

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/05/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CARRINGTON PLACE AT RURAL RETREAT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>514 NORTH MAIN STREET RURAL RETREAT, VA 24368</b>
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E 000	Initial Comments  An unannounced Emergency Preparedness survey was conducted 02/26/19 through 03/05/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Two complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS  An unannounced Medicare/Medicaid certification survey was conducted 2/26/19 through 3/5/19. Complaints were investigated during the survey. Corrections are required for compliance with the following Federal Long Term Care requirements. The Life Safety Code survey/report will follow.	F 000		
F 554 SS=D	<p>The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of 26 current Resident reviews and 2 closed record reviews.</p> <p>Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)</p> <p>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to assess 1 of 28 residents for medication self-administration (Resident #3).</p> <p>The findings included:  The facility staff failed to assess Resident #3 for self-administration of saline nasal spray.</p>	F 554	Resident #3 has been assessed by the Director of Nursing/Designee and Practitioner for the ability to safely self-administer medications. Resident #3's care plan has been updated by the Administrator/Designee to reflect the results of the assessment. Self-administration of medications will be documented by the Licensed Nurse on	4/19/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  04/18/2019
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 554	<p>Continued From page 1</p> <p>The clinical record of Resident #3 was reviewed 2/26/19 through 3/5/19. Resident #3 was admitted to the facility 4/5/17 and readmitted 1/8/19 with diagnoses that included but not limited to respiratory failure with hypoxia and hypercapnia, restless legs syndrome, diastolic heart failure, atrial fibrillation, obstructive sleep apnea, hypokalemia, constipation, idiopathic progressive neuropathy, gastro-esophageal reflux disease, hyperlipidemia, hypothyroidism, major depressive disorder, insomnia, anxiety, chronic pain syndrome, Vitamin D deficiency, benign paroxysmal vertigo, morbid obesity, hypertension, chronic obstructive pulmonary disease, type 2 diabetes mellitus, nasal congestion, and migraines.</p> <p>Resident #3's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/19 assessed the resident with a BIMS (brief interview for mental status) as 15. No evidence of delirium, behaviors affecting others or psychosis.</p> <p>A physician order dated 1/31/19 read "Doxycycline 100 mg (milligrams) bid (twice a day) x 10 days. Saline nasal spray prn (as needed). May self-administer. May keep at bedside. Voltaren gel tid (three times a day) prn-knees/hips [4g (grams)] arthralgia."</p> <p>The surveyor reviewed the clinical record and was unable to locate an assessment for self-administration of medications. The departmental note dated 1/31/19 5:24 p.m. did not have documentation of medication self-administration nor did the departmental note of 2/1/19 at 4:52 a.m., 4:13 p.m., or 4:59 p.m.</p>	F 554	<p>the Medication Administration Record.</p> <p>Residents will be interviewed and those that wish to self-administer medications will be assessed by the Director of Nursing/Designee and Practitioner to determine their ability to safely self-administer their medications. Care plans will be updated by the Administrator/Designee as indicated necessary to reflect the result of the assessment.</p> <p>Director of Nursing/Designee provided education to the Licensed Nurses on 04/17/19, 04/18/19 and 04/19/19 regarding the resident's right to self-administer medications once assessed by the Director of Nursing/Designee and Practitioner as safe to self-administer their own medications. Interviews will be conducted by the Administrator/Designee for three (3) residents with Brief Interview of Mental Status Score of 10 or greater weekly for three (3) months to determine if they wish to self-administer their medications. The review will also ensure that if they desire to self-administer meds, the resident has been assessed by the Director of Nursing/Designee and Practitioner to determine if they can safely do so and are permitted to self-administer their meds.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee</p>		

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F 554	Continued From page 2  The current comprehensive care plan dated 2/20/19 did not have medication self-administration identified.  The surveyor interviewed licensed practical nurse #1 on 3/4/19 at 3:43 p.m. The surveyor asked where the self-administration of medication assessment was located. L.P.N. #1 stated each time the resident wanted the saline spray, the nurse instructed her on the use of the medication and the medication was then documented on the medication administration record (MAR). Both the surveyor and L.P.N. #1 reviewed the February 2019 MARs. The saline order had been entered but there was no documentation that the resident had self-administered the medication.  The surveyor informed the director of nursing and the corporate registered nurse of the above concern and requested the policy on self-administration of medications on 3/4/19 at 3:45 p.m.  The surveyor reviewed the facility policy titled "Self-Administration of Medication." The policy read in part, "Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's: a. ability to read and understand medication labels; b. comprehension of the purpose and proper dosage and administration time for his or her medications; c. ability to remove medications from a container and to	F 554	Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.		

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F 554	Continued From page 3 ingest and swallow (or otherwise administer) the medication; and d. ability to recognize risks and major adverse consequences of his or her medications. 3. If the team determines that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications. 5. The staff and practitioner will document their findings and the choices of residents who are able to self-administer medications. 6. For self-administering residents, the nursing staff will determine who will be responsible (the resident or the nursing staff) for documenting that medications were taken. 12. Nursing staff will review the self-administered medication record on each nursing shift, and they will transfer pertinent information to the MAR kept at the nursing station, appropriately noting that the doses were self-administered.  The surveyor informed the administrator, director of nursing, the corporate registered nurse, the MDS regional registered nurse, and the regional executive of the above concern on 3/5/19 at 4:26 p.m.  No further information was provided prior to the exit conference on 3/5/19.	F 554			
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2)  §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:  §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe	F 557		4/19/19	

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F 557	<p>Continued From page 4 upon the rights or health and safety of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and observation, the facility staff failed to provide personal privacy for 1 of 28 residents in the survey sample (Resident #34).</p> <p>The findings included:</p> <p>Resident #34 was readmitted to the facility on 9/12/15 with the following diagnoses of, but not limited to anemia, neurogenic bladder, urinary tract infection, dementia, Multiple Sclerosis and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/17/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #34 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and being totally dependent on 2 staff members for bathing.</p> <p>On 3/1/19 at approximately 10 am, this surveyor and RN #1 (registered nurse) went into Resident #34's room. The resident was not in the bed and a CNA (certified nursing assistant) that was in the room stated that the resident was across the hallway getting a shower. This surveyor and RN #1 went across the hallway and the surveyor knocked on the door. When the CNA#1 opened the door, the surveyor and RN #1 observed the resident sitting on a shower chair with only a shirt on. The resident was left uncovered and exposed for anyone that was in the hallway to see her. RN #1 stated to the surveyor, "She should not have opened the door until the resident was</p>	F 557	<p>For Resident #34, the surveyor and RN #1 stepped into the shower room and closed the door at the time of the concern. There was no adverse effect to the resident.</p> <p>Bathing observations have been conducted for East wing and West wing by the Administrator/Designee to identify further issues with Dignity and respect during resident showers.</p> <p>Education has been provided by the Director of Nursing/Designee to nursing staff on 04/17/19, 04/18/19 and 04/19/19 including the certified nursing assistants that give showers regarding maintaining dignity and respect during bathing and showers to ensure that residents remain covered and unexposed. Observations will be conducted by the Director of Nursing/Designee on East Wing and West Wing for three (3) resident showers/baths weekly for three (3) months to ensure dignity and respect are maintained and residents remained covered and unexposed.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations</p>		

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F 557	Continued From page 5 covered."  The surveyor notified the administrative team of the above documented findings on 3/1/19 at 5:33 pm in the conference room.  No further information was provided to the surveyor prior to the exit conference on 3/5/19.	F 557	for revisions as indicated necessary to sustain substantial compliance.		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)  §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to honor 1 of 28 residents (Resident #19) preferences to sleep in a recliner and create a home-like environment for the resident.  The findings included:  The facility staff failed to provide a recliner per Resident #19's request in which to sleep.  The clinical record of Resident #19 was reviewed 2/26/19 through 3/5/19. Resident #19 was admitted to the facility 11/30/18 and readmitted 1/19/19 with diagnoses that included but not limited to methicillin resistant staphylococcus aureus, cellulitis, elevated white blood count, and anemia.	F 558	Resident #19 was provided a recliner at his bedside as well as an alternating air mattress for comfort by the Administrator/designee during the survey process. Resident #19 was interviewed by the Administrator/Designee and verbalized satisfaction with the recliner and the mattress.  Resident interviews have been conducted by the Administrator/Designee with cognitively intact residents (Brief Interview of Mental Status Score of 10 or greater) to ensure that needs and/or preferences are reasonably accommodated.  Education has been provided to the Interdisciplinary Team and nursing staff by the Administrator/Designee on 04/17/19,	4/19/19	

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F 558	<p>Continued From page 6</p> <p>Resident #19's 5-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/22/19 assessed the resident with a BIMS (brief interview for mental status) as 13/15. There were no assessed signs or symptoms of delirium, behaviors affecting others or psychosis.</p> <p>The surveyor reviewed the current comprehensive care plan for alteration in skin integrity dated 12/11/18. The care plan read, "I prefer to sleep in my recliner."</p> <p>The surveyor observed the resident and the room on each day of the survey from 2/26/19 through 3/5/19. The surveyor did not observe a recliner in the resident's room on 2/26/19 through 2/28/19.</p> <p>The surveyor interviewed the resident on 2/28/19 at 9:19 a.m. The resident was asked if he could get around the room without asking for staff's help. The resident stated, "I can get my clothes out of the chest but the girl that gives me a bath gets my clothes out of the wardrobe." The resident was asked about the comfort of the bed and asked if the bed was large enough. The resident stated he usually slept in his recliner at home.</p> <p>The surveyor observed wound care on 2/28/19 at 1:54 p.m. Resident #19 was observed in bed. Wound care performed to right great toe. The wound care nurse stated the resident had edema in both legs but has a hard time keeping the legs elevated. The wound care nurse stated the resident usually would sit in a recliner but there was no recliner in the room. The wound care nurse stated the resident had a recliner at home and at some time had a recliner in his room. The wound care nurse stated she would try to get the</p>	F 558	<p>04/18/19 and 04/20/19 . The education includes resident rights to reside and receive services in the facility with reasonable accommodation of resident's needs and preferences. Resident interviews will be conducted by the Administrator/Designee for three (3) residents weekly for three (3) months to ensure that the facility staff are providing reasonable accommodation of resident needs and preferences.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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F 558	<p>Continued From page 7</p> <p>resident a recliner and see about a bariatric bed.</p> <p>The surveyor reviewed the departmental notes from January 2019 through February 2019. On 1/3/19 12:20 p.m., the director of nursing documented that rehab was notified of increased assistance needed in repositioning in his recliner.</p> <p>Departmental note dated 1/25/19 at 6:37 a.m. read "rsdt (resident) sat up in chair at bedside this entire shift."</p> <p>Departmental note dated 1/29/19 at 5:51 a.m. read in part "RsdT is sitting up on side of bed ref (refused) to lay down."</p> <p>Departmental note dated 2/2/19 at 5:58 am read in part "RsdT ref to go to bed this shift."</p> <p>Departmental note dated 2/7/19 at 7:40 a.m. read in part "RsdT ref to go to bed most of shift finally went to bed at approx (approximately) 330 a.m. but was letting feet dangle off of bed after numerous requests to elevate them."</p> <p>Departmental note dated 2/9/19 at 3:56 a.m. read in part "RsdT is sitting up in w/c ref to go to bed until now."</p> <p>Departmental note dated 2/21/19 at 5:26 a.m. read in part "RsdT has been up this entire shift ref to go to bed."</p> <p>Resident #19 was observed on 3/4/19 at 10:00 a.m. The surveyor observed a recliner in the resident's room. Resident #19 stated, "I got my recliner. Now I need to work on my bed."</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the corporate registered nurse, the regional executive and the regional MDS registered nurse in the end of the day meeting on 3/5/19 at 4:26 p.m.</p>	F 558			



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F 558	Continued From page 8	F 558			
F 565 SS=D	<p>Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)</p> <p>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.</p> <p>§483.10(f)(6) The resident has a right to participate in family groups.</p> <p>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the</p>	F 565		4/19/19	

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F 565	<p>Continued From page 9</p> <p>families or resident representative(s) of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on Resident interview and staff interview the facility staff failed to provide adequate space for Resident Council meetings expressed by the facility's Resident Council Members.</p> <p>Findings included:</p> <p>On 02/28/19 at 11:05AM the surveyor asked the Residents during Resident council meeting "Is there enough space for everyone who wants to attend?" All in attendance: Resident #7, Resident #87, Resident #79, Resident #64, and Resident #16 voiced; "This room is too small and it's hot in here". The surveyor asked the Residents in attendance "Do you meet in this room often for Resident council meetings?" The Residents in attendance voiced that they meet in the room often for their monthly meetings.</p> <p>On 02/28/19 at 1:45PM the surveyor notified the administrator of the Resident council members' concern of inadequate space during the meeting that commenced on 02/28/19 at 11:05AM. The administrator voiced that the only reason they met in the classroom is because they needed a private room for the meeting with the surveyor and the dining rooms and activity rooms are not enclosed.</p> <p>No further information regarding this issue was provided to the survey team prior to the exit Conference on 03/05/19.</p>	F 565	<p>An adequate space has been provided for Resident Council Meetings.</p> <p>Resident interviews have been conducted by the Administrator/Designee with Resident Council Members on 04/17/19 to ensure that the space provided for Resident Council Committee Meetings to be held has adequate space and temperature.</p> <p>Education has been provided to the Interdisciplinary Team by the Administrator/Designee 04/17/19, 04/18/19 and 04/19/19 regarding ensuring that the space provided for Resident Council Committee Meeting is large enough to accommodate residents and their families that wish to attend. Observation of Resident Council Committee Meeting will be conducted by the Administrator/Designee monthly for three (3) months to ensure that the space provided for meeting accommodates those residents/families that wish to attend.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>CARRINGTON PLACE AT RURAL RETREAT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>514 NORTH MAIN STREET</b> <b>RURAL RETREAT, VA 24368</b>		
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F 565	Continued From page 10	F 565	sustain substantial compliance.	4/19/19	
F 580 SS=E	<p>Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)</p> <p>§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically</p>	F 580			

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F 580	<p>Continued From page 11</p> <p>update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, facility staff failed to notify physician or responsible party of change of condition for 5 of 28 residents in the survey sample (Residents #20, #41, #17 and #51).</p> <p>The findings included:</p> <p>1. The facility staff failed to notify the RP (responsible party) of a fall for Resident #20. Resident #20 was admitted to the facility on 8/31/18 with the following diagnoses of, but not limited to heart failure, diabetes, high blood pressure, dementia, Alzheimer's disease, depression and respiratory failure. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment reference Date) of 12/7/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. Resident #20 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and bathing.</p>	F 580	<p>For Resident #20, the physician and Responsible Party were notified by the Director of Nursing/Designee of the fall occurring on 2/25/19 during the survey process. For Resident #41, the physician and Responsible Party have been notified by Director of Nursing/Designee regarding the blood glucose reading &gt;450 on 2/11/19 at 9:00 pm. There was no adverse effect to the resident. For Resident #17, the physician and Responsible Party were notified by the Director of Nursing/Designee regarding meds not administered on 02/27/2019 at 9:00 pm including Zatador and Seroquel and on 2/28/2019 at 9:00 am that Zatador, Mobic, Propylene Glycol eye drops were not administered. The physician and Responsible Party were notified by the Director of Nursing/Designee on or before 04/19/2019 regarding the following blood glucose readings &gt;450 as well: 2/23/19 at 7:30, 11:30 on 2/1/19, 2/7/19, 2/10/2019, 2/19/2019 and 2/23/2019, 5:30pm on</p>		

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F 580	<p>Continued From page 12</p> <p>During the clinical record review of Resident #20's record, the surveyor noted the following documentation on the Nursing Communication Form that was dated and timed for "2/27/19 at 2:35 am" stated: "...resident was observed lying in floor-previous in bed and was attempting to self-transfer from the bed to the wheelchair beside bed." This fall occurred on 2/25/19 at 8:30 pm with no injuries documented by staff.</p> <p>On 2/27/19 at approximately 10 am, this surveyor called the resident's RP (responsible party). The surveyor asked the RP if she was called or notified when there was a change of condition or a fall. The RP stated, ""Your dad had a fall on 2/25/19, we have been busy and unable to call until now. The state is here."</p> <p>The surveyor notified the administrative team of the above documented findings on 2/27/19 at 5:33 pm in the conference room. The surveyor requested a copy of the falls assessment that the facility staff completed for this fall and the facility's policy for notifying the responsible party (RP)</p> <p>On 3/4/19 at 5:33 pm, the surveyor requested the above documented items from the administrative team.</p> <p>On 3/5/19 at approximately 11 am, the surveyor asked the ADON (assistant director of nursing) for the above documented items, which had been previously requested on 2/27/19 and 3/4/19. The ADON stated, "We don't have a post fall assessment for this resident. The only documentation we have is in the nurses' notes."</p> <p>On 3/5/19 at approximately 1:30 pm, the surveyor received the facility's policy titled, "Change in Resident's Condition or Status" which stated, "...the nurse will notify the resident's Attending</p>	F 580	<p>2/1/2019, 2/2/2019 and 2/8/2019. There were no adverse effects to the resident. For Resident #51, the physician and RP were notified by the Director of Nursing/Designee on or before 4/19/2019 regarding the Klonopin that was not administered for two out of the four ordered administration times on the following dates: 2/3/2019, 2/4/2019, 2/5/2019, 2/12/2019, 2/16/2019, 2/17/2019, 2/21/2019, 2/22/2019, 2/23/2019 and 2/24/2019. The medication nurse observed to drop Resident #51's Klonopin and then document notification to the physician that had not been Director of Nursing, nurse is no longer employed at the facility. There was no adverse effect to the resident.</p> <p>A review has been conducted by the Director of Nursing/Designee for residents experiencing falls in the previous thirty (30) days to ensure that the Responsible Party and Physician were notified, and notification is documented in the clinical record. A review of residents with current physician's orders for Accuchecks has been conducted by the Director of Nursing/Designee for the previous thirty (30) days to ensure that the physician was notified when notification parameters were met, and that physician notification was documented in the clinical record. A review has been conducted by the Administrator/Designee for the previous thirty (30) days of Electronic Medication Administration Records to ensure that the physician and Responsible Party have been notified of medications not</p>		

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F 580	<p>Continued From page 13</p> <p>Physician or physician on call when there has been a (an) ....accident or incident involving the resident ...Unless otherwise instructed by the resident, a nurse will notify the resident's representative ...Except in medical emergencies, notifications will be made within twenty-four (24) hours ..."</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p> <p>2. For Resident # 41, the facility staff failed to notify the physician of (blood sugars) greater than 450.</p> <p>Per clinical record review Resident #41 was admitted to the facility on 11/22/17. Diagnosis included, but were not limited to; diabetes mellitus, hypertension, hyperlipidemia, and obstructive sleep apnea.</p> <p>Section C (cognitive patterns) of the Resident's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/19/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.</p> <p>The Resident's comprehensive care plan included the problem area, "I am at risk for complications associated with hyper-or hypoglycemia". The interventions that included but were not limited to, "Monitor for s/s (signs and symptoms) of unstable blood sugar levels ...Perform Accuchecks as ordered ...Report abnormal findings to physician."</p> <p>On 03/01/19 at 2:31pm the surveyor reviewed Resident #41's record. Resident #41's physician's</p>	F 580	<p>administered and that the notifications are documented in the clinical record.</p> <p>Education has been conducted by the Director of Nursing/Designee with Licensed Nurses on 04/17/19, 04/18/19 and 04/19/19 regarding the following topics: ensuring the RP and physician are notified when a resident experiences a fall and that the notification is documented; ensuring that the physician is notified and notification is documented when blood glucose readings meet the notification parameters; ensuring that the physician and Responsible Party are notified when medications are not administered and the notification is documented in the clinical record. Additionally, Licensed nurses only document notification after the notification has been completed, not before. A review will be conducted by the Director of Nursing/Designee for three (3) residents weekly for three (3) months for the following areas. For residents experiencing incidents or falls in the previous thirty (30) days, the physician and responsible party have been notified of incidents including falls and the notification has been documented. For residents with current physicians <input type="checkbox"/> orders for accuchecks and notification parameters, the physician has been notified of blood glucose reading within the previous thirty (30) days that met specific notification parameters and the notification is documented. The physician and Responsible party have been notified of medications not administered and the notifications are documented in the</p>		

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F 580	<p>Continued From page 14</p> <p>orders contained an order dated 08/24/18 which read in part: " ACCUCHECKS BEFORE MEALS AND AT BEDTIMES NOTIFY MD (medical doctor) IF &lt;60 OR &gt;450".</p> <p>Resident #41 EMARs (electronic medication administration records) for February revealed that on 02/01/19 at 9:00pm the Residents BS (blood sugar) reading was 483.</p> <p>Per clinical record review there was no documentation to indicate that the MD had been notified.</p> <p>The surveyor reviewed the nursing progress notes and administration record "details" no notes were documented on 02/01/19.</p> <p>The surveyor spoke with the administrative team on 03/01/19 at 5:15pm regarding the concern of the physician not being notified.</p> <p>No further information regarding this issue was provided to the survey team prior to the exit Conference on 03/05/19.</p> <p>3. For Resident #17, facility staff failed to notify the physician when medications were not administered and when blood sugars were within notification parameters.</p> <p>Resident #17 was admitted to the facility on 4/19/16. Diagnoses included hypertension, gastroesophageal reflux disease, diabetes mellitus, anxiety, depression, asthma, and chronic pain. On the annual assessment with assessment reference date 2/7/17, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.</p>	F 580	<p>clinical record.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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F 580	<p>Continued From page 15</p> <p>Medication orders included Mobic 7.5 milligram one tablet by mouth daily started 1/10/19, Zatador eye drops one drop each eye twice a day, Seroquel 50 milligrams one tablet by mouth at bedtime, and propylene glycol 1 drop each eye 4 times a day.</p> <p>During clinical record review on 2/28/19, the surveyor noted that on 2/27/18 at 9 PM Zatador and Seroquel were documented as "not administered- meds not available". On 2/28/18 9 AM Zatador, Mobic, and propylene glycol eye drops were documented as "not administered- meds not available".</p> <p>The resident had a physician order for accuchecks three times every day before meals and at bedtime (notify MD for BG(blood glucose) &lt;60 or &gt;450). The documented blood sugar was greater than 450 at 7:30 on February 23, at 11:30 on February 1, 7, 10, 19, and 23, at 5:30 on February 1, 2, and 8.</p> <p>There were no nursing notes to indicate that the physician or nurse practitioner were notified of the medication omissions or of the high blood glucose readings. Nursing staff were unable to say whether the physician was notified of any individual occurrence or was routinely notified of the issues noted.</p> <p>The administrator and director of nursing were notified of the concerns with physician notification during a summary meeting on 3/1/19.</p> <p>4. For Resident #51, facility staff failed to notify the physician when a medication was not administered and documented that notification had been made when it had not been done.</p>	F 580			



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F 580	<p>Continued From page 16</p> <p>Resident #51 was readmitted to the facility on 3/25/18. Diagnoses included hypertension, diabetes mellitus, seizures, cerebral palsy, dementia, seizure disorder, anxiety, and schizophrenia. On the quarterly minimum data set assessment with assessment reference date 3/29/18, the resident scored 9/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.</p> <p>Clinical record review revealed an order for klonopin 1 milligram take with .5 milligram to equal 1.5 milligram by mouth before meals and at bedtime. The MAR (medication administration record) indicated the medication had not been administered at least two of the four ordered administrations on February 3, 4, 5, 12, 16, 17, 21, 22, 23 and 24. The physician was not notified of any of these occurrences. Surveyors observed the medication nurse hold the klonopin at 6:30 AM on 2/27/19 after dropping the klonopin on the floor. The nurse told the surveyor she was not going to administer it because she was near the end of the on time administration window in the electronic clinical record and she did not want to chart it was given late. The nurse charted in the medication notes at 8:59 AM "medication not administered physician aware". The surveyor asked the nurse what she told the physician and whether the physician had ordered the dose to not be administered. The nurse said she intended to complete a physician communication form to notify the physician that the medication had been missed. The surveyor asked how often medications were missed and the record reflected the physician was aware when the physician had not been notified. The nurse then called the physician office and reported that the</p>	F 580			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019  
FORM APPROVED  
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F 580	Continued From page 17 nurse had been unable to give the klonopin at 6:30 AM because the surveyors took the controlled medication log and she could not give the medication. The surveyor was unable to hear the physician response, but the nurse said she would rather have an order to give it at 9 so she would have until 10 AM to give the medication. The physician communication form listed no date or time and said only "6:30 AM medication not administered. Please refer to [director of nursing] with questions. No nursing note was made to explain the medication being administered several hours late that day.	F 580			
F 583 SS=D	Facility administration was made aware of the concern as the incident occurred on 2/27/19. Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)  §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.  §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident,	F 583		4/19/19	

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F 583	<p>Continued From page 18 including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview facility staff failed to provide privacy for two residents on the 100 hall.</p> <p>2/27/19 11:00 AM The surveyor was walking in the east wing 100 hall and observed two empty medication cards on the medication cart. The cards were face up and the residents' names, birth dates, room numbers, and drug and dosage were fully visible on both cards. The residents were Resident #89, later added to the sample for unrelated issues (Midodrine 5 mg twice daily for hypotension) and an unsampled resident (escitalopram 10 mg daily for anxiety).</p> <p>The director of nursing was notified of the concern on 2/27/19 at 11:20 AM. The medication cart had been moved behind the counter at the nurse's station at that time.</p>	F 583	<p>Resident #89 no longer resides in the facility. The medication cart containing the two (2) empty medication cards from 100 hall with exposed resident demographic information were removed from the hallway and secured behind the counter at the nurses station during the survey process on 2/27/19 by the Director of Nursing/Designee.</p> <p>Facility rounds, and observations have been conducted on both wings by the Director of Nursing/Designee to identify further issues with unprotected/exposed resident information.</p> <p>Education has been provided to current staff by the Director of Nursing/Designee on 04/17/19, 04/18/19 and 04/19/19 regarding securing resident information and medical records to maintain confidentiality of the resident's personal and medical information such as</p>		

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F 583	Continued From page 19	F 583	<p>medication cards are not left exposed on the medication cart. Facility rounds/observations will be conducted two (2) times weekly for three (3) months on both wings to ensure that resident specific personal and medical information is secured, unexposed and kept confidential. The rounds will also ensure that resident specific information such as medication cards are not left exposed on top of the medication cart.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		
F 584 SS=D	<p>Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)</p> <p>§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.</p> <p>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</p>	F 584		4/19/19	

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F 584	<p>Continued From page 20</p> <p>independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§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</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview facility staff failed to provide a clean, comfortable, homelike environment for 1 of 28 residents in the survey sample (Resident #15).</p> <p>Resident #15 was admitted to the facility on 11/22/15. Diagnoses included heart failure, hypertension, Alzheimer's disease, pneumonia, psychotic disorder, dysphagia, muscle weakness, difficulty walking, anxiety disorder, and urinary tract infections (UTI) On the quarterly minimum</p>	F 584	<p>Resident #15 was provided care, clean clothes, and bathed as she would tolerate during the survey process on 2/27/19 by the Director of Nursing/Designee. Resident #15 was also provided with a new mattress for her bed, the room including floors were cleaned and the brief was removed from beneath the resident's bed by the Administrator/Designee on 2/27/2019 as well.</p>		

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F 584	<p>Continued From page 21</p> <p>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. The resident was coded as needing assistance of 1-2 persons for toileting and was assessed as frequently incontinent of bladder and on a prompted toileting program.</p> <p>On arrival to the facility on 2/26/19, the surveyor observed the hallway where the resident resided smelled strongly of urine. The resident's door was closed. The surveyor entered the room and noted that the room smelled more strongly of urine than the hallway. The resident was eating lunch from a tray in the room. On 2:27 at 5 AM, surveyors entered the facility to observe night shift conditions. The hallway where the resident resided again smelled of urine, the resident's door was closed, and the odor of urine in the room was stronger than it had been in the hall. The resident appeared to be asleep. There appeared to be a soiled brief under the bed. On 02/27/19 at 9:01 AM the door was closed and the urine odor was stronger than at 5:30 AM. The surveyor's eyes watered on entry. There was what appeared to be a soiled brief under the bed. The resident had her eyes closed and was moving her arms and legs constantly saying I can't, I can't. The odor was apparent in the hall with the door closed. 02/27/19 09:45 AM The resident was standing in the room wearing gray sweatshirt and pants. Both had large wet urine stains- approximately 2X3 foot oval on the back of the shirt and pants. At 10:39 AM, the resident was back in bed, wearing different clothes, and the soiled brief was still under the bed. The odor was unchanged. On 2/27/19 at 10:47 AM, the</p>	F 584	<p>Facility rounds/observations have been conducted by the Administrator/Designee to ensure that residents currently residing in the facility are provided with a clean, comfortable homelike environment. The facility rounds/observations will include provision of care including incontinence care as the resident will allow.</p> <p>Education has been provided to the nursing staff by the Director of Nursing/Designee 04/17/19, 04/18/19 and 04/19/19 regarding provision of a clean, comfortable, homelike environment including incontinence care and bathing as the resident will allow. The education with the nursing staff will also include removing soiled briefs in a timely manner and minimizing odors. Facility rounds/observations will be conducted by the administrator/Director of Nursing/Designee two (2) times weekly for three (3) months to ensure that facility staff are providing clean, comfortable homelike environment, incontinence care is provided timely, soiled briefs are removed and odors are minimized and transient only with care.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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F 584	Continued From page 22 surveyor asked the director of nursing and corporate clinical consultant to go to the resident's room. The odor was extremely strong in the room, the soiled brief was still under the bed, and the mattress appeared to be wet. They said they would take care of the issues. The ombudsman was in the facility at noon and said she would check with the resident on her rounds. The ombudsman left a note for the surveyor before leaving stating threat the room appeared to have been cleaned, but still had a strong odor. Staff had reported that they were looking for a new mattress for the resident. At 1:30 PM, the odor in the room was faint and the floors appeared to have been cleaned. There was no soiled brief under the bed.  The surveyor reported the concerns to the administrator and director of nursing during a summary meeting on 2/27/19.	F 584			
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)  §483.15(d) Notice of bed-hold policy and return-  §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding	F 625		4/19/19	

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F 625	<p>Continued From page 23</p> <p>bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, facility document review and clinical record review, the facility staff failed to provide written information about the bed hold policy to the resident or the resident's representative prior to and upon transfer to the hospital or therapeutic leave. This information must be provided to all facility residents, regardless of their payment source and include the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; the reserve bed payment policy in the state plan, and the nursing facility's policies regarding bed-hold period permitting a resident to return. This failure affected 5 of 28 residents (Resident #3, Resident #11, Resident #19, Resident #74, and Resident #101).</p> <p>The findings included:</p> <p>1. The facility staff failed to offer bed hold information to Resident #3 and the resident representative when the resident was transferred to the hospital on 12/9/18, 12/26/18, and 1/4/19.</p>	F 625	<p>Residents and/or the responsible party have been provided with information about the bed hold requirements and bed hold policy by the Administrator/Designee during transfers/discharges effective 03/04/2019. Resident #101 no longer resides at the facility.</p> <p>A review has been conducted by the Administrator/Designee for the previous thirty (30) days to ensure that bed hold information was provided to the resident and resident responsible party in a written format should the resident have had a transfer to the hospital or gone on therapeutic leave.</p> <p>Education has been provided by the Administrator/Designee to the interdisciplinary team and Licensed Nurses 04/17/19, 04/18/19 and 04/19/19 regarding bed hold requirements and policy as well as the process by which bed hold information will be provided to the</p>		



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F 625	<p>Continued From page 24</p> <p>The clinical record of Resident #3 was reviewed 2/26/19 through 3/5/19. Resident #3 was admitted to the facility 4/5/17 and readmitted 1/8/19 with diagnoses that included but not limited to respiratory failure with hypoxia and hypercapnia, restless legs syndrome, diastolic heart failure, atrial fibrillation, obstructive sleep apnea, hypokalemia, constipation, idiopathic progressive neuropathy, gastro-esophageal reflux disease, hyperlipidemia, hypothyroidism, major depressive disorder, insomnia, anxiety, chronic pain syndrome, Vitamin D deficiency, benign paroxysmal vertigo, morbid obesity, hypertension, chronic obstructive pulmonary disease, type 2 diabetes mellitus, nasal congestion, and migraines.</p> <p>Resident #3's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/19 assessed the resident with a BIMS (brief interview for mental status) as 15. No evidence of delirium, behaviors affecting others or psychosis.</p> <p>The departmental note dated 12/9/18 at 11:10 a.m. read "Resident has agreed to go to ER (emergency room) for eval (evaluation), continues with increased confusion, shakiness, taking off oxygen, O2 sat (oxygen saturation) drops to 88 %, 911 called requested bariatric stretcher or resident will not agree to go to emergency room (ER). Mother notified. 11:42 a.m. Ambulance service and fire department transported resident to ambulance due to weather. Report called to hospital. 6:10 p.m. Hospital called stated resident would be sent to another hospital, has been intubated at this time. CO2 (carbon dioxide) levels high."</p>	F 625	<p>resident and/or resident <input type="checkbox"/>s responsible party. Ongoing monitoring will be conducted by the Administrator/Designee to ensure that if a resident is transferred to the hospital or is on therapeutic leave that the required written bed hold information is provided to the resident and/or responsible party. The review will be completed for three (3) residents weekly for three (3) months.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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F 625	<p>Continued From page 25</p> <p>The surveyor was unable to locate documentation of a bed hold offered and of the bed hold given to the resident representative.</p> <p>The departmental note dated 12/26/18 at 2:57 p.m. read "Resident's O2 sat 79% on 3 and ½ liters. Requesting to go to the er (emergency room). FNP (family nurse practitioner) notified of O2 sats, order received to send her to er. 911 notified of transfer."</p> <p>Departmental note dated 12/26/18 at 3:12 p.m. Report called to hospital.</p> <p>Departmental note dated 12/27/18 7:34 a.m. Resident admitted to hospital ICU (intensive care unit) with CHF (congestive heart failure).</p> <p>The surveyor was unable to locate documentation of a bed hold offered and of the bed hold given to the resident representative.</p> <p>The departmental note dated 1/4/19 at 12:32 p.m. read "Resident agreed to go to ER (emergency room) for eval (evaluation), has had noted mental status changes, along with body twitching, drop in O2 sats (saturation levels). VS (vital signs) 97.5-79-20-127/68 O2 sat 88%. Ambulance here to transport resident to ER."</p> <p>Departmental note dated 1/4/19 at 7:11p.m. read, "Resident admitted to hospital with renal failure."</p> <p>The surveyor was unable to locate documentation of a bed hold offered and of the bed hold given to the resident representative.</p> <p>The surveyor interviewed the director of nursing</p>	F 625			

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F 625	<p>Continued From page 26</p> <p>(DON) on 2/28/19 at 4:01 p.m. on information sent with residents when transported to the hospital. The DON stated face sheet, code status, pertinent laboratory test results, transfer sheets, care plan. The DON was asked if bed holds were offered to the resident and the resident representative. The DON stated she was not knowledgeable about that but nursing doesn't address that.</p> <p>The surveyor interviewed two staff nurses (licensed practical nurse #5 and registered nurse #3) on 2/28/19 at 4:20 p.m. about information sent with residents when transported to the hospital. Both stated bed holds were not offered.</p> <p>The administrator was informed of the concern with the facility not offering bed hold information to the resident and the resident representative on 3/1/19 at 3:20 p.m. The administrator stated the resident and family are provided information about bed holds on admission but are not routinely doing bed hold offers when sent out to the hospital. The surveyor requested the facility policy on bed holds.</p> <p>The surveyor reviewed the facility policy that was part of the Standard Admission Record and Agreement on 2/28/19. The "Notice of Bed Hold Policy" read "Name of resident has been sent to the hospital today. If the resident is on Medicaid and is admitted to the hospital, Virginia Medicaid does not pay to hold the resident's bed. Whatever the resident's payment source, unless the nursing home is paid to reserve the bed while the resident is in the hospital, the nursing home may move someone else into the resident's room. However, even if the nursing home is not paid to hold the bed, the resident may have the right to</p>	F 625			

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F 625	<p>Continued From page 27</p> <p>return as soon as a bed is available in a semi-private room in this nursing home as long as the resident still needs the services provided by this nursing home (and, if the resident is on Medicaid, he or she is eligible for Medicaid nursing home services).</p> <p>If the nursing home does not readmit the resident to the first available bed in a semi-private room when the resident is ready to leave the hospital, the resident has the right to: appeal the nursing home's decision to the Department of Medical Assistance Services, Appeals Division and file a complaint with the Office of Licensure and Certification."</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the corporate registered nurse, the regional executive and the regional MDS (minimum data set) registered nurse of the above concern on 3/5/19 at 4:26 p.m. No further information was provided prior to the exit conference on 3/5/19.</p> <p>2. The facility staff failed to offer bed hold information to the resident and resident representative when Resident #11 was transferred to the hospital on 2/20/19.</p> <p>The clinical record of Resident #11 was reviewed 2/26/19 through 3/5/19. Resident #11 was admitted to the facility 2/4/15 and readmitted 7/14/18 with diagnoses that included but not limited to acute respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, metabolic encephalopathy, difficulty in walking, muscle weakness, acute kidney failure, chronic pain syndrome, type 2 diabetes mellitus,</p>	F 625			

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F 625	<p>Continued From page 28</p> <p>hypertension, anxiety, hypothyroidism, major depressive disorder, bipolar disorder, polyneuropathy, hypokalemia, gastro-esophageal reflux disease, adult failure to thrive, schizoaffective disorder, urethral stricture, anemia, dysphagia, constipation, Parkinson's disease, urinary tract infection, chronic obstructive pulmonary disease, and Vitamin deficiency.</p> <p>Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/13/19 assessed the resident with a BIMS (brief interview for mental status) as 15. There were no assessed signs or symptoms of delirium, behaviors affecting others or psychosis.</p> <p>The departmental note dated 2/20/19 at 1:26 p.m. read "Resident sitting in w/c (wheelchair) in dining (sic) room, ate lunch, states shes (sic) not feeling well, very sleepy. States she hurts all over, chest and side pain. VS (vital signs) 97.1-69-18-130/79 O2 sat (saturation) 96%. NP (nurse practitioner) examined resident, order given to send to ER (emergency room) for eval (evaluation) and CT (computerized tomography) scan of head. Message left on RP (responsible party) answering machine."</p> <p>The surveyor was unable to locate documentation in the clinical record of bed hold information provided to the resident and the resident representative.</p> <p>The administrator was informed of the concern with the facility not offering bed hold information to the resident and the resident representative on 3/1/19 at 3:20 p.m. The administrator stated the resident and family are provided information</p>	F 625			

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F 625	<p>Continued From page 29</p> <p>about bed holds on admission but are not routinely doing bed hold offers when sent out to the hospital. The surveyor requested the facility policy on bed holds.</p> <p>The surveyor reviewed the facility policy that was part of the Standard Admission Record and Agreement on 2/28/19. The "Notice of Bed Hold Policy" read "Name of resident has been sent to the hospital today. If the resident is on Medicaid and is admitted to the hospital, Virginia Medicaid does not pay to hold the resident's bed. Whatever the resident's payment source, unless the nursing home is paid to reserve the bed while the resident is in the hospital, the nursing home may move someone else into the resident's room. However, even if the nursing home is not paid to hold the bed, the resident may have the right to return as soon as a bed is available in a semi-private room in this nursing home as long as the resident still needs the services provided by this nursing home (and, if the resident is on Medicaid, he or she is eligible for Medicaid nursing home services).</p> <p>If the nursing home does not readmit the resident to the first available bed in a semi-private room when the resident is ready to leave the hospital, the resident has the right to: appeal the nursing home's decision to the Department of Medical Assistance Services, Appeals Division and file a complaint with the Office of Licensure and Certification."</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the corporate registered nurse, the regional executive and the regional MDS (minimum data set) registered nurse of the above</p>	F 625			

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F 625	<p>Continued From page 30 concern on 3/5/19 at 4:26 p.m.</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>3. The facility staff failed to offer a bed hold to the resident and resident representative when Resident #19 was transferred to the hospital 1/12/19, 1/18/19, 1/20/19, and 2/13/19.</p> <p>The clinical record of Resident #19 was reviewed 2/26/19 through 3/5/19. Resident #19 was admitted to the facility 11/30/18 and readmitted 1/19/19 with diagnoses that included but not limited to methicillin resistant staphylococcus aureus, cellulitis, elevated white blood count, and anemia.</p> <p>Resident #19's 5-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/22/19 assessed the resident with a BIMS (brief interview for mental status) as 13/15. There were no assessed signs or symptoms of delirium, behaviors affecting others or psychosis.</p> <p>The departmental note dated 1/12/19 at 5:10 p.m. read, "FNP (family nurse practitioner) notified of residents confusion, and refusing care, order received to send resident to ER (emergency room). 011 (sic) called to transport resident, unable to notify rp (responsible party), no answer and mailbox full."</p> <p>The surveyor was unable to find documentation in the clinical record that bed hold information was provided to the resident and resident representative.</p> <p>The departmental note dated 1/18/19 at 7:46 p.m.</p>	F 625			

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NAME OF PROVIDER OR SUPPLIER  <b>CARRINGTON PLACE AT RURAL RETREAT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>514 NORTH MAIN STREET</b> <b>RURAL RETREAT, VA 24368</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 625	<p>Continued From page 31</p> <p>read, "Called _____ (name of medical staff), order given to send to er for eval (evaluation). RP number called mailbox full. 911 called to transport resident to er (emergency room). VS (vital signs) 149/96-92-18-98, unable to obtain O2 sat (saturation)."</p> <p>The surveyor was unable to find documentation in the clinical record that bed hold information was provided to the resident and resident representative.</p> <p>The departmental note dated 1/20/19 at 11:41 a.m. read in part, "Daughter states she has been talking with case worker wants father sent to (name of hospital omitted) for psych (psychiatric) eval (evaluation), NP (nurse practitioner) contacted, gave order to send resident to ER, hospital notified, daughter aware. DON (director of nursing) aware. RREMS (local emergency medical services) transported resident to hospital."</p> <p>The surveyor was unable to find documentation in the clinical record that bed hold information was provided to the resident and resident representative.</p> <p>The departmental note dated 2/13/19 at 6:33 a.m. read in part, "late entry for 502am (morning) rsdt (resident) transferring from commode to sit to stand lift rsdt let go of lift and ref (refused)to stand up held up by staff require assist of 4 o (sic) get rsdt to w/c (wheelchair), no injuries observed but rsdt stating he broke his left shoulder requesting to go to er (emergency room)nurse notified np (nurse practitioner) and received order to send rsdt to er, ems (emergency medical services) in to transport rsdt with assist of 4 to transfer to</p>	F 625			



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F 625	<p>Continued From page 32 stretcher rsdt tolerated fair, report called to er nurse at hospital."</p> <p>The surveyor was unable to find documentation in the clinical record that bed hold information was provided to resident and resident representative.</p> <p>The surveyor informed the administrator on 3/1/19 at 4:09 p.m. The administrator stated bed holds were not offered as the facility generally had bed available.</p> <p>The surveyor reviewed the facility policy that was part of the Standard Admission Record and Agreement on 2/28/19. The "Notice of Bed Hold Policy" read "Name of resident has been sent to the hospital today. If the resident is on Medicaid and is admitted to the hospital, Virginia Medicaid does not pay to hold the resident's bed. Whatever the resident's payment source, unless the nursing home is paid to reserve the bed while the resident is in the hospital, the nursing home may move someone else into the resident's room. However, even if the nursing home is not paid to hold the bed, the resident may have the right to return as soon as a bed is available in a semi-private room in this nursing home as long as the resident still needs the services provided by this nursing home (and, if the resident is on Medicaid, he or she is eligible for Medicaid nursing home services).</p> <p>If the nursing home does not readmit the resident to the first available bed in a semi-private room when the resident is ready to leave the hospital, the resident has the right to: appeal the nursing home's decision to the Department of Medical Assistance Services, Appeals Division and file a complaint with the Office of Licensure and</p>	F 625			

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F 625	<p>Continued From page 33 Certification."</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the corporate registered nurse, the regional executive and the regional MDS (minimum data set) registered nurse of the above concern on 3/5/19 at 4:26 p.m.</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>4. The facility staff failed to provide bed hold information to Resident #74 and to the resident representative when the resident was transferred to the hospital 9/16/18, 12/9/18, 1/1/19, and 3/2/19.</p> <p>The clinical record of Resident #74 was reviewed 2/26/19 through 3/5/19. Resident #74 was admitted to the facility 3/1/18 and readmitted 1/4/19 with diagnoses that included but not limited to Huntington's disease, neglected elder, Parkinson's disease, urinary tract infection, muscle weakness, dysphagia, unspecified psychosis not due to a substance or known physical condition, weakness, hypertension, post-traumatic stress disorder, ataxia, disorientation, anxiety, unspecified mood disorder, altered mental status, disorder of urea cycle metabolism, dementia in other disease classified elsewhere without behavioral disturbances, hepatic failure, and acute cystitis.</p> <p>Resident #74's 14-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/16/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. There was no evidence of delirium, no behaviors</p>	F 625			

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F 625	<p>Continued From page 34</p> <p>affecting others, and no evidence of psychosis.</p> <p>The departmental note dated 9/16/18 at 12:53 p.m. read in part "At this time he has a temp (temperature) of 102. 1:39 p.m. Several times was attempted to do the IV (intravenous) and no success. Appears to be dehydrated. Other #3 made aware and we are sending him to the hospital."</p> <p>The surveyor was unable to locate documentation in the clinical record that the resident and resident representative were provided information about bed holds.</p> <p>The departmental note dated 12/9/18 at 12:46 p.m. read "Resident fell and hit head, has laceration to back of head, moderate amt (amount) bleeding, controlled at this time. 911 called sent to ER (emergency room) for eval (evaluation), RP (responsible party) notified. Ambulance here to transport."</p> <p>The surveyor was unable to locate documentation in the clinical record that the resident and resident representative were provided information about bed holds.</p> <p>The departmental note dated 1/1/19 at 8:54 a.m. read in part "Resident having increased lethargy, weakness T (temperature) 102.4 p (pulse) 98 r (respirations) 20 bp (blood pressure) 103/34. sao2 (oxygen saturation) 93%. Other #3 notified received order to transfer to er (emergency room) due to resident having high fever and stating not feeling well and hurting all over. Attempted to notify _____ [RP (responsible party) name omitted], message left to return call to facility, 911 called for transport, report called to hospital</p>	F 625			

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F 625	<p>Continued From page 35 (name omitted), return call from RP received explained that resident had high fever and was being transported to er. To er via 911."</p> <p>The surveyor was unable to locate documentation in the clinical record that the resident and resident representative were provided information about bed holds.</p> <p>The departmental note dated 3/2/19 at 5:47 p.m. read "Called to resident room, roommate states resident fell out of bed and hit head. Reddened area noted with raised area to top of head. MD (medical doctor) notified, order given to send to ER (emergency room) for eval (evaluation). PEARL (pupils equal and reactive to light), grips equal. Alert. Spoke with RP (responsible party) he is aware. Resident up in w/c (wheelchair) propelling self to dinning (sic) room. No distress noted. 6:04 p.m. Ambulance here to transport resident to ER. Resident got up out of w/c by himself and sat on stretcher."</p> <p>The surveyor was unable to locate documentation in the clinical record that the resident and resident representative were provided information about bed holds.</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the corporate registered nurse, the regional executive and the regional MDS (minimum data set) registered nurse of the above concern on 3/5/19 at 4:26 p.m.</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>5. The facility staff failed to provide bed hold</p>	F 625			

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F 625	<p>Continued From page 36</p> <p>information to Resident #101 and the resident representative when the resident was transported to the hospital on 2/14/19.</p> <p>The clinical record of Resident #101 was reviewed 2/26/19 through 3/5/19. Resident #101 was admitted to the facility 1/31/19 and readmitted 2/15/19 with diagnosis that included but not limited to altered mental status, abnormal levels of serum enzymes, dementia without behavioral disturbances, Vitamin deficiency, hypothyroidism, seizures, difficulty in walking, muscle weakness, dysphagia, encephalopathy, chronic kidney disease, stage 2, hyperlipidemia, hypertension, fever, edema, insomnia, idiopathic peripheral autonomic neuropathy, type 2 diabetes mellitus, Parkinson's disease, repeated falls, frequent micturition, and hypoglycemia.</p> <p>Resident #101's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/7/19 assessed the resident with a BIMS (brief interview for mental status) as 11. No assessed signs or symptoms of delirium, behaviors affecting others or psychosis.</p> <p>The departmental note dated 2/14/19 at 5:05 p.m. read "This nurse spoke with (name omitted and hospital) ER (emergency room) she reported that Resident #101 was admitted to room (number omitted) with orthostatic hypotension. Wife aware ...."</p> <p>The surveyor was unable to locate documentation in the clinical record that the resident and resident representative were provided information about bed holds.</p> <p>The surveyor interviewed the director of nursing</p>	F 625			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019  
FORM APPROVED  
OMB NO. 0938-0391

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F 625	<p>Continued From page 37</p> <p>(DON) on 2/28/19 at 4:01 p.m. on information sent with residents when transported to the hospital. The DON stated face sheet, code status, pertinent laboratory test results, transfer sheets, care plan. The DON was asked if bed holds were offered to the resident and the resident representative. The DON stated she was not knowledgeable about that but nursing doesn't address that.</p> <p>The surveyor interviewed Resident #101's wife on 2/28/19 at 4:20 p.m. The wife stated she didn't know anything about bed holds.</p> <p>The surveyor interviewed two staff nurses (licensed practical nurse #5 and registered nurse #3) on 2/28/19 at 4:20 p.m. about information sent with residents when transported to the hospital. Both stated bed holds were not offered.</p> <p>The administrator was informed of the concern with the facility not offering bed hold information to the resident and the resident representative on 3/1/19 at 3:20 p.m. The administrator stated the resident and family are provided information about bed holds on admission but are not routinely doing bed hold offers when sent out to the hospital. The surveyor requested the facility policy on bed holds.</p> <p>The surveyor reviewed the facility policy that was part of the Standard Admission Record and Agreement on 2/28/19. The "Notice of Bed Hold Policy" read "Name of resident has been sent to the hospital today. If the resident is on Medicaid and is admitted to the hospital, Virginia Medicaid does not pay to hold the resident's bed. Whatever the resident's payment source, unless the nursing home is paid to reserve the bed while</p>	F 625			

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F 625	Continued From page 38 the resident is in the hospital, the nursing home may move someone else into the resident's room. However, even if the nursing home is not paid to hold the bed, the resident may have the right to return as soon as a bed is available in a semi-private room in this nursing home as long as the resident still needs the services provided by this nursing home (and, if the resident is on Medicaid, he or she is eligible for Medicaid nursing home services).  If the nursing home does not readmit the resident to the first available bed in a semi-private room when the resident is ready to leave the hospital, the resident has the right to: appeal the nursing home's decision to the Department of Medical Assistance Services, Appeals Division and file a complaint with the Office of Licensure and Certification."  The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the corporate registered nurse, the regional executive and the regional MDS (minimum data set) registered nurse of the above concern on 3/5/19 at 4:26 p.m.  No further information was provided prior to the exit conference on 3/5/19.	F 625			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		4/19/19	

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F 656	<p>Continued From page 39</p> <p>objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and clinical record review, the facility staff failed to develop a care plan addressing targeted behaviors for 1 of 28</p>	F 656	Resident #101 no longer resides in the facility.		



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F 656	<p>Continued From page 40 residents (Resident #101).</p> <p>The facility staff failed to develop a care plan to include non-pharmacological interventions prior to the use of Haldol (an antipsychotic medication) and Zoloft (an antidepressant) for Resident #101.</p> <p>The clinical record of Resident #101 was reviewed 2/26/19 through 3/5/19. Resident #101 was admitted to the facility 1/31/19 and readmitted 2/15/19 with diagnosis that included but not limited to altered mental status, abnormal levels of serum enzymes, dementia without behavioral disturbances, Vitamin deficiency, hypothyroidism, seizures, difficulty in walking, muscle weakness, dysphagia, encephalopathy, chronic kidney disease, stage 2, hyperlipidemia, hypertension, fever, edema, insomnia, idiopathic peripheral autonomic neuropathy, type 2 diabetes mellitus, Parkinson's disease, repeated falls, frequent micturition, and hypoglycemia.</p> <p>Resident #101's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/7/19 assessed the resident with a BIMS (brief interview for mental status) as 11. No assessed signs or symptoms of delirium, behaviors affecting others or psychosis.</p> <p>The current comprehensive care plan dated 2/11/19 included the problem onset that read "I am at risk for side effects r/t (related to) my psychotropic med (medication) use. I take Zoloft for a diagnosis of depression. Interventions: Monitor and document behaviors."</p> <p>A care plan was not developed for behaviors to include non-pharmacological interventions and person centered targeted behaviors for the use of</p>	F 656	<p>A review has been conducted by the Director of Nursing/Designee of care plans for current residents to ensure that residents with physician orders for psychotropic medications have non-pharmacological interventions as well as person centered targeted behaviors identified on the care plan prior to use of such meds.</p> <p>Education has been provided to licensed nurses by the Director of Nursing/Designee 04/17/19, 04/18/19 and 04/19/19 regarding appropriate and accurate update of the care plan for residents with physician's orders for psychotropic medications to ensure that the care plan reflects non-pharmacological interventions as well as person-centered targeted behaviors to be utilized prior to use of psychotropic medications. A care plan review will be conducted for three (3) residents weekly for three (3) months to ensure that residents with orders for psychotropic medications have their care plan updated to reflect non-pharmacological interventions to be utilized prior to the use of psychotropic medications as well as person-centered targeted behaviors to be monitored.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations</p>		

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F 656	Continued From page 41 Zoloft and Haldol.  Resident #101 received Haldol 2 mg (milligrams) by mouth on 2/16/19 at 8:54 p.m. and Haldol 2 mg po on 2/17/19 at 6:41 a.m. for yelling out. The information was located in the February 2019 detail notes. The clinical record did not have documentation of interventions utilized prior to the use of Haldol each time or identified behaviors for the use of Haldol and Zoloft.  The surveyor reviewed the facility policy titled "Behavioral Assessment, Intervention, and Monitoring" on 3/1/19. The policy read in part "Management: 2. The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of care. 7. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. 8. Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, at a minimum: a. a description of the behavioral symptoms including frequency, intensity, duration, outcomes, location, environment, and precipitating factors. b. Targeted and individualized interventions for the behavioral and/or psychosocial symptoms. c. The rationale for the intervention and approaches. d. Specific and measurable goals for targeted behaviors. e. How the staff will monitor for effectiveness of the intervention. 9. Non-pharmacologic approaches will be utilized	F 656	for revisions as indicated necessary to sustain substantial compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/05/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>CARRINGTON PLACE AT RURAL RETREAT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>514 NORTH MAIN STREET RURAL RETREAT, VA 24368</b>		
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F 656	Continued From page 42 to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms. 10. When medications are prescribed for behavioral symptoms, documentation will include rationale for use, potential underlying causes of the behavior, other approaches and interventions tried prior to the use of antipsychotic medications, potential risks and benefits of medications as discussed with the resident and/or family, specific target behaviors and expected outcomes, dosage, duration, monitoring for efficacy and adverse consequences, and plans for gradual dose reduction.  The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the corporate registered nurse of the above concern on 3/1/19 at 5:34 p.m.  No further information was provided prior to the exit conference on 3/5/19.	F 656			
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657			4/19/19

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F 657	<p>Continued From page 43</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, facility document review, and clinical record review, the facility staff failed to review and revise the current comprehensive care plan for 5 of 28 residents (Resident #362, Resident #11, Resident #3, Resident #19, and Resident #15).</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>The facility staff failed to review and revise the current comprehensive care plan to included targeted behaviors for the use of psychotropic medications and non-pharmacological interventions for pain for Resident #362.</li> </ol> <p>The clinical record of Resident #362 was reviewed 2/26/19 through 3/5/19. Resident #362 was admitted to the facility 2/11/19 with diagnoses that included but not limited to left fibula fracture, head injury, cataract, anemia, type 2 diabetes mellitus, urine retention, bipolar disorder, muscle weakness, difficulty in walking, encephalopathy, hypertension, chronic pain,</p>	F 657	<p>Resident #362 no longer resides in the facility. For resident #11, the care plan has been updated/revise by the Director of Nursing/Designee to include person-centered targeted behaviors as well as non-pharmacological interventions specific to the use of psychotropic medications. Resident #3 has had her care plan updated/revise by the Director of Nursing/Designee to include specific person-centered targeted behaviors as well as non-pharmacological interventions to be utilized prior to use of psychotropic medications. Resident #19 has had her care plan updated/revise by the Director of Nursing/Designee to include specific person-centered targeted behaviors as well as non-pharmacological interventions to be utilized prior to use of psychotropic medications. Resident #15 has had her care plan updated/revise by the Director of Nursing/Designee to include specific person-centered targeted behaviors as</p>		

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F 657	<p>Continued From page 44</p> <p>atherosclerotic heart disease, TIA (transient ischemic attacks), hyperlipidemia, intervertebral disc degeneration of lumbosacral region, and edema.</p> <p>The admission minimum data set (MDS) assessment had not yet been completed.</p> <p>The February 2019 physician orders were reviewed. Resident #362 was ordered Zoloft 100 mg (milligrams) one by mouth daily and Norco 5-325 tablet take one by mouth every 4 hours as needed for pain.</p> <p>The surveyor reviewed the current comprehensive care plan dated 2/21/19. The care plan read, "I have a diagnosis of anxiety/depression." Interventions: document behaviors. There were no specific targeted behaviors or non-pharmacological interventions documented.</p> <p>The current comprehensive care plan dated 2/21/19 read "I have potential for DEPRESSION secondary to physical losses or dependence." There were no identified targeted behaviors or non-pharmacological interventions documented.</p> <p>The current comprehensive care plan dated 2/21/19 read "I am at risk for side effects r/t (related to) psychotropic med (medication) use. I take Zoloft for a diagnosis of schizophrenia, bipolar disorder, anxiety and depression." Interventions: Monitor and document behaviors qshift (every shift). Side effects of medications were documented but there were no targeted behaviors or non-pharmacological interventions identified.</p> <p>The current comprehensive care plan dated</p>	F 657	<p>well as non-pharmacological interventions to be utilized prior to use of psychotropic medications.</p> <p>A review has been conducted by the Director of Nursing/Designee of care plans for current residents to ensure that residents with physician orders for psychotropic medications have non-pharmacological interventions as well as person centered targeted behaviors identified on the care plan prior to use of such meds.</p> <p>Education has been provided to licensed nurses by the Director of Nursing/Designee 04/17/19, 04/18/19 and 04/19/19 regarding appropriate and accurate update of the care plan for residents with physician orders for psychotropic medications to ensure that the care plan reflects non-pharmacological interventions as well as person-centered targeted behaviors to be utilized prior to use of psychotropic medications. A care plan review will be conducted for three (3) residents weekly for three (3) months to ensure that residents with orders for psychotropic medications have their care plan updated to reflect non-pharmacological interventions to be utilized prior to the use of psychotropic medications as well as person-centered targeted behaviors to be monitored.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3)</p>		

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F 657	<p>Continued From page 45</p> <p>2/21/19 read "I may experience pain r/t (related to) my recent fracture. I also have a diagnosis of degenerative disc disease, and chronic pain." The care plan did not have non-pharmacological approaches for pain management identified or documented. The care plan read "Identify and encourage coping mechanisms r/t pain management."</p> <p>The surveyor informed the administrator, the director of nursing (DON), the corporate registered nurse, and the assistant director of nursing of the above concern on 2/27/19 at 3:04 p.m. The DON was asked how does the staff know what behaviors are being targeted for Zoloft. The DON stated that behavior monitoring was not specific for Zoloft; it's for the entire shift. Staff have a drop down list when charting where they can choose from the full array of psychological symptoms. The DON stated when assessing prior to administering prn (whenever needed) narcotics, staff are documenting the non-pharmacological strategies after the administration."</p> <p>The surveyor requested the facility policy on pain management and psychotropic medications.</p> <p>The surveyor reviewed the facility policy titled "Behavioral Assessment, Intervention, and Monitoring" on 3/1/19. The policy read in part "Management:</p> <p>2. The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of care.</p> <p>7. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the</p>	F 657	<p>months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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F 657	<p>Continued From page 46</p> <p>resident's distress or loss of abilities.</p> <p>8. Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum: a. a description of the behavioral symptoms including frequency, intensity, duration, outcomes, location, environment, and precipitating factors. b. Targeted and individualized interventions for the behavioral and/or psychosocial symptoms. c. The rationale for the intervention and approaches. d. Specific and measurable goals for targeted behaviors. e. How the staff will monitor for effectiveness of the intervention.</p> <p>9. Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms.</p> <p>10. When medications are prescribed for behavioral symptoms, documentation will include rationale for use, potential underlying causes of the behavior, other approaches and interventions tried prior to the use of antipsychotic medications, potential risks and benefits of medications as discussed with the resident and/or family, specific target behaviors and expected outcomes, dosage, duration, monitoring for efficacy and adverse consequences, and plans for gradual dose reduction.</p> <p>The surveyor reviewed the facility policy titled "Pain-Clinical Protocol." The policy read "1. The physician and staff will identify individuals who have pain or who are at risk for having pain. 2. The physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain. 3. Staff will</p>	F 657			

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F 657	<p>Continued From page 47</p> <p>provide the elements of a comforting and appropriate physical and complementary interventions: for example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain."</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>2. The facility staff failed to review and revise the current comprehensive care plan to include targeted specific behaviors for the use of psychotropic medications and non-pharmacological interventions for Resident #11.</p> <p>The clinical record of Resident #11 was reviewed 2/26/19 through 3/5/19. Resident #11 was admitted to the facility 2/4/15 and readmitted 7/14/18 with diagnoses that included but not limited to acute respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, metabolic encephalopathy, difficulty in walking, muscle weakness, acute kidney failure, chronic pain syndrome, type 2 diabetes mellitus, hypertension, anxiety, hypothyroidism, major depressive disorder, bipolar disorder, polyneuropathy, hypokalemia, gastro-esophageal reflux disease, adult failure to thrive, schizoaffective disorder, urethral stricture, anemia, dysphagia, constipation, Parkinson's disease, urinary tract infection, chronic obstructive pulmonary disease, and Vitamin deficiency.</p> <p>Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/13/19 assessed the resident with a BIMS (brief interview for mental status) as 15.</p>	F 657			



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F 657	<p>Continued From page 48</p> <p>There were no assessed signs or symptoms of delirium, behaviors affecting others or psychosis.</p> <p>The February 2019 physician's orders were reviewed. Resident #11 had orders for Buspirone 7.5 mg (milligrams) by mouth tid (three times a day), Effexor XR 75 mg daily for depression, Trazodone 100 mg by mouth daily at bedtime, Geodon 20 mg by mouth bid (twice a day), and Valproic acid 250 mg twice a day.</p> <p>Resident #11's current comprehensive care plan dated 8/29/18 documented psychotropic drug use as a problem. Approaches checked were report to my physician any troublesome symptoms that could be associated with use of the drug, administer my medications as prescribed by the physician and implement behavioral interventions, educate me and/or my family on potential risks/benefits of psychotropic drug use, monitor me for effectiveness of psychotropic drug use, monitor me for changes that may suggest my dose may need reduction, discontinuation, or increasing, communicate changes and any pharmacy/interdisciplinary team recommendations to me and my physician, evaluate me on a periodic basis for a gradual dose reduction or discontinuation, if applicable.</p> <p>The current comprehensive care plan did not address targeted behaviors for Buspar, Geodon, Effexor, Trazodone and Valproic acid or identify non-pharmacological interventions. Two behaviors identified on the activity care plan dated 8/29/18 read, "I will occasionally have disrupting behaviors during activities-gets angry and wheels off."</p> <p>The psychiatric nurse practitioner progress note</p>	F 657			

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F 657	<p>Continued From page 49</p> <p>dated 12/3/18 read in part "Patient with schizoaffective disorder, on Geodon and Depakote for mood stability, pharmacy request eval (evaluation) for gdr (gradual dose reduction) of Depakote 250 mg bid, patient with med (medication) adjustments for depression, Effexor 37.5 mg added on 9/24/18 for reports of depression, today, patient reports feeling more depression, r/t (related to) bad situation her grandson is facing, she reports moods feel stable. Recommendation was to increase Effexor to 50 mg qd and do not recommend GDR for Depakote while adjusting Effexor." There were no targeted behaviors identified in the progress note other than situational with grandson.</p> <p>The psychiatric nurse practitioner progress note dated 12/27/18 read in part "Patient with depressive symptoms per her report, last visit increased Effexor to XR75 mg qd (every day), today she reports mild improvement, but has been sad past few days as her cousin recently deceased. She continues on buspar for anxiety and finds it helpful, Depakote Geodon for mood stability and trazodone for insomnia. Staff report patient has remained overall at baseline." The current comprehensive care plan did not identify any of these concerns.</p> <p>The psychiatric nurse practitioner progress note dated 1/16/19 read in part: "Patient with history of bipolar moods with mood instability. On buspar 7.5 mg tid has failed past attempts of gdr, with increase in anxiety. Patient reports moods are doing ok now, and sleep is good." The current comprehensive care plan did not identify any of these concerns.</p> <p>The surveyor informed the administrator, the</p>	F 657			

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F 657	<p>Continued From page 50</p> <p>director of nursing, the assistant director of nursing, the corporate registered nurse, the corporate MDS (minimum data set) assessment registered nurse, and the regional executive of the above concerns on 3/5/19 at 4:26 p.m.</p> <p>The surveyor requested the facility policy on psychotropic medications.</p> <p>The surveyor reviewed the facility policy titled "Behavioral Assessment, Intervention, and Monitoring" on 3/1/19. The policy read in part "Management:</p> <p>2. The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of care.</p> <p>7. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities.</p> <p>8. Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum: a. a description of the behavioral symptoms including frequency, intensity, duration, outcomes, location, environment, and precipitating factors. b. Targeted and individualized interventions for the behavioral and/or psychosocial symptoms. c. The rationale for the intervention and approaches. d. Specific and measurable goals for targeted behaviors. e. How the staff will monitor for effectiveness of the intervention.</p> <p>9. Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage</p>	F 657			

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F 657	<p>Continued From page 51</p> <p>behavioral symptoms.</p> <p>10. When medications are prescribed for behavioral symptoms, documentation will include rationale for use, potential underlying causes of the behavior, other approaches and interventions tried prior to the use of antipsychotic medications, potential risks and benefits of medications as discussed with the resident and/or family, specific target behaviors and expected outcomes, dosage, duration, monitoring for efficacy and adverse consequences, and plans for gradual dose reduction.</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>3. The facility staff failed to review and revise Resident #3's current comprehensive care plan to include specific targeted behaviors for the use of psychotropic medications and non-pharmacological interventions for psychotropic medications.</p> <p>The clinical record of Resident #3 was reviewed 2/26/19 through 3/5/19. Resident #3 was admitted to the facility 4/5/17 and readmitted 1/8/19 with diagnoses that included but not limited to respiratory failure with hypoxia and hypercapnia, restless legs syndrome, diastolic heart failure, atrial fibrillation, obstructive sleep apnea, hypokalemia, constipation, idiopathic progressive neuropathy, gastro-esophageal reflux disease, hyperlipidemia, hypothyroidism, major depressive disorder, insomnia, anxiety, chronic pain syndrome, Vitamin D deficiency, benign paroxysmal vertigo, morbid obesity, hypertension, chronic obstructive pulmonary disease, type 2 diabetes mellitus, nasal congestion, and migraines.</p>	F 657			

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F 657	<p>Continued From page 52</p> <p>Resident #3's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/19 assessed the resident with a BIMS (brief interview for mental status) as 15. No evidence of delirium, behaviors affecting others or psychosis.</p> <p>Resident #3's February 2019 physician's orders were reviewed. Resident #3 was prescribed Duloxetine 60 mg (milligrams) daily and Trazodone 50 mg at bedtime.</p> <p>The surveyor reviewed the current comprehensive care plan dated 2/20/19. Resident #3's had a care plan that read resident was at risk for side effects of psychotropic medications-antidepressants and antianxiety-dx (diagnosis) includes depression, anxiety, and neuropathy. Approaches: Document resident behavior.</p> <p>The surveyor was unable to locate specific targeted behaviors for psychotropic medication use or non-pharmacological interventions.</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the corporate registered nurse, the corporate MDS (minimum data set) assessment registered nurse, and the regional executive of the above concerns on 3/5/19 at 4:26 p.m.</p> <p>The surveyor requested the facility policy on psychotropic medications.</p> <p>The surveyor reviewed the facility policy titled "Behavioral Assessment, Intervention, and Monitoring" on 3/1/19. The policy read in part</p>	F 657			

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NAME OF PROVIDER OR SUPPLIER  <b>CARRINGTON PLACE AT RURAL RETREAT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>514 NORTH MAIN STREET</b> <b>RURAL RETREAT, VA 24368</b>		
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F 657	Continued From page 53 "Management: 2. The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of care. 7. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. 8. Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum: a. a description of the behavioral symptoms including frequency, intensity, duration, outcomes, location, environment, and precipitating factors. b. Targeted and individualized interventions for the behavioral and/or psychosocial symptoms. c. The rationale for the intervention and approaches. d. Specific and measurable goals for targeted behaviors. e. How the staff will monitor for effectiveness of the intervention. 9. Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms. 10. When medications are prescribed for behavioral symptoms, documentation will include rationale for use, potential underlying causes of the behavior, other approaches and interventions tried prior to the use of antipsychotic medications, potential risks and benefits of medications as discussed with the resident and/or family, specific target behaviors and expected outcomes, dosage, duration, monitoring for efficacy and adverse consequences, and plans for gradual dose reduction.	F 657			

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F 657	<p>Continued From page 54</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>4. The facility staff failed to review and revise the current comprehensive care plan to include targeted behaviors and non-pharmacological interventions when psychotropic medications were ordered and administered to Resident #19.</p> <p>The clinical record of Resident #19 was reviewed 2/26/19 through 3/5/19. Resident #19 was admitted to the facility 11/30/18 and readmitted 1/19/19 with diagnoses that included but not limited to methicillin resistant staphylococcus aureus, cellulitis, elevated white blood count, and anemia.</p> <p>Resident #19's 5-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/22/19 assessed the resident with a BIMS (brief interview for mental status) as 13/15. There were no assessed signs or symptoms of delirium, behaviors affecting others or psychosis.</p> <p>The February 2019 physician orders for Resident #19 were reviewed. Resident #19 had orders for Sertraline 100 mg (milligrams) 1 and ½ tablet daily and Amitriptyline 50 mg at bedtime.</p> <p>Resident #19's current comprehensive care plan dated 12/11/18 for psychotropic drug use. There were no targeted behaviors identified or non-pharmacological interventions for the antidepressants prescribed (Sertraline and Amitriptyline). Resident #19 also had a care plan that read resident was at risk for increasing confusion secondary to auditory hallucinations. There were no specific behaviors identified on the</p>	F 657			

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F 657	<p>Continued From page 55 care plan.</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the corporate registered nurse, the corporate MDS (minimum data set) assessment registered nurse, and the regional executive of the above concerns on 3/5/19 at 4:26 p.m.</p> <p>The surveyor requested the facility policy on psychotropic medications.</p> <p>The surveyor reviewed the facility policy titled "Behavioral Assessment, Intervention, and Monitoring" on 3/1/19. The policy read in part "Management:</p> <p>2. The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of care.</p> <p>7. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities.</p> <p>8. Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum: a. a description of the behavioral symptoms including frequency, intensity, duration, outcomes, location, environment, and precipitating factors. b. Targeted and individualized interventions for the behavioral and/or psychosocial symptoms. c. The rationale for the intervention and approaches. d. Specific and measurable goals for targeted behaviors. e. How the staff will monitor for effectiveness of the intervention.</p>	F 657			



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F 657	<p>Continued From page 56</p> <p>9. Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms.</p> <p>10. When medications are prescribed for behavioral symptoms, documentation will include rationale for use, potential underlying causes of the behavior, other approaches and interventions tried prior to the use of antipsychotic medications, potential risks and benefits of medications as discussed with the resident and/or family, specific target behaviors and expected outcomes, dosage, duration, monitoring for efficacy and adverse consequences, and plans for gradual dose reduction.</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>5. For Resident #15, the comprehensive care plan did not address recurring urinary tract infections, drug resistant infections, or orders for contact precautions.</p> <p>Resident #15 was admitted to the facility on 11/22/15 and readmitted on 11/18/18. Diagnoses included heart failure, hypertension, Alzheimer's disease, psychotic disorder, pneumonia, urinary tract infection (UTI), dementia with behavior disturbance, dysphagia, anxiety, muscle weakness, and difficulty walking. On the quarterly 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 symptoms of delirium, psychosis, or behaviors affecting care. The assessment indicated the resident ambulated and used the toilet with 1-2 person assistance, was frequently, but not always, incontinent, and on a prompted toileting program.</p>	F 657			

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F 657	Continued From page 57  Clinical record review revealed a the resident was treated for urinary tract infections on admission in November 2018 and in January and February 2019. There were orders for urinalysis with culture and sensitivity on 1/24 and 2/15. Contact precautions were ordered for antibiotic resistant urinary tract infection in February 2019. The resident's care plan did not address urinary tract infections.  The administrator and director of nursing were notified of the concern during a summary meeting on 3/4/19.	F 657			
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)  §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, facility staff failed to follow professional standards of practice for medication accountability for 6 of 28 residents and in all of the medication cart narcotic logs. (Resident #89, 91, 72, 79, 36, 3 and 72).  The findings included:  1. The facility staff failed to obtain a physician order prior to the administration of oxygen for Resident #89. Resident #89 was admitted to the facility on 1/26/19 with the following diagnoses of, but not	F 658	Resident #89 no longer resides in the facility. There was no adverse effect for Resident #89. Resident #91 no longer resides in the facility. There was no adverse effect for Resident #91. For Resident #79, there was no adverse effect to the resident. LPN #2 was provided education regarding the appropriate process for documentation in the narcotic log. The Director of Nursing/Designee has observed LPN #2's medication administration and documentation and provided additional education as needed. For Resident #36, the physician has been	4/19/19	

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F 658	<p>Continued From page 58</p> <p>limited to high blood pressure and respiratory failure. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/1/19, the resident was coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene. Resident #89 was also coded as being totally dependent on 2 staff members for bathing.</p> <p>On 2/28/19 at approximately 9:30 am, the surveyor went into Resident #89's room to conduct a resident interview. During this time, the resident was observed to be using Oxygen at 2 liters/minute by nasal cannula.</p> <p>At approximately 10 am, the surveyor and the corporate MDS nurse went into the resident's room. They were met in the doorway of the room as physical therapy was taking him to therapy in a wheelchair. The resident was observed to be wearing oxygen.</p> <p>The surveyor reviewed the clinical record of Resident #89. During this review, the surveyor could not find a physician order for the administration of oxygen. However, in the nurses' notes since admission on 1/26/19, the facility staff had documented that Resident #89 was receiving oxygen 2-3 liters/ minute by nasal cannula.</p> <p>The surveyor notified the administrative team of the above documented findings on 3/1/19 at 5:33 pm in the conference room. The surveyor asked the director of nursing (DON) if you needed an order to administer oxygen to a resident. The DON stated, "Yes we do." The surveyor requested a copy of the facility's policy on administration of oxygen.</p> <p>On 3/5/19 at approximately 10:30 am, the</p>	F 658	<p>notified for Lantus and accuchecks obtained/administered 1-3 hours after meals and at bedtime in January and February 2019. There was no adverse effect to the resident. Regarding the narcotic count sheets for current medication carts, the Director of Nursing/Designee has provided education to licensed nurses regarding signing the narcotic log attesting that the count is accurate at the beginning and end of each shift. For Resident #3, a late entry/addendum has been made to reflect the resident's refusal of the Lasix on 2/27/2019 at 11:17am by the Director of Nursing/Designee. The physician and responsible party have been notified regarding the resident's refusal of the medication and notification has been documented in the medical record. For resident #72, the physician and the responsible party have been notified regarding the medication variance in which Algera cream was not administered as ordered on 2/27/19. There was no adverse effect to the resident. The Licensed nurse was provided with education by the Director of Nursing/Designee regarding only signing that meds, creams, treatments have been administered immediately after administration and not before.</p> <p>A review has been conducted by the Director of Nursing/Designee for the previous thirty (30) days for the following areas:</p> <p>(A) Residents that currently utilize/require oxygen will have their physician's orders</p>		

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F 658	<p>Continued From page 59</p> <p>surveyor received a copy of the facility's policy for "Oxygen Administration". The policy read in part, "...Verify that there is a physician order for this procedure ..."</p> <p>At 11 am, LPN (licensed practical nurse) #1 that was responsible for the resident's care on 3/5/19 was interviewed in the conference room by the surveyor. The surveyor asked LPN #1 if you needed to obtain a physician order before administrating oxygen. LPN #1 stated, "Yes you do. But I assumed that there was an order without checking on this first."</p> <p>At approximately 1:30 pm, the surveyor interviewed the doctor responsible for this residents care. The doctor reviewed the physician's orders and progress notes and stated "There is not an order for the resident to be given oxygen. He must had this when they admitted him from the hospital."</p> <p>At 4:20 pm, the surveyor notified the administrative team of the above documented findings.</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p> <p>2. The facility staff failed to follow physician orders for the administration of insulin and performing blood sugar checks (Accu checks) for Resident #91.</p> <p>Resident #91 was admitted to the facility on 1/31/19 with the following diagnoses of, but not limited to anemia, atrial fibrillation, end stage renal disease, diabetes, heart failure and high blood pressure. On the admission MDS</p>	F 658	<p>reviewed to ensure that there is a physician's order for the oxygen.</p> <p>(B) Residents with physician's orders for insulin, accuchecks, and dialysis will have their EMAR reviewed to ensure that accuchecks are being performed and insulin is administered per the physician's order and documented appropriately.</p> <p>(C) Narcotic logs will be reviewed for the previous thirty (30) days by the Director of Nursing/Designee. Observations will be completed by the Director of Nursing/Designee at shift change to ensure that narcotic count is conducted, the log is signed by both nurses and controlled medication are accounted for. Additionally, medication administration observation will be conducted with current licensed nurses to ensure that controlled medications including pain medication is signed out on the narcotic inventory sheet only after the medication is administered not prior and that refused medications are documented appropriately, and physician made aware.</p> <p>(D) Electronic Medication Administration Records will be compared to physician's orders for the previous thirty (30) days by the Director of Nursing/Designee to identify medications administered and accuchecks performed outside the physician ordered time frame. The review will also identify whether the physician and responsible party were notified, and notification documented appropriately. Notifications to physician and responsible party will be made and documented in the clinical record as indicated necessary at</p>		

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F 658	<p>Continued From page 60</p> <p>(Minimum Data Set) with an ARD (Assessment Reference Date) date of 2/7/19, the resident was coded as requiring extensive assistance of 2 staff members for dressing, and personal hygiene. Resident #91 was also coded as being totally dependent on 2 staff members for bathing. The surveyor reviewed the clinical record of Resident #91 on 2/26/19 through 3/5/19. During this review, the surveyor noted the following physician's orders:</p> <p>" " ...Accu checks three times every day and at bedtime (6:30 am, 11:30 am, 4:30 pm and 9:00 pm) ...</p> <p>" Lantus Give 40 units in morning..."</p> <p>The surveyor reviewed the MAR (Medication Administration Record) for Resident #91 for February 2019. Resident #91 goes out of the facility to dialysis on Monday, Wednesday and Friday. During this review, the surveyor noted on dialysis days the facility staff documented in the detail section of the MAR for the Accu checks and insulin that was to be given at 6:30 am that the resident was not available. In addition, the Lantus insulin that was scheduled for 6:30 am on dialysis days were not being administered to the resident either because the resident was unavailable or gone to dialysis.</p> <p>In the detail section of the resident's MAR for February, the surveyor noted the following documentation:</p> <p>" " ...11:24 am 2/25/19 (Scheduled 2/5/19 9 pm) Accu checks three times every day before meals and at bedtime ...</p> <p>" 11:24am 2/25/19 (Scheduled 2/10/19 6:30 am) Accu checks three times every day before</p>	F 658	<p>the time of the review.</p> <p>Education has been provided to licensed nurses by the Director of Nursing/Designee 04/17/19, 04/18/19 and 04/19/19 regarding the following areas:</p> <p>(A) The physician must be contacted, and a physician's order must be obtained prior to the application and utilization of oxygen.</p> <p>(B) Accuchecks must be performed and medications including Insulin must be administered per the physician's order cannot be carried out. Notification must be documented in the clinical record as well. This also includes medications administered late or outside the permitted time frame.</p> <p>(C) Medications must only be documented after they are administered, never before. This includes the narcotic/controlled medication inventory log as well. If medications are refused, do not document as administered. If medications cannot be administered, you must notify physician and responsible party.</p> <p>(D) Controlled medications/Narcotics must be accounted for by two (2) nurses at shift change and the Narcotic/Controlled Medication count sheet must be signed by both nurses at shift change.</p> <p>The Director of Nursing/Designee will complete reviews for three (3) residents per week for three (3) months for the following areas to sustain substantial compliance:</p>		

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F 658	<p>Continued From page 61</p> <p>meals and at bedtime ...</p> <p>" 11:25 am 2/25/19 (Scheduled 4:30 pm 2/10/19) Accu checks three times every day before meals and at bedtime ...</p> <p>" 11:26 am 2/25/19 (Scheduled 6:30 am 2/13/19) Accu checks three times every day before meals and at bedtime ...</p> <p>" 11:26 am 2/25/19 (Scheduled 6 pm 2/18/19) Novalog ...Inject 5 units..."</p> <p>On 3/1/19 at approximately 1 pm, the surveyor asked corporate MDS nurse what these dates and times meant. The corporate MDS nurse stated "The first dates and times are the times the Accu checks and insulin were documented as being obtained and/or administrated. The dates and times in the parenthesis is the date and time the Accu checks or insulin were scheduled to be obtained and/or given."</p> <p>On 3/5/19 at 4:20 pm, the surveyor notified the administrative team of the above documented findings. The surveyor showed the corporate nurse the documentation of the above findings. The corporate nurse reviewed this but did not answer any questions regarding this. The surveyor asked the DON (director of nursing) what was the standard for the nurses' to follow when administering medications or obtaining blood sugars. The DON stated, "they have an hour before and after the time that these were schedule for." The surveyor requested a copy of the facility's policy on documentation.</p> <p>The surveyor received the facility's policy titled "Documentation of Medication Administration" which read in part " ...Administration of medication must be documented immediately after (never before) it is given ..."</p>	F 658	<p>(A) Three (3) residents that currently utilize/require oxygen will have their physician's orders reviewed to ensure that there is a physician's order for the oxygen and that the concentrator is set at the physician's ordered rate of liter flow.</p> <p>(B) Three (3) residents with physician's orders for insulin, accuchecks and dialysis will have their Electronic Medication Administration Record reviewed to ensure that accuchecks are being performed and insulin is administered per the physician's order and documented appropriately.</p> <p>(C) Narcotic logs/controlled medication count sheet/controlled medication inventory sheets and controlled medication count will be observed for each cart on both wings two (2) time per week for three (3) months to ensure that controlled medications are signed out after administration, not before; the controlled medication/narcotic count sheet is signed by both nurses at shift change after controlled med count is performed and medications are accounted for. Medication Administration observations will be conducted for two (2) licensed nurses weekly for three (3) months to ensure meds are administered, accuchecks are performed per the physician's orders.</p> <p>(D) Electronic Medication Administration Records will be compared to the active physician's orders for three (3) residents each week to ensure that accuchecks are performed and insulin is administered as ordered by the physician. Accuchecks and medications including insulin administered</p>		

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F 658	<p>Continued From page 62</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p> <p>3. In the narcotic log, it was noted that the nurse had signed out for a pain medication prior to the nurse giving this to Resident #79.</p> <p>Resident #79 was readmitted to the facility on 12/21/18 with the following diagnoses of, but not limited to heart failure, high blood pressure, end stage renal disease, diabetes and stroke. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/21/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #79 was also coded as requiring limited assistance of 1 staff member for dressing and personal hygiene. The surveyor was reviewing the narcotic log on hallway 500 with LPN (licensed practical nurse) #2 on 2/27/19 at approximately 5:20 am. It was noted that for Resident #79, the log had documentation on it with a date, name of medication, count and signature of the nurse. The surveyor asked LPN #2 if Percocet (pain medication) had been administered to resident. LPN #2 stated, "No it hasn't, I just sign out all the places on this sheet before I give it so that all I have to do is put the time it was given."</p> <p>On 3/1/19 at 5:33 pm, the surveyor notified the administrative team of the above documented findings. The surveyor asked the DON (director of nursing) what was the standard practice in the facility that she holds her nurses accountable to. The DON stated, "They are suppose to document in the narcotic log book after a pain medication is administered to a resident."</p>	F 658	<p>outside the physicians ordered time frame as well as documented physician and responsible party notification will be reviewed. Notifications to the physician and responsible party will be made and documented in the clinical record as indicated necessary at the time of the review.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>CARRINGTON PLACE AT RURAL RETREAT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>514 NORTH MAIN STREET</b> <b>RURAL RETREAT, VA 24368</b>		
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F 658	<p>Continued From page 63</p> <p>The surveyor requested and received a copy of the facility's policy titled "Documentation of Medication Administration" which read in part " ...Administration of medication must be documented immediately after (never before) it is given ..."</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p> <p>4. The facility staff failed to The facility staff failed to notify the physician when Resident #36's blood sugar and insulin were given 1-3 hours after the scheduled time.</p> <p>Resident #36 was admitted to the facility on 8/5/15 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, diabetes and dementia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/18/18, the resident was coded as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible score of 15. Resident #36 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and bathing.</p> <p>The resident had a physician order for " ...Lantus 100 unit/ml (milliliter) Administer every night at bedtime ..." This medication was scheduled to be given at 9 pm. The surveyor reviewed the January 2019 MAR (Medication Administrative Record) along with the nurses documentation in the nursing notes. On numerous dates, the surveyor noted documentation in the detail section of the MAR that the insulin was being administrated as given 1-3 hours after it was scheduled to be given to the resident.</p>	F 658			



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F 658	<p>Continued From page 64</p> <p>The physician had ordered blood sugars to be checked three times a day before meals and at bedtime. Again, on numerous dates and times the facility staff had documented in the detail section of the MAR that these blood sugars were obtained 1-3 hours after meals and at bedtime.</p> <p>The surveyor noted the following documentation, in the detail section, which stated the following:</p> <p>" ...10:34 am 2/25/19 ....accu checks ...scheduled for 1/15/19 at 7:30 am Locked by _____ (initials of nurse) as administrated, computer did not accept final signature ...</p> <p>10:34 am 2/25/19 ...Lantus ... scheduled for 1/21/19 9:00 pm. Locked by (initials of nurse) as administrated, computer did not accept final signature ..."</p> <p>The surveyor did not find any documentation that the physician had been made of aware or notified of the above documented findings.</p> <p>On 3/5/19 at 4:20 pm, the surveyor notified the administrative team of the above documented findings. The surveyor showed the corporate nurse of the documentation that the computer would not accept final signature and asked what was wrong with the computer and how long was this being noted for. The corporate nurse reviewed the documentation and did not answer the surveyor questions as to why or how long this computer problem was going on in the facility. The surveyor asked the DON what the process was for when the staff receives a physician order for insulin or Accu checks. The DON stated, "The nurses are to give the medications as ordered by the physician."</p>	F 658			

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F 658	<p>Continued From page 65</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p> <p>5. The facility staff failed to sign the narcotic count sheet as being accurate at the beginning and ending of the shift on 4 of 4 units medication cart.</p> <p>On 2/27/19 at 5:30 am, the surveyor was reviewing the narcotic log on each of the medication carts located on each unit. The surveyor reviewed these books for January and February 2019. In doing so, the surveyor noted that the narcotic logs were left blank or had 1 nurse signature when the narcotics were counted at the beginning or ending of the nursing shifts. The surveyor asked LPN (licensed practical nurse) #2 if these count sheets in the narcotic logbook was supposed to be left blank and/or have information missing on them. LPN #2 stated, "The oncoming and off going nurses' count the narcotics in the medication cart for each shift and day. After you count, you are to sign the log and that means the narcotic count was correct. You are not supposed to leave without doing this."</p> <p>On 3/5/19 at 4:20 pm, the surveyor notified the administrative team of the above documented findings. The surveyor asked the DON (director of nursing) how the counting of narcotics were to be done by the nurses'. The DON stated, "The nurse coming in and the nurse leaving will count the narcotics together. Then they are to sign their name for the date and time that this was done. The nurses are not suppose to leave the building before this is completed."</p> <p>The surveyor requested and received the facility's</p>	F 658			

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F 658	<p>Continued From page 66</p> <p>policy on documentation of narcotics titled, "Controlled Substance". This policy read in part, "...Nursing staff must count controlled medications at the end of each shift. The nurse coming in and the nurse going of duty must make the count together. They must document and report any discrepancies to the director of nursing ..."</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p> <p>6. The facility staff failed to follow professional standards of practice for medication administration to Resident #3. Registered Nurse #1 charted medication administered when the medication was actually removed from the pill cup by the resident.</p> <p>The clinical record of Resident #3 was reviewed 2/26/19 through 3/5/19. Resident #3 was admitted to the facility 4/5/17 and readmitted 1/8/19 with diagnoses that included but not limited to respiratory failure with hypoxia and hypercapnia, restless legs syndrome, diastolic heart failure, atrial fibrillation, obstructive sleep apnea, hypokalemia, constipation, idiopathic progressive neuropathy, gastro-esophageal reflux disease, hyperlipidemia, hypothyroidism, major depressive disorder, insomnia, anxiety, chronic pain syndrome, Vitamin D deficiency, benign paroxysmal vertigo, morbid obesity, hypertension, chronic obstructive pulmonary disease, type 2 diabetes mellitus, nasal congestion, and migraines.</p> <p>Resident #3's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/19 assessed the resident with a BIMS (brief interview for mental status) as 15. No evidence of delirium, behaviors affecting others or</p>	F 658			

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F 658	<p>Continued From page 67 psychosis.</p> <p>The surveyor interviewed Resident #3 on 2/27/19 at 11:17a.m. During the interview, registered nurse #1 came in Resident #3's room to administer the morning medications. Resident #3 stated she didn't want the diuretic as she was going to get up and go to activities. Resident #3 was given the pill cup and removed the diuretic.</p> <p>The surveyor reviewed Resident #3's February 2019 physician's orders. Resident #3 had orders for Lasix 40 mg (milligram) tablet take one by mouth twice a day.</p> <p>The surveyor reviewed the February 2019 medication administration record. The 2/27/19 9:00 a.m. box for Lasix had been documented with the initials of R.N. #1. Initialed boxes on medication administration records indicated the medication was administered. Resident #3 refused the medication on 2/27/19 as witnessed by the surveyor.</p> <p>The surveyor informed the director of nursing of the above concern on 3/1/19 at 3:50 p.m. The DON stated if medications were not administered due to refusal, she would expect the nurses to document refused. The DON stated the standard of practice was to chart and document refusal.</p> <p>The surveyor interviewed R.N. #1 on 3/1/19 at 3:52 p.m. about the medication Lasix documented as administered when the resident had refused the medication. R.N. #1 stated, "Did I do that? I can go in and fix it."</p> <p>The surveyor requested the facility policy on standards of practice for medication</p>	F 658			

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F 658	<p>Continued From page 68</p> <p>administration from the director of nursing on 3/1/19 at 4:03 p.m.</p> <p>The surveyor reviewed the facility policy and standard of practice for medication administration on 3/1/19. The policy titled "Documentation of Medication Administration" read in part, "3. Documentation must include, as a minimum: e. Reason(s) why a medication was withheld, not administered, or refused."</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the corporate registered nurse of the above concern on 3/1/19 at 5:34 p.m. and again on 3/5/19 at 4:26 p.m.</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>7. For Resident #72 the facility staff failed to document a treatment was not applied.</p> <p>Per clinical record review Resident #72 was admitted to the facility on 02/16/17. Diagnoses included but not limited to diabetes mellitus, chronic obstructive pulmonary disease, morbid obesity, difficulty walking, and muscle weakness.</p> <p>Section C (cognitive patterns) of the Resident's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/14/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.</p> <p>Resident #72's comprehensive care plan was reviewed and contained a problem area for "Potential for skin breakdown related to impaired mobility and incontinence ...I am morbidly obese and often have moisture associated skin</p>	F 658			

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F 658	<p>Continued From page 69</p> <p>damage". The interventions included but were not limited to, "Medications as ordered. Treatments as ordered".</p> <p>On 02/26/19 at 5:04pm the surveyor interviewed Resident #72. Resident #72 voiced to the surveyor that her genital wart treatment was not being applied per order. On 02/27/19 at 10:33am the surveyor asked the Resident if her Algera cream had been applied that morning. Resident #72 stated "I do not remember the last time I had it. I can't apply it because I can't see down there."</p> <p>On 02/28/19 at 9:45am Resident #72's record was reviewed. Resident #72's physician's order contained an order dated 11/27/18 which read in part "Apply Algera Cream to genital warts every other day". The Resident's e-TAR (electronic treatment administration record) for the month of February was reviewed. Algera cream was scheduled to be administered on 02/27/19 at 6:00am. The ETAR contained initials under the date 02/27/19 at 6:00am indicating that Resident #72's treatment was applied. On 02/28/19 at 10:00am Resident #72 voiced to the surveyor that her genital warts treatment was not applied yesterday as documented. Resident #72 stated "The nurse said she would apply it today".</p> <p>On 03/01/19 at 03:50pm the surveyor spoke to the DON (director of nursing) about the concern of staff documenting treatment as administered when the treatment was not administered per Resident. The DON voiced to the surveyor that she expects staff to document if the medication is not given or refused.</p> <p>The surveyor requested a standards of practice for medication administration and documentation.</p>	F 658			

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F 658	Continued From page 70 The facility was unable to provide the surveyor with the 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 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."  The surveyor spoke with the administrative team on 03/01/19 at 5:15pm regarding the concern of Resident #72's treatment not being administered as ordered and the treatemnt documented as administered.  No further information regarding this issue was provided to the survey team prior to the exit Conference on 03/05/19.	F 658			
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 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		4/19/19	

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F 684	<p>Continued From page 71</p> <p>care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, clinical record review, and facility document review, facility staff failed to ensure the highest practicable well-being for 11 of 28 residents in the survey sample (Resident #89, 20, 110, 36, 34, 91, 72, 47, 15, 17, and 51).</p> <p>The findings included:</p> <p>1. The facility staff failed to follow physician orders when Resident #89 returned from being seen at the emergency room. Resident #89 was admitted to the facility on 1/26/19 with the following diagnoses of, but not limited to high blood pressure and respiratory failure. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/1/19, the resident was coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene. Resident #89 was also coded as being totally dependent on 2 staff members for bathing.</p> <p>During the clinical record review on 2/28/19, the surveyor noted that Resident #89 was in the emergency room on 2/6/19. The surveyor could not find any documentation of this visit in the clinical record. The surveyor requested and received copies of this visit. The DON (director of nursing) was asked where these copies were found. The DON stated, "I had to call the hospital and they faxed them over to me." According to this documentation, the emergency room doctor wrote an order for the resident to be seen by the doctor in the facility in 2-3 days for a follow up.</p>	F 684	<p>Resident #89 no longer resides at the facility. For Resident #20, the physician and the responsible party were notified by the Director of Nursing/Designee of the variance in obtaining accuchecks for the following dates and times: 2/5/19 at 7:57 am, 2/6/19 at 1:57 am, 2/6/19 at 8:26 am as well as the insulin variances in the February 2019 Medication Administration Record for Lantus including Lantus administered on 2/9/19 at 3:11 am. There were no adverse effects for Resident #20. Resident #110 no longer resides at the facility. For Resident #36, the physician and the responsible party have been notified by the Director of Nursing/Designee regarding administration of insulin/Lantus 1-3 hours after it was scheduled to be administered in January 2019. The physician and responsible party were also notified regarding Lantus documented as administered on 2/25/19 at 10:34 am but was scheduled for 1/21/19. The physician and the responsible party have been notified regarding accuchecks obtained in January 2019 1-3 hours after meals and bedtime as well as accucheck documented as obtained on 2/25/19 at 10:34 am but was originally scheduled for 1/15/19 at 7:30 pm. There were no adverse effects for the resident related to these variances. The notifications have been documented in the clinical record by the Director of Nursing/Designee. Resident #91 no longer resides in the</p>		



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F 684	<p>Continued From page 72</p> <p>The surveyor reviewed the progress notes for Resident #89. There were no progress notes in the clinical record within this period. The facility doctor did not see the resident until 2/18/19.</p> <p>The surveyor notified the administrative team of the above documented findings on 3/1/19 at 5:33 pm in the conference room.</p> <p>The surveyor interviewed the facility doctor on 3/5/19 at approximately 2 pm. The doctor reviewed the clinical record and stated, "He was only seen on 2/18/19 for another problem."</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p> <p>2. The facility staff failed to follow physician orders for obtaining Accu checks (blood sugar) and the administration of insulin (blood sugar) for Resident #20.</p> <p>Resident #20 was admitted to the facility on 8/31/18 with the following diagnoses of, but not limited to heart failure, diabetes, high blood pressure, dementia, Alzheimer's disease, depression and respiratory failure. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment reference Date) of 12/7/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. Resident #20 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and bathing.</p> <p>During the clinical record review from 2/26/18 through 3/5/19, the surveyor noted on the MAR (Medication Administration Record) and the detail report for February 2019, that Accu checks were not being performed as ordered by the doctor. The physician ordered the Accu checks to be</p>	F 684	<p>facility. For Resident #34 the physician and the responsible party have been notified by the Director of Nursing/Designee regarding the medication variance for Metformin ordered on 2/28/2019 and started on 3/1/19. There were no adverse effects for the resident related to the medication variance. For Resident #72, the physician and responsible party have been notified by the Director of Nursing/Designee regarding the medication variance on 2/27/2019 at 6:00 am for Algera cream. The licensed nurse has been in-serviced regarding the six (6) rights of medication administration to include accurate documentation of medications after administration not before. There were no adverse effects for the resident related to the medication variance. For Resident #15, the physician has been notified by the Director of Nursing/Designee regarding the variance related to vital signs and weights ordered on 2/23/19 for one (1) week. There was no adverse effect for Resident #15 related to the variance involving vital signs and weights everyday for one (1) week. For Resident #17, the physician and responsible party were notified by the Director of Nursing/Designee of the following medication variances: 2/27/19 at 9:00 pm for Zatador and Seroquel, 2/28/19 at 9:00 a, for Zatador, Mobic and Propylene glycol eye drops. The physician has also been notified by the Director of Nursing/Designee of the accucheck variances regarding notification parameters in February 2019. These</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>CARRINGTON PLACE AT RURAL RETREAT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>514 NORTH MAIN STREET</b> <b>RURAL RETREAT, VA 24368</b>		
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F 684	<p>Continued From page 73</p> <p>obtained three times every day before meals and at bedtime.</p> <p>According to the detail report of the MAR, the Accu checks were not documented as being completed as ordered. The surveyor noted the following notations:</p> <p>" ...7:57 am 2/5/19 (Scheduled: 5:30 pm 2/4/19) ...</p> <p>" ...1:51 am 2/6/19 (Scheduled: 9:00 pm 2/5/19) ...</p> <p>" ...8:26 am 2/6/19 (Scheduled: 5:30 pm 2/5/19) ..."</p> <p>The surveyor also noted Lantus Insulin was to be given to the resident at bedtime. The surveyor noted the following in the detail section of the resident's MAR which stated " ...3:11 am 2/9/19 (Scheduled: 9:00 pm 2/8/19) ..."</p> <p>The surveyor continued to note numerous throughout the MAR for February.</p> <p>On 3/1/19 at approximately 1:30 pm, the surveyor asked the corporate MDS nurse what the dates and times meant on this detail report. The corporate MDS nurse stated, "The first time and date is when the Accu check and/or insulin was administrated. The numbers in the parenthesis are the schedule dates and times these were to be done."</p> <p>On 3/5/19 at 4:20 pm, the surveyor notified the administrative team of the above documented findings. The surveyor showed this documentation to the corporate nurse and she reviewed it. The corporate nurse did not offer an explanation in regards to why this was occurring.</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p>	F 684	<p>include: 2/23/19 at 7:30 am blood glucose was greater than 450; at 11:30 am on 2/1/19, 2/7/19, 2/10/19, 2/19/19 and 2/23/19 blood glucose was greater than 450; and at 5:30 pm on 2/1/19, 2/2/19 and 2/8/19 blood glucose was greater than 450. The notifications have been documented in the clinical record by the Director of Nursing/Designee. There were no adverse effects for the resident related to these variances. For Resident #47, the physician and responsible party were notified by the Director of Nursing/Designee regarding the following medication variances: Cipro from 1/11/19 through 1/24/19 for a total of 29 doses instead of the ordered 28 doses, gentamycin from 1/29/19 through 2/8/19 in which the electronic medication administration record reflects twenty-seven (27) doses administered instead of the prescribed forty-two (42) doses. There were no adverse effects for the resident related to the antibiotic variances. For Resident #51, the physician and the responsible party have been notified by the Director of Nursing/Designee of the medication variances involving Klonopin on the following dates 2/3/19, 2/4/19, 2/5/19, 2/12/2019, 2/16/19, 2/21/19, 2/22/19, 2/23/19 and 2/24/19. The medication nurse observed on 2/27/19 at 6:30 am is no longer employed at the facility. The physician and the responsible party have been notified of the medication variance on 2/27/19 at 6:30 am involving Klonopin. Notifications have been documented by the Director of Nursing/Designee in the</p>		

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F 684	<p>Continued From page 74</p> <p>3. The facility staff failed to follow physician orders for the administration of an antibiotic to Resident #110.</p> <p>Resident #110 was admitted to the facility on 1/7/19 with the following diagnoses of, but not limited to anemia, high blood pressure, obstructive uropathy, UTI and multidrug resistant organism. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/14/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. Resident #110 was also coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene.</p> <p>During the clinical record review from 2/26/19 through 3/5/19, the surveyor noted that the resident was ordered to have Vancomycin 500 mg to infuse IV for 10 days. This order was started being administrated by the facility staff on 2/23/19 at 9:00 pm. On the detail section of the resident's MAR (Medication Administration Record) for February 2019, the following was documented: " ...11:56 am 2/23/19 (Scheduled for 2/23/19 9:00 am) ...Med not available from pharmacy. Pharmacy notified ... " 3:17 am 3/9/19 (Scheduled for 3/2/19 at 9:00 pm not given; awaiting pharmacy arrival ..."</p> <p>The surveyor notified the administrative team on 3/5/19 at 4:20 pm in the conference room.</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p> <p>4. The facility staff failed to follow physician</p>	F 684	<p>clinical record. There were no adverse effects for the resident related to the medication variances.</p> <p>Reviews have been conducted by the Administrator/Director of Nursing/Designee in the following areas: to identify further variances and verify that medication administration is consistent with physician's orders: (A) The Administrator/Director of Nursing/Designee has reviewed the emergency room documentation for resident's ER visits within the previous thirty (30) days to ensure that recommendations have been followed and residents returning to the facility from the ER have been seen by the physician upon returning and hospital paperwork related to the ER visit are present on the clinical records. (B) The Director of Nursing/Designee has reviewed Electronic Medication Administration Records and physician's orders for the previous thirty (30) days for residents with physician's orders for accuchecks/blood glucose checks, specific notification parameters, and insulin administration to identify further variances requiring correction and notification to the physician and responsible party and verify that physician's orders have been followed. (C) The Director of Nursing/Designee has reviewed the Electronic Medication Administration Records and physician's orders for the previous (30) days for residents with physician orders for antibiotic medications as well as diabetic</p>		

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F 684	<p>Continued From page 75</p> <p>orders for obtaining Accu (blood sugar) checks and for the administration of insulin for Resident #36.</p> <p>Resident #36 was admitted to the facility on 8/5/15 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, diabetes and dementia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/18/18, the resident was coded as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible score of 15. Resident #36 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and bathing.</p> <p>The resident had a physician order for " ...Lantus 100 unit/ml (milliliter) Administer every night at bedtime ..." This medication was scheduled to be given at 9 pm. The surveyor reviewed the January 2019 MAR (Medication Administrative Record) along with the nurses documentation in the nursing notes. On numerous dates, the surveyor noted documentation in the detail section of the MAR that the insulin was being administrated as given 1-3 hours after it was scheduled to be given to the resident.</p> <p>The physician had ordered blood sugars to be checked three times a day before meals and at bedtime. Again, on numerous dates and times the facility staff had documented in the detail section of the MAR that these blood sugars were obtained 1-3 hours after meals and at bedtime.</p> <p>The surveyor noted the following documentation, in the detail section, which stated the following: " ...10:34 am 2/25/19 ....accu checks ...scheduled for 1/15/19 at 7:30 am Locked by _____ (initials of nurse) as administrated, computer did</p>	F 684	<p>medications i.e. Metformin to identify further variances requiring correction and notification to the physician and responsible party and to verify that medications have been administered per the physician's orders.</p> <p>(D) The Director of Nursing/Designee has reviewed physician's orders, EMARs, and notes for the previous thirty (30) days to identify residents with physician's orders to have vital signs and or weights obtained at an increased frequency and determine if these were obtained and documented as ordered.</p> <p>(E) The Director of Nursing/Designee has compared the physicians' orders with the EMAR for the previous thirty (30) days to verify that medications have been administered per physician's orders and identify any further variances/omissions requiring correction and further notification to the physician and responsible party.</p> <p>(F) The Director of Nursing/Designee will compare the current physician's orders with the medications available in the medication cart to ensure that physicians ordered medications are available for administration.</p> <p>Education has been provided by the Director of Nursing/Designee to the Licensed Nurses and interdisciplinary team on 04/17/19, 04/18/19 and 04/19/19 regarding the following topics: (A) Hospital discharge paperwork form ER visits should be filed on the clinical record upon return. Physicians orders communicated in the hospital ER discharge paperwork must be followed in</p>		

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F 684	<p>Continued From page 76</p> <p>not accept final signature ... 10:34 am 2/25/19 ...Lantus ... scheduled for 1/21/19 9:00 pm. Locked by (initials of nurse) as administrated, computer did not accept final signature ..."</p> <p>The surveyor did not find any documentation that the physician had been made of aware or notified of the above documented findings.</p> <p>On 3/5/19 at 4:20 pm, the surveyor notified the administrative team of the above documented findings. The surveyor showed the corporate nurse of the documentation that the computer would not accept final signature and asked what was wrong with the computer and how long was this being noted for. The corporate nurse reviewed the documentation and did not answer the surveyor's questions as to why or how long this computer problem was going on in the facility. The surveyor asked the DON what the process was for when the staff receives a physician order for insulin or Accu checks. The DON stated, "The nurses are to give the medications as ordered by the physician."</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p> <p>5. The facility staff failed to follow physician orders for obtaining Accu checks and/or the administration of Resident #91's insulin. Resident #91 was admitted to the facility on 1/31/19 with the following diagnoses of, but not limited to anemia, atrial fibrillation, end stage renal disease, diabetes, heart failure and high blood pressure. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) date of 2/7/19, the resident was</p>	F 684	<p>a timely fashion. Residents transported to the ER for evaluation should be placed on the physicians list at the facility upon return to the facility for follow up assessment and physicians visit.</p> <p>(B) Physician's orders must be followed regarding these areas: medications must be administered via the six (6) nights of medication administration and within the permitted time frame for medication administration. Medication administration must be documented after administration of the medication administered on the EMAR. Any variance or physician order that cannot be followed requires that the nurse call the physician timely as well as the responsible party to relay the details of the variance. Notifications to the physician and responsible party must be documented in the clinical record. This includes medications that are unavailable. The physician may wish to give an order to hold the medication this includes all routes of medications, insulin, accuchecks, specifically ordered notification parameters, vital signs, physician's ordered weights. If medications are identified as unavailable please contract the physician, the pharmacy, the responsible party and the Director of Nursing/Designee. Steps will need to be taken at that time to obtain the medication or other physicians orders.</p> <p>(C) The Administrator/Director of Nursing/Designee will complete the following reviews for three (3) residents weekly for three (3) months: Hospital, ER discharge documents will be reviewed to ensure that physician orders</p>		

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F 684	<p>Continued From page 77</p> <p>coded as requiring extensive assistance of 2 staff members for dressing, and personal hygiene. Resident #91 was also coded as being totally dependent on 2 staff members for bathing. The surveyor reviewed the clinical record of Resident #91 on 2/26/19 through 3/5/19. During this review, the surveyor noted the following physician's orders:</p> <ul style="list-style-type: none"> <li>o "...Accu checks three times every day and at bedtime (6:30 am, 11:30 am, 4:30 pm and 9:00 pm) ...</li> <li>o Lantus Give 40 units in morning..."</li> </ul> <p>The surveyor reviewed the MAR (Medication Administration Record) for Resident #91 for February 2019. Resident #91 goes out of the facility to dialysis on Monday, Wednesday and Friday. During this review, the surveyor noted on dialysis days the facility staff documented in the detail section of the MAR for the Accu checks and insulin that was to be given at 6:30 am that the resident was not available. In addition, the Lantus insulin that was scheduled for 6:30 am on dialysis days were not being administered to the resident either because the resident was unavailable or gone to dialysis.</p> <p>In the detail section of the resident's MAR for February, the surveyor noted the following documentation:</p> <ul style="list-style-type: none"> <li>o "...11:24 am 2/25/19 (Scheduled 2/5/19 9 pm) Accu checks three times every day before meals and at bedtime ...</li> <li>o 11:24am 2/25/19 (Scheduled 2/10/19 6:30 am) Accu checks three times every day before meals and at bedtime ...</li> <li>o 11:25 am 2/25/19 (Scheduled 4:30 pm</li> </ul>	F 684	<p>communicated in the discharge paperwork have been followed and that the ER paperwork is available on the clinical record. The weekly review will also include review of the facility's physicians list to ensure that the residents transferred back to the facility from the ER have been added to the list of residents to be seen and assessed by the practitioner.</p> <p>(D) The Director of Nursing/Designee will review active physician's orders and current EMAR for residents with physician's orders for accuchecks specific notification parameters, and insulin administration to ensure that these things were carried out following the physicians order and documented appropriately in the clinical record.</p> <p>(E) The Director of Nursing/Designee will review physician's orders and compare to electronic medication administration record for three (3) residents with orders for antibiotic medications as well as diabetic medication i.e. Metformin to ensure that medications are available and administered as ordered by the physician and documented appropriately in the clinical record.</p> <p>(F) The Director of Nursing/Designee will review active physician's orders and compare these to the electronic medication administration record for three (3) residents weekly for three (3) months. To ensure that meds are administered as ordered by the physician within the acceptable time frame and administration of medication is documented accurately in the clinical record. Additionally, if variances are identified the review will</p>		

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F 684	<p>Continued From page 78</p> <p>2/10/19) Accu checks three times every day before meals and at bedtime ...</p> <p>o 11:26 am 2/25/19 (Scheduled 6:30 am 2/13/19) Accu checks three times every day before meals and at bedtime ...</p> <p>o 11:26 am 2/25/19 (Scheduled 6 pm 2/18/19) Novalog ...Inject 5 units..."</p> <p>On 3/1/19 at approximately 1 pm, the surveyor asked corporate MDS nurse what these dates and times meant. The corporate MDS nurse stated "The first dates and times are the times the Accu checks and insulin were documented as being obtained and/or administrated. The dates and times in the parenthesis is the date and time the Accu checks or insulin were scheduled to be obtained and/or given."</p> <p>On 3/5/19 at 4:20 pm, the surveyor notified the administrative team of the above documented findings. The surveyor showed the corporate nurse the documentation of the above findings. The corporate nurse reviewed this but did not answer any questions regarding this. The surveyor asked the DON (director of nursing) what was the standard for the nurses' to follow when administering medications or obtaining blood sugars. The DON stated, "they have an hour before and after the time that these were schedule for." The surveyor requested a copy of the facility's policy on documentation.</p> <p>The surveyor received the facility's policy titled "Documentation of Medication Administration" which read in part " ...Administration of medication must be documented immediately after (never before) it is given ..."</p> <p>No further information was provided to the</p>	F 684	<p>need to ensure that the physician and responsible party are notified, and notification documented.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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F 684	<p>Continued From page 79 surveyor prior to the exit conference on 3/5/19.</p> <p>6. The facility staff failed to administer a physician ordered medication, Metformin, for Resident #34.</p> <p>Resident #34 was readmitted to the facility on 9/12/15 with the following diagnoses of, but not limited to anemia, neurogenic bladder, urinary tract infection, dementia, Multiple Sclerosis and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/17/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #34 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and being totally dependent on 2 staff members for bathing.</p> <p>During the clinical record review 3/1/19 at 9:45 am, the surveyor noted a physician order in the clinical record dated and timed for 2/28/19 at 3:30 pm which stated, "Metformin 250 mg (milligram) po (by mouth) BID (twice a day)."</p> <p>At 9:50 am, the surveyor notified the unit manager #2 of the above documented findings with the regional MDS (Minimum Data Set) coordinator being present. The resident was not started on Metformin as ordered on 2/28/19 until after this time on 3/1/19.</p> <p>At 5:33 pm on 3/1/19, the surveyor notified the administrative team of the above documented findings.</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/2/19.</p>	F 684			



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F 684	<p>Continued From page 80</p> <p>7. For Resident #72 the facility staff failed to administer the treatment Algera as ordered by the physician.</p> <p>Per clinical record review Resident #72 was admitted to the facility on 02/16/17. Diagnoses included but not limited to diabetes mellitus, chronic obstructive pulmonary disease, morbid obesity, difficulty walking, and muscle weakness.</p> <p>Section C (cognitive patterns) of the Resident's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/14/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.</p> <p>Resident #72's comprehensive care plan was reviewed and contained a problem area for "Potential for skin breakdown related to impaired mobility and incontinence ...I am morbidly obese and often have moisture associated skin damage". The interventions included but were not limited to, "Medications as ordered. Treatments as ordered".</p> <p>On 02/26/19 at 5:04pm the surveyor interviewed Resident #72. Resident #72 voiced to the surveyor that her genital wart treatment was not being applied per order. On 02/27/19 at 10:33am the surveyor asked the Resident if her Algera cream had been applied that morning. Resident #72 stated "I do not remember the last time I had it. I can't apply it because I can't see down there."</p> <p>On 02/28/19 at 10:00am Resident #72's record was reviewed. Resident #72's physician's order contained an order dated 11/27/18 which read in part "Apply Algera Cream to genital warts every other day". The Resident's e-TAR (electronic</p>	F 684			

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F 684	<p>Continued From page 81</p> <p>treatment administration record) for the month of February was reviewed. Algera cream was scheduled to be administered on 02/27/19 at 6:00am. The ETAR contained initials under the date 02/27/19 at 6:00am indicating that Resident #72's treatment was applied. On 02/28/19 at 10:05am Resident #72 voiced to the surveyor that her genital warts treatment was not applied yesterday as documented. Resident #72 stated "The nurse said she would apply it today".</p> <p>On 03/01/19 at 1:00pm Resident #72 voiced to the surveyor that her cream was applied today and stated "I have never seen nurses not follow physician's orders".</p> <p>The surveyor spoke with the administrative team on 03/01/19 at 5:15pm regarding the concern of Resident #72's treatment not being administered as ordered.</p> <p>No further information regarding this issue was provided to the survey team prior to the exit conference on 03/05/19.</p> <p>8. For Resident #15, facility staff failed to obtain vital signs as ordered.</p> <p>Resident #15 was admitted to the facility on 11/22/15 and readmitted on 11/18/18. Diagnoses included heart failure, hypertension, Alzheimer's disease, psychotic disorder, pneumonia, urinary tract infection (UTI), dementia with behavior disturbance, dysphagia, anxiety, muscle weakness, and difficulty walking. On the quarterly 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 symptoms of</p>	F 684			

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F 684	<p>Continued From page 82</p> <p>delirium, psychosis, or behaviors affecting care. The assessment indicated the resident ambulated and used the toilet with 1-2 person assistance, was frequently, but not always, incontinent, and on a prompted toileting program.</p> <p>Clinical record review revealed a physician order dated 2/23/19 for daily blood pressure, heart rate, and weight daily times one week and record.</p> <p>There was a nursing note dated 2/23/19 indicating there was an order for" bp/p/weight daily for a week". Only the 2/28 blood pressure and pulse was documented. No weight was documented after 2/19/19. The director of nursing was notified on 2/28/19 that the surveyor was unable to locate the ordered vital signs. The director of nursing was able to locate vital signs for 2/28/19.</p> <p>9. For Resident #17 facility staff failed to ensure physician orders for medication administration were followed and that the physician was notified when those orders were not followed, and to ensure that the physician was notified of information necessary for diabetes management.</p> <p>Resident #17 was admitted to the facility on 4/19/16. Diagnoses included hypertension, gastroesophageal reflux disease, diabetes mellitus, anxiety, depression, asthma, and chronic pain. On the annual assessment with assessment reference date 2/7/17, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.</p> <p>Medication orders included Mobic 7.5 milligram</p>	F 684			

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F 684	<p>Continued From page 83</p> <p>one tablet by mouth daily started 1/10/19, Zatador eye drops one drop each eye twice a day, Seroquel 50 milligrams one tablet by mouth at bedtime, and propylene glycol 1 drop each eye 4 times a day.</p> <p>During clinical record review on 2/28/19, the surveyor noted that on 2/27/18 at 9 PM Zatador and Seroquel were documented as "not administered- meds not available". On 2/28/18 9 AM Zatador, Mobic, and propylene glycol eye drops were documented as "not administered- meds not available".</p> <p>The resident had a physician order for accuchecks three times every day before meals and at bedtime (notify MD for BG(blood glucose) &lt;60 or &gt;450). The documented blood sugar was greater than 450 at 7:30 on February 23, at 11:30 on February 1, 7, 10, 19, and 23, at 5:30 on February 1, 2, and 8.</p> <p>There were no nursing notes to indicate that the physician or nurse practitioner were notified of the medication omissions or of the high blood glucose readings. Nursing staff were unable to say whether the physician was routinely notified of the issues noted.</p> <p>The administrator and director of nursing were notified of the concern that the physician was not notified when medications were not administered or when the blood glucose levels were over 450 so that treatment could be adjusted if necessary during a summary meeting on 3/1/19.</p> <p>10. For Resident #47, facility staff failed to administer antibiotics for the ordered duration.</p>	F 684			

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F 684	<p>Continued From page 84</p> <p>Resident #47 was admitted to the facility on 4/6/16. Diagnoses included heart failure, hypertension, peripheral vascular disease, wound infection, diabetes mellitus, dementia, hemiplegia, Parkinson's, schizophrenia, cardiopulmonary disease, dysphagia, open wound to the left foot and methicillin resistant staphylococcus infection. On the quarterly minimum data set assessment with assessment reference date 2/12/19, the resident scored 11/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behavior symptoms.</p> <p>During clinical record review, the surveyor noted a telephone order dated 1/11/19 for cipro 500 mg (milligram) PO (by mouth) BID (twice a day) X 14 days (total of 28 doses). The medication administration record documented administration from 1/11 through 1/24 for a total of 29 doses. A telephone order for gentamycin 60 mg IM (intramuscular injection) TID (three times a day) X 14 days was written on 1/29/19. The order was entered for three times a day from 1/29 through 2/8/19 (10 full days) The MAR indicated the resident received the medication once on 1/29/19, twice on 1/30/19, 1/31 through 2/6, once on 2/7 and two times on 2/8. The MAR indicated the resident received 27 of the prescribed 42 doses.</p> <p>The administrator and director of nursing were notified of the omission of antibiotic medications during summary meetings on 3/4/19.</p> <p>11. For Resident #51, facility staff failed to administer klonopin as ordered.</p> <p>Resident #51 was readmitted to the facility on 3/25/18. Diagnoses included hypertension,</p>	F 684			

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F 684	<p>Continued From page 85</p> <p>diabetes mellitus, seizures, cerebral palsy, dementia, seizure disorder, anxiety, and schizophrenia. On the quarterly minimum data set assessment with assessment reference date 3/29/18, the resident scored 9/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.</p> <p>Clinical record review revealed an order for klonopin 1 milligram take with .5 milligram to equal 1.5 milligram by mouth before meals and at bedtime. The MAR (medication administration record) indicated the medication had not been administered at least two of the four ordered administrations on February 3, 4, 5, 12, 16, 17, 21, 22, 23 and 24. Surveyors observed the medication nurse hold the klonopin at 6:30 AM on 2/27/19 after dropping the klonopin on the floor. The nurse told the surveyor she was not going to administer it because she was near the end of the on time administration window in the electronic clinical record and she did not want to chart it was given late. The nurse charted in the medication notes at 8:59 AM "medication not administered physician aware". The surveyor asked the nurse what she told the physician and whether the physician had ordered the dose to not be administered. The nurse said she intended to complete a physician communication form to notify the physician that the medication had been missed. The surveyor asked how often medications were missed and the record reflected the physician was aware when the physician had not been notified. The nurse then called the physician office and reported that the nurse had been unable to give the klonopin at 6:30 AM because the surveyors took the controlled medication log and she could not give</p>	F 684			

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F 684	Continued From page 86 the medication. The surveyor was unable to hear the physician response, but the nurse said she would rather have an order to give it at 9 so she would have until 10 AM to give the medication. The physician communication form listed no date or time and said only "6:30 AM medication not administered. Please refer to [director of nursing] with questions. No nursing note was made to explain the medication being administered several hours late that day.	F 684			
F 686 SS=D	Facility administration was made aware of the concern as the incident occurred on 2/27/19. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)  §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, facility staff failed to provide wound treatment for 1 of 28 residents in the survey sample (Resident #47).  Resident #47 was admitted to the facility on	F 686	For Resident #47, the physician and the responsible party were notified that the treatment was held on 2/11/19. There was no adverse effect for the resident related to the treatment variance.	4/19/19	

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F 686	Continued From page 87 4/6/16. Diagnoses included heart failure, hypertension, peripheral vascular disease, wound infection, diabetes mellitus, dementia, hemiplegia, Parkinson's, schizophrenia, cardiopulmonary disease, dysphagia, open wound to the left foot and methicillin resistant staphylococcus infection. On the quarterly minimum data set assessment with assessment reference date 2/12/19, the resident scored 11/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behavior symptoms.  During clinical record review, the surveyor noted a physician order dated 1/14/19 for clean ulcer with soap and water, rinse, pat dry, apply calcium alginate to wound bed, skin prep to wound, and cover with ABD pads and kerlix every day and PRN. The treatment administration record indicated on 2/11/19 "was held. special requirement not met". The resident's nurse and the director of nursing were unable to explain what the special requirement was or why the treatment had not been done. There was no nursing progress note for that date.  The TAR for January documented on 1/11/19, a similar note indicating not dressing applied with no associated note to explain why the dressing was not applied.  The administrator and director of nursing were notified of the omissions in wound care during summary meetings on 3/4/19.	F 686	The Director of Nursing/Designee has conducted a review of physician's orders and treatment administration records for the previous thirty (30) days to identify further variances requiring corrective measures and physician and responsible party notifications, to ensure treatments are completed per the physician's order.  Education has been provided by the Director of Nursing/Designee to Licensed Nurses regarding completing treatments as ordered by the physician and documenting the treatment administration appropriately after it is completed. A review will be completed by the Director of Nursing/Designee of physician orders for treatments and the ETAR for three (3) residents per week for three (3) months to ensure treatments are being administered as ordered by the physician and documented appropriately after administration.  The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii)  §483.25(b)(2) Foot care. To ensure that residents receive proper treatment	F 687		4/19/19	



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F 687	<p>Continued From page 88</p> <p>and care to maintain mobility and good foot health, the facility must:</p> <p>(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and</p> <p>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and clinical record review, the facility staff failed to provide podiatry services consistent with professional standards of practice to prevent complications from the resident's medical condition for 1 of 28 residents (Resident #11).</p> <p>The findings included:</p> <p>The facility staff failed to provide podiatry services to Resident #11 in a timely manner. The physician ordered a podiatry consult on 12/10/18 for ingrown toenails and was started on Keflex 500 mg (milligrams) qid (four times a day) x 10 days. Resident #11 was not seen until 2/7/19 when the resident was treated again for an ingrown toenail and seen by the podiatrist.</p> <p>The clinical record of Resident #11 was reviewed 2/26/19 through 3/5/19. Resident #11 was admitted to the facility 2/4/15 and readmitted 7/14/18 with diagnoses that included but not limited to acute respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, metabolic encephalopathy, difficulty in walking, muscle weakness, acute kidney failure, chronic pain syndrome, type 2 diabetes mellitus,</p>	F 687	<p>For Resident #11, podiatry services were provided.</p> <p>A review has been completed by the Administrator/Director of Nursing/Designee for current residents to ensure that podiatry services have been provided.</p> <p>Education has been provided to the licensed nurses and the interdisciplinary team by the Administrator/Director of Nursing/Designee regarding provision of podiatry services. A review will be completed by the Administrator/Designee weekly for three (3) residents for three (3) months to ensure resident are having podiatry services coordinated, set up and provided to them.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations</p>		

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F 687	<p>Continued From page 89</p> <p>hypertension, anxiety, hypothyroidism, major depressive disorder, bipolar disorder, polyneuropathy, hypokalemia, gastro-esophageal reflux disease, adult failure to thrive, schizoaffective disorder, urethral stricture, anemia, dysphagia, constipation, Parkinson's disease, urinary tract infection, chronic obstructive pulmonary disease, and Vitamin deficiency.</p> <p>Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/13/19 assessed the resident with a BIMS (brief interview for mental status) as 15. There were no assessed signs or symptoms of delirium, behaviors affecting others or psychosis.</p> <p>The clinical record contained a nursing communication form dated 12/9/18 and read "Rsd (resident) c/o (complained of) (L) &amp; (R) (left and right) great toe pain. Pus noted to outer edge of toenail. Area cleaned, ABT (antibiotic) oint (ointment) and band-aid applied." This form had been faxed to the physician with a return response dated 12/10/18 "See order." Physician order dated 12/10/18 read "1. Start Keflex 500 mg (milligrams) po (by mouth) qid (four times a day) x 10 days. 2. Consult podiatry."</p> <p>The surveyor was unable to locate the podiatry consult in the clinical record and informed the corporate registered nurse of the above on 3/4/19 at 5:42 p.m.</p> <p>The surveyor received the podiatry consult dated 2/7/19-two months after the original order of 12/10/18. The podiatry consult read "Pt (patient) seen for new foot and nail evaluation and treatment. No new complaints. Left hallux nails</p>	F 687	for revisions as indicated necessary to sustain substantial compliance.		

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F 687	Continued From page 90 are mildly ingrown. Tibial-paronychia." Unable to read most of handwriting but Resident #11 was prescribed Keflex 500 mg tid (three times a day) x 7 days. The surveyor asked the director of nursing if podiatry services come to the facility. The DON stated some residents go out to a local podiatrist as well as seen in the facility.  The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the regional executive, the corporate registered nurse and the corporate registered nurse MDS of the above concern on 3/5/19 at 4:26 p.m.  The surveyor reviewed the facility policy on "Nursing Care of the Resident with Diabetes Mellitus" on 3/5/19. The policy read under "Complications Associated with Diabetes" to include 5. Foot complications-neuropathy, dry skin, calluses, poor circulation, ulcers. Skin and Foot Care included: 8. Toenails should only be trimmed by personnel qualified to do so (this can be regular associates, and does not have to be a podiatrist). 9. Care of corns and/or calluses should be referred to qualified individuals (which may require health care provider or podiatrist intervention)."  No further information was provided prior to the exit conference on 3/5/19.	F 687			
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)  §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		4/19/19	

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F 690	<p>Continued From page 91</p> <p>admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(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;</p> <p>(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</p> <p>(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.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, clinical record review, and facility document review, facility staff failed to provide incontinence care or catheter care for 3 of 28 residents in the survey sample (Resident #34, 15 and 45).</p>	F 690	<p>For Resident #34, the physician was notified, order clarified, and 18 French/10 cc balloon catheter was inserted and secured with a leg strap during the survey process by the licensed nurse. For Resident #15, incontinence care was</p>		

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F 690	<p>Continued From page 92</p> <p>The findings included:</p> <p>1. The facility staff failed to have the correct physician ordered foley catheter size in Resident #34 and failed to have the foley catheter secured with a leg strap.</p> <p>Resident #34 was readmitted to the facility on 9/12/15 with the following diagnoses of, but not limited to anemia, neurogenic bladder, urinary tract infection, dementia, Multiple Sclerosis and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/17/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #34 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and being totally dependent on 2 staff members for bathing.</p> <p>On 03/01/19 09:55 am, the surveyor observed the resident in the shower room. The surveyor asked the CNA (certified nursing assistant) #1 if she could lift the Foley catheter up so the surveyor would see what size the foley catheter was in the resident. CNA #1 picked up foley catheter, closest to where it was inserted into the resident, with bare hands and no gloves on. The size of the Foley catheter was observed to be an 18 French with a 10 cc balloon. The Foley catheter was also hanging freely by the resident's leg and not secured with a leg strap. The regional MDS (Minimum Data Set) coordinator was with surveyor during this entire observation. The MDS regional nurse told the CNA that the leg straps were in Central Supply room.</p> <p>The surveyor reviewed the resident's clinical</p>	F 690	<p>provided, and the resident was assisted to change clothes and take a bath as tolerated and permitted by Resident #15 by the Director of Nursing/Designee during the survey process. Fore Resident #45, the physician and responsible party were notified by the Director of Nursing/Designee regarding her antibiotic variance. There was no adverse effect to the resident related to the variance and education has been provided to current staff regarding isolation precautions including contact precautions requirements when entering the room. Additional education included ensuring that treatment is accurately documented in the clinical record. Resident #45 was provided another trash can on or before 04/19/2019.</p> <p>Review and observations have been conducted by the Director of Nursing/Designee on or before 04/19/2019 for the following areas:</p> <p>(A) Review of physician's orders and resident observations have been conducted by the Director of Nursing/Designee for residents with current orders for catheters to verify that currently placed catheters are consistent with the physician's orders for catheter size and balloon size and that residents with orders for catheters also have physician's orders for a leg strap and the leg strap is in place upon observation.</p> <p>(B) Facility rounds, and resident observations have been conducted by the Director of Nursing/Designee for both wings to ensure that incontinence care is</p>		

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F 690	<p>Continued From page 93</p> <p>record after the above documented findings on 3/1/19. The surveyor noted the resident had a physician order for an 18 French Foley catheter with a 5 cc balloon.</p> <p>The surveyor notified the administrative team of the above documented findings on 3/5/19 at 5:33 pm in the conference room. The surveyor requested and received copies of the facility's policy on Foley catheters. The policy read in part, "...The physician's order for an indwelling urinary catheter will be based on an appropriate medical justification, and will specify the type (Foley, suprapubic, 3-way), catheter size, and balloon capacity (in cubic centimeters) and other parameters, as indicated ..."</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p> <p>3. For Resident #15, facility staff failed to provide incontinence care to ensure the resident remained clean and odor free.</p> <p>02/28/19 01:34 PM The resident and room smelled of urine when surveyors entered on 2/26 and throughout the day on 2/27/19. The resident is ambulatory and staff reported toileting her frequently. The CNA documentation listed under bladder continence that the resident was not incontinent on 2/27/19.</p> <p>There was a current UTI. The resident was supposed to be on contact precautions and they</p>	F 690	<p>provided timely and residents are clean and odor free.</p> <p>(C) A review has been conducted by the Director of Nursing/Designee on or before 04/19/2019 for residents with current orders for antibiotic therapy. The Director of Nursing/Designee will review and compare the current physicians other with the electronic medication administration record to ensure that physicians orders for antibiotic therapy have been followed for residents with current orders for antibiotic therapy and that antibiotic treatment has been initiated in a timely manner. The SON/Designee will also review the clinical record for residents currently receiving antibiotic therapy to ensure that treatment is accurately documented.</p> <p>Education has been provided to Licensed nurses by the Director of Nursing/Designee regarding ensuring that catheters places are consistent with the physician's order for catheter size and balloon size, catheter care is provided as needed, and that leg straps are utilized to secure the catheter. Education has also been provided to licensed nurses regarding following physicians orders for antibiotic therapy and implementing antibiotic therapy in a timely manner and accurately documenting treatment in the clinical record. Inservice education has also been provided to current employees regarding following the required measures and steps when entering the room and providing care for a resident with orders for isolation precautions. Education has been provided to nursing staff by the</p>		

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F 690	<p>Continued From page 94</p> <p>were not started. The resident was admitted to the hospital with sepsis.</p> <p>Urinary Catheter or UTI 02/28/19 01:16 PM The resident apparently has UTI originating in January, continuing through February. Lab orders 1/24, 2/15 and with cultures- no u/a after the 2/15 orders. Culture showed ESBL. Contact precaution phone orders written 2/25 and 2/26. The resident was not placed on precautions. Sent to ED on 2/28/18. No nursing note to indicate she left the building.</p> <p>4. For Resident #45, while treating a urinary tract infection, facility staff failed to initiate antibiotic treatment in a timely manner, to ensure contact precautions were followed, and to accurately document treatment.</p> <p>Resident #45 was readmitted to the facility on 1/17/17 with diagnoses including heart failure, hypertension, diabetes mellitus, dementia, anxiety, bipolar disorder, psychotic disorder, and schizophrenia. On the quarterly minimum data set assessment with assessment reference date 12/24/18 the resident scored 9/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.</p> <p>On 02/26/19, the surveyor observed an isolation cart outside the resident's room. The surveyor</p>	F 690	<p>Director of Nursing/Designee regarding provision of incontinence care in a timely manner and maintaining the resident in a clean and odor free condition. Facility rounds, and resident observations will be conducted by the Director of Nursing/Designee for three (3) residents total each week for three (3) months for residents with physician's orders for a catheter. These observations will capture both wings and include observing to ensure that the currently placed catheter follows the current physician's orders regarding catheter size and balloon size, catheter care is provided and that the catheter is secured with a leg strap. Facility Rounds and resident observations will also be conducted by the Director of Nursing/Designee throughout the facility and including both wings to total three (3) resident observations weekly for three (3) months to ensure that incontinence care has been provided and residents are clean, dry, and odor free. Residents that choose to refuse care will have refusals documented in the nurses notes and on the care plan. The physician and RP will also need to be notified regarding refusals of care and notifications should be documented in the clinical record. A review will be conducted by the Director of Nursing/Designee for three (3) residents weekly for three (3) months and include residents with current orders for antibiotic therapy. The medical record review will compare the physician's orders with the EMAR to ensure that antibiotic treatment is administered per the physician's order and in a timely manner and that treatment</p>		

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F 690	<p>Continued From page 95</p> <p>asked the nurse why the resident was on contact precautions. The nurse said the resident was on contact isolation for urine, so the room was on isolation. On 02/27/19 at 08:39 AM, a CNA answered a call light and turned it off without using gown, glove, or hand sanitizer. The CNA then retrieved the the breakfast tray. The aid then washed hands approximately 9 seconds. The surveyor observed staff entering and leaving the room without donning PPE through the morning. On 02/28/19 at 09:00 AM the surveyor asked the nurse what kind of precautions were necessary when visiting the resident. She said that a resident had ESBL in urine, so "don't go playing in the pee". The surveyor asked what that meant and she said to wear gloves. The surveyor asked if contact precautions usually meant to wear gowns and she said that it did, but she had used the last one. She said she thought they had put gowns in the cart at least once the day before. She called for a staff member to bring gowns because there were none in the cart. The CNA brought a 10 pack and a second package containing 4 gowns and placed them in the cart. 28/19 at 9:30 AM, The surveyor visited the resident in the room. When leaving the room, the surveyor noted the trash can in the room had a broken lid which required 2 hands to open, then fell closed again while the surveyor removed PPE. It was difficult to leave the room without opening the trash can with bare hands.</p> <p>A nurse's note dated 2/24/19 at 7:36 PM as a late entry for 1330 (1:30 PM) "NP notified of ua C&amp;S results. Orders taken for contact precautions and to continue macrobid as ordered". A telephone order for "1- Macrobid 100 mg(milligram) BID(twice per day) X 10 days 2- contact precautions" was written by a different nurse on</p>	F 690	<p>is clearly and appropriately documented in the clinical record. Facility rounds/observations will be conducted by the Administrator/Director of Nursing/Designee for three (3) residents total each week for three (3) months and will include residents with current physician's orders for isolation precautions. The observations should include appropriate Director of Nursing donning and removal of required personal protective equipment, availability of personal protective equipment, and that isolation equipment is functional and specific to that residents' room i.e. trash can lid is functional and remains in the effected resident's room solely.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		



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F 690	Continued From page 96 2/25/19 at 8 PM. This order was written more than 30 hours after the note indicated the order was given by the nurse practitioner (NP).  A nurse's note entered 2/26/19 at 4:32 AM documented "resident is in a bad mood and is refusing medications blood sugar checks. Multiple attempts made...". The nurses work 7-7 Shifts. The insulin MAR had N (for see note) documented for 9 PM and 10 PM accuchecks and insulin administration on 2/25/19. The 9 PM oral medications were documented as administered: Macrobid 100 mg, Latanoprost 0.005% eye drops, atorvastatin 10 mg, carvedilol 3.125 mg, travatan Z 0.004% eye drops; and 10 PM medications: depakote 500 mg, timoptic 0.25% eye drops, Zyprexa 5 mg, ativan 0.5 mg, and melatonin 3 mg. It was unclear which medications were refused and which were administered. The nurse was unable to confirm whether the Macrobid had been administered that night.  The administrator and director of nursing were notified of the concerns with urinary tract infection treatment during summary meetings on 3/1 and 3/4/2019.	F 690			
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)  § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		4/19/19	

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F 695	<p>Continued From page 97 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide necessary respiratory care and services that is in accordance with professional standards of practice, the resident's care plan, and the resident's choice for 4 of 28 residents (Resident #3, Resident #11, Resident #89 and Resident #312).</p> <p>The findings included:</p> <p>1. The facility staff failed to ensure oxygen was set at the physician ordered amount and failed to store Resident #3's Bi-PAP mask in a plastic bag.</p> <p>The clinical record of Resident #3 was reviewed 2/26/19 through 3/5/19. Resident #3 was admitted to the facility 4/5/17 and readmitted 1/8/19 with diagnoses that included but not limited to respiratory failure with hypoxia and hypercapnia, restless legs syndrome, diastolic heart failure, atrial fibrillation, obstructive sleep apnea, hypokalemia, constipation, idiopathic progressive neuropathy, gastro-esophageal reflux disease, hyperlipidemia, hypothyroidism, major depressive disorder, insomnia, anxiety, chronic pain syndrome, Vitamin D deficiency, benign paroxysmal vertigo, morbid obesity, hypertension, chronic obstructive pulmonary disease, type 2 diabetes mellitus, nasal congestion, and migraines.</p> <p>Resident #3's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/19 assessed the resident with a BIMS (brief interview for mental status) as 15. No</p>	F 695	<p>For Resident #3, the oxygen concentrator flow rate was adjusted by the Licensed nurse during the survey process to the appropriately physician ordered flow rate. The Bi-PAP mask was also stored in a plastic bag during the survey process for Resident #3 as well. There were no adverse effects for Resident #3 associated with the oxygen variance. For Resident #11, the oxygen cannula dated 2/15/19 was changed by other #2 during the survey process. There were no adverse effects for the resident. For Resident #312, the C-PAP mask was cleaned and placed in a plastic bag at the bedside in a clean and sanitary manner during the survey process. Resident #89 no longer resides in the facility.</p> <p>The Administrator/Director of Nursing/Designee have completed medical record/physician order review for current order and facility rounds/resident observations for residents residing in the facility with physician's orders for oxygen, Bi-PAP and C-PAP utilization review/observations will be conducted on both wings and include the following criteria:</p> <p>(A) Residents with physician's orders for oxygen are receiving oxygen at the physician's ordered flow rate.</p> <p>(B) Respiratory equipment such as oxygen cannulas not in use, neb masks, Bi-PAP and C-PAP masks will be stored in a plastic bag in a clean sanitary fashion</p>		

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F 695	<p>Continued From page 98</p> <p>evidence of delirium, behaviors affecting others or psychosis. Section O Special Treatments, Procedures, and Programs assessed the resident used oxygen while a resident at the facility and non-invasive mechanical ventilation.</p> <p>Resident #3's current comprehensive care plan dated 2/20/19 read "I have a potential for difficulty breathing related to chronic conditions-dx (diagnosis): COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure) and obstructive sleep apnea. Approaches: O2 per order, Bi-Pap as ordered."</p> <p>The surveyor interviewed Resident #3 on 2/27/19 at 11:14 a.m. Resident #3 was in bed and currently receiving oxygen at 3 liters/nasal cannula via oxygen concentrator. Resident #3 stated the oxygen ordered was 2 liters. The surveyor also observed a bi-pap mask lying on the nightstand along with the headgear. Neither were in a bag. Resident #3 stated she doesn't always use bi-pap.</p> <p>The surveyor interview licensed practical nurse #5 on 2/27/19 at 11:21 a.m. L.P.N. #5 was asked what liter Resident #3's oxygen was ordered. L.P.N. #5 stated 2 liters. Resident #3 stated maybe somebody bumped the machine. L.P.N. #5 adjusted the amount of oxygen on the concentrator.</p> <p>L.P.N. #5 was asked about storage of oxygen masks. L.P.N. #5 stated, "Masks should be stored in a plastic bag."</p> <p>Resident #3's February 2019 physician's orders read in part "O2 at 2L/NC (liters/nasal cannula and Bi-Pap to be worn every night at bedtime,</p>	F 695	<p>and labeled with the date that it was last changed and replaced with clean equipment or cleaned (BiPAP/CPAP masks).</p> <p>(C) Residents that require oxygen use will have their physician's orders reviewed to ensure that they have a physician's order to utilize oxygen.</p> <p>(D) Residents with physician's orders for oxygen or other respiratory equipment i.e. nebs have their respiratory equipment changed out and dated per the physician's order.</p> <p>Education has been provided to current employees by the Director of Nursing/Designee with regards to the following areas:</p> <p>(A) Oxygen is a medication and must be administered to the resident at the correct flow rate per minute. Licensed nurses must adjust oxygen settings as it is considered a medication. Residents requiring oxygen must have a physician's order to utilize oxygen flow rate that is appropriate for the resident.</p> <p>(B) Residents with orders for and utilize respiratory equipment will have their equipment stored in a clean and sanitary manner, in a clean plastic bag and dated at the bedside. This includes but is not limited to oxygen cannula, oxygen mask, Bi-PAP and CPAP masks. Respiratory equipment will be replaced and/or cleaned per the physician's order but generally no less frequently than every week.</p> <p>(C) Medical Record/current physician order review as well as facility rounds/resident observations will be</p>		

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F 695	<p>Continued From page 99 document refusals."</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the regional registered nurse consultant, and the corporate registered nurse MDS of the above concern on 3/1/19 at 5:34 p.m. The director of nursing was asked if masks should be placed in a plastic bag when not in use. The DON stated "yes."</p> <p>The surveyor reviewed the facility policy for CPAP-BiPAP and oxygen administration provided by the facility on 3/5/19.</p> <p>The facility policy titled "Oxygen Administration" read "10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered."</p> <p>The "CPAP/BiPap Support" policy read in part "1. There are general guidelines for cleaning. Specific cleaning instructions are obtained from the manufacturer/supplier of the PAP device. 7. Masks, nasal pillows and tubing: Clean daily by placing in warm, soapy water and soaking/agitating for 5 minutes. Mild dish detergent is recommended. Rinse with warm water and allow it to air dry between uses."</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>2. The facility staff failed to follow the physician order that read to change the O2 (oxygen) tubing to concentrator and E tank every week on Tuesday 11-7 for Resident #11.</p> <p>The clinical record of Resident #11 was reviewed</p>	F 695	<p>conducted by the Administrator/Director of Nursing/Designee throughout the facility including both wings for a total of three (3) residents per week for three (3) months. The following criteria will be included in the weekly review:</p> <p>a. Oxygen is administered at the correct physicians ordered flow rate and those residents requiring oxygen must have a physician's order for the oxygen.</p> <p>b. Respiratory equipment is stored in a clean, sanitary manner such as plastic bags labeled at the bed side with the date the respiratory equipment was changed out or cleaned. Respiratory equipment may include but not be limited to oxygen cannulas, masks, humidification bottle, CPAP/Bi-PAP masks and tubing, and nebulizer masks. Unless otherwise specified in a physician's order, respiratory equipment should be replaced and/or cleaned and labeled every seven (7) days.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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F 695	<p>Continued From page 100</p> <p>2/26/19 through 3/5/19. Resident #11 was admitted to the facility 2/4/15 and readmitted 7/14/18 with diagnoses that included but not limited to acute respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, metabolic encephalopathy, difficulty in walking, muscle weakness, acute kidney failure, chronic pain syndrome, type 2 diabetes mellitus, hypertension, anxiety, hypothyroidism, major depressive disorder, bipolar disorder, polyneuropathy, hypokalemia, gastro-esophageal reflux disease, adult failure to thrive, schizoaffective disorder, urethral stricture, anemia, dysphagia, constipation, Parkinson's disease, urinary tract infection, chronic obstructive pulmonary disease, and Vitamin deficiency.</p> <p>Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/13/19 assessed the resident with a BIMS (brief interview for mental status) as 15. There were no assessed signs or symptoms of delirium, behaviors affecting others or psychosis.</p> <p>Resident #11's current comprehensive care plan dated 8/29/18 read that the resident has an ineffective airway clearance related to dx (diagnosis) of respiratory failure and dyspnea. Approaches: O2 per MD (medical doctor) orders.</p> <p>The surveyor observed and spoke with Resident #11 during the initial tour on 2/26/19 at 1:21 p.m. Resident #11 stated oxygen was mainly used at night but stated today she was not feeling well. Resident #11 was in bed and an oxygen concentrator was observed on the left side of the bed. The oxygen concentrator was set at 2 liters and the resident was receiving oxygen from a</p>	F 695			

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F 695	<p>Continued From page 101 nasal cannula. The tubing was dated 2/15/19.</p> <p>The surveyor was met by other #2 (central supply) as the surveyor exited Resident #11's room. Other #2 stated he was the manager on duty Sunday, got distracted and did not change Resident #11's tubing. Other #2 stated the only one in the building not changed. Other #2 stated, "I had the same issue last year with the same resident."</p> <p>Resident #11's February 2019 physician's orders were reviewed. Resident #11's current oxygen orders were oxygen 2 L (liters) per min (minute) per nc (nasal cannula) prn (as needed) and Change O2 tubing to concentrator and E Tank every week on Tuesday on 11-7."</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the regional registered nurse of the above concern on 3/1/19 at 5:34 p.m.</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>Findings included:</p> <p>3. For Resident #312 the facility staff failed to store a C-PAP mask in a clean and sanitary manner.</p> <p>Per clinical record review Resident #312 was admitted to the facility on 02/06/19. Diagnoses</p>	F 695			

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F 695	<p>Continued From page 102</p> <p>included, but were not limited to, muscle weakness, essential (primary) hypertension, chronic obstructive pulmonary disease, and sleep apnea.</p> <p>Section C (cognitive patterns) of the Resident's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/13/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.</p> <p>The surveyor observed Resident #312 during initial tour on 02/26/19 at 2:00pm. The surveyor observed a C-PAP (continuous positive airway pressure) mask for sleep apnea on Resident #312's night stand not covered or bagged. On 02/27/19 at 10:46am during an interview with Resident #312, the C-PAP mask was observed by the surveyor on the floor by Resident #312's bed. The C-PAP mask was not enclosed in a bag. The surveyor asked Resident #312 why his C-PAP mask was on the floor and where was his bag to place it in? The Resident stated "They never put it in a bag".</p> <p>On 02/28/19 at 5:13pm the surveyor spoke to the DON (director of nursing) regarding Resident #312's C-PAP mask not stored in a bag while not being used. She stated that she expects the C-PAP mask to be placed in a bag when not in use. The surveyor requested a facility policy on infection control and storage of respiratory equipment at this time.</p> <p>On 03/01/19 the surveyor was provided with copies of policies/procedures titled "CPAP/BiPAP Support" and "Infection Control Guidelines for All Nursing Procedures". The policies did not</p>	F 695			

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F 695	<p>Continued From page 103 address storage of the C-PAP mask.</p> <p>No further information regarding this issue was provided to the survey team prior to the exit conference on 03/05/19.</p> <p>4. The facility staff failed to obtain a physician order prior to the administration of oxygen to Resident #89.</p> <p>Resident #89 was admitted to the facility on 1/26/19 with the following diagnoses of, but not limited to high blood pressure and respiratory failure. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/1/19, the resident was coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene. Resident #89 was also coded as being totally dependent on 2 staff members for bathing.</p> <p>On 2/28/19 at approximately 9:30 am, the surveyor went into Resident #89's room to conduct a resident interview. During this time, the resident was observed to be using Oxygen at 2 liters/minute by nasal cannula.</p> <p>At approximately 10 am, the surveyor and the corporate MDS nurse went into the resident's room. They were met in the doorway of the room as physical therapy was taking him to therapy in a wheelchair. The resident was observed to be wearing oxygen.</p> <p>The surveyor reviewed the clinical record of Resident #89. During this review, the surveyor could not find a physician order for the administration of oxygen. However, in the nurses' notes since admission on 1/26/19, the facility staff</p>	F 695			



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F 695	<p>Continued From page 104</p> <p>had documented that Resident #89 was receiving oxygen 2-3 liters/ minute by nasal cannula.</p> <p>The surveyor notified the administrative team of the above documented findings on 3/1/19 at 5:33 pm in the conference room. The surveyor asked the director of nursing (DON) if you needed an order to administer oxygen to a resident. The DON stated, "Yes we do." The surveyor requested a copy of the facility's policy on administration of oxygen.</p> <p>On 3/5/19 at approximately 10:30 am, the surveyor received a copy of the facility's policy for "Oxygen Administration". The policy read in part, "...Verify that there is a physician order for this procedure ..."</p> <p>At 11 am, the surveyor interviewed LPN (licensed practical nurse) #1 that was responsible for the resident's care on 3/5/19 in the conference room. The surveyor asked LPN #1 if you needed to obtain a physician order before administrating oxygen. LPN #1 stated, "Yes you do. But I assumed that there was an order without checking on this first."</p> <p>At approximately 1:30 pm, the surveyor interviewed the doctor responsible for this residents care. The doctor reviewed the physician's orders and progress notes and stated, "There is not an order for the resident to be given oxygen. He must had this when they admitted him from the hospital."</p> <p>At 4:20 pm, the surveyor notified the administrative team of the above documented findings.</p>	F 695			

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F 695	Continued From page 105	F 695			
F 697 SS=D	<p>Pain Management CFR(s): 483.25(k)</p> <p>§483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide non-pharmacological interventions prior to pain medication administration for 1 of 28 residents (Resident #362).</p> <p>The findings included:</p> <p>The facility staff failed to provide non-pharmacological interventions prior to the administration of pain medication on 2/11/19 at 6:18 p.m. for Resident #362.</p> <p>The clinical record of Resident #362 was reviewed 2/26/19 through 3/5/19. Resident #362 was admitted to the facility 2/11/19 with diagnoses that included but not limited to left fibula fracture, head injury, cataract, anemia, type 2 diabetes mellitus, urine retention, bipolar disorder, muscle weakness, difficulty in walking, encephalopathy, hypertension, chronic pain, atherosclerotic heart disease, TIA (transient ischemic attacks), hyperlipidemia, intervertebral disc degeneration of lumbosacral region, and</p>	F 697	<p>Resident #362 no longer resides in the facility.</p> <p>Resident interviews will be completed by Director of Nursing/Designee for alert/oriented resident <input type="checkbox"/>s with Brief Interview of Mental Status Score 10 or greater to determine what non-pharmacological intervention is most effective. A review has been conducted by the Director of Nursing/Designee for residents residing in the facility with current physician <input type="checkbox"/>s orders for as needed/PRN narcotic analgesic medications. The clinical record review will acknowledge documentation for the previous seven (7) days including progress notes, physician <input type="checkbox"/>s orders, Electronic Medication Administration Records, and the care plan to identify residents requiring non-pharmacological interventions prior to utilization of PRN narcotic analgesics. The Director of Nursing/Designee will identify potential person-centered non-pharmacological</p>	4/19/19	

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F 697	<p>Continued From page 106 edema.</p> <p>The admission minimum data set (MDS) assessment had not yet been completed.</p> <p>The February 2019 physician orders were reviewed. Resident #362 was ordered Norco 5-325 tablet take one by mouth every 4 hours as needed for pain.</p> <p>The current comprehensive care plan dated 2/21/19 read "I may experience pain r/t (related to) my recent fracture. I also have a diagnosis of degenerative disc disease, and chronic pain." The care plan did not have non-pharmacological approaches for pain management identified or documented. The care plan read "Identify and encourage coping mechanisms r/t pain management."</p> <p>The surveyor reviewed the February 2019 electronic medication administration records (eMARs). Resident #362 was administered Norco 5-325 mg on 2/11/19 at 6:18 p.m. for pain that the resident rated as 7/10. The eMAR details read the medication was for "pain management." The surveyor was unable to locate any non-pharmacological interventions prior to use on 2/11/19.</p> <p>The surveyor informed the administrator, the director of nursing (DON), the corporate registered nurse, and the assistant director of nursing of the above concern on 2/27/19 at 3:04 p.m. The DON stated when assessing prior to administering prn (whenever needed) narcotics, staff are documenting the non-pharmacological strategies after the administration. The surveyor was unable to locate documentation of</p>	F 697	<p>interventions for current residents that have physician's orders to receive as needed/PRN narcotic analgesic medications.</p> <p>Education has been provided to Licensed Nurses by the Director of Nursing/Designee regarding ensuring that non-pharmacological interventions for pain management must be attempted and monitored for effectiveness prior to administration of as needed/PRN narcotic analgesic pain medication. The Licensed nurse must document the pain assessment, the person-centered non-pharmacological intervention attempted for pain management and the effectiveness prior to administering as needed/PRN narcotic analgesic medication to the resident. The Director of Nursing/Designee will conduct ongoing monitoring for a total of three (3) residents weekly for three (3) months. The Director of Nursing/Designee will review the clinical record including progress notes, Electronic Medication Administration Record, care plan and physician's orders to identify if non-pharmacological interventions have been identified and utilized first, before/prior to administration of as needed/PRN narcotic analgesic medications. The review will also observe for appropriate documentation regarding the resident's pain status, intervention, treatment and effectiveness.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3)</p>		

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F 697	Continued From page 107 non-pharmacologic interventions prior to medication administration in the clinical record. The surveyor requested the facility policy on pain management.  The surveyor reviewed the facility policy titled "Pain-Clinical Protocol." The policy read "1. The physician and staff will identify individuals who have pain or who are at risk for having pain. 2. The physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain. 3. Staff will provide the elements of a comforting and appropriate physical and complementary interventions: for example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain."  No further information was provided prior to the exit conference on 3/5/19.	F 697	months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.		
F 698 SS=E	Dialysis CFR(s): 483.25(I)  §483.25(I) 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, facility staff failed to coordinate care with the hemodialysis center for 1 of 28 residents in the survey sample (Resident #91).  The findings included:	F 698	Resident #91 no longer resides in the facility.  A review has been conducted by the Director of Nursing/Designee for residents residing in the facility that have physician <input type="checkbox"/> s orders for dialysis services.	4/19/19	

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F 698	<p>Continued From page 108</p> <p>Resident #91 was admitted to the facility on 1/31/19 with the following diagnoses of, but not limited to anemia, atrial fibrillation, end stage renal disease, diabetes, heart failure and high blood pressure. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) date of 2/7/19, the resident was coded as requiring extensive assistance of 2 staff members for dressing, and personal hygiene. Resident #91 was also coded as being totally dependent on 2 staff members for bathing.</p> <p>During the clinical record review on 3/5/19 at approximately 9 am, the surveyor requested documentation of communication between the facility and the dialysis center. Resident #91 goes out to the dialysis on Monday, Wednesday and Friday.</p> <p>The surveyor received copies of the communication sheets that were requested. The surveyor reviewed these sheets and noted there was documentation missing or left blank by the facility and the dialysis center. These sheets were dated from 2/1/19 to 3/1/19.</p> <p>The surveyor notified the administrative team on 3/5/19 at 4:20 pm in the conference room. The DON (director of nursing) stated, "I will look into that."</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p>	F 698	<p>The Director of Nursing/Designee has reviewed the dialysis communication document for residents receiving dialysis services for the previous thirty (30) days regarding accurate and thorough documentation/communication between the facility and the dialysis center.</p> <p>Education has been provided to the licensed nurses by the Director of Nursing/Designee regarding ensuring that the Dialysis Communication Document is thoroughly completed with no omitted information on the document. A review will be conducted by the Director of Nursing/Designee three (3) times per week for three (3) months for residents residing in the facility receiving dialysis services to ensure that the dialysis communication document is thoroughly completed with no omitted information or details. Variances/identified concerns will be communicated to the Dialysis center by the Director of Nursing/Designee for resolution.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3)	F 744		4/19/19	

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F 744	<p>Continued From page 109</p> <p>§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, clinical record review, and facility document review, facility staff failed to provide behavior-specific interventions for 1 of 28 residents in the survey sample (Resident #15).</p> <p>Resident #15 was admitted to the facility on 11/22/15 and readmitted on 11/18/18. Diagnoses included heart failure, hypertension, Alzheimer's disease, psychotic disorder, pneumonia, urinary tract infection (UTI), dementia with behavior disturbance, dysphagia, anxiety, muscle weakness, and difficulty walking. On the quarterly 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 symptoms of delirium, psychosis, or behaviors affecting care. The assessment indicated the resident ambulated and used the toilet with 1-2 person assistance, was frequently, but not always, incontinent, and on a prompted toileting program.</p> <p>Clinical record review revealed a physician order dated 2/10/19 "take one 0.5 mg (milligram) xanax tow and one 0.5 mg xanax in two hours". The order did not give an indication for the administration of xanax. Nursing notes on 2/10 were limited to 2/10/2019 8:38 AM "no negative behaviors noted "7p-7a". On the medication administration record, the question "Did Resident resident exhibit behaviors this shift?" Was</p>	F 744	<p>For resident #15, specific person-centered targeted behaviors have been identified and documented. Additionally, non-pharmacologic behavior specific interventions have also been identified, established, and documented in the clinical record for Resident #15.</p> <p>A review has been conducted by the Director of Nursing/Designee for residents with diagnosed dementia and will include the following areas for review: (A) Clinical record review for residents diagnosed with dementia to determine what psychotropic medications they receive what person-centered target behaviors are specific to each individual resident with dementia, what non-pharmacological interventions as well as behavior specific interventions have been identified, implemented, and documented as well as effectiveness of these interventions related to the administration of psychotropic medications. (B) The review for residents currently diagnosed with dementia will also observe for appropriate diagnosis and indication for use fourteen (14) day restriction on orders for PRN/as needed psychotropic medications unless the physician has re-evaluated the medication and</p>		

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F 744	<p>Continued From page 110</p> <p>answered "N" (no) for both shifts on 2/10/19.</p> <p>A nurse's note dated 2/14/19 at 9:25 PM documented "late entry for 2/14/19 13:30: New orders received for Haldol 5 mg/ml give 5 mg IM now due to increased aggitation, IM Haldol 5mg/ml given at 13:35 without complication, no effective results noted RSD only became more aggitated". Haldol did not appear on the physician order list or on the medication administration record. There were no notes indicating the resident exhibited behaviors. On the medication administration record, the question " Did Resident resident exhibit behaviors this shift?" Was answered "N" (no) for both shifts on 2/14/19.</p> <p>The administrative team was notified of the concerns with psychotropic medications, their reasons for administration, and lack of documentation during a summary meeting on 3/4/19.</p>	F 744	<p>documented in a progress note detailing why he/she wishes to continue the medication.</p> <p>(C) Review will include verification regarding appropriate documentations supporting the targeted behavior in the progress notes or on the electronic medication administration record.</p> <p>(D) Review of care plan to ensure the targeted behaviors, the behavior-specific interventions and non-pharmacological interventions are listed on the care plan.</p> <p>Education has been provided to the interdisciplinary team and the licensed nurses by the Director of nursing/Designee regarding the following areas:</p> <p>(A) Ensuring that targeted behaviors are identified and documented for the utilization of psychotropic medications.</p> <p>(B) Ensuring that non-pharmacologic, person-centered behavior specific interventions have been identified and documented in the clinical record including the care plan.</p> <p>(C) Ensuring that effectiveness of non-pharmacologic, behavior specific interventions is documented in the clinical record as well.</p> <p>The Administrator/Director of Nursing/Designee will conduct a weekly review for three (3) residents per week for three (3) months for the following areas:</p> <p>(A) Residents with physician's order for psychotropic medications will be reviewed to ensure that non-pharmacologic behavior specific interventions are identified in the clinical record for the use</p>		

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F 744	Continued From page 111	F 744	<p>of these medication and that these behaviors and non-pharmacologic behavior specific interventions have been documented.</p> <p>(B) The physician <input type="checkbox"/>s orders for as needed/PRN, psychotropic medications include a fourteen (14) day timeframe for use until the resident can be re-evaluated by the physician for continued utilization of the medication.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		
F 755 SS=F	<p>Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)</p> <p>§483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p>	F 755		4/19/19	



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F 755	<p>Continued From page 112</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, facility staff failed to provide safe medication storage and labeling and to keep medications available for administration on 5 of 6 medication carts and for 4 of 28 residents in the survey sample (Resident # 110, 34, 45, 72, and 17.</p> <p>The findings included:</p> <p>1. The facility staff failed to provide safe storage and labeling in 5 out of 6 medication carts in the nursing facility.</p> <p>1(a). On 2/26/19 at 4:25 pm, the surveyor observed loose pills in the drawers for the 500 hallway medication cart:</p> <ul style="list-style-type: none"> <li>" (1) Black capsule</li> <li>" (1) med. round pill yellow</li> <li>" (1) pink med pill</li> <li>" (4) white oblong pills</li> </ul>	F 755	<p>The loose pills identified in the drawers of 500 hallway med cart on 2/26/19 at 4:25 pm, 600 hallway med cart on 2/26/19 at 4:45 pm, 200 hallway med cart drawers on 2/26/19 at 6:02 pm, 100 hallway med cart drawers on 2/26/19 at 6:00 pm have been removed and discarded by the Director of Nursing/Designee during the survey process. The Besivance sus 0.6% eye drops with the opened date 9/21/18 identified on the 500-hallway med cart were discarded by the Director of Nursing/Designee during the survey process. Levemir insulin identified on the 500-hallway med cart with no opened date on the vial was discarded by the Director of Nursing/Designee during the survey process. The Latanoprost sol 0.005% identified on the 300-hallway med cart with no open on them at 5:37 pm on 2/26/19+ were discarded by the Director</p>		

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F 755	<p>Continued From page 113</p> <ul style="list-style-type: none"> <li>" (1) orange capsule</li> <li>" 4 white med pills</li> <li>" 1 yellow large pill</li> <li>" 1 blue oblong pill</li> <li>" 1 small round pill</li> <li>" 1 pink round small pill</li> <li>" 1/2 LARGE white round pill</li> <li>" 1 orange round med pill</li> <li>" 1 small white pill</li> <li>" Besivance Sus 0.6% 9/21/18 eye drops opened date of 11/6/18 but not discarded after 30 days</li> <li>" Levemir Insulin had no opened date on the vial</li> </ul> <p>1(b). At 4:45 pm, the surveyor observed the following in the 600 hallway medication cart drawers:</p> <ul style="list-style-type: none"> <li>" 1 small orange pill</li> <li>" 1/2 pink med round pill</li> <li>" 1 blue oblong pill</li> <li>" 1 large oblong yellow pill</li> <li>" 1/2 sm. purple oblong pill</li> <li>" 1/2 blue oblong pill</li> </ul> <p>1(c). At 5:37 pm, the surveyor observed the following in the 300 hallway medication cart drawers:</p> <ul style="list-style-type: none"> <li>" Latanoprost sol 0.005% no open date on it</li> </ul> <p>1(d). At 6:02 pm, the surveyor observed the following in the 200 hallway medication cart drawers:</p> <ul style="list-style-type: none"> <li>" 1 teal colored oblong capsule</li> <li>" 1 brown round pill</li> <li>" 1 med white round pill</li> <li>" 2 white oblong pills</li> <li>" 1 small round white pill</li> <li>" 1/2 white pill round</li> </ul>	F 755	<p>of Nursing/Designee during the survey process. There were no adverse effects for residents related to the documented areas identified on the medication carts. Resident #110 no longer resides in the facility. For Resident #72, the physician and the responsible party were notified regarding the variance for the Gentian Violet 1%. There were no adverse effects for the resident related to the variance. For Resident #17, the physician and the responsible party were notified by the Director of Nursing/Designee regarding the variances for the following medications and dates:</p> <p>(A) 2/27/19 at 9:00 pm Zatador and Seroquel not administered, not available (B) 2/28/19 at 9:00 am Zatador, Mobic, Propylene glycol eye drops not administered, not available</p> <p>There were no adverse effects for Resident #17 related to the variances identified medications are available as ordered by physician for administration. For Resident #45, medications including Ativan are available for administration. The physician and responsible party were notified by the Director of Nursing/Designee regarding the variance for the Ativan identified as detailed below:</p> <p>(A) 2/27/19 <input type="checkbox"/> Ativan 0.5 mg not available at 10 am and 2 pm (B) 2/28/19 <input type="checkbox"/> Ativan 0.5 mg no available at 10 am and 2 pm (C) The resident took her last Ativan on 2/26/19</p> <p>There was no indication that Ativan was obtained, received, or codes were obtained by the licensed nurse to use the</p>		

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F 755	<p>Continued From page 114</p> <p>" 1 small round tan pill</p> <p>1(e). At approximately 6:05 pm, the surveyor observed the following in the drawers of 100 hallway medication cart:</p> <p>" 1 white capsule " 1 yellow and black oblong pill " 1 small pink round pill " 1 orange capsule " 1 med round white pill</p> <p>The surveyor notified the director of nursing (DON) and the corporate nurse of the above documented findings on 2/26/19 at 6:30 pm. The surveyor notified the administrative staff of the above documented findings on 3/5/19 at 4:20 pm. The surveyor asked the director of nursing (DON) how medications were to be stored and labeled once they were opened. The DON stated, "When the medication is opened, the nurses' are to document the date in which it was opened and discard the medication after 30 days. The pills should be kept in the cards and in the medication cart when not administering them. If they see a pill loose in the drawers of the med cart than they are to dispose of medications appropriately."</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p> <p>2. The facility staff failed to ensure a medication was available at the time of the scheduled administration for Resident # 110.</p> <p>The facility staff failed to follow physician orders for the administration of an antibiotic to Resident #110.</p> <p>Resident #110 was admitted to the facility on 1/7/19 with the following diagnoses of, but not</p>	F 755	<p>back up supply to administer the Ativan on 2/27 and 2/28 at 10 pm even though these doses were documented as administered. For Resident #34 there was no information or details listed on the 2567 for F755.</p> <p>For current residents residing in the facility, the Director of Nursing/Designee conducted a Medication Administration Record to medication cart review to ensure that medications ordered and listed on the Medication Administration Record were available on the medication carts for both wings.</p> <p>Education has been provided to licensed nurses by the Director of Nursing/Designee regarding the following areas:</p> <p>(A) Procedures <input type="checkbox"/> a facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of drugs and biologicals) to meet the needs of the residents.</p> <p>(B) When the licensed nurse identifies that a medication is unavailable for administration per the physician order, the licensed nurse will contact the physician, responsible party, the pharmacy and the Director of Nursing/Designee at that time so that assistance may be provided to obtain the medication.</p> <p>(C) A weekly verification will be completed for three (3) months by the Director of nursing/Designee to observe the Medication Administration Record and verify that medications are available on</p>		

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F 755	<p>Continued From page 115</p> <p>limited to anemia, high blood pressure, obstructive uropathy, UTI and multidrug resistant organism. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/14/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. Resident #110 was also coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene.</p> <p>During the clinical record review from 2/26/19 through 3/5/19, the surveyor noted that the resident was ordered to have Vancomycin 500 mg to infuse IV for 10 days. This order was started being administrated by the facility staff on 2/23/19 at 9:00 pm. On the detail section of the resident's MAR (Medication Administration Record) for February 2019, the following was documented:</p> <ul style="list-style-type: none"> <li>o " ...11:56 am 2/23/19 (Scheduled for 2/23/19 9:00 am) ...Med not available from pharmacy. Pharmacy notified ...</li> <li>o 3:17 am 3/9/19 (Scheduled for 3/2/19 at 9:00 pm not given; awaiting pharmacy arrival ..."</li> </ul> <p>The surveyor notified the administrative team on 3/5/19 at 4:20 pm in the conference room.</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p> <p>3. For Resident #72 the facility staff failed to ensure the medication Gentian Violet 1% was available for administration for six consecutive doses.</p> <p>Per clinical record review Resident #72 was admitted to the facility on 02/16/17. Diagnoses</p>	F 755	<p>the medication cart as ordered by the physician and as listed on the Medication Administration Record.</p> <p>Necessary measures to ensure that medications are available for administration as ordered include the following:</p> <p>(A) A weekly verification will be completed for three (3) months by the Director of Nursing/Designee to observe the Medication Administration Record and verify that medications are available on the medication cart as ordered by the physician and as listed on the Medication Administration Record.</p> <p>(B) A random weekly review/observation will be completed by the Director of Nursing/Designee for three (3) residents on each wing for a total of six (6) residents weekly for three (3) months to ensure that the medications available on the medication cart are consistent with the physician's orders and the medication administration record.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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F 755	<p>Continued From page 116</p> <p>included but not limited to diabetes mellitus, chronic obstructive pulmonary disease, morbid obesity, difficulty walking, and muscle weakness.</p> <p>Section C (cognitive patterns) of the Resident's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/14/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.</p> <p>Resident #72's comprehensive care plan was reviewed and contained a problem area for "Potential for skin breakdown related to impaired mobility and incontinence ...I am morbidly obese and often have moisture associated skin damage". The interventions included but were not limited to, "Medications as ordered. Treatments as ordered".</p> <p>Resident #72's clinical record was reviewed on 02/26/19 at 05:29pm. Resident #72's physician's order contained an order dated 02/20/19 which read in part "Gentian Violet 1% solution apply to tongue and cheeks three times a day for 3 days total". The Resident's eMAR (electronic medication administration record) for the month of February was reviewed and contained an entries marked "N" indicating the medication was unavailable for administration on 02/21/19 at 10pm; 02/22/19 at 6am, 2pm, and 10pm; 02/23/19 at 6am and 2pm. The following documentation was reviewed under administration record "details" which read I part: On 2/21/19 at 9:57pm "Gentian Violet 1% solution...scheduled for 2/21/19 10:00pm has not arrived new order"; 02/22/19 3:57am " Gentian Violet 1% solution...scheduled for 2/22/19 6:00am has not arrived from pharmacy at this time"; 02/22/19 11:06am "Gentian Violet 1%</p>	F 755			

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F 755	<p>Continued From page 117</p> <p>solution...scheduled for 2/22/19 2:00pm, unavailable, will write new order when available from pharmacy"; 02/22/19 5:12pm "Gentian Violet 1% solution...scheduled for 2/22/19 10:00pm, unavailable"; 02/23/19 4:12am "Gentian Violet 1% solution...scheduled for 2/23/19 6:00am was not administered".</p> <p>The surveyor spoke with the administrative team on 02/27/19 at 3:13pm regarding the concern of Resident #72's medication not being available for administration.</p> <p>No further information regarding this issue was provided to the survey team prior to the exit conference on 03/05/19.</p> <p>4. For Resident #17, facility staff failed to ensure medications were available for administration.</p> <p>Resident #17 was admitted to the facility on 4/19/16. Diagnoses included hypertension, gastroesophageal reflux disease, diabetes mellitus, anxiety, depression, asthma, and chronic pain. On the annual assessment with assessment reference date 2/7/17, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.</p> <p>Medication orders included Mobic 7.5 milligram one tablet by mouth daily started 1/10/19, Zatador eye drops one drop each eye twice a day, Seroquel 50 milligrams one tablet by mouth at bedtime, and propylene glycol 1 drop each eye 4 times a day.</p> <p>During clinical record review on 2/28/19, the surveyor noted that on 2/27/18 at 9 PM Zatador and Seroquel were documented as "not</p>	F 755			

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F 755	<p>Continued From page 118</p> <p>administered- meds not available". On 2/28/18 9 AM Zatador, Mobic, and propylene glycol eye drops were documented as "not administered- meds not available".</p> <p>Nursing staff were unable to offer an explanation for four physician ordered medications being unavailable to administration.</p> <p>The administrator and director of nursing were notified of the concerns with physician notification during a summary meeting on 3/1/19.</p> <p>5. For Resident #45, facility staff failed to ensure the antianxiety medication ativan was available for administration.</p> <p>Resident #45 was readmitted to the facility on 1/17/17 with diagnoses including heart failure, hypertension, diabetes mellitus, dementia, anxiety, bipolar disorder, psychotic disorder, and schizophrenia. On the quarterly minimum data set assessment with assessment reference date 12/24/18 the resident scored 9/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.</p> <p>During clinical record review, the surveyor noted a physician order written 12/12/17 for ativan 0.5 mg (milligram) by mouth 3 times a day for anxiety. 2/27/19 Ativan .5 mg by mouth not available for the 10 AM and 2 PM doses and on 2/28/19 for the 10 AM and 2 PM doses. The medication administration record (MAR) documented ativan as administered at 10 PM on 2/27 and 2/28. It was documented as administered on 3/1 at 10 AM and 2 PM. The</p>	F 755			

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F 755	Continued From page 119 narcotic record indicated that the resident took her last ativan on 2/26/19. There was no indication in the notes that the nurse had received the ativan. 03/01/19 03:20 PM The surveyor discussed the issue with the Director of Nursing. She offered to investigate whether the nurse had called the physician and the pharmacy and gotten a code to allow her to obtain the medication from the backup supply. She did not obtain information that the nurse had received codes to use the backup supply to administer ativan to the resident on 2/27 or 2/28 at 10 PM.  On 3/1/19, the administrator and director of nursing were aware that ativan was unavailable for administration on 2/27 and 2/28/19 and that the 10 PM doses had been documented as administered on those dates.	F 755			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-  §483.45(d)(1) In excessive dose (including duplicate drug therapy); or  §483.45(d)(2) For excessive duration; or  §483.45(d)(3) Without adequate monitoring; or  §483.45(d)(4) Without adequate indications for its use; or  §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be	F 757		4/19/19	



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F 757	<p>Continued From page 120 reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure 2 of 28 residents were free of an unnecessary medication (Resident #11 and Resident #64).</p> <p>The findings included:</p> <p>1. The facility staff failed to follow the physician's order for medication administration for Resident #11. Resident #11 received 41 doses of Keflex 500 mg (milligrams) instead of 40 doses as ordered.</p> <p>The clinical record of Resident #11 was reviewed 2/26/19 through 3/5/19. Resident #11 was admitted to the facility 2/4/15 and readmitted 7/14/18 with diagnoses that included but not limited to acute respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, metabolic encephalopathy, difficulty in walking, muscle weakness, acute kidney failure, chronic pain syndrome, type 2 diabetes mellitus, hypertension, anxiety, hypothyroidism, major depressive disorder, bipolar disorder, polyneuropathy, hypokalemia, gastro-esophageal reflux disease, adult failure to thrive, schizoaffective disorder, urethral stricture, anemia, dysphagia, constipation, Parkinson's disease, urinary tract infection, chronic obstructive pulmonary disease, and Vitamin deficiency.</p>	F 757	<p>For Resident #11, the physician and the responsible party were notified by the Director of Nursing/Designee of the medication variance with Keflex. There were no adverse effects for the resident related to the medication variance. For Resident #64, the physician and the responsible party were notified by the Director of Nursing/Designee of the variance with Macrochantin from 12/20/18 through 12/27/18. There were no adverse effects for the resident related to the medication variance.</p> <p>The Director of Nursing/Designee has conducted a review to verify that antibiotic medications have been administered as ordered by the physician. The Director of Nursing/Designee has reviewed the Electronic Medication Administrator Records as well as the physician's orders for the previous thirty (3) days for residents with physician's orders for antibiotic medications to identify further variances requiring correction and notification to the physician and responsible party.</p> <p>Education has been provided to the licensed nurses by the Director of Nursing/Designee regarding the six (6) rights of medication administration,</p>		

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F 757	<p>Continued From page 121</p> <p>Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/13/19 assessed the resident with a BIMS (brief interview for mental status) as 15. There were no assessed signs or symptoms of delirium, behaviors affecting others or psychosis.</p> <p>A physician order dated 12/10/18 read "1. Keflex 500 mg po (by mouth) qid (four times a day) x 10 days for infected ingrown toenail. 2. Consult podiatry."</p> <p>A review of the December 2018 electronic medication administration record (eMAR) had documentation that Keflex 500 mg was administered 41 doses. The physician order was for 40 doses.</p> <p>The surveyor informed the corporate registered nurse of the above concern on 3/4/19 at 5:45 p.m.</p> <p>On 3/5/19, the corporate RN stated the first dose was removed from the facility stat box and was not counted in the total amount. The "Starter Kit Product Utilization Form" for 12/10/18 indicated Cephalexin 250 mg (2) were removed by licensed practical nurse #1 on 12/10/18 at 4:00 p.m.</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the corporate registered nurse, the regional executive, and the corporate MDS registered nurse of the above concern on 3/5/19 at 4:26 p.m.</p> <p>The surveyor reviewed the facility policy titled "Administering Medications" on 3/5/19. The</p>	F 757	<p>administering medications as ordered by the physician and the regulatory requirements that state each resident's drug regimen must be free from unnecessary drugs. This includes medication in excessive doses or for excessive duration. Ongoing monitoring and review will be conducted by the Director of Nursing/Designee weekly for three (3) residents for three (3) months. The Director of Nursing/Designee will review physicians' orders and compare to the Electronic Medication Administration Record for three (3) residents with orders for antibiotic medications to ensure that medications are administered as ordered by the physician. The review will verify that no excessive doses were administered and notification to the physician and responsible party are completed for further variances identified and documented in the clinical record.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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F 757	<p>Continued From page 122</p> <p>policy read in part "Preparation 1. Verify that there is a physician medication order for this procedure."</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>2. The facility staff administered Macroductin 100 mg (milligrams) to Resident #64 for 3 extra days (6 doses) after the urine culture showed the bacteria (Enterobacter Cloacae) was resistant and 7 days with a culture showing resistance to the medication.</p> <p>The clinical record of Resident #64 was reviewed 2/26/19 through 3/5/19. Resident #64 was admitted to the facility 12/18/15 with diagnoses that included multiple sclerosis, urinary tract infection, gastro-esophageal reflux disease, chronic pain, major depressive disorder, muscle weakness, difficulty in walking, attention-deficit hyperactivity disorder, overactive bladder, and Vitamin deficiency.</p> <p>Resident #64's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #64 had no assessed signs or symptoms of delirium, behaviors that affected others or psychosis.</p> <p>A telephone order dated 12/20/18 read "UA &amp; C&amp;S (urine culture and sensitivity), Macroductin 100 mg bid (twice a day) x 7 days, change Foley to 16 Fr (French) with 5 cc (cubic centimeters) balloon."</p> <p>The surveyor reviewed the urine culture results. The urine culture results showed Resident #64</p>	F 757			

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F 757	<p>Continued From page 123</p> <p>was resistant to the current medication prescribed [Nitrofurantoin (Macrochantin)]. The culture results were returned on 12/23/18. Resident #64 received seven (7) more doses of Macrochantin after the culture result on 12/23/18. The urine culture was reviewed by the nurse practitioner on 12/26/18. Resident #64 received Macrochantin bid on 12/26/18 and one dose on 12/27/18 at 9:00 a.m.</p> <p>The surveyor interviewed the assistant director of nursing and the facility's infection preventionist on 3/5/19 at 3:18 p.m. The surveyor showed the ADON the urine culture results obtained by 12/23/18. When asked if the nurses should notify the physician when the culture came back on 12/23/18 showing the antibiotic currently ordered (Macrochantin) was resistant to the bacteria. The ADON stated, "Nurses need to step-up to the plate when an antibiotic ordered is resistant."</p> <p>Resident #64 received Macrochantin 100 mg for 7 days or 14 doses for the urine culture/sensitivity that the results reviewed the bacteria was resistant to the medication.</p> <p>The assistant director of nursing/infection preventionist stated she didn't identify that the medication ordered to treat Resident #64's urinary tract infection was resistant to the bacteria.</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the corporate registered nurse, the regional executive, and the corporate MDS registered nurse of the above concern in the end of the day meeting on 3/5/19 at 4:26 p.m.</p>	F 757			

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F 757	Continued From page 124 No further information was provided prior to the exit conference on 3/5/19.	F 757			
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)  §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehensive assessment of a resident, the facility must ensure that---  §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;  §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;  §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and  §483.45(e)(4) PRN orders for psychotropic drugs	F 758		4/19/19	

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F 758	<p>Continued From page 125</p> <p>are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure 7 of 28 residents were free of an unnecessary psychotropic medication (Resident #3, Resident #11, Resident #15, Resident #36, Resident #70, Resident #101, and Resident #362). There were no identified resident specific targeted behaviors identified.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. The facility staff failed to identify person-centered targeted behaviors for the use of psychotropic medications (Zoloft) for Resident #362.</li> </ol> <p>The clinical record of Resident #362 was reviewed 2/26/19 through 3/5/19. Resident #362 was admitted to the facility 2/11/19 with diagnoses that included but not limited to left fibula fracture, head injury, cataract, anemia, type 2 diabetes mellitus, urine retention, bipolar disorder, muscle weakness, difficulty in walking, encephalopathy, hypertension, chronic pain,</p>	F 758	<p>Resident #362 no longer resides in the facility. For Resident #11, person-centered specific targeted behaviors have been identified and documented in the clinical record including the care plan by the Director of Nursing/Designee for use of psychotropic medications that included Buspirone, Effexor, Trazodone, Geodon, and Valproic Acid. For Resident #3, person-centered specific targeted behaviors have been identified and documented in the clinical record including the care plan by the Director of Nursing/Designee for use of psychotropic medication that include Duloxetine and Trazadone. Resident #101 no longer resides at the facility. For Resident #36, person-centered targeted behaviors have been identified, documented and monitored in the clinical record by the Director of Nursing/Designee for the use of psychotropic medication that includes Xanax. For Resident #15, specific person-centered targeted behaviors have</p>		

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F 758	<p>Continued From page 126</p> <p>atherosclerotic heart disease, TIA (transient ischemic attacks), hyperlipidemia, intervertebral disc degeneration of lumbosacral region, and edema.</p> <p>The admission minimum data set (MDS) assessment had not yet been completed.</p> <p>The February 2019 physician orders were reviewed. Resident #362 was ordered Zoloft 100 mg (milligrams).</p> <p>The surveyor reviewed the current comprehensive care plan dated 2/21/19. The care plan read, "I have a diagnosis of anxiety/depression." Interventions: document behaviors. There were no specific targeted behaviors or non-pharmacological interventions documented.</p> <p>The current comprehensive care plan dated 2/21/19 read "I have potential for DEPRESSION secondary to physical losses or dependence." There were no identified targeted behaviors or non-pharmacological interventions documented.</p> <p>The current comprehensive care plan dated 2/21/19 read "I am at risk for side effects r/t (related to) psychotropic med (medication) use. I take Zoloft for a diagnosis of schizophrenia, bipolar disorder, anxiety and depression." Interventions: Monitor and document behaviors qshift (every shift). Side effects of medications were documented but there were no targeted behaviors or non-pharmacological interventions identified.</p> <p>The surveyor informed the administrator, the director of nursing (DON), the corporate registered nurse, and the assistant director of</p>	F 758	<p>been identified and documented in the clinical record including the care plan by the Director of Nursing/Designee. Additionally, non-pharmacological interventions have been identified, implemented and documented in the clinical record including the care plan b the Director of Nursing/Designee regarding the variance with Xanax on 2/10/19 and Haldol on 2/14/19. There were no adverse effects for the resident related to the variance.</p> <p>A review has been conducted by the Director of Nursing/Designee for residents with physician's orders for psychotropic medications to include the following areas:</p> <p>(A) Person-centered specific targeted behaviors have been identified and documented I the clinical record including the care plan.</p> <p>(B) Non-pharmacological behavior specific interventions have been identified, implemented and documented in the clinical record including the care plan.</p> <p>(C) Effectiveness of interventions is monitored and documented in the clinical record</p> <p>(D) Psychotropic medications are administered for specific targeted behaviors only and there is documented indication for use of the psychotropic education (i.e. in the physician's order, progress note, care plan, Electronic Medication Administration Record etc.)</p> <p>(E) Appropriate diagnosis and indication for use of the psychotropic medication. As needed/PRN psychotropic medications</p>		

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F 758	<p>Continued From page 127</p> <p>nursing of the above concern on 2/27/19 at 3:04 p.m. The DON was asked how does the staff know what behaviors are being targeted for Zoloft. The DON stated that behavior monitoring was not specific for Zoloft; it's for the entire shift. Staff have a drop down list when charting where they can choose from the full array of psychological symptoms.</p> <p>The surveyor requested the facility policy on psychotropic medications and the drop down box for Resident #362's targeted behaviors.</p> <p>The surveyor reviewed the facility policy titled "Behavioral Assessment, Intervention, and Monitoring" on 3/1/19. The policy read in part "Management:</p> <p>2. The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of care.</p> <p>7. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities.</p> <p>8. Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum: a. a description of the behavioral symptoms including frequency, intensity, duration, outcomes, location, environment, and precipitating factors. b. Targeted and individualized interventions for the behavioral and/or psychosocial symptoms. c. The rationale for the intervention and approaches. d. Specific and measurable goals for targeted behaviors. e. How the staff will monitor for</p>	F 758	<p>have a 14-day restriction on tire frame for administration unless the physician has re-evaluated use of he medication and documented rationale in a progress note specifying the details of why he/she wishes to continue us of the medication. (F) Review verified that there is appropriate documentation that supports the targeted behavior or use of medication in the clinical record including progress notes, Electronic Medication Administration Record, care plan.</p> <p>Education has been provided by the Director of Nursing/Designee to Licensed Nurses regarding the following areas: (A) Regulatory guidance for psychotropic drugs: A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include but are not limited to drugs in the following categories: antipsychotic, anti-depressant, anti-anxiety and hypnotic. Based on a comprehensive assessment of a resident, the facility must ensure that 1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; 2) Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contra-indicated, in an effort to discontinue use of these drugs; 3) Residents do not receive psychotropic drugs pursuant to a PRN/as needed order unless that medication is necessary to treat a diagnosed specific condition that is</p>		



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F 758	<p>Continued From page 128</p> <p>effectiveness of the intervention.</p> <p>9. Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms.</p> <p>10. When medications are prescribed for behavioral symptoms, documentation will include rationale for use, potential underlying causes of the behavior, other approaches and interventions tried prior to the use of antipsychotic medications, potential risks and benefits of medications as discussed with the resident and/or family, specific target behaviors and expected outcomes, dosage, duration, monitoring for efficacy and adverse consequences, and plans for gradual dose reduction.</p> <p>The DON provided a "screenshot" of the drop down box (special requirements) used for psychotropic medication targeted behaviors. The "Special Requirement Type (View Only)" included a drop down box for "Behavior Types." The following behaviors were included in the drop down box that staff can choose for the behavior. This was not person-centered. The drop down box included throwing food, smearing food, smearing bodily wastes, disruptive sounds, other-see nurses notes, disrobing in public, hitting self, scratching self, pacing, rummaging, public sexual acts, hitting, kicking, pushing, scratching, grabbing, sexually abusing, threatening, screaming, and cursing. None of the behaviors in the drop-down box are resident specific.</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>2. The facility staff failed to identify person-centered targeted specific behaviors for</p>	F 758	<p>documented in the clinical record; and 4) PRN/as needed orders for psychotropic drugs are limited to 14 days unless the attending physician or practitioner determines that it is appropriate for the PRN/as needed order to be extended beyond the 14 days, he or she should document their rationale in the resident's medical record and indicate duration for the as needed/PRN order. Finally, PRN orders for anti-psychotic drugs are limited to 14 days and cannot be reviewed unless the attending physician or prescribing practitioner evaluate the resident for the appropriateness of that medication.</p> <p>(B) Facility staff must ensure that targeted behaviors are identified and documented for the utilization of psychotropic medications.</p> <p>(C) Facility staff must ensure that non-pharmacologic, person-centered behavior specific interventions have been identified, implemented and documented in the clinical record including but not limited to the care plan.</p> <p>(D) Facility staff will monitor the effectiveness of non-pharmacologic, behavior-specific interventions and ensure effectiveness is documented in the clinical record as well.</p> <p>The Administrator/Director of Nursing/Designee will conduct a weekly review for three (3) residents per week for three (3) months for the following areas:</p> <p>(A) Residents with physician's orders for psychotropic medications will be reviewed to ensure that person-centered targeted behaviors are identified and documented in the clinical record including but not</p>		

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F 758	<p>Continued From page 129</p> <p>the use of psychotropic medications for Resident #11.</p> <p>The clinical record of Resident #11 was reviewed 2/26/19 through 3/5/19. Resident #11 was admitted to the facility 2/4/15 and readmitted 7/14/18 with diagnoses that included but not limited to acute respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, metabolic encephalopathy, difficulty in walking, muscle weakness, acute kidney failure, chronic pain syndrome, type 2 diabetes mellitus, hypertension, anxiety, hypothyroidism, major depressive disorder, bipolar disorder, polyneuropathy, hypokalemia, gastro-esophageal reflux disease, adult failure to thrive, schizoaffective disorder, urethral stricture, anemia, dysphagia, constipation, Parkinson's disease, urinary tract infection, chronic obstructive pulmonary disease, and Vitamin deficiency.</p> <p>Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/13/19 assessed the resident with a BIMS (brief interview for mental status) as 15. There were no assessed signs or symptoms of delirium, behaviors affecting others or psychosis.</p> <p>The February 2019 physician's orders were reviewed. Resident #11 had orders for Buspirone 7.5 mg (milligrams) by mouth tid (three times a day), Effexor XR 75 mg daily for depression, Trazodone 100 mg by mouth daily at bedtime, Geodon 20 mg by mouth bid (twice a day), and Valproic acid 250 mg twice a day.</p> <p>Resident #11's current comprehensive care plan dated 8/29/18 documented psychotropic drug use</p>	F 758	<p>limited to the care plan.</p> <p>(B) Non-pharmacological behavior-specific interventions have been identified, implemented and documented in the clinical record including but not limited to the care plan.</p> <p>(C) Effectiveness of interventions is monitored and documented in the clinical record.</p> <p>(D) Psychotropic medications are only administered for specific targeted behaviors and there is documented indication for use of the psychotropic medication (i.e. in the physician's orders, progress note, care plan, electronic medication administration record.)</p> <p>(E) Appropriate diagnosis and indication for use of the psychotropic medication, as needed/PRN psychotropic medications have a fourteen (14) day restriction on time frame for use unless the physician has re-evaluated use of the medication and documented rationale in the progress note specifying the details as to why he/she wishes to continue use of the medication.</p> <p>(F) Verify that there is appropriate documentation that supports the targeted behavior and use of the medication in the clinical record including progress notes, electronic medication administration record, care plan etc.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary</p>		

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F 758	<p>Continued From page 130</p> <p>as a problem. Approaches checked were report to my physician any troublesome symptoms that could be associated with use of the drug, administer my medications as prescribed by the physician and implement behavioral interventions, educate me and/or my family on potential risks/benefits of psychotropic drug use, monitor me for effectiveness of psychotropic drug use, monitor me for changes that may suggest my dose may need reduction, discontinuation, or increasing, communicate changes and any pharmacy/interdisciplinary team recommendations to me and my physician, evaluate me on a periodic basis for a gradual dose reduction or discontinuation, if applicable.</p> <p>The current comprehensive care plan did not address targeted behaviors for Buspar, Geodon, Effexor, Trazodone and Valproic acid or identify non-pharmacological interventions. Two behaviors identified on the activity care plan dated 8/29/18 read, "I will occasionally have disrupting behaviors during activities-gets angry and wheels off."</p> <p>The psychiatric nurse practitioner progress note dated 12/3/18 read in part "Patient with schizoaffective disorder, on Geodon and Depakote for mood stability, pharmacy request eval (evaluation) for gdr (gradual dose reduction) of Depakote 250 mg bid, patient with med (medication) adjustments for depression, Effexor 37.5 mg added on 9/24/18 for reports of depression, today, patient reports feeling more depression, r/t (related to) bad situation her grandson is facing, she reports moods feel stable. Recommendation was to increase Effexor to 50 mg qd and do not recommend GDR for Depakote while adjusting Effexor." There were</p>	F 758	<p>team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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F 758	<p>Continued From page 131</p> <p>no targeted behaviors identified in the progress note other than situational with grandson.</p> <p>The psychiatric nurse practitioner progress note dated 12/27/18 read in part "Patient with depressive symptoms per her report, last visit increased Effexor to XR75 mg qd (every day), today she reports mild improvement, but has been sad past few days as her cousin recently deceased. She continues on buspar for anxiety and finds it helpful, Depakote Geodon for mood stability and trazodone for insomnia. Staff report patient has remained overall at baseline." The current comprehensive care plan did not identify any of these concerns.</p> <p>The psychiatric nurse practitioner progress note dated 1/16/19 read in part: "Patient with history of bipolar moods with mood instability. On buspar 7.5 mg tid has failed past attempts of gdr, with increase in anxiety. Patient reports moods are doing ok now, and sleep is good." The current comprehensive care plan did not identify any of these concerns.</p> <p>The surveyor informed the administrator, the director of nursing (DON), the corporate registered nurse, and the assistant director of nursing of the above concern on 2/27/19 at 3:04 p.m. The DON was asked how does the staff know what behaviors are being targeted. The DON stated that behavior monitoring was not specific for a drug; it's for the entire shift. Staff have a drop down list when charting where they can choose from the full array of psychological symptoms.</p> <p>The surveyor requested the facility policy psychotropic medications and the drop down box</p>	F 758			

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F 758	Continued From page 132 for behaviors.  The surveyor reviewed the facility policy titled "Behavioral Assessment, Intervention, and Monitoring" on 3/1/19. The policy read in part "Management: 2. The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of care. 7. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. 8. Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum: a. a description of the behavioral symptoms including frequency, intensity, duration, outcomes, location, environment, and precipitating factors. b. Targeted and individualized interventions for the behavioral and/or psychosocial symptoms. c. The rationale for the intervention and approaches. d. Specific and measurable goals for targeted behaviors. e. How the staff will monitor for effectiveness of the intervention. 9. Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms. 10. When medications are prescribed for behavioral symptoms, documentation will include rationale for use, potential underlying causes of the behavior, other approaches and interventions tried prior to the use of antipsychotic medications, potential risks and benefits of medications as	F 758			

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F 758	<p>Continued From page 133</p> <p>discussed with the resident and/or family, specific target behaviors and expected outcomes, dosage, duration, monitoring for efficacy and adverse consequences, and plans for gradual dose reduction.</p> <p>The DON provided a "screenshot" of the drop down box (special requirements) used for psychotropic medication targeted behaviors. The "Special Requirement Type (View Only)" included a drop down box for "Behavior Types." The following behaviors were included in the drop down box that staff can choose for the behavior. This was not person-centered. The drop down box included throwing food, smearing food, smearing bodily wastes, disruptive sounds, other-see nurses notes, disrobing in public, hitting self, scratching self, pacing, rummaging, public sexual acts, hitting, kicking, pushing, scratching, grabbing, sexually abusing, threatening, screaming, and cursing. None of the behaviors in the drop-down box are resident specific.</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>3. The facility staff failed to identify person-centered targeted behaviors for the use of psychotropic medications for Resident #3.</p> <p>The clinical record of Resident #3 was reviewed 2/26/19 through 3/5/19. Resident #3 was admitted to the facility 4/5/17 and readmitted 1/8/19 with diagnoses that included but not limited to respiratory failure with hypoxia and hypercapnia, restless legs syndrome, diastolic heart failure, atrial fibrillation, obstructive sleep apnea, hypokalemia, constipation, idiopathic progressive neuropathy, gastro-esophageal reflux</p>	F 758			

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F 758	<p>Continued From page 134</p> <p>disease, hyperlipidemia, hypothyroidism, major depressive disorder, insomnia, anxiety, chronic pain syndrome, Vitamin D deficiency, benign paroxysmal vertigo, morbid obesity, hypertension, chronic obstructive pulmonary disease, type 2 diabetes mellitus, nasal congestion, and migraines.</p> <p>Resident #3's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/19 assessed the resident with a BIMS (brief interview for mental status) as 15. No evidence of delirium, behaviors affecting others or psychosis.</p> <p>Resident #3's February 2019 physician's orders were reviewed. Resident #3 was prescribed Duloxetine 60 mg (milligrams) daily and Trazodone 50 mg at bedtime.</p> <p>The surveyor reviewed the current comprehensive care plan dated 2/20/19. Resident #3's had a care plan that read resident was at risk for side effects of psychotropic medications-antidepressants and antianxiety-dx (diagnosis) includes depression, anxiety, and neuropathy. Approaches: Document resident behavior.</p> <p>The surveyor was unable to locate specific targeted behaviors for psychotropic medication use or non-pharmacological interventions.</p> <p>The surveyor informed the administrator, the director of nursing (DON), the corporate registered nurse, and the assistant director of nursing of the above concern on 2/27/19 at 3:04 p.m. The DON was asked how does the staff know what behaviors are being targeted. The</p>	F 758			

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F 758	<p>Continued From page 135</p> <p>DON stated that behavior monitoring was not specific for a drug; it's for the entire shift. Staff have a drop down list when charting where they can choose from the full array of psychological symptoms.</p> <p>The surveyor requested the facility policy psychotropic medications and the drop down box for behaviors.</p> <p>The surveyor reviewed the facility policy titled "Behavioral Assessment, Intervention, and Monitoring" on 3/1/19. The policy read in part "Management:</p> <p>2. The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of care.</p> <p>7. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities.</p> <p>8. Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum: a. a description of the behavioral symptoms including frequency, intensity, duration, outcomes, location, environment, and precipitating factors. b. Targeted and individualized interventions for the behavioral and/or psychosocial symptoms. c. The rationale for the intervention and approaches. d. Specific and measurable goals for targeted behaviors. e. How the staff will monitor for effectiveness of the intervention.</p> <p>9. Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use</p>	F 758			



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F 758	<p>Continued From page 136 of antipsychotic medications to manage behavioral symptoms.</p> <p>10. When medications are prescribed for behavioral symptoms, documentation will include rationale for use, potential underlying causes of the behavior, other approaches and interventions tried prior to the use of antipsychotic medications, potential risks and benefits of medications as discussed with the resident and/or family, specific target behaviors and expected outcomes, dosage, duration, monitoring for efficacy and adverse consequences, and plans for gradual dose reduction.</p> <p>The DON provided a "screenshot" of the drop down box (special requirements) used for psychotropic medication targeted behaviors. The "Special Requirement Type (View Only)" included a drop down box for "Behavior Types." The following behaviors were included in the drop down box that staff can choose for the behavior. This was not person-centered. The drop down box included throwing food, smearing food, smearing bodily wastes, disruptive sounds, other-see nurses notes, disrobing in public, hitting self, scratching self, pacing, rummaging, public sexual acts, hitting, kicking, pushing, scratching, grabbing, sexually abusing, threatening, screaming, and cursing. None of the behaviors in the drop-down box are resident specific.</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the corporate registered nurse, the corporate MDS (minimum data set) assessment registered nurse, and the regional executive of the above concerns on 3/5/19 at 4:26 p.m.</p> <p>No further information was provided prior to the</p>	F 758			

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F 758	<p>Continued From page 137 exit conference on 3/5/19.</p> <p>4. The facility staff failed to identify specific targeted behaviors for Resident #101. Resident #101 was prescribed Zoloft and Namenda.</p> <p>The clinical record of Resident #101 was reviewed 2/26/19 through 3/5/19. Resident #101 was admitted to the facility 1/31/19 and readmitted 2/15/19 with diagnosis that included but not limited to altered mental status, abnormal levels of serum enzymes, dementia without behavioral disturbances, Vitamin deficiency, hypothyroidism, seizures, difficulty in walking, muscle weakness, dysphagia, encephalopathy, chronic kidney disease, stage 2, hyperlipidemia, hypertension, fever, edema, insomnia, idiopathic peripheral autonomic neuropathy, type 2 diabetes mellitus, Parkinson's disease, repeated falls, frequent micturition, and hypoglycemia. Resident #101's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/7/19 assessed the resident with a BIMS (brief interview for mental status) as 11. No assessed signs or symptoms of delirium, behaviors affecting others or psychosis.</p> <p>The surveyor reviewed Resident #101's current comprehensive care plan. The care plan dated 2/11/19 read in part "I am at risk for side effects r/t (related to) my psychotropic med (medication) use. I take Zoloft for a diagnosis of depression. Approaches: Monitor and document behaviors. Administer my psychotropics as ordered." The activity care plan dated 2/6/19 for withdrawn: isolates self-did have that the resident spends most of time in room, does not talk very much, and stays in bed a big portion of day.</p>	F 758			

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F 758	<p>Continued From page 138</p> <p>Resident #101 also had a care plan dated 2/11/19 that read "I have noted cognitive loss r/t (related to) my diagnosis of Alzheimer's disease, dementia, altered mental status, and encephalopathy. Approaches: I will discuss concerns about confusion and disease processes with my provider and family as needed, I am aware the provider will review my medications, as well as pharmacy, staff will observe for any s/s (signs/symptoms) of infection and notify my provider, I ask that the staff provide reorientation as needed, and I ask that the staff promote dignity, talk to me and ensure my privacy when providing care."</p> <p>Resident #101's February 2019 physician's orders read in part, "Sertraline 100 mg (milligrams) take one tablet by mouth daily and Memantine 10 mg by mouth two times a day."</p> <p>The surveyor informed the administrator, the director of nursing (DON), the corporate registered nurse, and the assistant director of nursing of the above concern on 2/27/19 at 3:04 p.m. The DON was asked how does the staff know what behaviors are being targeted. The DON stated that behavior monitoring was not specific for a drug; it's for the entire shift. Staff have a drop down list when charting where they can choose from the full array of psychological symptoms.</p> <p>The surveyor requested the facility policy psychotropic medications and the drop down box for behaviors.</p> <p>The surveyor reviewed the facility policy titled "Behavioral Assessment, Intervention, and Monitoring" on 3/1/19. The policy read in part</p>	F 758			

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F 758	Continued From page 139 "Management: 2. The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of care. 7. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. 8. Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum: a. a description of the behavioral symptoms including frequency, intensity, duration, outcomes, location, environment, and precipitating factors. b. Targeted and individualized interventions for the behavioral and/or psychosocial symptoms. c. The rationale for the intervention and approaches. d. Specific and measurable goals for targeted behaviors. e. How the staff will monitor for effectiveness of the intervention. 9. Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms. 10. When medications are prescribed for behavioral symptoms, documentation will include rationale for use, potential underlying causes of the behavior, other approaches and interventions tried prior to the use of antipsychotic medications, potential risks and benefits of medications as discussed with the resident and/or family, specific target behaviors and expected outcomes, dosage, duration, monitoring for efficacy and adverse consequences, and plans for gradual dose reduction.	F 758			

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F 758	<p>Continued From page 140</p> <p>The DON provided a "screenshot" of the drop down box (special requirements) used for psychotropic medication targeted behaviors. The "Special Requirement Type (View Only)" included a drop down box for "Behavior Types." The following behaviors were included in the drop down box that staff can choose for the behavior. This was not person-centered. The drop down box included throwing food, smearing food, smearing bodily wastes, disruptive sounds, other-see nurses notes, disrobing in public, hitting self, scratching self, pacing, rummaging, public sexual acts, hitting, kicking, pushing, scratching, grabbing, sexually abusing, threatening, screaming, and cursing. None of the behaviors in the drop-down box are resident specific.</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>5. The facility staff failed to identify and monitor targeted behaviors of Resident # 36 while taking Xanax twice a day for anxiety.</p> <p>Resident #36 was admitted to the facility on 8/5/15 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, diabetes and dementia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/18/18, the resident was coded as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible score of 15. Resident #36 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and bathing.</p> <p>During the clinical record review on 3/4/19 at 2:04 pm, the surveyor noted a physician order Xanax</p>	F 758			

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F 758	<p>Continued From page 141</p> <p>that was given to the resident two times a day for anxiety. The surveyor could not find documentation of targeted behaviors for Resident #36 in the clinical record.</p> <p>At 3:30 pm, the surveyor asked the DON (director of nursing) where the staff was to document targeted behaviors in the clinical record. The DON stated, "On the MAR they have drop down boxes that has behaviors listed but they are not specific for each resident."</p> <p>On 3/5/19 at 4:20 pm, the surveyor notified the administrative team of the above documented findings.</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p> <p>7. For Resident #15, staff failed to ensure that psychotropic medications Haldol and xanax were only administered for the treatment of specific symptoms after non pharmacologic interventions were attempted.</p> <p>Resident #15 was admitted to the facility on 11/22/15 and readmitted on 11/18/18. Diagnoses included heart failure, hypertension, Alzheimer's disease, psychotic disorder, pneumonia, urinary tract infection (UTI), dementia with behavior disturbance, dysphagia, anxiety, muscle weakness, and difficulty walking. On the quarterly 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 symptoms of delirium, psychosis, or behaviors affecting care. The assessment indicated the resident ambulated and used the toilet with 1-2 person assistance, was frequently, but not always, incontinent, and on a prompted toileting program.</p>	F 758			

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F 758	Continued From page 142  Clinical record review revealed a physician order dated 2/10/19 "take one 0.5 mg (milligram) xanax tow and one 0.5 mg xanax in two hours". The order did not give an indication for the administration of xanax. Nursing notes on 2/10 were limited to 2/10/2019 8:38 AM "no negative behaviors noted "7p-7a". On the medication administration record, the question " Did Resident resident exhibit behaviors this shift?" Was answered "N" (no) for both shifts on 2/10/19.  A nurse's note dated 2/14/19 at 9:25 PM documented "late entry for 2/14/19 13:30: New orders received for Haldol 5 mg/ml give 5 mg IM now due to increased aggitation, IM Haldol 5mg/ml given at 13:35 without complication, no effective results noted RSD only became more aggitated". Haldol did not appear on the physician order list or on the medication administration record. There were no notes indicating the resident exhibited behaviors. On the medication administration record, the question " Did Resident resident exhibit behaviors this shift?" Was answered "N" (no) for both shifts on 2/14/19.  The administrative team was notified of the concerns with psychotropic medications, their reasons for administration, and lack of documentation during a summary meeting on 3/4/19.	F 758			
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)  The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		4/19/19	

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F 760	<p>Continued From page 143</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, facility staff failed to ensure residents were free of unnecessary medications for 6 of 28 residents in the survey sample (Resident #36, 101, 19, 362, 45, and 17).</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>The facility staff failed to ensure Resident #36 was free of unnecessary medications.</li> </ol> <p>Resident #36 was admitted to the facility on 8/5/15 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, diabetes and dementia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/18/18, the resident was coded as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible score of 15. Resident #36 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and bathing.</p> <p>During the clinical record review on 3/4/19 at 2:04 pm, the surveyor noted a physician order Xanax that was given to the resident two times a day for anxiety. The surveyor could not find documentation of targeted behaviors for Resident #36 in the clinical record to support the continued use of Xanax.</p> <p>At 3:30 pm, the surveyor asked the DON (director of nursing) where the staff was to document targeted behaviors in the clinical record. The DON stated, "On the MAR they have drop down boxes that has behaviors listed but they are not</p>	F 760	<p>For Resident #36, person centered targeted behaviors have been identified, documented and monitored in the clinical record by the Director of Nursing/Designee for the use of psychotropic medication that includes Xanax. The physician and the responsible party have been notified of the variance by the Director of Nursing/Designee. There were no adverse effects to the resident related to the variance. Resident #362 no longer resides at the facility. Resident #101 no longer resides at the facility. For Resident #19, the physician and the responsible party have been notified by the Director of Nursing/Designee regarding the medication variances for Lantus and Novolog sliding scale insulin the technical issue with the computer resulting in the inability to document the amount of sliding scale insulin has been resolved for Resident #19. There were no adverse effects to resident #19 related to the medication variances for Lantus and Novolog insulin. For resident #17, the physician and the responsible party have been notified by the Director of Nursing/Designee regarding the omitted accuchecks prior to insulin administration for the following dates and times: 7:30am, 11:30am and 5:30pm on 2/5/19, 2/11/19, 2/12/19, 2/14/19 and 2/26/19. There were no adverse effects to the resident related to the variances for omitted accuchecks. For Resident #45, the physician and the responsible party have been notified by the Director of Nursing/Designee</p>		



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F 760	<p>Continued From page 144 specific for each resident."</p> <p>On 3/5/19 at 4:20 pm, the surveyor notified the administrative team of the above documented findings.</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p> <p>2. The facility staff failed to follow the physician-ordered parameters for the administration of sliding scale insulin for Resident #362 and failed to document when insulin was administered.</p> <p>The clinical record of Resident #362 was reviewed 2/26/19 through 3/5/19. Resident #362 was admitted to the facility 2/11/19 with diagnoses that included but not limited to left fibula fracture, head injury, cataract, anemia, type 2 diabetes mellitus, urine retention, bipolar disorder, muscle weakness, difficulty in walking, encephalopathy, hypertension, chronic pain, atherosclerotic heart disease, TIA (transient ischemic attacks), hyperlipidemia, intervertebral disc degeneration of lumbosacral region, and edema.</p> <p>The admission minimum data set (MDS) assessment had not yet been completed.</p> <p>Resident #362's current comprehensive care plan dated 2/21/19 read "I have a dx (diagnosis) of diabetes and hyperglycemia. Approaches: Administer routine medications as ordered per MD (medical doctor)."</p> <p>Resident #362's February 2019 physician's orders were reviewed. Resident #362 had orders that read "Novolog 100 unit/ml (milliliter) vial</p>	F 760	<p>regarding the insulin variances on 1/16/19 at 11:30am and 5:30pm; and on 2/26/19 at 7:30am, 11:30am and 5:30pm. There were no adverse effects for resident #45 related to these variances.</p> <p>A review has been conducted by the Director of Nursing/Designee of the following areas:</p> <p>(A) Residents with physician's orders for psychotropic medications have had a clinical record review to ensure that person-centered specific targeted behavior have been identified and documented in the clinical record.</p> <p>(B) Residents with physician's orders for insulin including sliding scale insulin for specific parameters have had their physician's orders and electronic medication administration record reviewed for the previous thirty (30) days to identify further variances with following physician's orders for parameters for the administration of sliding scale insulin as well as omissions in the documentation on the electronic medication administration record when insulin was administered.</p> <p>The physician and responsible party have been notified of findings and notifications have been documented in the clinical record by the Director of Nursing/Designee. Additionally, the Administrator/Director of Nursing/Designee have reviewed the documentation regarding amount of insulin administered for those resident's with physician's orders for insulin to ensure that Licensed Nurses are about to document the specific amount of insulin</p>		

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F 760	<p>Continued From page 145</p> <p>Inject 5 units subcutaneously before meals****Hold for blood sugars less than 140**** and Levemir 100 unit/ml vial inject 60 units subcutaneously twice a day."</p> <p>The surveyor reviewed the February 2019 blood sugars documented on the electronic insulin medication administration record (Insulin MAR).</p> <p>The blood sugar documented for 2/15/19 at 7:30 a.m. was 135. Resident #362 was administered Novolog 5 units in the left upper quadrant. Insulin should have been held per the physician order to hold insulin when blood sugar was less than 140.</p> <p>The blood sugar on 2/17/19 at 7:30 a.m. was 99 and 5 units of Novolog was administered in the left upper quadrant. The insulin should have been held per the physician order.</p> <p>The blood sugar on 2/21/19 at 7:30 a.m. was 77 and 5 units of Novolog were administered in the left lower quadrant. Insulin should have been held per the physician order.</p> <p>The blood sugar on 2/21/19 at 5:30 p.m. was 126 and 5 units of Novolog was administered in the left upper arm. Insulin should have been held per the physician order.</p> <p>The surveyor informed the director of nursing of the above issue on 2/27/19 at 4:32 p.m.</p> <p>A review of the insulin MAR details for February 2019 found the following areas of concern:</p> <p>Levemir scheduled for administration on 2/14/19 at 8:00 p.m. was not documented administered until 10:00 p.m.</p>	F 760	<p>administered.</p> <p>(C) The Director of Nursing/Designee have conducted a review for resident□s with physician□s orders for Accuchecks and sliding scale insulin for the previous thirty (3) days to identify further variances in which the physicians order was not followed to obtain blood glucose reading prior to insulin administration to ensure that insulin is only administered when blood sugar readings were within the administration parameters. Additionally, the review will identify further variances with physician□s orders to hold insulin when blood glucose readings met the hold parameters. The physician and responsible party have been notified of further variances identified and notification documented in the clinical record by the Director of Nursing/Designee.</p> <p>Education has been provided to the licensed nurses by the Director of Nursing/Designee regarding the following areas:</p> <p>(A) The facility must ensure that its residents are free of significant medication errors.</p> <p>(B) Licensed nurses are expected to follow the six (6) rights of medication administration and administer medications as ordered by the physician</p> <p>(C) Residents with physician□s order for psychotropic medications must have person centered specific targeted behaviors identified and documented for the use of psychotropic medications.</p> <p>(D) The licensed nurses must follow physician□s orders for accuchecks and</p>		

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F 760	Continued From page 146 Levemir scheduled for administration on 2/15/19 at 8:00 a.m. was not documented administered until 11:48 a.m. Novolog insulin scheduled for 2/15/19 at 7:30 a.m. was not documented administered until 11:48 a.m. Levemir scheduled for administration on 2/15/19 at 8:00 p.m. was not documented as administered until 2/15/19 at 9:43 p.m. Levemir scheduled for administration on 2/16/19 at 8:00 p.m. was not documented as administered until 2/17/19 at 1:42 a.m. Novolog scheduled for administration for 2/20/19 at 7:30 a.m. was not documented as administered until 2/20/19 at 10:26 a.m. Levemir scheduled for administration on 2/20/19 at 8:00 a.m. was not documented as administered until 10:26 a.m. Novolog scheduled for administration on 2/20/19 at 11:30 a.m. was not documented as administered until 5:48 p.m. Levemir scheduled for administration on 2/20/19 at 8:00 p.m. was not documented as administered until 2/20/19 10:19 p.m. Levemir scheduled for administration on 2/21/19 at 8:00 a.m. was not documented as administered until 2/21/19 at 6:57 p.m. Novolog scheduled for administration on 2/21/19 at 7:30 a.m., 11:30 a.m., and 5:30 p.m. was not documented administered until 2/21/19 at 6:57 p.m. Levemir scheduled for administration on 2/21/19 at 8:00 p.m. was not documented as administered until 2/21/19 at 9:28 p.m. Levemir scheduled for administration on 2/22/19 at 9:00 p.m. was not documented as administered until 2/23/19 at 12:09 a.m. Levemir scheduled for administration on 2/24/19 at 8:00 p.m. was not documented as	F 760	administration of sliding scale insulin if there are physician ordered parameters for the administration of insulin, the licensed nurse must also accurately document the administration of medications including but not limited to insulin administration. (E) The licensed nurse must follow physician's orders to hold insulin when blood glucose readings meet the hold parameters. The Director of Nursing/Designee will conduct a weekly review for three (3) residents for three (3) months of the following areas: (A) Residents with physician's orders for insulin will: a. Have their medication including insulin administered per the physician order and documented in the clinical record b. The six (6) nights of medication administration has been followed for administration of medications including but not limited to insulin c. Have accuchecks obtained per the physician's orders and insulin including sliding scale insulin either administered or held based on the physicians ordered parameter. d. Omitted medications including accuchecks and insulin must be documented accurately in the clinical record the physician and responsible party must be notified timely at the time of omission and documented appropriately in the clinical record.  The results of the interviews and reviews		

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FORM APPROVED  
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F 760	<p>Continued From page 147</p> <p>administered until 9:35 p.m. Novolog scheduled for administration on 2/25/19 at 7:30 a.m. was not documented as administered until 8:40 a.m. Novolog scheduled for administration on 2/25/19 at 11:30 a.m. was not documented as administered until 6:09 p.m. Levemir scheduled for administration on 2/25/19 at 8:00 p.m. was not documented as administered until 2/26/19 at 2:20 a.m. Novolog scheduled for administration on 2/26/19 at 7:30 a.m. was not documented as administered until 9:03 a.m. Levemir scheduled for administration on 2/26/19 at 8:00 a.m. was not documented as administered until 9:03 a.m. Levemir scheduled for administration on 2/26/19 at 8:00 p.m. was not documented as administered until 11:14 p.m.</p> <p>The surveyor informed the administrator and team of the above concern in the end of the day meeting on 3/5/19 at 4:26 p.m. The administrator stated the facility had trouble with "routers" and replaced them so they would communicate better. The surveyor asked for specific dates but none were provided.</p> <p>The surveyor requested and reviewed the facility policy for the care of diabetics and the medication administration policy. The policy titled "Nursing Care of the Resident with Diabetes Mellitus" read "8. Assist the resident with his or her special medication regimen, as ordered and as needed." The policy titled "Documentation of Medication Administration" read in part "3. Documentation must include, as a minimum: d. Date and time of administration."</p>	F 760	<p>will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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F 760	<p>Continued From page 148</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>3. The facility staff failed to document when Lantus and Humulin insulin were administered to Resident #101.</p> <p>The clinical record of Resident #101 was reviewed 2/26/19 through 3/5/19. Resident #101 was admitted to the facility 1/31/19 and readmitted 2/15/19 with diagnosis that included but not limited to altered mental status, abnormal levels of serum enzymes, dementia without behavioral disturbances, Vitamin deficiency, hypothyroidism, seizures, difficulty in walking, muscle weakness, dysphagia, encephalopathy, chronic kidney disease, stage 2, hyperlipidemia, hypertension, fever, edema, insomnia, idiopathic peripheral autonomic neuropathy, type 2 diabetes mellitus, Parkinson's disease, repeated falls, frequent micturition, and hypoglycemia.</p> <p>Resident #101's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/7/19 assessed the resident with a BIMS (brief interview for mental status) as 11. No assessed signs or symptoms of delirium, behaviors affecting others or psychosis.</p> <p>The current comprehensive care plan dated 2/11/19 read "I have a dx (diagnosis) of diabetes. Approaches: Administer routine medications as ordered per MD (medical doctor)."</p> <p>Resident #101's February 2019 physician's orders read in part "Lantus 100 unit/ml (milliliter) vial inject 25 units subcutaneously bid (twice a day) ***Hold if less than 140***." Humulin N 100 units/ml take 17 units subcutaneously every day</p>	F 760			

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F 760	<p>Continued From page 149 was ordered 1/31/19 and discontinued 2/14/19.</p> <p>The surveyor reviewed the February 2019 electronic insulin medication administration record (e-Insulin MAR).</p> <p>The following issues with the February 2019 MARs were identified: 2/1/19 Lantus scheduled at 9:00 p.m. was not documented as administered until 2/1/19 at 10:37 p.m. 2/2/19 Lantus scheduled for 9:00 p.m. was not documented as administered until 2/3/19 at 2:32 a.m. 2/4/19 Lantus scheduled for 9:00 p.m. was held. Documentation of this did not occur until 2/5/19 at 2:01 a.m. 2/6/19 Lantus scheduled for 9:00 p.m. was not documented as administered until 11:07 p.m. 2/7/19 Lantus scheduled at 9:00 p.m. was not documented administered until 11:55 p.m. 2/8/19 Lantus scheduled at 9:00 p.m. was not documented as administered until 11:14 p.m. 2/9/19 Lantus scheduled at 9:00 p.m. was not documented as administered until 11:11 p.m. 2/11/19 Lantus scheduled at 9:00 p.m. was not documented as administered until 2/12/19 at 4:00 a.m. 2/11/19 Humulin scheduled at 9:00 a.m. was not documented as administered until 11:17 a.m. 2/12/19 Lantus scheduled at 9:00 p.m. was not documented as administered until 2/13/19 at 4:53 a.m. 2/15/19 Lantus scheduled for administration at 9:00 p.m. was not documented as administered until 2/16/19 at 12:17 a.m. 2/16/19 Lantus scheduled for administration at 9:00p.m. was not documented as administered until 2/17/19 at 5:36 a.m.</p>	F 760			

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>CARRINGTON PLACE AT RURAL RETREAT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>514 NORTH MAIN STREET</b> <b>RURAL RETREAT, VA 24368</b>		
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F 760	<p>Continued From page 150</p> <p>2/17/19 Lantus scheduled for administration at 9:00 p.m. was not documented as administered until 2/17/19 at 11:41 p.m.</p> <p>2/18/19 Humulin scheduled for administration at 7:30 a.m. was not documented as omitted until 11:34 a.m.</p> <p>2/20/19 Lantus scheduled for 9:00 p.m. was not documented as administered until 2/21/19 at 12:14 a.m.</p> <p>2/21/19 Lantus scheduled for administration at 9:00 p.m. was not documented as given until 2/22/19 1:10 a.m.</p> <p>2/22/19 Lantus scheduled for administration at 9:00 p.m. was not documented as administered until 2/23/19 at 3:35 a.m.</p> <p>2/23/19 Lantus scheduled for administration at 9:00 p.m. was not documented administered until 2/23/19 at 10:29 p.m.</p> <p>Second entry for 2/23/19 9:00 p.m. Lantus insulin was documented as administered on 2/25/19 at 10:52 a.m. The entry read "Unsigned record removed: Other documentation not complete."</p> <p>2/25/19 Lantus scheduled for administration at 9:00 p.m. was not documented as administered until 2/25/19 at 10:15 p.m.</p> <p>2/26/19 Lantus scheduled for administration at 9:00 a.m. was not documented as administered until 2/26/19 at 11:25 a.m.</p> <p>2/26/19 Lantus scheduled for administration at 9:00 p.m. was not documented as administered until 2/27/19 at 12:50 a.m.</p> <p>The surveyor informed the administrator and team of the above concern in the end of the day meeting on 3/5/19 at 4:26 p.m. The administrator stated the facility had trouble with "routers" and replaced them so they would communicate better. The surveyor asked for specific dates but none were provided.</p>	F 760			

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F 760	<p>Continued From page 151</p> <p>The surveyor requested and reviewed the facility policy for the care of diabetics and the medication administration policy. The policy titled "Nursing Care of the Resident with Diabetes Mellitus" read "8. Assist the resident with his or her special medication regimen, as ordered and as needed." The policy titled "Documentation of Medication Administration" read in part "3. Documentation must include, as a minimum: d. Date and time of administration."</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>4. The facility staff failed to document when Lantus and Novolog sliding scale insulin were administered to Resident #19.</p> <p>The clinical record of Resident #19 was reviewed 2/26/19 through 3/5/19. Resident #19 was admitted to the facility 11/30/18 and readmitted 1/19/19 with diagnoses that included but not limited to methicillin resistant staphylococcus aureus, cellulitis, elevated white blood count, and anemia.</p> <p>Resident #19's 5-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/22/19 assessed the resident with a BIMS (brief interview for mental status) as 13/15. There were no assessed signs or symptoms of delirium, behaviors affecting others or psychosis.</p> <p>The current comprehensive care plan dated 12/11/18 identified a problem that read, "I am at risk for complications associated with hyper-or-hypoglycemia. Approaches: Discuss with me any concerns, fears, issues regarding</p>	F 760			



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F 760	<p>Continued From page 152</p> <p>diabetic diagnosis. Perform accuchecks as ordered."</p> <p>Resident #19's February 2019 physician's orders were reviewed. Resident #19 had orders that read Lantus 100 unit/ml (milliliter) inject 40 units subcutaneously twice daily and Novolog 100 unit/ml vial use sliding scale three times a day before meals for blood sugars as follows: 151-200=3 units 201-250=6 units 251-300=9 units 301-350=12 units 351-400=15 units Contact doctor for blood sugar greater than 400.</p> <p>The surveyor reviewed the February 2019 electronic insulin medication administration record. The entry for Novolog sliding scale did not document the amount of sliding scale insulin administered. Documentation included the nurse's initials, the accuchecks result and the site of insulin administration. The insulin eMAR had no recorded amount of Novolog sliding scale insulin documented for the entire month of February 2019. Novolog sliding scale ordered three times a day (8:00 a.m., 12:00 p.m., and 5:00 p.m.).</p> <p>The surveyor reviewed the February 2019 insulin details. The insulin details had no documentation of the amount of sliding scale insulin administered. The surveyor informed the director of nursing of the above concern on 3/4/19 at 12:07 p.m. The DON stated she would have to research the issue.</p> <p>The surveyor informed the administrator and team of the above concern in the end of the day</p>	F 760			

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F 760	<p>Continued From page 153</p> <p>meeting on 3/5/19 at 4:26 p.m. The administrator stated the facility had trouble with "routers" and replaced them so they would communicate better. The surveyor asked for specific dates but none were provided.</p> <p>The surveyor requested and reviewed the facility policy for the care of diabetics and the medication administration policy. The policy titled "Nursing Care of the Resident with Diabetes Mellitus" read "8. Assist the resident with his or her special medication regimen, as ordered and as needed." The policy titled "Documentation of Medication Administration" read in part "3. Documentation must include, as a minimum: d. Date and time of administration."</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>5. For Resident #17, facility staff failed to ensure blood sugar was measured prior to administration to ensure insulin was only administered when blood sugar was within administration parameters.</p> <p>Resident #17 was admitted to the facility on 4/19/16. Diagnoses included hypertension, gastroesophageal reflux disease, diabetes mellitus, anxiety, depression, asthma, and chronic pain. On the annual assessment with assessment reference date 2/7/17, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.</p> <p>Medication orders included an order dated 9/19/18 for "Novolog 100 unit/milliliter vial inject 15 units subcutaneously daily before meals***hold if blood sugar less than 120****".</p>	F 760			

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F 760	<p>Continued From page 154</p> <p>The medication administration record (MAR) or nursing notes did not document blood sugars at 7:30 AM, 11:30 AM, or 5:30 PM on February 5, 11, 12, 14, and 26.</p> <p>The surveyor asked the medication nurse where to find the missing blood sugars. The nurse said that they would be documented with the insulin administration or with the nurse's notes or under the order "accu checks three times every day before meals and at bedtime (notify MD for BG&lt;60 or &gt;450). No blood sugars were documented under that order at 7:30 AM, 11:30 AM, or 5:30 PM on February 5, 11, 12, 14, and 26.</p> <p>The administrator and director of nursing were made aware of the concern during a summary meeting on 3/1/19.</p> <p>6. For Resident #45, facility staff failed to follow hold orders for insulin when blood glucose readings met the hold parameters.</p> <p>Resident #45 was readmitted to the facility on 1/17/17 with diagnoses including heart failure, hypertension, diabetes mellitus, dementia, anxiety, bipolar disorder, psychotic disorder, and schizophrenia. On the quarterly minimum data set assessment with assessment reference date 12/24/18 the resident scored 9/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.</p> <p>Clinical record review revealed an order for "Novolog 100 u/ml inject 24 units SQ before meals **hold if blood sugar less than 140**". The</p>	F 760			

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F 760	Continued From page 155 February insulin medication administration record (MAR) indicated the resident received insulin on 1/16/19 with blood sugar 134 at 11:30 and 119 at 5:30 PM. The February insulin MAR was blank on at 7:30 AM, 11:30 AM, and 5:30 PM on February 26. The record did not contain nursing notes to explain the omissions.  The administrator and director of nursing were made aware of concerns with insulin administration during summary meetings on 2/28, 3/1, and 3/4.	F 760			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		4/19/19	

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F 761	<p>Continued From page 156</p> <p>quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, clinical record review, and facility document review, facility staff failed to ensure medications available on 5 of 6 medication carts.</p> <p>The findings included:</p> <p>1(a). The facility staff failed to provide safe storage and labeling in 5 out of 6 medication carts in the nursing facility.</p> <p>On 2/26/19 at 4:25 pm, the surveyor observed loose pills in the drawers for the 500 hallway medication cart:</p> <ul style="list-style-type: none"> <li>o (1) Black capsule</li> <li>o (1) med. round pill yellow</li> <li>o (1) pink med pill</li> <li>o (4) white oblong pills</li> <li>o (1) orange capsule</li> <li>o 4 white med pills</li> <li>o 1 yellow large pill</li> <li>o 1 blue oblong pill</li> <li>o 1 small round pill</li> <li>o 1 pink round small pill</li> <li>o 1/2 LARGE white round pill</li> <li>o 1 orange round med pill</li> <li>o 1 small white pill</li> <li>o Besivance Sus 0.6% 9/21/18 eye drops opened date of 11/6/18 but not discarded after 30 days</li> <li>o Levemir Insulin had no opened date on the vial</li> </ul> <p>1(b). At 4:45 pm, the surveyor observed the following in the 600 hallway medication cart drawers:</p>	F 761	<p>The loose pills identified in the drawers of 500 hallway med cart on 2/26/19 at 4:25 pm, 600 hallway med cart on 2/26/19 at 4:45 pm, 200 hallway med cart drawers on 2/26/19 at 6:02 pm, 100 hallway med cart drawers on 2/26/19 at 6:00 pm have been removed and discarded by the Director of Nursing/Designee during the survey process. The Besivance sus 0.6% eye drops with the opened date 9/21/18 identified on the 500-hallway med cart were discarded by the Director of Nursing/Designee during the survey proves. Levemir insulin identified on the 500-hallway med cart with no opened date on the vial was discarded by the Director of Nursing/Designee during the survey process. The Latanoprost sol 0.005% identified on the 300-hallway med cart with no open on them at 5:37 pm on 2/26/19+ were discarded by the Director of Nursing/Designee during the survey process. There were no adverse effects for residents related to the documented areas identified on the medication carts.</p> <p>The Director of Nursing/Designee conducted a medication cart audit to clean out debris, ensure that no loose medications were found, all medications were labeled appropriately with the open date, and no expired medications were contained in the medication carts for both wings.</p>		

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F 761	<p>Continued From page 157</p> <ul style="list-style-type: none"> <li>o 1 small orange pill</li> <li>o 1/2 pink med round pill</li> <li>o 1 blue oblong pill</li> <li>o 1 large oblong yellow pill</li> <li>o 1/2 sm. purple oblong pill</li> <li>o 1/2 blue oblong pill</li> </ul> <p>1(c). At 5:37 pm, the surveyor observed the following in the 300 hallway medication cart drawers:</p> <ul style="list-style-type: none"> <li>o Latanoprost sol 0.005% no open date on it</li> </ul> <p>1(d). At 6:02 pm, the surveyor observed the following in the 200 hallway medication cart drawers:</p> <ul style="list-style-type: none"> <li>o 1 teal colored oblong capsule</li> <li>o 1 brown round pill</li> <li>o 1 med white round pill</li> <li>o 2 white oblong pills</li> <li>o 1 small round white pill</li> <li>o 1/2 white pill round</li> <li>o 1 small round tan pill</li> </ul> <p>1(e). At approximately 6:05 pm, the surveyor observed the following in the drawers of 100 hallway medication cart:</p> <ul style="list-style-type: none"> <li>o 1 white capsule</li> <li>o 1 yellow and black oblong pill</li> <li>o 1 small pink round pill</li> <li>o 1 orange capsule</li> <li>o 1 med round white pill</li> </ul> <p>The surveyor notified the director of nursing (DON) and the corporate nurse of the above documented findings on 2/26/19 at 6:30 pm. The surveyor notified the administrative staff of the above documented findings on 3/5/19 at 4:20 pm. The surveyor asked the director of nursing (DON) how medications were to be stored and</p>	F 761	<p>Education has been provided to licensed nurses by the Director of Nursing/Designee regarding the medication cart cleanliness and proper labeling and dating of medications. A weekly verification will be completed for three (3) months by the Director of nursing/Designee to observe the medication carts.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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F 761	Continued From page 158 labeled once they were opened. The DON stated, "When the medication is opened, the nurses' are to document the date in which it was opened and discard the medication after 30 days. The pills should be kept in the cards and in the medication cart when not administering them. If they see a pill loose in the drawers of the med cart than they are to dispose of medications appropriately." No further information was provided to the surveyor prior to the exit conference on 3/5/19.	F 761			
F 773 SS=E	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii)  §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain physician ordered laboratory tests for 4 of 28 residents (Resident #3, Resident #74, Resident #36, and Resident #15).  The findings included: 1. The facility staff failed to obtain physician ordered laboratory tests for Resident #3.	F 773	Physician notifications were completed on Residents #3, #74, #36 and #15.  Labs were audited/reviewed by Director of Nursing/Designee on 3/6/2019 to ensure completion, documentation, notifications to physician and responsible party and results obtained from the pharmacy,	4/19/19	

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F 773	<p>Continued From page 159</p> <p>The clinical record of Resident #3 was reviewed 2/26/19 through 3/5/19. Resident #3 was admitted to the facility 4/5/17 and readmitted 1/8/19 with diagnoses that included but not limited to respiratory failure with hypoxia and hypercapnia, restless legs syndrome, diastolic heart failure, atrial fibrillation, obstructive sleep apnea, hypokalemia, constipation, idiopathic progressive neuropathy, gastro-esophageal reflux disease, hyperlipidemia, hypothyroidism, major depressive disorder, insomnia, anxiety, chronic pain syndrome, Vitamin D deficiency, benign paroxysmal vertigo, morbid obesity, hypertension, chronic obstructive pulmonary disease, type 2 diabetes mellitus, nasal congestion, and migraines.</p> <p>Resident #3's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/19 assessed the resident with a BIMS (brief interview for mental status) as 15. No evidence of delirium, behaviors affecting others or psychosis.</p> <p>A physician order dated 12/18/18 read in part, "CBC (complete blood count), CMP (comprehensive metabolic panel), TSH (thyroid stimulating hormone), A1C (hemoglobin A1C), lipids, B12, Vitamin D, Magnesium level today and again in 3 months."</p> <p>The surveyor reviewed the laboratory section of the clinical record but was unable to locate the results of the A1C ordered to be done 12/18/18.</p> <p>A physician order dated 1/10/19 read in part, "BMP (basic metabolic panel) in 1 month." The surveyor reviewed the laboratory section of the</p>	F 773	<p>Education will be provided to licensed nurses by the Director of Nursing/Designee regarding obtaining ordered labs, reporting results to physician, physician and responsible party notification, and ensuring lab results have been received and report is filed within the clinical record. Director of Nursing/Designee will audit/review labs ordered for three (3) residents daily for three (3) months.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		



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F 773	<p>Continued From page 160</p> <p>clinical record but was unable to locate the results of the BMP ordered to be done in February 2019.</p> <p>The surveyor informed the unit manager licensed practical nurse #2 on 3/4/19 at 4:41 p.m. L.P.N. #2 stated she would call the laboratory.</p> <p>No further results were provided by L.P.N. #2.</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the regional executive, the corporate MDS registered nurse and the regional registered nurse of the above concern on 3/5/19 at 4:26 p.m.</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>2. The facility staff failed to obtain a physician ordered uric acid level for Resident #74.</p> <p>The clinical record of Resident #74 was reviewed 2/26/19 through 3/5/19. Resident #74 was admitted to the facility 3/1/18 and readmitted 1/4/19 with diagnoses that included but not limited to Huntington's disease, neglected elder, Parkinson's disease, urinary tract infection, muscle weakness, dysphagia, unspecified psychosis not due to a substance or known physical condition, weakness, hypertension, post-traumatic stress disorder, ataxia, disorientation, anxiety, unspecified mood disorder, altered mental status, disorder of urea cycle metabolism, dementia in other disease classified elsewhere without behavioral disturbances, hepatic failure, and acute cystitis.</p> <p>Resident #74's 14-day minimum data set (MDS)</p>	F 773			

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F 773	<p>Continued From page 161</p> <p>assessment with an assessment reference date (ARD) of 1/16/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. There was no evidence of delirium, no behaviors affecting others, and no evidence of psychosis.</p> <p>A telephone order dated 11/23/18 read "uric acid level dx (diagnosis) right hand swelling."</p> <p>The surveyor reviewed the laboratory section of the clinical record but was unable to locate the results of the uric acid level.</p> <p>The surveyor informed the director of nursing of the above concern on 3/5/19 at 11:22 a.m.</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the regional executive, the corporate MDS registered nurse and the regional registered nurse of the above concern on 3/5/19 at 4:26 p.m.</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>3. The facility staff failed to identify and monitor targeted behaviors of Resident # 36 while taking Xanax twice a day for anxiety.</p> <p>Resident #36 was admitted to the facility on 8/5/15 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, diabetes and dementia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/18/18, the resident was coded as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible score of 15. Resident #36 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and</p>	F 773			

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F 773	<p>Continued From page 162 bathing.</p> <p>During the clinical record review on 3/4/19 at 2:04 pm, the surveyor noted a physician order Xanax that was given to the resident two times a day for anxiety. The surveyor could not find documentation of targeted behaviors for Resident #36 in the clinical record.</p> <p>At 3:30 pm, the surveyor asked the DON (director of nursing) where the staff was to document targeted behaviors in the clinical record. The DON stated, "On the MAR they have drop down boxes that has behaviors listed but they are not specific for each resident."</p> <p>On 3/5/19 at 4:20 pm, the surveyor notified the administrative team of the above documented findings.</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/5/19.</p> <p>4. For Resident #15, facility staff failed to obtain a urinalysis as ordered.</p> <p>Resident #15 was admitted to the facility on 11/22/15 and readmitted on 11/18/18. Diagnoses included heart failure, hypertension, Alzheimer's disease, psychotic disorder, pneumonia, urinary tract infection (UTI), dementia with behavior disturbance, dysphagia, anxiety, muscle weakness, and difficulty walking. On the quarterly 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 symptoms of delirium, psychosis, or behaviors affecting care. The assessment indicated the resident ambulated and used the toilet with 1-2 person assistance, was frequently, but not always,</p>	F 773			

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F 773	Continued From page 163 incontinent, and on a prompted toileting program.  During clinical record review, the surveyor noted a telephone order dated 2/14/19 for urinalysis with culture and sensitivity. There was a second order dated 2/19/19 for valium prior to a straight catheterization to obtain the sample for urinalysis. No notes between 2/14 and 2/19 indicated an attempt to obtain the sample or to notify the physician it had not been obtained.  The administrator and director of nursing were notified of the concern during a summary meeting on 3/4/19.	F 773			
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g)  §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide physician ordered adaptive devices for 1 of 28 residents (Resident #11).  The findings included:  The facility staff failed to provide a divided plate to Resident #11 on 2/26/19 at the evening meal.  The clinical record of Resident #11 was reviewed 2/26/19 through 3/5/19. Resident #11 was admitted to the facility 2/4/15 and readmitted	F 810	For Resident #11, a divided plate was provided.  A review has been completed by the Administrator/Director of Nursing/Designee for current residents to ensure that adaptive devices have been provided for eating.  Education has been provided to the licensed nurses and the interdisciplinary team by the Administrator/Director of Nursing/Designee regarding provision of	4/19/19	

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F 810	<p>Continued From page 164</p> <p>7/14/18 with diagnoses that included but not limited to acute respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, metabolic encephalopathy, difficulty in walking, muscle weakness, acute kidney failure, chronic pain syndrome, type 2 diabetes mellitus, hypertension, anxiety, hypothyroidism, major depressive disorder, bipolar disorder, polyneuropathy, hypokalemia, gastro-esophageal reflux disease, adult failure to thrive, schizoaffective disorder, urethral stricture, anemia, dysphagia, constipation, Parkinson's disease, urinary tract infection, chronic obstructive pulmonary disease, and Vitamin deficiency.</p> <p>Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/13/19 assessed the resident with a BIMS (brief interview for mental status) as 15. There were no assessed signs or symptoms of delirium, behaviors affecting others or psychosis. Section G Functional Status was reviewed. Resident #11 required supervision and one person physical support. No impairment in upper extremity assessed (G0400A).</p> <p>Resident #11's current comprehensive care plan dated 8/29/18 had the problem that the resident was at nutritional risk. The approaches on the care plan did not have divided plate listed.</p> <p>The February 2019 physician's order read in part "Low sodium diet with divided plate."</p> <p>The surveyor observed the evening meal on 2/26/19. Resident #11 was served the evening meal at 6:24 p.m. The surveyor compared the ticket to the tray set-up. The tray ticket said,</p>	F 810	<p>adaptive devices to residents for eating. A review will be completed by the Administrator/Designee weekly for three (3) residents for three (3) months to ensure residents are having adaptive devices for eating provided to them.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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F 810	Continued From page 165 "Divided dish." Resident #11's meal of French fries, cole slaw, fish, and brownie was served on a regular plate. The surveyor asked certified nursing assistant #2 to read the tray ticket. C.N.A. #2 stated the resident didn't get a divided plate. "She's supposed to have one. Maybe they ran out."  The surveyor informed the administrator, the director of nursing, the assistant director of nursing and the regional registered nurse of the above concern on 3/1/19 at 5:34 p.m.  No further information was provided prior to the exit conference on 3/5/19.	F 810			
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	F 842		4/19/19	

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F 842	<p>Continued From page 166</p> <p>§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-</p> <ul style="list-style-type: none"> <li>(i) To the individual, or their resident representative where permitted by applicable law;</li> <li>(ii) Required by Law;</li> <li>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</li> <li>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</li> </ul> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <ul style="list-style-type: none"> <li>(i) The period of time required by State law; or</li> <li>(ii) Five years from the date of discharge when there is no requirement in State law; or</li> <li>(iii) For a minor, 3 years after a resident reaches legal age under State law.</li> </ul> <p>§483.70(i)(5) The medical record must contain-</p> <ul style="list-style-type: none"> <li>(i) Sufficient information to identify the resident;</li> <li>(ii) A record of the resident's assessments;</li> <li>(iii) The comprehensive plan of care and services provided;</li> <li>(iv) The results of any preadmission screening and resident review evaluations and</li> </ul>	F 842			

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F 842	<p>Continued From page 167</p> <p>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, facility document review, and clinical record review, the facility staff failed to ensure a complete and accurate record for 3 of 28 residents (Resident #3, Resident #19, and Resident #15).</p> <p>The findings included:</p> <p>1. The facility staff failed to document accurately medication administered to Resident #3. Registered Nurse #1 charted medication administered when the medication was actually removed from the pill cup by the resident.</p> <p>The clinical record of Resident #3 was reviewed 2/26/19 through 3/5/19. Resident #3 was admitted to the facility 4/5/17 and readmitted 1/8/19 with diagnoses that included but not limited to respiratory failure with hypoxia and hypercapnia, restless legs syndrome, diastolic heart failure, atrial fibrillation, obstructive sleep apnea, hypokalemia, constipation, idiopathic progressive neuropathy, gastro-esophageal reflux disease, hyperlipidemia, hypothyroidism, major depressive disorder, insomnia, anxiety, chronic pain syndrome, Vitamin D deficiency, benign paroxysmal vertigo, morbid obesity, hypertension, chronic obstructive pulmonary disease, type 2 diabetes mellitus, nasal congestion, and migraines.</p> <p>Resident #3's annual minimum data set (MDS)</p>	F 842	<p>For Resident #3, a late entry/addendum has been made by the Director of Nursing/Designee to reflect the resident's refusal of the Lasix on 2/27/19 at 11:17 am. The physician and responsible party have been notified regarding the resident's refusal of the medication and notification has been documented in the medical record. For Resident #19, the physician and responsible party have been notified by the Director of Nursing/Designee regarding the variance related to the omitted weights for the week of 02/10/19 through 2/16/19. For Resident #15, person-centered specific targeted behaviors have been identified and documented in the clinical record. The physician was notified by the Director of Nursing/Designee regarding symptoms requiring treatment with psychotropic medication orders were entered into the clinical record for psychotropic medications to specify indication for utilization of the Xanax ordered.</p> <p>A review has been conducted by the Director of Nursing/Designee for the following areas: (A) Review of the electronic medication administration record for resident refusals of medication for the previous thirty (30)</p>		



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F 842	<p>Continued From page 168</p> <p>assessment with an assessment reference date (ARD) of 2/6/19 assessed the resident with a BIMS (brief interview for mental status) as 15. No evidence of delirium, behaviors affecting others or psychosis.</p> <p>The surveyor interviewed Resident #3 on 2/27/19 at 11:17a.m. During the interview, registered nurse #1 came in Resident #3's room to administer the morning medications. Resident #3 stated she didn't want the diuretic as she was going to get up and go to activities. Resident #3 was given the pill cup and removed the diuretic.</p> <p>The surveyor reviewed Resident #3's February 2019 physician's orders. Resident #3 had orders for Lasix 40 mg (milligram) tablet take one by mouth twice a day.</p> <p>The surveyor reviewed the February 2019 medication administration record. The 2/27/19 9:00 a.m. box for Lasix had been documented with the initials of R.N. #1. Initialed boxes on medication administration records indicated the medication was administered. Resident #3 refused the medication on 2/27/19 as witnessed by the surveyor.</p> <p>The surveyor informed the director of nursing of the above concern on 3/1/19 at 3:50 p.m. The DON stated if medications were not administered due to refusal, she would expect the nurses to document refused. The DON stated the standard of practice was to chart and document refusal.</p> <p>The surveyor interviewed R.N. #1 on 3/1/19 at 3:52 p.m. about the medication Lasix documented as administered when the resident had refused the medication. R.N. #1 stated, "Did</p>	F 842	<p>days has been completed additional review to ensure that the physician and responsible party have been notified regarding refusals and the notification has been documented in the medical record.</p> <p>(B) Review of physician's orders for physician ordered weights will be completed by the Director of Nursing/Designee for the previous thirty (30) days to ensure that weights have been obtained as ordered by the physician.</p> <p>(C) Residents with physician's orders for psychotropic medications have been reviewed by the Director of Nursing/Designee to ensure that person-centered specific targeted behaviors have been identified and documented in the clinical record. Additionally, the physician has been notified by the Director of Nursing/Designee regarding resident's with behavioral symptoms requiring treatment with psychotropic medications. Residents with physician's order for psychotropic medications will be reviewed by the Director of Nursing/Designee to ensure that the physicians order includes indication for utilization of psychotropic medications.</p> <p>Education was provided to licensed nursing staff regarding documentation and notification to physician and responsible party for resident's refusal of medications; indication and implementation of person-centered targeted behaviors prior to utilization of psychotropic medications. A review will be</p>		

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F 842	<p>Continued From page 169</p> <p>I do that? I can go in and fix it."</p> <p>The surveyor requested the facility policy on standards of practice for medication administration from the director of nursing on 3/1/19 at 4:03 p.m.</p> <p>The surveyor reviewed the facility policy and standard of practice for medication administration on 3/1/19. The policy titled "Documentation of Medication Administration" read in part, "3. Documentation must include, as a minimum: e. Reason(s) why a medication was withheld, not administered, or refused."</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the corporate registered nurse of the above concern on 3/1/19 at 5:34 p.m. and again on 3/5/19 at 4:26 p.m.</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>2. The facility staff failed to document weights for Resident #19 in the clinical record.</p> <p>The clinical record of Resident #19 was reviewed 2/26/19 through 3/5/19. Resident #19 was admitted to the facility 11/30/18 and readmitted 1/19/19 with diagnoses that included but not limited to methicillin resistant staphylococcus aureus, cellulitis, elevated white blood count, and anemia.</p> <p>Resident #19's 5-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/22/19 assessed the resident with a BIMS (brief interview for mental status) as 13/15.</p>	F 842	<p>conducted by the Director of Nursing/Designee on three (3) residents weekly for three (3) months to ensure documentation and notification of refusal of medications, completion of physician ordered weights, and indication and implementation of person-centered targeted behaviors prior to the utilization of psychotropic medications.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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F 842	<p>Continued From page 170</p> <p>There were no assessed signs or symptoms of delirium, behaviors affecting others or psychosis.</p> <p>Resident #19's current comprehensive care plan dated 1/15/19 identified the problem of nutrition. Approaches: Weigh and monitor results on admission x 3 days, weekly x 4 then monthly if stable.</p> <p>A faxed dietary communication form dated 1/18/19 read, "1. Add Prostat 30 m (milliliters) bid (twice a day) x 30 days given skin breakdown with low Alb (albumin) level (2-8) and poor po (by mouth) intake. 2. Monitor weekly weights." Physician response "Agree with above."</p> <p>The surveyor reviewed the weights entered in the computer. Weekly weights beginning 1/18/19 were not found. The staff have documented weights on 2/4/19, 2/5/19, 2/6/19 and 2/22/19.</p> <p>The surveyor informed the director of nursing (DON) of the above inability to locate weekly weights on 3/4/19 at 1:35 p.m. The DON provided weights recorded on paper for 1/26/19, 1/30/19-the note read out, and 2/25/19.</p> <p>The departmental note dated 1/30/19 at 7:37 p.m. read "Resident out for appointment at wound clinic. Upon return went to bed and refused to have weight obtained."</p> <p>The departmental note dated 2/1/19 at 4:31 p.m. read "Resident refuses to be weighed."</p> <p>The surveyor was unable to locate a weight for the week of 2/10/19 through 2/16/19. The DON has written the weight was recorded in a note but the surveyor was unable to locate a note with a</p>	F 842			

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F 842	<p>Continued From page 171 documented weight during the time.</p> <p>The surveyor asked the DON if the weights provided on paper were part of the clinical record. The DON stated she would expect staff to document weights in the computer.</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the regional executive, the regional registered nurse and the corporate MDS RN of the above finding in the end of the day meeting on 3/5/19 at 4:26 p.m.</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>3. For Resident #15, facility staff failed to document behaviors exhibited by the resident which required treatment, and to document communication with the physician concerning symptoms requiring treatment with psychotropic medications, and to enter orders for psychotropic medications into the clinical record.</p> <p>Clinical record review revealed a physician order dated 2/10/19 "take one 0.5 mg (milligram) xanax tow and one 0.5 mg xanax in two hours". The order did not give an indication for the administration of xanax. Nursing notes on 2/10 were limited to 2/10/2019 8:38 AM "no negative behaviors noted "7p-7a". On the medication administration record, the question " Did Resident resident exhibit behaviors this shift?" Was answered "N" (no) for both shifts on 2/10/19.</p> <p>A nurse's note dated 2/14/19 at 9:25 PM documented "late entry for 2/14/19 13:30: New orders received for Haldol 5 mg/ml give 5 mg IM now due to increased aggitation, IM Haldol</p>	F 842			

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F 842	Continued From page 172 5mg/ml given at 13:35 without complication, no effective results noted RSD only became more agitated". Haldol did not appear on the physician order list or on the medication administration record. There were no notes indicating the resident exhibited behaviors. On the medication administration record, the question " Did Resident resident exhibit behaviors this shift?" Was answered "N" (no) for both shifts on 2/14/19.  The administrative team was notified of the concerns with psychotropic medications, their reasons for administration, and lack of documentation during a summary meeting on 3/4/19.	F 842			
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)  §483.75(g) Quality assessment and assurance.  §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, and in the course of a complaint investigation, facility staff failed to ensure quality assurance programs meet the needs of the facility.  03/01/19 10:49 AM met 2/8/18, 3/15/18, 4/19/18, 7/19/18, 8/23/18, 11/21/18, 1/16/19 (medical director was listed as present but didn't sign in), 2/21/19	F 867	On 03/01/19, the Regional Nurse Consultant developed an action plan for Narcotic Medication Reconciliation. Opportunities for improvement related to nursing documentation timely initiation of physician orders, target behavior monitoring and Infection Control, was identified, and a PIP was developed.	4/19/19	

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F 867	<p>Continued From page 173</p> <p>Issues addressed: education for new QAPI, and PIP (plan in place)</p> <p>Current PIPs- falls/interventions</p> <p>Weight loss</p> <p>Infection control- implemented tracking log to include cultures were all received and appropriate intervention in place; the infection control plan concentrated on tracking and treating, but did not address nursing practices during care.</p> <p>Dining compliance- infection control, getting correct menu, and temperature control- administrator gets daily test tray</p> <p>Decreasing bed alarms- goal decrease by 25% and actual results decreased 33%</p> <p>Hot beverage safety- post injury- extensive interventions</p> <p>New this week= medication administration administration and narcotic reconciliation</p> <p>Had started narcotic reconciliation in the fall, but it concentrated on different issues- counting pages in the book, etc. It had not addressed other issues such as the count. We knew that the counts were an issue in the fall, but had not realized the problem was ongoing. The policy has not been changed.</p> <p>The PIPs had not covered nursing documentation; timely initiation of orders, documentation of behaviors, etc.;</p>	F 867	<p>On 04/27/19 QAPI meeting was held with attendance by The Medical Director, Regional Nurse Consultant, and Regional Director of Operations. Discussion included:</p> <p>Policy Change on Narcotic Reconciliation (A)Two licensed nurses (typically, the nurse arriving on duty and the nurse departing from duty) are required to conduct a reconciliation (i.e. Change of Shift Count)of controlled substances in accordance with facility policy and sign a signature log attesting to the completion and accuracy of the count.</p> <p>(B)The reconciliation process should include:</p> <ul style="list-style-type: none"> <li>comparison of the actual amount of available medication versus the amount of medication available as listed on the perpetual inventory count sheet(i.e. controlled substance count sheet); both nurses should visualize both the count sheet and the actual amount of medication count comparing the number of medication packages (i.e. cards, boxes, bottles, etc.) versus the number of controlled substances count sheets; the number of medications packages and the number of controlled substances count sheets should be equal.</li> </ul> <p>(C)It is recommended that this Change of Shift Reconciliation process be applied to all controlled substances (Schedule II through Schedule 5) and that both nurses</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019  
FORM APPROVED  
OMB NO. 0938-0391

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F 867	Continued From page 174	F 867	<p>performing the reconciliation visualize both the medications being counted and the count sheet.</p> <p>(D)If inaccuracies are noted, the DON or designee should be notified immediately. Nurses involved with noting the discrepancy are not permitted to leave the facility until debriefed by the DON or designee.</p> <p>03/01/19 QAPI meeting held to discuss 2567/ Plan of correction, review audits and monitoring review compliance. Regional Director of Operation in attendance.</p> <p>On 03/21/19, The Regional Nurse Consultant educated the QAPI committee on the facility QAPI policy / process used to monitor, sustain facility operational performance through self-identification and improvement in areas where opportunities for improvement have been identified. Monthly QAPI Compliance Audit by the Regional NurseConsultant/Regional Director of Operation to validate compliance with monthly meetings being held and progress on ongoing performance improvement areas that were self-identified. Review of compliance for any need to re-evaluate and revise the action plans will be documented monthly x 3, then Quarterly. Audits will be kept in the Administrator office.</p> <p>The results of the interviews and reviews will be discussed by the Director of</p>		

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F 867	Continued From page 175	F 867	Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.		
F 880 SS=F	<p>Infection Prevention &amp; Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or</p>	F 880		4/19/19	



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F 880	<p>Continued From page 176</p> <p>infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the</p>	F 880	<p>Certified nursing assistant was educated on proper Foley care and infection control</p>		

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F 880	<p>Continued From page 177</p> <p>facility staff failed to provide an effective infection control program and failed to follow infection control guidelines for 5 of 28 residents in the survey sample (Resident #74, Resident #45, Resident #15, Resident #17, and Resident #34).</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. The facility staff failed to implement a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards. The line listing of resident infections from 2018 and 2019 was incomplete.</li> </ol> <p>The surveyor interviewed the assistant director of nursing on 3/5/19 at 3:53 p.m. The ADON (also the infection preventionist) was asked for the line listing for resident infections for 2018 and 2019.</p> <p>A review of the 2018 line listing for resident infections did not identify date of cultures if done, culture results, treatment that included type of precautions, outcomes and adverse events.</p> <p>On the current infection log for 2019, the name of the antibiotic ordered, start date and end date of the antibiotic, identified pathogen, date of culture if done, total days of antibiotic therapy, outcome and adverse events were not captured on the log.</p> <p>The ADON did have a map where the residents with infections currently were located. The ADON stated, "The bare minimum for documentation was done. With the new corporate registered</p>	F 880	<p>practices on 03/01/2019. Resident #15 was placed on contact precautions and personal protective equipment was provided to staff. Physician and responsible party were notified of the failure to initiate antibiotic therapy for Resident #45 in a timely manner.</p> <p>Education was provided to nursing staff regarding infection control practices and hand hygiene on 03/02/19 and 03/03/19. Assistant Director of Nursing was educated by Director of Nursing/Designee regarding infection control and line listing on 03/02/2019. An audit/review was conducted for all residents receiving antibiotic therapy to ensure initiation of treatment and implementation of contact precautions if necessary.</p> <p>Director of Nursing/Designee will provide comprehensive infection control education to licensed nursing staff and the interdisciplinary team to include tracking of infections, physician notification, initiation of treatment, documentation and implementation of isolation if deemed necessary. A review will be completed by the Director of Nursing/Designee weekly for three (3) residents weekly for three (3) months to initiation of treatment and implementation of contact precautions if necessary.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee</p>		

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F 880	<p>Continued From page 178</p> <p>nurse, I am involved in the monthly clinical call and have started using the McGeer's surveillance criteria starting in January 2019." The ADON provided the surveyor with copies of the McGeer's criteria currently in use.</p> <p>The surveyor reviewed the facility policy on infection control for antibiotic use. The policy included to document on the facility-approved antibiotic surveillance tracking form the following:</p> <ol style="list-style-type: none"> <li>Resident name and medical record number</li> <li>Unit and room number</li> <li>Date symptoms appeared</li> <li>Name of antibiotic</li> <li>Start date of antibiotic'</li> <li>Pathogen identified</li> <li>Site of infection</li> <li>Date of culture</li> <li>Stop date</li> <li>Total days of therapy</li> <li>Outcome;</li> <li>Adverse effects</li> </ol> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the regional registered nurse, the regional executive, the corporate MDS registered nurse of the above concern during the end of the day meeting on 3/5/19 at 4:26 p.m.</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>2. The facility staff failed to wash hands or hand sanitize after removing gloves and exiting the room of Resident #74.</p> <p>The clinical record of Resident #74 was reviewed 2/26/19 through 3/5/19. Resident #74 was</p>	F 880	Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.		

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F 880	<p>Continued From page 179</p> <p>admitted to the facility 3/1/18 and readmitted 1/4/19 with diagnoses that included but not limited to Huntington's disease, neglected elder, Parkinson's disease, urinary tract infection, muscle weakness, dysphagia, unspecified psychosis not due to a substance or known physical condition, weakness, hypertension, post-traumatic stress disorder, ataxia, disorientation, anxiety, unspecified mood disorder, altered mental status, disorder of urea cycle metabolism, dementia in other disease classified elsewhere without behavioral disturbances, hepatic failure, and acute cystitis.</p> <p>Resident #74's 14-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/16/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. There was no evidence of delirium, no behaviors affecting others, and no evidence of psychosis.</p> <p>The surveyor observed a skin assessment on 2/27/19 at 8:25 a.m. Licensed practical nurse #4 completed the skin assessment and was assisted by certified nursing #1. L.P.N. #4 and C.N.A. #1 donned gloves. Upon completion of the skin assessment observation, C.N.A. #1 removed gloves and exited the resident's room. As C.N.A. #1 walked down the hall towards the nursing station, C.N.A. #1 stopped and started to push a resident in the wheelchair towards the dining room. C.N.A. #1 left the resident in the dining room. The surveyor asked C.N.A. #1 if she had purell in the uniform pocket. C.N.A. #1 stated "No. There's purell back by the sink." C.N.A. #1 was never observed to wash her hands or use hand sanitizer after exiting Resident #74's room and proceeding to the dining room.</p>	F 880			

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F 880	<p>Continued From page 180</p> <p>The surveyor informed the administrator, the director of nursing, the assistant director of nursing and the regional registered nurse of the above concern with handwashing on 3/1/19 at 5:34 p.m. and requested the facility policy on handwashing. The DON was asked if hands should be washed after removing gloves. The DON stated wash hands or hand hygiene.</p> <p>The surveyor reviewed the facility policy titled "Infection Control Guidelines for All Nursing Procedures" on 3/5/19. The policy read in part "General Guidelines 3. Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: d. After removing gloves."</p> <p>No further information was provided prior to the exit conference on 3/5/19.</p> <p>3. The facility staff failed to follow infection control guidelines in regards to Resident #34's Foley catheter.</p> <p>Resident #34 was readmitted to the facility on 9/12/15 with the following diagnoses of, but not limited to anemia, neurogenic bladder, urinary tract infection, dementia, Multiple Sclerosis and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/17/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #34 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and being totally dependent on 2 staff members for bathing.</p> <p>On 03/01/19 at 9:55 am, the surveyor observed</p>	F 880			

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F 880	<p>Continued From page 181</p> <p>the resident in the shower room. The surveyor asked the CNA (certified nursing assistant) #1 if she could lift the Foley catheter tubing up so the surveyor would see what size the foley catheter was in the resident. CNA #1 picked up foley catheter, closest to where it was inserted into the resident, with bare hands and no gloves on. The size of the Foley catheter was observed to be an 18 French with a 10 cc balloon. The Foley catheter tubing was also hanging freely by the resident's leg and not secured with a leg strap. The regional MDS (Minimum Data Set) coordinator was with surveyor during this entire observation. The MDS regional nurse told the CNA that the leg straps were in Central Supply room. The surveyor asked the regional MDS nurse if the CNA should have used gloves before touching the Foley catheter. The regional MDS nurse stated, "Yes, you never touch a Foley catheter tubing with your bare hands."The surveyor notified the administrative team of the above documented findings on 3/1/19 at 5:33 pm in the conference room.</p> <p>No further information was provided to the surveyor prior to the exit conference on 3/2/19.</p> <p>4. For Resident #15, facility staff failed to operationalize contact isolation in a manner to protect the resident and other residents from exposure to infectious agents.</p> <p>Resident #15 was admitted to the facility on 11/22/15 and readmitted on 11/18/18. Diagnoses included heart failure, hypertension, Alzheimer's disease, psychotic disorder, pneumonia, urinary tract infection (UTI), dementia with behavior disturbance, dysphagia, anxiety, muscle weakness, and difficulty walking. On the</p>	F 880			

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F 880	<p>Continued From page 182</p> <p>quarterly 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 symptoms of delirium, psychosis, or behaviors affecting care. The assessment indicated the resident ambulated and used the toilet with 1-2 person assistance, was frequently, but not always, incontinent, and on a prompted toileting program.</p> <p>During clinical record review, the surveyor noted a telephone order dated 2/14/19 for urinalysis with culture and sensitivity. There was a second order dated 2/19/19 for valium prior to a straight catheterization to obtain the sample for urinalysis. No notes between 2/14 and 2/19 indicated an attempt to obtain the sample or to notify the physician it had not been obtained. On 2/20/19, an order was written for Macrobid 100 milligrams three times per day for 10 days for urinary tract infection. On 2/25/19, an order was written to continue Macrobid and to start contact precautions for UTI/ESBL ( urinary tract infection with extended spectrum beta lactimase). An order for contact precautions was written on 2/26/19.</p> <p>The resident was not on contact precautions when the surveyors entered the facility on 2/26/19. The surveyor asked nurses and CNAs working on 2/28 if they had been informed that the resident had an antibiotic resistant urinary tract infection and was supposed to be placed on contact precautions and none reported being aware of the order. No sign had been placed on the room door and not PPE had been placed in the room or outside the room. The director of nursing did not express awareness that the resident should be on contact precautions during</p>	F 880			

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F 880	<p>Continued From page 183</p> <p>the events documented in F584. The resident was admitted to the hospital for sepsis on 2/28/19. The record did not contain a nursing note to indicate the resident had left the building.</p> <p>5. For Resident #17, facility staff failed to properly implement contact precautions to protect a resident roomed with a resident with an active infection requiring contact precautions.</p> <p>Resident #17 was admitted to the facility on 4/19/16. Diagnoses included hypertension, gastroesophageal reflux disease, diabetes mellitus, anxiety, depression, asthma, and chronic pain. On the annual assessment with assessment reference date 2/7/17, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.</p> <p>On 02/26/19, the surveyor observed an isolation cart outside the resident's room. The surveyor asked the nurse why the resident was on contact precautions. The nurse said the resident's room mate was on contact isolation for urine, so the room was on isolation. 02/27/19 08:39 AM CNA answered call light and turned it off without using gown, glove, or hand sanitizer. The CNA then retrieved the room mate's breakfast tray. The aid then washed hands approximately 9 seconds. 02/28/19 09:00AM the surveyor asked the nurse what kind of precautions were necessary when visiting the resident. She said that a resident had ESBL in urine, so "don't go playing in the pee". The surveyor asked what that meant and she said to wear gloves. The surveyor asked if contact precautions usually meant to wear gowns and she said they it did, but she had used the last</p>	F 880			



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F 880	<p>Continued From page 184</p> <p>one. The surveyor asked if it was the same one gown that was in the cart all morning yesterday when CNAs were in and out without wearing PPE. She said she thought they had put gowns in the cart at least once the day before. She called for a staff member to bring gowns because there were none in the cart. The CNA brought a 10 pack and a second package containing 4 gowns and placed them in the cart.</p> <p>The surveyor donned gown and gloves and interviewed the resident. The resident said that staff rarely wore gown and gloves when in the room, although most staff would wear gloves when cleaning her or helping her clean up. She said she was unaware of any special precautions she was supposed to take while her room was on isolation. She said she had not been instructed to wash her hands more often.</p> <p>On 2/28/19 at 9:30AM, The surveyor visited the resident in the room. When leaving the room, the surveyor noted the trash can in the room had a broken lid which required 2 hands to open, then fell closed again while the surveyor removed PPE. It was difficult to leave the room without opening the trash can with bare hands.</p> <p>The administrator and director of nursing were notified of the concerns with contact precautions during a summary meeting on 3/1/19.</p> <p>6. For Resident #45, while treating a urinary tract infection, facility staff failed to initiate antibiotic treatment in a timely manner, to ensure contact precautions were followed, and to accurately document treatment.</p> <p>Resident #45 was readmitted to the facility on</p>	F 880			

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F 880	<p>Continued From page 185</p> <p>1/17/17 with diagnoses including heart failure, hypertension, diabetes mellitus, dementia, anxiety, bipolar disorder, psychotic disorder, and schizophrenia. On the quarterly minimum data set assessment with assessment reference date 12/24/18 the resident scored 9/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.</p> <p>On 02/26/19, the surveyor observed an isolation cart outside the resident's room. The surveyor asked the nurse why the resident was on contact precautions. The nurse said the resident was on contact isolation for urine, so the room was on isolation. On 02/27/19 at 08:39 AM, a CNA answered a call light and turned it off without using gown, glove, or hand sanitizer. The CNA then retrieved the the breakfast tray. The aid then washed hands approximately 9 seconds. The surveyor observed staff entering and leaving the room without donning PPE through the morning. On 02/28/19 at 09:00AM the surveyor asked the nurse what kind of precautions were necessary when visiting the resident. She said that a resident had ESBL in urine, so "don't go playing in the pee". The surveyor asked what that meant and she said to wear gloves. The surveyor asked if contact precautions usually meant to wear gowns and she said that it did, but she had used the last one. She said she thought they had put gowns in the cart at least once the day before. She called for a staff member to bring gowns because there were none in the cart. The CNA brought a 10 pack and a second package containing 4 gowns and placed them in the cart. 28/19 at 9:30AM, The surveyor visited the resident in the room. When leaving the room, the surveyor noted the trash can in the room had</p>	F 880			

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F 880	<p>Continued From page 186</p> <p>a broken lid which required 2 hands to open, then fell closed again while the surveyor removed PPE. It was difficult to leave the room without opening the trash can with bare hands.</p> <p>A nurse's note dated 2/24/19 at 7:36 PM as a late entry for 1330 (1:30 PM) "NP notified of ua C&amp;S results. Orders taken for contact precautions and to continue macrobid as ordered". A telephone order for "1- Macrobid 100 mg(milligram) BID(twice per day) X 10 days 2- contact precautions" was written by a different nurse on 2/25/19 at 8 PM. This order was written more than 30 hours after the note indicated the order was given by the nurse practitioner (NP).</p> <p>A nurse's note entered 2/26/19 at 4:32 AM documented "resident is in a bad mood and is refusing medications blood sugar checks. Multiple attempts made...". The nurses work 7-7 Shifts. The insulin MAR had N (for see note) documented for 9PM and 10 PM accuchecks and insulin administration on 2/25/19. The 9 PM oral medications were documented as administered: Macrobid 100 mg, Latanoprost 0.005% eye drops, atorvastatin 10 mg, carvedilol 3.125 mg, travatan Z 0.004% eye drops; and 10 PM medications: depakote 500 mg, timoptic 0.25% eye drops, Zyprexa 5 mg, ativan 0.5 mg, and melatonin 3 mg. It was unclear which medications were refused and which were administered. The nurse was unable to confirm whether the Macrobid had been administered that night.</p> <p>The administrator and director of nursing were notified of the concerns with contact precautions and urinary tract infection treatment during summary meetings on 3/1 and 3/4/2019.</p>	F 880			

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F 881 SS=F	<p>Antibiotic Stewardship Program CFR(s): 483.80(a)(3)</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement an effective antibiotic stewardship program.</p> <p>The findings included:</p> <p>The facility staff failed to implement its protocol for antibiotic use and to monitor actual antibiotic use and failed to notify the physician when the antibiotic ordered for Resident #64 on 12/20/18 after the final urine culture indicated the prescribed antibiotic was resistant to the organism. Resident #64 received the antibiotic for 3 more days after the final culture results were sent to the facility.</p> <p>The surveyor interviewed the assistant director of nursing on 3/5/19 at 2:54 p.m. The ADON (also the infection preventionist) was asked for the line listing for resident infections for 2018 and 2019.</p> <p>A review of the 2018 line listing for resident infections did not identify date of cultures if done, culture results, treatment that included type of precautions, outcomes and adverse events.</p>	F 881	<p>Resident #64 physician was notified on 3/6/19 that after the final urine culture indicated the prescribed antibiotic was resistant to the organism, the resident received the antibiotic for three (3) more days after the final culture results by Director of Nursing.</p> <p>The December 2018 and January 2019 Antibiotic line listings were updated on 3/10/19 to include the date the antibiotic was started, the length of time the antibiotic was prescribed, the date of the onset of symptoms, the type of culture obtained, the results of the culture and any interventions performed, by the Director of Nursing.</p> <p>On 03/20/19, the Regional Director of Clinical operations provided training to the Director of Nursing, Unit Managers and Administrator on Infection Control, Surveillance, Antibiotic stewardship that has a written antibiotic use protocols on antibiotic prescribing, including</p>	4/19/19	

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F 881	<p>Continued From page 188</p> <p>On the current infection log for 2019, the name of the antibiotic ordered, start date and end date of the antibiotic, identified pathogen, date of culture if done, total days of antibiotic therapy, outcome and adverse events were not captured on the log.</p> <p>The ADON did have a map where the residents with infections currently were located. The ADON stated, "The bare minimum for documentation was done. With the new corporate registered nurse, I am involved in the monthly clinical call and have started using the McGeer's surveillance criteria starting in January 2019." The ADON provided the surveyor with copies of the McGeer's criteria currently in use.</p> <p>The surveyor reviewed the facility policy on infection control for antibiotic use titled "Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes." The policy read in part, "Antibiotic usage and outcome data will be collected and documented using a facility approved surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship.</p> <p>2. The IP (infection preventionist) or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify situations that are not consistent with the appropriate use of antibiotics.</p> <p>a. Therapy may require further review and possible changes if:</p> <p>(1) The organism is not susceptible to antibiotic chosen</p> <p>(2) The organism is susceptible to narrower spectrum antibiotic</p>	F 881	<p>the documentation of the indication, dosage, and duration of use of antibiotics; The use of McGeer criteria for Infection Surveillance.</p> <p>Infection control surveillance and Antibiotic stewardship tracking audit will be performed by Director of Nursing/Designee once per week for 4 weeks then once per month. The Regional Director of Clinical Operations will Audit the overall Infection Prevention and Control Program (IPCP); The annual review of the IPCP policies and practices;The review of the surveillance and antibiotic stewardship programs; and Tracking once monthly for three months.</p> <p>The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.</p>		

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F 881	<p>Continued From page 189</p> <p>(3) Therapy was ordered for prolonged surgical prophylaxis; or</p> <p>(4) Therapy was started awaiting culture, but culture results and clinical findings do not indicate need for antibiotics.</p> <p>4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include:</p> <ol style="list-style-type: none"> <li>Resident name and medical record number</li> <li>Unit and room number</li> <li>Date symptoms appeared</li> <li>Name of antibiotic</li> <li>Start date of antibiotic'</li> <li>Pathogen identified</li> <li>Site of infection</li> <li>Date of culture</li> <li>Stop date</li> <li>Total days of therapy</li> <li>Outcome;</li> <li>Adverse effects</li> </ol> <p>A review of the line listing of resident infections did not include all of the above components on either the 2018 forms or the forms for 2019.</p> <p>The policy also read under "Policy Interpretation and Implementation" that included:</p> <p>3. Appropriate indications for use of antibiotics to include</p> <ol style="list-style-type: none"> <li>Criteria met for clinical definition of active infection or suspected sepsis</li> <li>Pathogen susceptibility, based on culture and sensitivity, to antimicrobial</li> </ol> <p>6. When antibiotics are prescribed over the phone, the primary care practitioner will assess the resident within 72 hours of the telephone</p>	F 881			

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F 881	<p>Continued From page 190 order.</p> <p>7. When a culture and sensitivity (C&amp;S) is ordered, it will be completed, and: a. Lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.</p> <p>The surveyor interviewed the assistant director of nursing also the facility's infection preventionist on 3/5/19 at 3:18 p.m. The surveyor discussed the concern of the failure of the current antibiotic stewardship program with the ADON. Resident #64's clinical record was reviewed with the ADON. A telephone order dated 12/20/18 read "UA &amp; C&amp;S (urine culture and sensitivity), Macrochantin 100 mg bid (twice a day) x 7 days, change Foley to 16 Fr (French) with 5 cc (cubic centimeters) balloon."</p> <p>The surveyor reviewed the urine culture results. The urine culture results showed Resident #64 was resistant to the current medication prescribed [Nitrofurantoin (Macrochantin)]. The culture results were returned on 12/23/18. Resident #64 received seven (7) more doses of Macrochantin after the culture result on 12/23/18. The urine culture was reviewed by the nurse practitioner on 12/26/18. Resident #64 received Macrochantin bid on 12/26/18 and one dose on 12/27/18 at 9:00 a.m.</p> <p>Resident #64 received Macrochantin 100 mg for 7 days or 14 doses for the urine culture/sensitivity that bacteria was resistant.</p> <p>The surveyor showed the ADON the urine culture results of Resident #64 obtained by 12/23/18.</p>	F 881			

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F 881	<p>Continued From page 191</p> <p>When asked if the nurses should notify the physician when the culture came back on 12/23/18 showing the antibiotic currently ordered (Macroclantin) was resistant to the bacteria. The ADON stated, "Nurses need to step-up to the plate when an antibiotic ordered is resistant."</p> <p>A review of the December 2018 line list for resident infections did not include the actual start date of 12/20/18-the date was documented as 12/26/18 when the onset of symptoms started. The line list also had documentation that a culture was not done when in fact a culture and sensitivity was obtained on 12/20/18. Resident #64 was ordered Rocephin 1 gram IM (intramuscularly) on 12/26/18 and prior to that, Macroclantin was ordered on 12/20/18.</p> <p>The ADON stated she did not identify that the antibiotic ordered was resistant. "I didn't pick up on that."</p> <p>The ADON was asked if Resident #64 had been seen by the physician within 72 hours of the telephone order as per the policy. The ADON stated the residents are usually seen within 24 hours. A physician note was not found for 12/23/18 but a progress note was written 12/26/18 by the nurse practitioner.</p> <p>The facility staff administered Macroclantin 100 mg (milligrams) to Resident #64 for 3 extra days (6 doses) after the urine culture showed the bacteria (Enterobacter Cloacae) was resistant and 7 days with a culture showing resistance to the medication.</p> <p>Resident #64 was admitted to the facility 12/18/15 with diagnoses that included multiple sclerosis,</p>	F 881			



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NAME OF PROVIDER OR SUPPLIER  <b>CARRINGTON PLACE AT RURAL RETREAT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>514 NORTH MAIN STREET RURAL RETREAT, VA 24368</b>		
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F 881	Continued From page 192 urinary tract infection, gastro-esophageal reflux disease, chronic pain, major depressive disorder, muscle weakness, difficulty in walking, attention-deficit hyperactivity disorder, overactive bladder, and Vitamin deficiency.  Resident #64's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #64 had no assessed signs or symptoms of delirium, behaviors that affected others or psychosis.  The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the corporate registered nurse, the regional executive, and the corporate MDS registered nurse of the above concern in the end of the day meeting on 3/5/19 at 4:26 p.m.  No further information was provided prior to the exit conference on 3/5/19.	F 881			
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)  §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and in the course of a complaint investigation, facility staff failed to provide an odor free environment For residents on 1 of 6 halls in the building.  When entereng the facility on 2/27/19 at 5:20 AM	F 921	Rooms that were noticed to have odors were deep cleaned to include cleaning of bedroom and bathroom.  A deep cleaning schedule was implemented on a rotating schedule from	4/19/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/05/2019</b>
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F 921	Continued From page 193 , the entry hall smelled of urine. Several residents on the 500 and 600 hall smelled of urine or their rooms did. The hall and nurse's station area at 5 AM on 2/27/19 smelled of urine. two residents were in the area. There was a strong odor outside room 611, while the odor was less inside the room. Room 609 smelled of urine. Room 608 had a strong odor which spilled out into the hall. Room 605 smelled less strongly than the others. Room 603 had an extremely strong odor of urine. Room 510 had an odor of urine that reached into the hall. Around 10:45 AM, the surveyor took the director of nurse and the regional nurse to room 603 and drew their attention to the extremely strong odor of urine in the room and a soiled brief under the bed since 5:20 AM or earlier. At 11:25 AM, the surveyor walked down the west 600 hall and the urine odor filled the length of the hall.	F 921	the housekeeping services group. A review has been completed by Administrator/Designee for current residents to ensure that deep cleaning is being completed. A review has been completed by Director of Nursing/Designee to ensure rounding is completed appropriately and as indicated.  Education has been provided to the licensed nursing staff and the interdisciplinary team by the Administrator/Director of Nursing/Designee regarding cleanliness of room as well as appropriate rounding to include changing of soiled bed linens, removal of dirty linens, bagging of dirty linens and trash, and removal of soiled briefs from the room. Additionally nursing staff were educated of proper peri care and incontinence care. A review will be completed by the Administrator/Designee weekly for three (3) residents for three (3) months to ensure residents are clean and free from odors.  The results of the interviews and reviews will be discussed by the Director of Nursing/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee Meeting (QAPI). The interdisciplinary team (IDT) will make recommendations for revisions as indicated necessary to sustain substantial compliance.		