in-service all licensed nursing staff on the procedure for offering non-pharmacological interventions to residents for pain management prior to administering pain medication, per resident care plan interventions.	

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F 697	Continued From page 53 signed by the physician on 11/7/18. Orders included but were not limited to: "Tramadol HCl Tablet 10 mg (milligram) Give 1 tablet by mouth every 6 hours as needed for pain." On 11/16/18 at 9:31 am, the surveyor spoke with LPN # 2 (licensed practical nurse) and asked where non-pharmacological interventions for pain are documented in the clinical record. LPN # 2 stated to the surveyor that she documents the in the progress notes if any non-pharmacological interventions are applied. The surveyor reviewed the progress notes for Resident # 481 and did not locate any documentation of non-pharmacological interventions attempted prior to the administration of Tramadol HCl prn for Resident # 481 on the following dates: 11/2/18 at 9:57 am 11/3/18 at 5:20 am 11/4/18 at 4:25 am 11/4/18 at 1:45 pm 11/5/18 at 12:06 am 11/5/18 at 8:20 am 11/5/18 at 10:24 pm 11/6/18 at 9:37 am 11/6/18 at 7:51 pm 11/7/18 at 2:35 am 11/7/18 at 8:47 am 11/7/18 at 9:04 pm 11/8/18 at 4:09 am 11/10/18 at 9:54 am 11/12/18 at 9:40 am 11/12/18 5:10 pm 11/13/18 at 7:50 pm 11/14/18 at 11:53 am On 11/16/18 at 3:45 pm, the administrative team was made aware of the findings as stated above.	F 697	Monitoring: The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Manager will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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F 697	Continued From page 54 No further information regarding this issue was presented to the survey team prior to the exit conference on 11/16/18.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to have complete and accurate post documentation on the dialysis communication form for 1 of 38 residents in the survey sample (Resident #72). The findings included: Resident #72 was readmitted to the facility on 8/4/18 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia, depression, manic depression and status post hip fracture. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/11/18 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #72 was also coded as requiring extensive assistance of dressing, personal hygiene and bathing. The surveyor performed a clinical record review on Resident #73 on 11/15/18. During this review, the surveyor noted incomplete documentation on	F 698	F698 Corrective Action(s): Resident #72□s attending physician was notified that the facility failed to document appropriately on the post dialysis assessment. A facility Incident and Accident form was completed for this incident. Resident #73 should have been Resident #72. Identification of Deficient Practices/Corrective Action(s): All other residents receiving dialysis may have been potentially affected. The DON, ADON and/or unit managers will conduct a 100% audit of all resident residents receiving dialysis treatment to identify residents at risk for not having their post dialysis assessments completed appropriately. Residents identified at risk will be corrected at time of discovery with	12/28/18

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F 698	Continued From page 55 the dialysis communication sheets that are to be completed pre/post dialysis. The following dates had no documentation by nursing in the post dialysis section of the communication form: 11/12/18, 11/9/18, 10/29/18, 10/24/18and 10/9/18. On 11/15/18 at approximately 5:30 pm, the surveyor notified the unit manager #1 of the above documented findings. Unit Manager #1 stated, "I can see where there is no documentation by nursing for the post dialysis assessments." The surveyor notified the administrative team of the above documented findings on 11/16/18 at 1:50 pm. No further information was provided to the surveyor prior to the exit conference on 11/16/18.	F 698	their attending physicians notified. A facility Incident & Accident Form will be completed for each negative finding. Systemic Change(s): Facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record & physician orders remains the source document for the development and monitoring of the provision of care, which includes proper assessment of patients after dialysis treatment. The DON will in-service all licensed staff on the procedure for completing post dialysis assessments per physician orders. Monitoring: The DON will be responsible for maintaining compliance. The DON and/or designee will conduct chart audits weekly to ensure post dialysis assessments are being completed properly. Any/all negative findings and or errors will be corrected at time of discovery, disciplinary action will be taken as needed and the attending physician notified. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		12/28/18

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F 761	Continued From page 56 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to store, label and discard medications after the expiration date on 1 of 8 nursing units in the nursing facility (Unit 3 Main). The findings included: The facility staff failed to store, label and discard medications after the expiration date on Unit 3. On 11/15/18 at 9:32 am, the surveyor observed the following on the medication cart on Unit 3: " Found 3 bottles in boxes with no labels on	F 761	F761 Corrective Action(s): The eye drops Prolensa, Durezol, Besivance, and Combigen have been discarded. The Levothroxin, Metoprolol, and Docusate Sodium found in the 5th drawer have been discarded. The Novalog Flexpens found in the 1st drawer have been discarded with new vials obtained per physician orders.	

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	495092	A. BUILDING _____ B. WING _____	C 11/16/2018

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F 761	Continued From page 57 them with directions for staff on use of the following eye drops: 1. Prolensa 0.007% bottle 0.6 ml (3 bottles) eye drops 2. Durezol 0.5% (1 bottle) (eye drops) 3. Besivance 0.6% 2 ml (1 bottle) (eye drops) " Found 1 label loose in the bottom of the bag that the above meds were in. The label stated the resident's name, Combigen eye drops Left eye 5 ml Dispensed from pharmacy 1/2/18. " Found the following meds in the 5th drawer loose and not in a container for a specific resident. These were still in the original packet and labeled as to what medication it is: 1. Levothroxine 100 mcg 1 pill 2. Metoprolol 25 mg 1 pill 3. Doscate Sodium 8.6/50mg " The following insulins were found in the 1st drawer: 1. Novalog Flexpen date opened 10/5/18 2. Novalog Flexpen date opened 10/13/18 The surveyor notified unit manager #1 of the above documented findings at 10 am. Unit Manager #1 stated, "Let me go and talk to the resident about these eye drops and I will get back to you." At 10:15 am, unit manager #1 returned to the surveyor and stated, "I spoke to the resident and she told me she hasn't used the eye drops since February of this year. The insulins that were in the medication cart should had been discarded when they expired."	F 761	Identification of Deficient Practices & Corrective Action(s): All other Medications may have potentially been affected. The DON and/or designee will conduct a 100% review of all medication carts and medication rooms to identify any existing mislabeled, expired or discontinued medications. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Accident form will be completed for each incident identified. Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. The licensed nursing staff will be in-serviced by the pharmacy consultant and/or DON on the policy for monitoring medications to ensure proper labeling, dating and removal of all expired or discontinued medications and supplies from the medication carts and medication room. Monitoring: The DON is responsible for maintaining compliance. The DON or Unit Manager will perform weekly audits of all medication rooms and medication carts to ensure that medications are being labeled and dated appropriately and that all expired or discontinued medications are being removed per protocol. Detail findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or	

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F 761	Continued From page 58 At 10:30 am, the surveyor notified the director of nursing, assistant director of nursing and the administrator of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 11/16/18.	F 761	practice.	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to obtain a physician order prior to performing a laboratory test for 1 of 38 residents in the survey sample (Resident #80). The findings included: Resident #80 was readmitted to the facility on 10/19/15 with the following diagnoses of, but not limited to anemia, high blood pressure, heart failure and diabetes. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/12/18, the resident was	F 773	F773 Corrective Action(s): Resident #80□s attending physician has been notified that the facility obtained a Comprehensive Metabolic Panel and a Lipid Profile without a physician order. A facility Incident & Accident form has been completed for this incident. Identification of Deficient Practices/Corrective Action(s): All other residents may have potentially been affected. A 100% audit of resident clinical records will be completed to	12/28/18

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F 773	Continued From page 59 coded as having their short term and long-term memory ok. The resident was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing. During the initial tour on 11/14/18 at 1 pm, the surveyor conducted a resident interview in which the resident stated, "They just draw my blood a lot here recently. I don't believe the doctors have been ordering bloodwork like that. Could you check into that for me?" The surveyor performed a clinical record review on Resident #80 on 11/15 thru 11/16/18. During the clinical record review, the surveyor noted that on 11/5/18 the resident had the following laboratory tests results in the clinical record: Comprehensive Metabolic Panel and Lipid Profile. There was not a physician order for these laboratory tests to be performed in the clinical record. On 11/16/18 at 2:30 pm, the surveyor notified the director of nursing (DON) of the above documented findings. At 3 pm, the DON stated to the surveyor, "These labs should had been drawn on 12/3/18. I believe what happened was our usual lab person was off that week. The person filling in did not look at the lab slip because it did have a collection date on it for 12/3/18. Instead, they went and drew this lab on 11/5/18." The surveyor notified the administrative team on 11/16/18 at approximately 3:15 pm of the above documented findings. No further information was provided to the	F 773	identify residents who have had laboratory tests completed without a physician order. All negative findings will be reported to the attending physicians. A Facility Incident & Accident form will be completed for each incident. Systemic Changes: The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed staff will be inserviced on the policy and procedure for obtaining resident laboratory tests, which includes obtaining a physician order prior to obtaining the lab test. Monitoring: The DON is responsible for maintaining compliance. The DON or ADON will review all lab tests results weekly to ensure that all resident lab tests obtained had an appropriate physician order for the lab tests prior to obtaining. Any negative findings will be reported to the attending physician and the appropriate disciplinary action taken for staff involved. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice.	

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F 773	Continued From page 60 surveyor prior to the exit conference on 11/16/18.	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 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	F 842		12/28/18

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F 842	Continued From page 61 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. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review the facility staff failed to maintain a complete and accurate clinical record for 1 of 38 Residents, Resident #36. The findings included: For Resident #36, the facility staff failed to sustain	F 842	F842 Corrective Action(s): Residents #36□s attending physician was notified that the facility failed to ensure that accurate weights were recorded in the clinical record. A facility Medication Error form was completed for this incident.	

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F 842	Continued From page 62 accurate documentation of the Resident's weight on the TAR (treatment administration record). The clinical record review revealed that Resident #36 had been admitted to the facility on 06/14/18 with a readmission date of 08/03/18. Diagnoses included, but were not limited to, sepsis, obstructed and reflux uropathy, type 2 diabetes mellitus, acute kidney failure, hypertension, and benign prostatic hyperplasia with lower urinary tract symptoms. The clinical record for Resident #36 was reviewed on 11/15/18 at 3:15pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 08/22/18 coded the Resident as 15 of 15 in section C, cognitive patterns. Resident #36's clinical record was reviewed on 11/15/18. It contained a POS (physician's order summary) which read in part: "Weight on shower days Monday and Thursdays...." Resident #36's TAR (treatment administration record) for the month of November 2018 was reviewed and contained an entry which read in part, "Weight on shower days Monday and Thursdays...."127 (127 pounds) was entered under wt (weight) column for 11/01/18. 127.2 (127.2 pounds) was entered under wt (weight) column for 11/05/18. The TAR was coded "RI" indicating refused/informed consent for entries on 11/08/18 and 11/12/18. The surveyor noted an entry under "weight summary" dated 11/01/18 at 12:41pm for Resident #36 which read in part, "167.5 LBS (pounds) (mechanical lift)".	F 842	Identification of Deficient Practices/Corrective Action(s): All other residents with orders to obtain weights may have been potentially affected. The DON, ADON, and/or designee will conduct a 100% audit of all residents with orders to obtain weights to ensure that weights are entered into the clinical record appropriately. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. Systemic Change(s): The facility procedure for inputting resident weights into the clinical record has been reviewed with no changes warranted at this time. The DON and/or designee will in-service all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders including, specifically, inputting accurate resident weights into the clinical record so as to provide improved care to the residents. Monitoring: The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform weekly audits during Risk Management to monitor for compliance for ensuring	

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F 842	Continued From page 63 The surveyor noted an entry under "weight summary" dated 11/01/18 at 12:41pm for Resident #36 which read in part, "166.4 LBS (pounds) (mechanical lift)". On 11/16/18 at 11:35am the surveyor reviewed the above findings with the unit manager. The unit manager voiced that the weights documented on Resident #36's TAR was not accurate. The surveyor requested the unit manager to weigh the Resident. The surveyor reported the concern to the director of nursing, and assistant director of nursing on 11/16/18 at approximately 1:00 pm. On 11/16/18 at 2:40pm the unit manager reported to the surveyor that Resident #36 weighed 170 pounds. Resident was weighed via mechanical lift. No further information was provided prior to exit.	F 842	weights are entered into the chart appropriately. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	