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

PRINTED: 05/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495338	A. BUILDING _____ B. WING _____	C 05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF ABINGDON	600 WALDEN ROAD ABINGDON, VA 24210

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E 000	Initial Comments An unannounced Medicare/Medicaid standard survey was conducted 4/30/19 through 5/2/19. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000	**Disclaimer** **This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding taken.**	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Standard Survey was conducted 04/30/19 through 05/02/19. Three complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 97 at the time of the survey. The survey sample consisted of 21 current Resident reviews and 5 closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	**F-550 Resident Rights** **#1. Resident #194 was discharged home on 5/01/19 and no further corrective action was possible. Resident #54 was advised by Administrator on 5/23/19 that she may utilize the day room on Unit 1 for family visits and that she may also utilize the Unit 1 hallway to get to the lobby whenever desired. Housekeeper 1 had previously submitted a resignation and her last day of employment at the facility was 5/01/19.**	6/03/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James E. Kyle Jr. TITLE: Administrator (X6) DATE: 5/27/19

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

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interviews and clinical record review it was determined the facility staff failed to treat 2 of 26 residents with respect during a conversation (Resident #194 and #54). Findings: Resident #194 was admitted to the facility on 4-11-19. She had diagnoses which included peripheral vascular disease and cerebral vascular accident.	F 550	**The phone(s) available for residents use were checked by maintenance staff on 5/2/19 and ability to place long distance phone calls without a passcode was restored on 5/2/19.** **#2. We acknowledge all residents have the potential to be affected by this practice.** **#3. Resident Council members were advised by Administrator on 5/23/19 the ability to place long distance calls without a pass code had been restored on the phones available for resident use in the dayroom areas. Resident Council Members were also advised by Administrator on 5/23/19 they could utilize the day room on Unit 1 for family visits and the Unit 1 hallway to get to the lobby whenever desired.** **An audit of all resident care plans and physician orders was conducted by MDS LPN on 5/24/19 to ensure the care plan and physician orders addressed any residents with communication issues.** **The Director of Nursing/Designee will complete education for all staff members regarding Understanding Resident Rights and Dignity prior to 6/13/19**	

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F 550	Continued From page 2 The latest MDS (minimum data set) assessment, dated 4-16-19, coded the resident with severely impaired cognitive issues. This was according to the staff input--because the resident didn't speak English and was not able to complete the interview. She required the total assistance of at least one staff member to complete any of the ADL (activities of daily living)activities. The CCP, implemented on 4-12-19, documented the assistance this resident needed for ADLs (activities for daily living). The resident was a total assist for all the ADLs. This care plan did not document the resident's communication issues with regards to her speaking Italian rather than English. The physician orders, signed and dated on 4/2/19, did not address the communication issue. The resident was native Italian and spoke very little English. On 4/30/19 at 3:14 PM the resident was observed in her room. Her eyes were closed and the resident did not respond to verbal cues. A staff member was asked if the resident was interviewable. She responded the resident was Italian and very hard of hearing so she was not interviewable. The surveyor asked how the staff could communicate with this resident. The surveyor was told on the initial tour that this resident's son came every day to speak to her and determine her needs. The staff member added the resident's son had asked staff to prompt her to speak English--because she was falling back on her native Italian since her admission.	F 550	**#4. The Director of Nursing, Assistant Director of Nursing, Unit Manager/ designee will conduct observational rounds to ensure resident rights are being honored in regards to being treated with dignity and respect. 3 times per week x 4 weeks, then 1 time per week x 1 month then monthly x 1 month or until compliance is achieved and maintained. Any concerns noted related to Resident Rights and Dignity will be documented on a Concern and Comment form and logged to track identified concerns and issues to ensure appropriate actions are taken and the issue or concern is resolved. All results and findings of the rounds/audits will be brought by DON and reviewed in the monthly facility QAPI meeting x 3 months or until compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Rehabilitation Coordinator, Medical Director, Environmental Services Director, Admissions Director, Dietary Manager, Social Services Director, Activity Director, Medical Records Director and Maintenance Director.**	

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F 550	Continued From page 3 On 5/1/19 at 9:43 AM HSK I (housekeeping I) was heard telling the resident to "Speak EnglishII" This command was repeated 8 times while HSK I was cleaning around the resident who was seated at the nursing desk. The command was loud and abrasive to the listener and totally non-productive as the resident continued to speak Italian--and was pretty much ignored by passersby staff members. RN I (unit manager) was seated next to the surveyor at the nursing desk. She did not respond to the issue until the surveyor asked if that conversation was appropriate for a resident that did not speak English. RN I said the resident's son had requested that staff tell the resident to speak English--because she could if prompted. for the gruff tone and said she was doing what she had been told to do if Resident 194 spoke Italian. On 5/1/19 at 10:02 Am the resident's FM1 (family member) was interviewed about his mother's care at the facility. He said they really needed an interpreter to translate for his mother when he was not around. "They do not have an interpreter for her and she doesn't speak very good English. It is broken at best, but a very few phrases". FM I went on to say he came in every evening to speak to his mother because they had no one to interpret for her and he wanted her to hear her own language at least once a day. FM I was asked if he told staff to insist she speak English	F 550		

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F 550	Continued From page 4 He stated, "No, she only understands a few phrases like 'let's go eat' but otherwise, my mother doesn't understand English." The administrative staff were notified on 5/1/19 at 1:37 PM. No additional information was provided prior to the survey team exit. 2. Based on resident interview, staff interview and resident council meeting minutes, facility staff restricted access to building amenities based on residents' room location for 1 of 2 nursing units and failed to make telephones available for resident use. Prior to attending the resident council meeting, the surveyor reviewed resident council meeting minutes on 5/01/19. The minutes from January 25 2019– The administrator attended to tell residents about changes to the building which included closing the doors between side 1 (short term for rehab) and side 2 and restricting residents' use of the dining/day room on that hall to residents on the hall. Residents asked about their current use to visit with family or watch TV and the administrator told them to use the side 2 day room. Five of the residents in attendance asked specific, individual questions about their past use and were told to use other rooms. The surveyor had heard about this policy from Resident #54 on 4/30/19 during the initial screening process. The resident had been in the habit of using that room for family visits. It was close enough to the resident's room that it could be reached by walking with a walker or self-propelled wheelchair. The resident also enjoyed sitting in a chair that was not a wheelchair. The resident had not attended any resident council meetings while in the building.	F 550		

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F 550	Continued From page 5	F 550		

On 5/1/19 at 10:30 AM, the surveyor observed the regularly scheduled resident council meeting before asking survey specific questions at the end of the meeting. Residents again expressed displeasure at being banned from use of the dining/day room on side 1. They discussed the noise and crowding in the side 2 day room, where residents from side 2 are taken to sit between meals and activities. One resident also remarked that the majority of rooms on side 1 were private while the rooms on side 2 were all doubles and more people were sharing the day room.

A resident complained about not being able to use the phones in the building. The resident said the phone available to the residents did not allow you to call long distance- Families as close as 20 miles away are long-distance. The resident said the phone system asks for a pass code when you call out. Resident council members discussed the administrator telling the residents not to use the phone in the other day room to call families. The resident expressed concern about not being able to make a private call. The resident also said that when families call, they have a hard time getting through. No one answers the incoming calls. After the resident council meeting, the surveyor attempted to make a call to the local ombudsman number and the Office of Licensure and Certification complaint hotline (an 800 number). The surveyor was unable to complete either call without a pass code.

Both concerns were reported to the administrator and director of nursing during a summary meeting on 5/1/19. The administrator said that neither of the residents' concerns was true. The administrator asserted that residents had not

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F 550	Continued From page 6 been told they could not use the day room on side 1 and said that residents could make US phone calls without restrictions. On 5/2/19, a corporate representative informed surveyors that phone settings had been changed so that residents could make outside phone calls without restriction. 3. For Resident #54, access to building amenities was reported to be based on the resident's room location. Resident #54 was admitted to the facility on 6/17/16. Diagnoses included heart failure cardiopulmonary disease, hypertension, diabetes mellitus, generalized muscle weakness, unsteady gait, insomnia, anxiety, and depression. On the quarterly minimum data set assessment with assessment reference date 3/19/19, 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. During the initial screening process on 4/30/19, the resident reported having been banned from using the big room on unit 1 when family visits. The resident said they have been told to use the dining room, which has no chairs for them, or the conference room which is locked on weekends. The resident has no chair for visitors in her room. Resident #54 also stated that residents have been told not to go through the other unit (unit 1) to get to the lobby, but to go around the other way. They can get someone to push their wheelchairs if it's too far. The resident said that having to ask staff to take her to a room where she could sit outside her own room limited her activity within the building.	F 550		

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F 550	Continued From page 7 The surveyor observed that the resident's room was just a couple of doors from the closed fire doors at the end of the unit 2 hall and the shortest route to the lobby would be through unit 2. The resident's concerns were reported to the administrator and director of nursing during a summary meeting on 5/1/19. The administrator asserted that residents had not been told they could not use the day room on side 1.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and resident interview, facility staff failed to create a home-like environment by providing a chair in the resident's room. Resident #54 was admitted to the facility on 8/17/18. Diagnoses included heart failure cardiopulmonary disease, hypertension, diabetes mellitus, generalized muscle weakness, unsteady gait, insomnia, anxiety, and depression. On the quarterly minimum data set assessment with assessment reference date 3/19/19, 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.	F 558	**F-558 Reasonable Accommodation** **#1. Resident #54 was advised by Administrator on 5/23/19 that she may utilize the day room on Unit 1 for family visits and that she may also utilize the Unit 1 hallway to get to the lobby whenever desired.** **#2. We acknowledge all residents have the potential to be affected by this practice.** **#3. Residents, Resident Council, were advised by Administrator, on 5/23/19 they could utilize the Unit 1 day room for family visits and the Unit 1 hallway to get to the lobby whenever desired. An audit of all resident rooms, dining rooms, and day rooms was conducted by maintenance staff on 5/23/19 to determine where additional chairs may be required. Additional chairs were ordered on 5/3/19 and will be placed in resident rooms as delivered.**	6/13/19

F558 continued

Any concerns noted related to needs/ preferences will be documented on a Concern and Comment form and logged to track identified concerns and issues to ensure appropriate actions are taken and the issue or concern is resolved. All results and findings of the audits will be brought by Administrator and reviewed in the monthly facility QAPI meeting x 3 months or until compliance is achieved.

The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Rehabilitation Coordinator, Medical Director, Environmental Services Director, Admissions Director, Dietary Manager, Social Services Director, Activity Director, Medical Records Director and Maintenance Director.

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F 558	Continued From page 8 During the initial screening process on 4/30/19, the resident reported having been banned from using the big room on unit 1 when family visits. The resident said they have been told to use the dining room, which has no chairs for them, or the conference room which is locked on weekends. The resident has no chair for visitors in her room. Her only chair is a wheelchair. She stated that the last time her family visited on the weekend, the adults stood and the children bounced on the bed. The surveyor observed that the only chairs in the resident's room were the wheelchairs. The surveyor had to stand while interviewing the resident. The surveyor reported the concern to the administrator and director of nursing during a summary meeting on 5/1/19.	F 558	**The Director of Nursing/Designee will complete education for all staff members regarding Understanding Resident Rights and Dignity prior to 6/13/19** **#4. Administrator/Designee will interview residents to ensure their needs/ preferences are being met, Interviews will be conducted with 3 residents per week x 4 weeks, then 1 resident per week for x 4 weeks, then monthly x 1 month or until compliance is achieved and maintained.** **(continued on separate page)**	
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §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- (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	F 580	**F-580 Notify of Changes** **#1. The physician/nurse practitioner for Resident #74 was notified by the facility Director of Nursing on 5/24/19 that a medication was previously withheld and the facility had failed to notify the physician at the time the medication was withheld. Resident #74 was assessed by the Director of Nursing On 5/24/19 with no negative outcomes identified.**	6/13/19

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F 580	Continued From page 9 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). (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- (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 update the address (mailing and email) and phone number of the resident representative(s). §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 clinical record review, and staff interview, the facility staff failed to notify the physician of changes in Resident condition for 2 of 26 Residents in the survey sample, Resident #74 and Resident # 12.	F 580	**The physician/nurse practitioner for Resident #12 was notified by the facility Director of Nursing on 5/24/19 that a medication was previously withheld and the facility had failed to notify the physician at the time the medication was withheld. Resident #12 was assessed by the Director of Nursing on 5/24/19 with no negative outcomes identified.** **#2. We acknowledge all residents have the potential to be affected by this practice.** **#3. An audit was conducted by the Assistant Director of Nursing on 5/24/19 of current resident's medication administration record for the past 30 days to determine if any other resident's medications were withheld without physician notification. Any resident noted who had medication withheld without physician notification will be assessed for adverse outcomes, his/her physician will be notified and a medication error report will be completed. The Director of Nursing/designee will complete education with licensed nursing staff regarding medication administration, administering medications according to current physician's orders, omissions and required documentation and notifications on or before 6/13/19.**	

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F 560	Continued From page 10 The findings included: 1. The facility staff held physician ordered Lantus for Resident # 74 without notifying the physician. Resident # 74 was a 78-year-old-female who was admitted to the facility on 8/17/18. Diagnoses included but were not limited to, type 2 diabetes mellitus, anemia, major depressive disorder, and chronic kidney disease. The clinical record for Resident # 74 was reviewed on 4/30/19 at 2:15 pm. The most recent MDS (minimum data set) assessment for Resident # 74 was a quarterly assessment with an ARD (assessment reference date of 3/27/19. Section C of the MDS assessment indicated documented that Resident # 74 had a BIMS (brief interview for mental status) score of 13 out of 15, which indicated that Resident # 74 was cognitively intact. The current plan of care for Resident # 74 was reviewed and revised on 4/10/19. The facility staff documented a focus area for Resident # 74 as, "I am an insulin dependent diabetic and am at risk for hypo/hyperglycemia and complications of the disease." Interventions included but were not limited to, "Observe for s/s of hypoglycemia (diaphoresis, irritability, confusion, shallow respirations, bounding pulse) and hyperglycemia (drowsiness, thirst, rapid pulse, deep respirations). Check blood sugar and report to MD/NP (medical doctor/nurse practitioner) as needed.	F 560	**#4. The Director of Nursing/Assistant Director of Nursing/Unit Manager/ designee will review documentation to ensure no medications are being held without the required notifications and documentation for 5 resident records weekly x 4 weeks, then 3 resident records weekly x 4 weeks, then monthly x 1 or until compliance is achieved and maintained. Any concerns noted related to medications being withheld will be documented on a Concern and Comment form and logged to track identified concerns and issues to ensure appropriate actions are taken and the issue or concern is resolved. All results and brought to the QAPI Committee by the Director of Nursing Services and reviewed in the monthly facility QAPI meetings x 3 months or until compliance is achieved.** **The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Rehabilitation Coordinator, Medical Director, Environmental Services Director, Admissions Director, Dietary**	

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F 580	Continued From page 11 The physician signed the current orders for Resident # 74 on 4/3/19. Orders included but were not limited to, "Lantus 100 unit/ml (milliliter) vial inject 15 units once daily in the morning subcutaneous." On 5/2/19 at 8:00 am, the surveyor reviewed the April 2019 MAR (medication administration record) for Resident # 74. The surveyor observed that Lantus 15 units had not been administered to Resident # 74 on 4/15/19, 4/19/19, 4/20/19, 4/26/19, and 4/29/19. The surveyor reviewed the nurse's notes from 4/15/19 at 5:24 am. The nurse's note was documented as, "Lantus 100 unit/ml vial inject 15 units ...scheduled for 4/15/19 at 6:00 am. BS (blood sugar) is 102." The surveyor did not locate documentation that the physician was notified that Lantus was held on 4/15/19. A nurse's note was documented on 4/19/19 at 5:40 am. The nurse's note was documented as, "Lantus 100 unit/ml vial inject 15 units ...scheduled for 4/19/19 at 6:00 am was held.. BS 71." The surveyor did not locate documentation of physician notification that Lantus was held on 4/19/19. The surveyor did not observe any documentation in the clinical record on 4/20/19 as to why the physician ordered Lantus was held and did not locate documentation of physician notification. The surveyor did not observe any documentation in the clinical record on 4/26/19 as to why the physician ordered Lantus was held and did not locate documentation of physician notification. A nurse's note was documented on 4/29/19 at	F 580	**Manager, Social Services Director, Activity Director, Medical Records Director and Maintenance Director.**	

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F 580	Continued From page 12 6:03 am was documented as, "Lantus 100 unit/ml vial inject 15 units ... scheduled for 4/29/19 6:00 am was held..blood sugar 98." The surveyor reviewed the facility standing orders and did not locate any orders to hold Lantus due to decreased blood sugar levels. On 5/2/19 at 10:30 am, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 5/2/19. 2. For Resident #12, facility staff failed to notify the physician and responsible party that medications were frequently being held for sleep. Resident #12 was admitted to the facility on 9/30/16. Diagnoses included hemiplegia, atrial fibrillation, diabetes mellitus, schizoaffective disorder, vascular dementia with behavioral disturbance, atherosclerotic heart disease, anxiety, pseudobulbar affect, and neuromuscular disorder of the bladder. On the quarterly minimum data set assessment with assessment reference date 1/24/19, the resident was assessed with short and long term memory impairment and severely impaired cognitive skills. The resident was assessed as without signs of delirium, psychosis, or behaviors affecting care. The most recent physician note was dated 4/2/19 and documented there were no acute issues per staff. The plan indicated 'continue current medications and treatment plans as ordered.' During clinical record review, the surveyor noted that the resident's medications were held at the	F 580		

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F 580	Continued From page 13 following times in April: 6 AM Norco 5-325 tablet- April 2, 3, 4, 6, 7, 8, 9, 10, 11, 16, 17, 22, 23, 24, 25, and 30. All dates except 4/22 held by medication nurse 1; 4/22 held by medication nurse 2 9 AM all medications scheduled- April 3, 12, 14, 17, 27, and 30. All held by medication nurse 2 12 PM Norco 5-325 tablet- April 1, 8, and 19. 1 held by medication nurse 3, 2 by nurse 5 6 PM Norco 5-325 tablet- April 5, 6, 7, 17, 20, 21, and 28. 5 held by nurse 6; 1 each by medication nurses 1 and 2. 9 PM all medications held- April 1, 3, 9, 15, 17, 23, 29, and 30. All held by medication nurse 1. The resident had an order for Lisinopril 10 mg tablet, give 1 tab by mouth daily. Hold if pulse is less than 60 or blood pressure is less than 100- held for parameters April 5, 11, 15, 16, 22, and 30. Held for lethargy April 3, 12, 14, 17, and 27; asleep April 8; unable to obtain blood pressure April 13, 18. Per the MAR, all scheduled medications were administered on April 26. One or more medications were held every other day in April. Nursing notes indicated the medications (other than lisinopril) were held either for sleeping or for sedation. On 4/3/19, the resident received milk of magnesia at 6:52 AM and 6 AM medication was held for sleep. On 4/6/19, the resident received an enema at 5:47 AM and 6 AM medication was held for sleep. There were no days that the physician or responsible party were notified that medications were held. The surveyor asked the unit manager about notifying the physician. She stated that there was an order to hold medications for sedation or lethargy. After the surveyor explained the concerns to the director of	F 580		

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F 580	Continued From page 14 nursing, a corporate clinical representative (CCR1) brought the requested copies. He stated that there was no need to notify because the resident was on comfort care and the order to hold for sedation covered all holds. The surveyor stated that a large proportion of the holds were for 'resident asleep' and sleep is not sedation. The physician was not notified on the 6 days in April that the lisinopril was held for meeting hold parameters or for the two dates the nurse was unable to obtain a blood pressure. The surveyor requested the physician notification policy, but did not receive it. The administrator and director of nursing were notified of the concerns on 5/2/19.	F 580		
F 583 SS=D	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	**F-583 Personal Privacy** **#1. Resident #60 was assessed by the Assistant Director of Nursing on 5/27/19 with no negative outcomes noted.** **In-service education regarding resident rights including privacy was provided to LPN #1 (treatment nurse) on 5/1/19 by the Director of Nursing Services.** **#2. We acknowledge all residents have the potential to be affected by this practice.** **#3. The Director of Nursing/designee will complete education for nursing staff regarding Understanding Resident Rights, including privacy prior to 6/13/19.**	6/13/19

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F 583	Continued From page 16 including those delivered through a means other than a postal service. §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, staff interview and clinical record review it was determined the facility staff failed to provided personal privacy during an examination and treatment for 1 of 26 residents (Resident #60.) Findings: Resident #60 was admitted to the facility on 3/8/19. Her diagnoses included congestive heart failure, atrial fibrillation, hypertension, and chronic obstructive pulmonary disease. Resident #60's MDS (minimum data set) dated 4-6-19 coded the resident as cognitively unimpaired. The resident required staff assistance for all the activities of daily living. The resident's CCP (comprehensive care plan) implemented on 4/24/19 documented the resident required assistance with all the ADLs (activities of daily living) and was admitted to the facility with pressure ulcers. The staff was directed to follow	F 583	**#4. The Director of Nursing/Assistant Director of Nursing/Unit Manager/ designee will conduct observational rounds to ensure resident rights are being honored in regards to privacy 3 times per week x 4 weeks, then 1x week times 4 weeks then monthly x 1 month or until compliance is achieved and maintained. Any concerns noted related to resident rights and privacy will be documented on a Concern and Comment form and logged to track identified concerns and issues to ensure appropriate actions are taken and the issue or concern is resolved.** **All results and findings of the audits will be brought by the Director of Nursing and reviewed in the monthly facility QAPI meetings x 3 months or until compliance is achieved.** **The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Rehabilitation Coordinator, Medical Director, Environmental Services Director,**	

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F 583	Continued From page 16 the physician's order to treat the pressure ulcers. The physician's orders, signed and dated on 4-3-19, documented a daily treatment for pressure ulcers on both feet and the left calf. On 05/01/19 at 10:27 AM LPN I (treatment nurse) was observed to change the dressing on the resident's right calf and both feet. LPN I prepared her supplies as CNA I uncovered the resident for her treatment. Resident #60 was uncovered from the waist down and her brief was observed to be exposed. The doors were closed during this procedure --but the window blinds remained open. Resident #60 was on a first floor room with a view to the parking lot. A car was observed parked just a few feet from her window in the lot beyond. The staff members failed to protect the resident's personal privacy during this treatment. The administrative staff were notified on 5/1/19 at 1:37 PM. No additional information was provided prior to the survey team exit.	F 583	**Admissions Director, Dietary Manager, Social Services Director, Activity Director, Medical Records Director and Maintenance Director.**	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate	F 622	**F-622 Transfer and Discharge** **#1. We acknowledge that transfer paperwork was not provided to the receiving hospital. Resident #65 was assessed on 5/24/19 by the Director of Nursing with no negative outcomes related to the transfer to the hospital noted.** **#2. We acknowledge all residents have the potential to be affected by this practice.**	6/13/19

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F 622	Continued From page 17 because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's	F 622	**#3. The Director of Nursing/designee will complete education for licensed nursing staff regarding proper procedure for transfer and discharge, including all information required to be sent with resident upon transfer, prior to 6/13/19.** **#4. The Director of Nursing/Assistant Director of Nursing/Unit Manager/ designee will review documentation for all resident transfers/discharges weekly x 8 weeks, then 1 resident transfer weekly x 1 month or until compliance is achieved and maintained. Any concerns noted related to transfers to hospital will be documented on a Concern and Comment form and logged to track identified concerns and issues to ensure appropriate actions are taken and the issue or concern is resolved.** **All results and findings of the audits will be brought by the Director of Nursing and reviewed in the monthly facility QAPI meetings x 3 months or until compliance is achieved.** **The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of**	

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F 622	Continued From page 18 medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(I) of this section. (B) In the case of paragraph (c)(1)(I)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(I)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to ensure that the	F 622	**Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Rehabilitation Coordinator, Medical Director, Environmental Services Director, Admissions Director, Dietary Manager, Social Services Director, Activity Director, Medical Records Director and Maintenance Director.**	

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F 622	Continued From page 19 appropriate information was communicated to the receiving facility upon transfer to the hospital for 1 of 26 Residents in the survey sample, Resident # 65. The findings included: The facility staff failed to ensure that the comprehensive care plan goals were sent with Resident # 65 upon transfer to the hospital. Resident # 65 was a 67-year-old-female who was admitted to the facility on 3/7/19. Diagnoses included but were not limited to; major depressive disorder, hypertension, anxiety disorder, and chronic obstructive pulmonary disease. The clinical record for Resident # 65 was reviewed on 4/30/19 a 4:09 pm. The most recent MDS (minimum data set) assessment for Resident # 65 was a quarterly assessment with an ARD (assessment reference date) of 3/26/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 65 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 65 was cognitively intact. On 5/1/19 at 3:02 pm, the surveyor observed a nurse's note in Resident # 65's clinical record dated 4/6/19 at 7:24 am. The nurse's note was documented as, Resident is complaining of back pain that radiates into stomach, rated pain 9 on a scale from 0-10. Vital signs: B/P (blood pressure) 128/60, HR (heart rate) 58, Resp (respirations) 18, Temp (temperature) 98.2, 02 94%. Gave scheduled Lortab 5/325 mg at 5 am resident stated "It helped a little bit however it wears off fast." Resident told CNA (certified nursing	F 622		

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F 622	Continued From page 20 assistant) that she would like to be sent to ER (emergency room). When this nurse spoke to resident she stated "I would rather just get another pain pill and stay here, can you call the doctor and see if she will give me another pain pill?" Called (Nurse practitioner's name withheld) and notified her of the situation. She stated "This has been going on for around a week, send her to the hospital to be examined further." Notified resident she agreed to be sent to the emergency room. Called (Ambulance service name withheld) and requested transportation. Called report to (Nurse's name withheld) at (Hospital's name withheld)." On 5/1/19 at 4:30 pm, the surveyor spoke with the administrative team and asked the facility to provide the surveyor with the information that was sent with Resident # 65 when she was transferred to the hospital on 4/6/19. On 5/2/19 at 7:30 am, the regional director of clinical services provided the surveyor with information that the facility sent a face sheet, MAR (medication administration record), POS (physician's order sheet), code status sheet, copies of labs and x-rays from the past 30 days and a "Nursing Home To Hospital Transfer Form" to the hospital with Resident # 65 when she was transferred to the hospital on 4/6/19. The surveyor asked the regional director of clinical services if the facility had sent a copy co the comprehensive care plan goals for Resident # 65 to the hospital on 4/6/19. The regional director of clinical services informed the surveyor that the facility did not send a copy of comprehensive care plan goals with Resident # 65 when she was sent to the hospital on 4/6/19.	F 622		

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F 622	Continued From page 21 On 5/2/19 at 10:00 am, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 5/2/19.	F 622		
F 625 SS=D	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 bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §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	F 625	**F-625 Notice of Bed hold policy** **#1. Resident #65 was assessed by Director of Nursing Services on 5/24/19 and no adverse outcomes were noted related to the transfer to hospital. Resident returned to the same room/bed that she had previously occupied when she returned from the hospital later the same day on 4/6/19.** **#2. We acknowledge all residents have the potential to be affected by this practice. On 5/27/19 the Assistant Director of Nursing completed an audit of hospital transfers for the past 30 days. On or before 5/28/19, residents identified as not receiving the bed hold policy upon transfer will be given a copy of the bed hold policy by the Director of Nursing and the Resident Representative for those affected will be mailed a copy of the bed hold policy by the Director of Social Services.** **#3. The Director of Nursing/designee will complete education for licensed nursing staff**	6/13/19

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F 625	Continued From page 22 by; Based on staff interview and clinical record review the facility staff failed to provide a written notice of bed hold for 1 of 26 Residents in the survey sample, Resident # 66. The findings included: The facility staff failed to issue a written notice of bed hold for Resident # 65. Resident # 65 was a 67-year-old-female who was admitted to the facility on 3/7/19. Diagnoses included but were not limited to; major depresaive disorder, hypertension, anxiety disorder, and chronic obstructive pulmonary disease. The clinical record for Resident # 65 was reviewed on 4/30/19 a 4:09 pm. The most recent MDS (minimum data set) assessment for Resident # 65 was a quarterly assessment with an ARD (assessment reference date) of 3/26/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 65 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 65 was cognitively intact. On 5/1/19 at 3:02 pm, the surveyor observed a nurse's note in Resident # 65's clinical record dated 4/6/19 at 7:24 am. The nurse's note was documented as, Resident is complaining of back pain that radiates into stomach, rated pain 9 on a scale from 0-10. Vital signs: B/P (blood pressure) 128/60, HR (heart rate) 58, Resp (respirations) 18, Temp (temperature) 98.2, 02 94%. Gave scheduled Lortab 5/325 mg at 5 am resident stated "It helped a little bit however it wears off	F 625	**regarding proper procedure for transfer and discharge including all required information to be sent with the resident upon transfer, including written notice of the bed hold policy, prior to 6/13/19. The Director of Social Services also sends a copy of the written notice of bed hold policy to the resident's representative/ responsible party.** **#4. The Director of Nursing/Assistant Director of Nursing/Unit Manager/ designee will review documentation for all residents with transfers/ discharges weekly x 8 weeks, then 1 resident with transfer/ discharge weekly x 1 month or until compliance is achieved and maintained. Any concerns noted related to transfers to hospital will be documented on a Concern and Comment form and logged to track identified concerns and issues to ensure appropriate actions are taken and the issue or concern is resolved.** **All results and findings of the audits will be brought by the Director of Nursing and reviewed in the monthly facility QAPI meetings x 3 months or until compliance is achieved.**	

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F 625	Continued From page 23 fast." Resident told CNA (certified nursing assistant) that she would like to be sent to ER (emergency room). When this nurse spoke to resident she stated "I would rather just get another pain pill and stay here, can you call the doctor and see if she will give me another pain pill?" Called (Nurse practitioner's name withheld) and notified her of the situation. She stated "This has been going on for around a week, send her to the hospital to be examined further." Notified resident she agreed to be sent to the emergency room. Called (Ambulance service name withheld) and requested transportation. Called report to (Nurse's name withheld) at (Hospital's name withheld)." On 5/1/19 at 4:30 pm, the surveyor spoke with the administrative team and asked the facility to provide evidence that notice of bed hold was given when resident was sent to the hospital on 4/6/19. On 5/2/19 at 7:30 am, the regional director of clinical services informed the surveyor that she was unable to find evidence that a bed hold was offered to Resident # 65 upon transfer to the hospital on 4/6/19. On 5/2/19 at 10:00 am, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 5/2/19.	F 625	**The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Rehabilitation Coordinator, Medical Director, Environmental Services Director, Admissions Director, Dietary Manager, Social Services Director, Activity Director, Medical Records Director and Maintenance Director.**	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(6) §483.45(e) Psychotropic Drugs.	F 758	**F758 Unnecessary Psychotropic** **#1. The psychotropic medication ordered for resident #79 was discontinued on 5/15/19.**	6/13/19

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F 758	Continued From page 24 §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 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758	**Resident #79 was assessed by the Director of Nursing and no negative outcomes noted on 5/24/19.** **#2. All residents who have PRN orders for psychotropic medications have the potential to be affected by this practice. On 5/27/19 the Assistant Director of Nursing completed an audit of all PRN psychotropic medications to ensure no PRN psychotropic medications were ordered for longer than 14 days and that PRN psychotropic medication orders have a stop date. No orders were found without a stop date within 14 days of the order date and no other residents were found to be affected.** **#3. The Director of Nursing/designee will complete education for all Licensed Nursing staff on facility policy regarding psychotropic medication use including PRN orders and stop dates prior to 6/13/19.** **#4. The Director of Nursing/Unit Manager/ designee will audit resident medication administration records to ensure PRN psychotropic medication orders are for no longer than 14 days and that PRN psychotropic medication orders have a stop date for 5 residents per week for**	

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F 758	Continued From page 25 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review, and facility document review, the facility staff failed to ensure that 1 of 26 Residents in the survey sample were free of unnecessary psychotropic medications, Resident # 79 . 1. Facility staff failed to ensure Resident # 79 was free from unnecessary psychotropic medications. Resident # 79 was ordered Ativan as a PRN (as needed) medication for longer than 14 days, and without a stop date. Resident # 79, an 83 year-old female, was admitted to the facility on 2/23/17 with diagnoses that included atrial fibrillation, vascular dementia, delusional disorder, depressive disorder, hypertension, constipation, history of coronary artery bypass graft, and pacemaker placement. According to the most recent Minimum Data Set, a Quarterly review with an Assessment Reference Date of 4/2/19, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. Review of the Electronic Medication Administration Record (EMAR) in Resident # 79's Electronic Health Record revealed the following medication order, "Ativan 0.5 mg (milligrams) tablet. 1 tablet by mouth every 12 hours as needed." The order was dated 4/17/19. There	F 758	**4 weeks, then 3 residents per week for 4 weeks, then 3 residents per month x 1 month or until compliance is achieved and maintained. Any concerns noted related to PRN Psychotropic medications will be documented on a Concern and Comment form and logged to track identified concerns and issues to ensure appropriate actions are taken and the issue or concern is resolved.** **All results and findings of the audits will be brought by the Director of Nursing and reviewed in the monthly facility QAPI meeting x 3 months or until compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Rehabilitation Coordinator, Medical Director, Environmental Services Director, Admissions Director, Dietary Manager, Social Services Director, Activity Director, Medical Records Director and Maintenance Director.**	

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F 758	Continued From page 26 was no stop date for the Ativan order. (NOTE: Ativan [Lorazepam] is a short acting benzodiazepine used to treat anxiety and irritability with psychiatric or organic disorders. Given orally, it has an onset of one hour with a peak of two hours. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 722.) Review of the EMAR's for the months of April and May 2019 revealed the as needed Ativan had not been administered as of the date of review, May 1. 2109 The findings were discussed with the Administrator, Director of Nursing, and two corporate nurse consultants during a meeting with the survey team at 5.00 p.m. on 5/1/19.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and facility document review, the facility failed to ensure a med error rate less than 5 percent. There were 3 errors in 25 opportunities for a medication error rate of 12%. The findings included: The facility staff failed to administer Flonase, Lactulose, and Memantine.	F 759	**F759 Medication Error Rates** **#1. Resident #9 was assessed by Director of Nursing on 5/24/19 with no adverse outcomes noted related to the medication administration. A medication error report was completed on 5/24/19 by the Director of Nursing for resident #9 and the physician/nurse practitioner was notified. There were no new orders for resident #9.** **Resident #1 was discharged (expired) on 5/8/19 and no other corrective action was possible.** **#2. All residents have the potential to be affected by this practice.**	6/13/19

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F 759	Continued From page 27 The record review revealed that Resident # 9 was admitted to the facility on 7/7/17. Diagnoses included but were not limited to; constipation, hypertension, anxiety, and major depressive disorder. On 5/1/19 at 8:43 am, the surveyor conducted a medication pass observation with LPN (licensed practical nurse) # 1. The surveyor observed LPN # 1 prepare and administer the following medications; Toprimate, Ferrous sulfate, Calcium +D, Oxybutin ER, Lisinopril, Paroxetine, Vitamin C, and Lorazepam. LPN # 1 stated, "She gets Flonase." The surveyor did not observed LPN # 1 administer Flonase to Resident # 9. On 5/1/19 at 9:00 am, the surveyor observed LPN # 1 prepare and administer the following medications, Potassium chloride ER, Mamantine, Lorazepam, Med Plus. During the administration of medications to Resident #1 , the surveyor observed a white pill fall out of Resident #1 's mouth onto her shirt. LPN # 1 used a gloved hand, retrieved the pill from Resident #1 's shirt, and discarded the pill. LPN # 1 informed the surveyor that the pill that fell from Resident #1 's mouth was Mamantine and that she had to get another pill from the cubex. The record review revealed that Resident #1 was admitted to the facility on 4/11/19. Diagnoses included but were not limited to, dementia, major depressive disorder, anxiety, and insomnia. On 5/1/19 at 11:45 am, the surveyor reconciled the medications given during the medication pass observation with Resident #9 with the current physician's orders. The surveyor observed that	F 759	**#3. The Director of Nursing/designee will complete education for all Licensed Nursing staff on medication administration, administering of medications according to current physician orders, omissions, required documentation and notification(s).** **#4. The Director of Nursing/Assistant Director of Nursing/Unit Manager/ designee will conduct medication pass observations 3 times per week x 4 weeks, then 1 x per week for 4 weeks then 1 x per month for 1 month or until compliance is achieved and maintained. Any concerns noted related to medications being withheld will be documented on a Concern and Comment form and logged to track identified concerns and issues to ensure appropriate actions are taken and the issue or concern is resolved.** **Results and findings of the audits will be brought by the Director of and reviewed in the monthly facility QAPI meeting x 3 months or until compliance is achieved.** **The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of**	

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F 759	Continued From page 28 "Flonase allergy RLF (relief) 50 mcg (micrograms) spray 1 spray each nostril every day" had been documented as having been administered although the surveyor did not observe the administration of Flonase. The surveyor also observed that "Lactulose give 15 ml (milliliter) by mouth twice a day" had been documented as administered although the surveyor did not observe the administration of Lactulose to Resident # 9. The surveyor reconciled the medications given during the medication pass observation with Resident #1 with the current physician's orders. The surveyor observed that "Mamantine HCL 10 mg (milligram) tablet by mouth twice a day" had been documented as administered, although the surveyor did not observe LPN # 1 obtain the medication from the cubex and administer it to Resident # . On 5/1/19, the surveyor called the facility pharmacy and spoke with (Pharmacy staff's name withheld). The surveyor asked the pharmacy staff member if she could verify if Mamantine 10 mg had been removed from the cubex for Resident #1 . The pharmacy staff member reported to the surveyor that Mamantine 10 mg had not been removed from the cubex for Resident #1 . On 5/1/19 at 1:19 pm, the surveyor spoke with Resident # 9 . The surveyor asked Resident # 9 if she had received her Flonase with her morning medications. Resident # stated, "No." The surveyor asked Resident # 9 if she had received her Lactulose with her morning medications. Resident # 9 stated, "No I can't take that, it makes me sick."	F 759	**Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Rehabilitation Coordinator, Medical Director, Environmental Services Director, Admissions Director, Dietary Manager, Social Services Director, Activity Director, Medical Records Director and Maintenance Director.**	

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F 759	Continued From page 29 The facility policy on "Medication Administration" contained documentation that included but was not limited to, ..."Documentation 3. Initial and record after the medication is administered to the resident." ... On 5/1/19 at 4:00 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 5/2/19.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review and facility document review, the facility staff failed to ensure that 1 of 26 Residents in the survey sample was free of significant medication errors. Resident # 74. The findings included The facility staff failed to administer physician ordered insulin on 4/15/19, 4/19/19, 4/20/19 Resident # 74 was a 78-year-old-female who was admitted to the facility on 8/17/18. Diagnoses included but were not limited to; type 2 diabetes mellitus, anemia, major depressive disorder, and	F 760	**F760 Significant Med Errors** **#1. The physician for Resident #74 was notified by the facility Director of Nursing on 5/24/19 that a medication was previously withheld and the facility had failed to notify the physician at the time the medication was withheld. A medication error report was completed on 5/24/19 by the Director of Nursing Services. Resident #74 was assessed by the Director of Nursing with no negative outcomes noted on 5/24/19.** **#2. We acknowledge all residents** **Assistant Director of Nursing completed an audit of current insulin orders to ensure parameters for physician notification are present as ordered.**	6/13/19

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F 760	Continued From page 30 chronic kidney disease. The clinical record for Resident # 74 was reviewed on 4/30/19 at 2:15 pm. The most recent MDS (minimum data set) assessment for Resident # 74 was a quarterly assessment with an ARD (assessment reference date of 3/27/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 74 had a BIMS (brief interview for mental status) score of 13 out of 15, which indicated that Resident # 74 was cognitively intact. The current plan of care for Resident # 74 was reviewed and revised on 4/10/19. The facility staff documented a focus area for Resident # 74 as, "I am an insulin dependent diabetic and am at risk for hypo/hyperglycemia and complications of the disease." Interventions included but were not limited to, "Observe for s/s of hypoglycemia (diaphoresis, irritability, confusion, shallow respirations, bounding pulse) and hyperglycemia (drowsiness, thirst, rapid pulse, deep respirations). Check blood sugar and report to MD/NP (medical doctor/nurse practitioner) as needed. The physician signed the current orders for Resident # 74 on 4/3/19. Orders included but were not limited to, "Lantus 100 unit/ml (milliliter) vial inject 15 units once daily in the morning subcutaneous." On 5/2/19 at 8:00 am, the surveyor reviewed the April 2019 MAR (medication administration record) for Resident # 74. The surveyor observed that Lantus 15 units had not been administered to Resident # 74 on 4/15/19, 4/19/19, 4/20/19,	F 760	**#3. The Director of Nursing/designee will complete education for licensed nursing staff regarding medication administration, administering of medications according to current physician orders, omissions, required documentation and physician notification when a medication is withheld without specific parameters prior to 6/13/19.** **#4. The Director of Nursing/Assistant Director of Nursing/Unit Manager/ designee will review documentation to ensure medication are not being withheld without specific parameters and required notification and documentation is in place for any medications that are withheld, for 5 resident records weekly x 4 weeks, then 3 resident records weekly x 1 month, then monthly x 1 month or until compliance is achieved and maintained. Any concerns noted related to medications being withheld will be documented on a Concern and Comment form and logged to track identified concerns and issues to ensure appropriate actions are taken and the issue or concern is resolved.**	

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F 760	Continued From page 31 4/26/19, and 4/29/19. The surveyor reviewed the nurse's notes from 4/15/19 at 5:24 am. The nurse's note was documented as, "Lantus 100 unit/ml vial inject 15 units ...scheduled for 4/15/19 at 6:00 am. BS (blood sugar) is 102." The surveyor did not locate documentation that the physician was notified that Lantus was held on 4/15/19. A nurse's note was documented on 4/19/19 at 5:40 am. The nurse's note was documented as, "Lantus 100 unit/ml vial inject 15 units ...scheduled for 4/19/19 at 6:00 am was held,. BS 71." The surveyor did not locate documentation of physician notification that Lantus was held on 4/19/19. The surveyor did not observe any documentation in the clinical record on 4/20/19 as to why the physician ordered Lantus was held and did not locate documentation of physician notification. The surveyor did not observe any documentation in the clinical record on 4/26/19 as to why the physician ordered Lantus was held and did not locate documentation of physician notification. A nurse's note was documented on 4/29/19 at 6:03 am was documented as, "Lantus 100 unit/ml vial inject 15 units ... scheduled for 4/29/19 6:00 am was held..blood sugar 98." The surveyor reviewed the facility standing orders and did not locate any orders to hold Lantus due to decreased blood sugar levels. On 5/2/19 at 10:30 am, the surveyor spoke with the administrative team regarding the findings as stated above. The administrative team agreed	F 760	**All results and findings of the audits will be brought to the QAPI Committee by the Director of Nursing Services and reviewed in the monthly facility QAPI meetings x 3 months or until compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Rehabilitation Coordinator, Medical Director, Environmental Services Director, Admissions Director, Dietary Manager, Social Services Director, Activity Director, Medical Records Director and Maintenance Director**	

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F 760	Continued From page 32 that Lantus is a long acting insulin and should not have been held without physician notification of low blood sugar and physician orders to hold the Lantus. No further information regarding this issue was presented to the survey team prior to the exit conference on 5/2/19.	F 760		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on facility staff interview and document review it was determined the facility staff failed to conduct quarterly quality assurance meetings with a medical director present. Findings: On 5/2/19 at 10:30 AM the quality assurance	F 868	**F-868 QAA Committee** **#1. A Quality Assurance and Performance Improvement Committee meeting has been scheduled by the administrator for May 28, 2019 at 10:00am. No residents were identified as being affected.** **#2. We acknowledge all residents have the potential to be affected by this practice.** **#3. The Quality Assurance and Performance Improvement Committee meetings will be scheduled on a monthly basis by the administrator going forward and the schedule will be provided to the Medical Director.** **#4. The Director of Nursing Services will monitor on an ongoing monthly basis to ensure monthly Quality Assurance and Improvement Committee meetings are held, that committee members including the Medical Director are present and that appropriate documentation including sign in sheets are completed.**	6/13/19

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F 868	Continued From page 33 program was reviewed with the facility administrator. The administrator provided the surveyor with sign-up sheets for the quality assurance meets conducted since the last survey. The eight meetings were conducted on the following dates: 1. 3/8/18 2. 4/24/18 3. 6/19/18 4. 9/28/18 5. 10/5/18 6. 10/17/18 7. 12/28/18 8. 2/28/19 On 4/24/18, 9/28/18, and 12/28/18 the medical director did not register on the sign in sheets. The administrator told the surveyor the medical director had been out on maternity leave and another physician was supposed to fill in for her during her absence. The physician had attended one meeting and signed in--but was unable to attend all the meetings as they were scheduled. No additional information was provided prior to the survey team exit.	F 868	**Any concerns noted related to the QAPI Committee will be documented on a Concern and Comment form and logged to track identified concerns and issues to ensure appropriate actions are taken and the issue or concern is resolved. All results and findings of the audits will be brought by the Administrator and reviewed in the monthly facility QAPI meetings x 3 months or until compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Rehabilitation Coordinator, Medical Director, Environmental Services Director, Admissions Director, Dietary Manager, Social Services Director, and the Activities Director.**	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880	**F880 Infection Prevention and Control** **#1 Resident # 9 was assessed by the Director of Nursing on 5/24/19 and had no adverse outcomes related to the handwashing during medication administration.**	6/13/19

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F 880	Continued From page 34 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880	**Resident # 44 was assessed by the Director of Nursing on 5/24/19 and had no adverse outcomes related to the sanitizing of non-critical resident care items during medication administration. Resident # 4 was assessed by the Director of Nursing on 5/24/19 and had no adverse outcomes related to the handwashing during wound care. LPN #1 and LPN #2 were provided 1:1 education by the Director of Nursing on 5/1/19 regarding handwashing during wound care, handwashing during medication administration and on sanitizing medical equipment before and after resident use.** **#2. We acknowledge all residents have the potential to be affected by this practice.** **#3 The Director of Nursing/designee will complete education with licensed nursing staff regarding medication administration proper infection control practices including handwashing during medication administration, sanitizing medical equipment before and after resident use and handwashing during wound care on or before 6/13/19.** **#4. The Director of Nursing/Assistant Director of Nursing/Unit Managers/ designee**	

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F 880	Continued From page 35 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and facility document review, the facility staff failed to provide a safe sanitary environment to help prevent the development and transmission of communicable diseases and infections during medication pass observation, and observation of wound care. The findings included The facility staff failed to appropriately wash hands and sanitize medical equipment during a medication pass observation. The facility staff failed to appropriately wash hands during a wound care observation. On 5/1/19 at 8:43 am, the surveyor was conducting a medication pass observation with LPN # 1 (licensed practical nurse). The surveyor	F 880	**will conduct medication pass observations proper infection control practices including handwashing during medication administration and wound care and sanitizing medical equipment before and after resident use and, medication observations 3 times per week x 4 weeks, then 1x per week x 4 weeks then 1 x per month for 1 month, and wound care observations 2 x per week, x 4 weeks, then 1x per week x 4 weeks then 1 x per month for 1 month or until compliance is achieved and maintained. Any concerns noted related to handwashing during medication administration or wound care will be documented on a Concern and Comment form and logged to track identified concerns and issues to ensure appropriate actions are taken and the issue or concern is resolved.** **All results and findings of the audits will be brought by the Director of Nursing Services and reviewed in the monthly facility QAPI meetings x 3 months or until compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set**	

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F 880	Continued From page 36 observed LPN # 1 as she administered medications to Resident # 9. The surveyor observed LPN # 1 as she washed her hands, turned off the faucet, and then dried her hands with a paper towel and discarded the used paper towel into the trash. On 5/1/19 at 9:00 am, the surveyor observed LPN # 1 as she administered medication to Resident # 44 (not sampled). LPN # 1 informed the surveyor that she needed to assess Resident # 44's vital signs prior to medication administration. The surveyor observed LPN # 1 remove a stethoscope, blood pressure cuff, and portable pulse oximetry monitor from the medication cart. LPN # 1 entered Resident # 44's room. Resident # 44 was observed lying in bed. The surveyor observed LPN # 1 as she placed the stethoscope on the bed with Resident # 44. LPN # 1, the placed the blood pressure cuff on Resident # 44's right arm, placed the portable pulse oximetry monitor on a finger on Resident # 44's left hand. LPN # 1 removed the stethoscope from Resident # 44's bed, placed the stethoscope in her eare , and obtained Resident # 44's blood pressure and read the pulse and oxygen saturation levels from the portable pulse oximetry monitor that had been placed on Resident # 44's left finger. The surveyor observed LPN # 1 as she removed the stethoscope, portable blood pressure cuff, and portable pulse oximetry monitor from Resident # 44's room and placed them in the medication cart without sanitizing the items. On 5/1/19 at 9:20 am, the surveyor observed wound care of Resident # 4 with LPN # 2. The surveyor observed LPN # 2 as she sanitized the surface of an over bed table with Sani wipes and allowed the surface time to dry. LPN # 2 set up	F 880	**Coordinator, Rehabilitation Coordinator, Medical Director, Environmental Services Director, Admissions Director, Dietary Manager, Social Services Director, Activity Director, Medical Records Director and Maintenance Director.**	

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F 880	Continued From page 37 the work area appropriately with all needed materials. LPN # 2 went into the bathroom, washed her hands, turned off the faucet, then dried her hands with a paper towel and discarded the towel in the trash. LPN # 2 was assisted by the ADON (assistant director of nursing) in turning Resident # 4. The surveyor observed LPN # 2 as she removed the old dressing and discarded the old dressing. LPN # 2 was observed as she removed and discarded her gloves. LPN # 2 went into the bathroom, washed her hands, turned off the faucet, and dried hands with a dry paper towel and discarded the used paper towel into the trash. LPN # 2 applied clean gloves and cleaned Resident # 4's wound appropriately, applied treatment as ordered, and covered the wound. The surveyor observed LPN # 2 remove and discard her gloves. LPN # 2 went into the bathroom, washed her hands, turned off the faucet, then dried her hands on a clean paper towel and discarded the paper towel into the trash. The facility policy on "Hand Hygiene Technique" contained documentation that included but was not limited to, ..." General Guidelines b. When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off faucet." ... The facility policy on "Cleaning and Disinfecting Non-Critical Resident-Care Items" contained documentation that included but was not limited to,	F 880		

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F 880	Continued From page 38 ..."General Guidelines d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment)." ... On 5/1/19 at 3:40 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 5/2/19.	F 880		