State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0105	A. BUILDING: _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - LAUREL MEADOWS	16600 DANVILLE PIKE LAUREL FORK, VA 24352

(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) COMPLETE DATE
F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 4/23/19 through 4/25/19. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 58 at the time of the survey. The survey sample consisted of 15 current Resident reviews and 3 closed record reviews.	F 000	**F 001** **Director of Nursing** **12 VAC 5-371-200 (B) (1),** Cross References to F Tag 658 Cross Reference POC for F Tag 658 **Nursing Services** **12 VAC 5-371-220 (H)** - Cross Reference to F Tag 580 Cross Reference POC for F Tag 580 **12 VAC 5-371-220 (A, B, D)** - Cross Reference to F Tag 684 Cross Reference POC for F Tag 684 **12 VAC 5-371-220 (C) (3) and (G)** - Cross Reference to F Tag 690 Cross Reference POC for F Tag 690	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: Director of Nursing 12 VAC 5-371-200 (B) (1), cross reference to F Tag 658 Nursing Services 12 VAC 5-371-220 (H) cross reference to F Tag 580 12 VAC 5-371-220 (A, B, D) cross reference to F Tag 684 12 VAC 5-371-220 (C) (3) and (G) cross reference to F tag 690 Dietary Services 12 VAC 5-371-340 (A,) cross reference to F tag	F 001	**Dietary Services** **12 VAC 5-371-340 (A)** - Cross Reference to F Tag 812 Cross Reference POC for F Tag 812 **Pharmaceutical Services** **12 VAC 371-300 (H)** - Cross Reference to F Tag 756 Cross Reference POC for F Tag 756 **12 VAC 371-300 (H)** - Cross Reference to F Tag 758 Cross Reference POC for F Tag758 **Clinical Records** **12 VAC 371-360 (A) (E) (7)** - Cross Reference to F Tag 842 Cross Reference POC for F Tag 842 **Completion Date: June 7, 2019**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wrightsky Darnell — TITLE: Administrator — (X5) DATE: 6-7-19

State of Virginia

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F 001	Continued From page 1 812 Pharmaceutical services. 12 VAC 5-371-300 (H) cross reference to F tag 756 12 VAC 5-371-300 (H) cross reference to F tag 758 Clinical Records 12 VAC 5-371-360 (A) (E) (7) cross reference to F Tag 842	F 001		

PRINTED: 05/15/2019
FORM APPROVED
OMB NO. 0938-0391

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

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/23/19 through 04/25/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/23/19 through 4/25/19. One complaint was 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 60 certified bed facility was 58 at the time of the survey. The survey sample consisted of 15 current Resident reviews and 3 closed record reviews.	F 000		
F 580 SS=D	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,	F 580	**F580** **Corrective Action(s)** Resident #53's attending physician has been notified that facility staff failed to notify the attending physician that resident #53 refused their physician ordered Victoza insulin on 4/5 & 4/9/19. A Facility Incident & Accident form has been completed for this incident. Resident #25's attending physician has been notified that facility staff failed to notify the attending physician that resident #25 refused their sliding scale Novolog insulin coverage on 3/12, 3/13, 3/15, 3/16, 3/17, 3/19, 3/20, 3/21/19. A Facility Incident & Accident form has been completed for this incident.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wrightley C Darnell — TITLE: Administrator — (X6) DATE: 6-7-19

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 580	Continued From page 1 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). (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 staff interview, facility document review and clinical record review, the facility staff failed to notify the physician when medications were refused by the resident or not administered by the	F 580	**Identification of Deficient Practices & Corrective Action(s):** All other residents receiving physician ordered insulin and physician ordered sliding scale insulin coverage may have potentially been affected. The DON and Unit Manager will conduct a 100% review of all MAR's for residents receiving physician ordered insulin and sliding scale insulin for the last 30 days to identify residents that had refused their physician ordered insulins or sliding scale insulins with no physician notification. An incident & accident form will be completed for all negative findings and will be corrected at time of discovery. **Systemic Change(s):** The facility policy and procedures have been reviewed and no changes are warranted at this time. The 24 Hour Report and documentation in the medical record will serve as the source document for communicating changes in resident condition/status, refusal of medical care and treatment and proper notification to responsible parties and physicians. Licensed staff will be inserviced by the DON and/or Regional nurse consultant on the Notification of Rights & Services and issued a copy of company policy and procedure. The inservice will include staff education on the timeliness of notification to the attending physician and responsible party when changes or refusals of treatment, medications or condition occur in order to prevent a delay of services while promoting continuity of care.	

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F 580	Continued From page 2 nurse for 2 of 18 residents (Resident #53 and Resident #25). The findings included: 1. The facility staff failed to notify the physician when Resident #53 refused insulin (Victoza) on two dates (4/5/19 and 4/9/19). Victoza was held on 4/5/19 and 4/9/19. There was no evidence the physician was informed of the insulin held on 4/5/19 and 4/9/19. Resident #53 was admitted to the facility 5/21/07 and readmitted 1/16/19 with diagnoses that included but not limited to type 2 diabetes mellitus with diabetic neuropathy, sepsis, multiple sclerosis, hyperlipidemia, hypertension, anemia, age related osteoporosis, chronic kidney disease, idiopathic scoliosis, paranoid schizophrenia, depressive disorder, chronic obstructive pulmonary disease, and pressure ulcer of sacrum. Resident #53's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/9/19 assessed the resident with a BIMS (brief interview for mental status) Summary Score as 15/15. There were no signs or symptoms of delirium or behaviors affecting others. Resident #53 did exhibit delusions. Problem for nutrition was care planned with onset date of 4/10/19. Resident #53 has significant weight loss, was at risk for hypoglycemia/hyperglycemia type 2 diabetes mellitus. Approaches: Administer meds (medications) per MD (medical doctor) orders." The April 2019 physicians orders read in part "Victoza 3-pak 18 mg/3ml (milligrams/milliliter)	F 580	**Monitoring:** The DON is responsible for maintaining compliance. The DON will complete weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be corrected at time of discovery. Aggregate findings of these audits will be reported to the QA committee for review, analysis and recommendation for changes in facility policy, procedure and/or practice. **Completion Date: June 7, 2019**	

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F 580	Continued From page 3	F 580		

pen Inj (inject) 1.8 mg (milligrams) subq (subcutaneously) daily DM (diabetes mellitus)." The surveyor reviewed the April medication administration record (eMAR). There were "N"s in the boxes for 4/1/19, 4/5/19, 4/7/19 and 4/9/19. N=not administered. The surveyor reviewed the notes at the end of the eMAR. Resident #53 had refused the insulin Victoza on 4/1/19 and 4/5/19; however the RP (responsible party) and MD had been informed. Resident #53 also refused the insulin Victoza on 4/5/19 and 4/9/19. The documentation for 4/5/19 read "Inj 1.8 scheduled for 04/05/19 7:30 a.m. was held" and the documentation for 4/9/19 read "Inj 1.8 scheduled for 4/9/19 7:30a.m. was held."

The surveyor reviewed the departmental noted for 4/5/19 timed 2:42 a.m., 8:45 a.m., 2:28 p.m., and 9:01 p.m. There was no documentation the physician was made aware the resident had refused the insulin and the surveyor was unable to locate a physician order to hold the Victoza insulin on 4/5/19 and 4/9/19. The departmental notes for 4/9/19 timed at 12:52 a.m., 9:36 a.m., 1:52 p.m., 2:30p.m., 4:38 p.m., and 11:52 p.m. did not have documentation the physician was informed that Victoza had been held. The timed note of 7:44 a.m. did document the Victoza had been held but no documentation that the physician had been informed.,

The surveyor informed the interim director of nursing of the above concern on 4/25/19 11:42 a.m. and requested the facility policy on notification/change of condition, diabetes mellitus, and physician's orders. The interim DON stated she would expect the nursing staff to inform the physician when medications were refused x2.

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F 580	Continued From page 4	F 580		

The facility policy titled "Change in a Resident's Condition or Status" read in part "1 The nurse will notify the resident's Attending Physician or physician on call when there has been a (an) e. need to alter the resident's medical treatment significantly and f. refusal of treatment or medications two (2) or more consecutive times."

The facility policy titled "Medication and Treatment Orders" read in part "1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state."

The surveyor informed the administrator, the interim director of nursing, the minimum data set coordinator and the corporate registered nurse of the above concern on 4/25/19 at 12:51 p.m.

No further information was provided prior to the exit conference on 4/25/19.

2. The facility staff failed to inform the physician when Resident #25 refused sliding scale insulin (Novolog).

The clinical record of Resident #25 was reviewed 4/23/19 through 4/25/19. Resident #25 was admitted to the facility 11/28/15 and readmitted 3/11/19 with diagnosis that included but not limited to type 2 diabetes mellitus, fracture of right pubis, heart failure, atrial fibrillation, edema, chronic ischemic heart disease, chronic obstructive pulmonary disease, and chronic kidney disease (stage III).

Resident #25's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/18/19 assessed the

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F 580	Continued From page 5	F 580		

resident with a BIMS (brief interview for mental status) as 15/15. Resident #25 had no signs or symptoms of delirium, psychosis, or behaviors affecting others.

Resident #25's current comprehensive care plan was reviewed. The problem nutrition with onset date of 3/20/19 identified the resident to be at risk for hypo/hyperglycemia due to type 2 diabetes. Approaches: Administer meds (medications) per MD (medical doctor) order.

The March 2019 physician's orders read in part "Novolog 100 units/ml (milliliter) flexpen SSI (sliding scale insulin) with accuchecks AC/HS (before meals and at bedtime)
150-200=3 units
201-250=5 units
251-300=7 units
301-350=9 units
351-400=11 units,
> (greater than) 400=13 units less than 60 or greater than 500 on 2 occasions 6 hours apart."

The March 2019 electronic medication administration records (eMARs) were reviewed. The following date/times had "N" in the administration box:
3/12/19 4:30 p.m. BS was 171
3/13/19 6:00 a.m. BS was 161
3/15/19 6:00 a.m. BS was 223
3/16/19 6:00 a.m. BS was 201
3/16/19 at 4:30 p.m. BS was not recorded-resident was not available.
3/17/19 6:00 a.m. BS was 180
3/19/19 at 4:30 p.m. BS was 219
3/19/19 at 8:30 p.m. BS was 262
3/20/19 6:00 a.m. BS was 193
3/20/19 at 4:30 p.m. BS was 231.

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F 580	Continued From page 6 3/21/19 6:00 a.m. BS was 209 3/21/19 at 11:30 a.m. BS was 212. The above blood sugar results did not have evidence that the sliding scale insulin was administered. There was no documentation on the eMAR that the sliding scale insulin had been administered. The 3/12/19 4:30 p.m. insulin was refused by the resident. There was no evidence the physician had been informed. Resident #25 should have been administered 3 units of SSI. The 3/13/19 6:00 a.m. insulin was refused by the resident. There was no evidence the physician had been informed of the refusal. The 3/15/19 6:00 a.m. insulin was refused by the resident. There was no evidence the physician had been informed of the refusal. The 3/16/19 6:00 a.m. insulin was refused by the resident. There was no evidence the physician had been informed of the refusal. The 3/17/19 6:00 a.m. insulin was refused by the resident. There was no evidence the physician had been informed of the refusal. The 3/19/19 4:30 p.m. and 8:30 p.m. insulin was refused by the resident. There was no evidence the physician had been informed of the refusal. The 3/20/19 6:00 a.m. and 4:30 p.m. insulin was refused by the resident. There was no evidence the physician had been informed of the refusal. The 3/21/19 6:00 a.m. and 11:30 a.m. insulin was refused by the resident. There was no evidence the physician had been informed of the refusal. The surveyor informed the interim director of nursing of the above concern on 4/25/19 at 10:43 a.m. and requested the physician's orders for March and April 2019, March and April	F 580		

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F 684	Continued From page 8 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow physician orders for 2 of 18 residents (Resident #54 and Resident #25). The findings included: 1. The facility staff failed to follow physician's orders for TED hose (TED is an abbreviation for thromboembolic disease) for Resident #54. The clinical record of Resident #54 was reviewed 4/23/19 through 4/25/19. Resident #54 was admitted to the facility 6/5/15 and readmitted 3/12/19 with diagnoses that included but not limited to acute respiratory failure, hypomagnesemia, protein-calorie malnutrition, urine retention, hydronephrosis, bipolar disorder, major depressive disorder, hypertension, anxiety, arthritis, dorsalgia, and pneumonia. Resident #54's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/19/19 assessed the resident with a BIMS (brief interview for mental status) Summary Score as 14/15. Resident #54 was assessed with inattention, disorganized	F 684	**F684** **Corrective Action(s):** Resident #54's attending physician was notified that the facility staff failed to apply resident 54's TED stocking per physician order. A facility Incident & Accident form was completed for this incident. Residents #25's attending physicians was notified that the facility failed toapply TED stockings per physician order, failed to obtain orthostatic blood pressures per physician order and failed to notify the attending physician of daily weight changes of 3-5 pounds per physician order. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered TED Stocking, Daily weight orders and orthostatic blood pressure orders may have potentially been affected. The DON, and Unit Manager will conduct a 100% audit of all resident's physician orders and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.	

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F 684	Continued From page 9 thinking but without evidence of psychosis or behaviors that affected others. Resident #54's current comprehensive care plan identified ADL (activities of daily living) as a potential concern with interventions listed to include TED hose-on in am (morning), off in pm (evening). The April 2019 physician's orders included an order dated 3/26/19 for TEDs on qam (every morning) and off qpm (every evening). The surveyor observed Resident #54 on 4/24/19 at 2:21 p.m. Resident #54 was sitting in the activity area near the television doing a word search. The surveyor did not observe TED hose on the resident and the resident stated they were not on. The surveyor observed Resident #54 again at 4:22 p.m. Licensed practical nurse #1 was asked to check for the TED hose. L.P.N. #1 stated, "No TED hose on." Resident #54 stated again the TED hose had not been put on. "They are put on at bedtime." The surveyor informed the administrator, the interim director of nursing, the minimum data set coordinator, and the corporate registered nurse of the above concern on 4/25/19 at 12:51 p.m. No further information was provided prior to the exit conference on 4/25/19. 2. The facility staff failed to follow physician's orders for TED hose, failed to obtain orthostatic blood pressures for Resident #25, and failed to inform the physician of weight gain of 3-5 pounds. The clinical record of Resident #25 was reviewed	F 684	**Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and administering physician ordered medications and treatments. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. To include following the TED Stocking orders, Daily weight change orders and orthostatic blood pressure orders per physician order.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495323	A. BUILDING _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - LAUREL MEADOWS	16600 DANVILLE PIKE LAUREL FORK, VA 24352

(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 684	Continued From page 10 4/23/19 through 4/25/19. Resident #25 was admitted to the facility 11/28/15 and readmitted 3/11/19 with diagnosis that included but not limited to type 2 diabetes mellitus, fracture of right pubis, heart failure, atrial fibrillation, edema, chronic ischemic heart disease, chronic obstructive pulmonary disease, and chronic kidney disease (stage III). Resident #25's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/18/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #25 had no signs or symptoms of delirium, psychosis, or behaviors affecting others. Resident #25's current comprehensive care plan was reviewed. Blood pressures or TED hose were not addressed on the current care plan. Resident #25's current comprehensive care plan was reviewed. The care plan identified nutrition with weight fluctuations as a risk and approaches were in part to monitor weights, labs, and intakes. (A) Resident #25's clinical record included a telephone order dated 4/23/19 at 2:00 p.m. that read in part "TEDs qam (every morning)and off qpm (every evening)." The surveyor observed Resident #25 on 4/23/19 through 4/25/19. On 4/24/19 at 2:55 p.m., the surveyor observed Resident #25 sitting in a wheelchair with both feet on the ground. The surveyor did not observe TED hose on the resident. The surveyor and the interim director of nursing observed Resident #25 on 4/24/19 at 4:03 p.m.	F 684	**Monitoring:** The DON will be responsible for maintaining compliance. The DON, and/or Unit Managerwill perform weekly MAR audits on all residents to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: June 7, 2019**	

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F 684	Continued From page 11 Resident #25 did not have TED hose on and stated she had not had them all day. The resident stated nobody put them on her. (B). Resident #25's April 2019 physician's orders read in part "Orthostatic blood pressure to be taken daily-start date 3/11/19." A review of the April 2019 medication administration record found that the results for blood pressures obtained while the resident was lying only. The surveyor was unable to locate blood pressures for the sitting and standing positions. The vital signs summary form was reviewed for April 2019. One summary form had no type of blood pressure documented, another form had blood pressure-lying documented, and a third form had lying blood pressures and then a blood pressure of unknow type documented. The time difference on this third form between the lying BP and the second BP was an hour or greater. The surveyor informed the interim director of nursing and the corporate registered nurse on 4/25/19 at 9:07 a.m. The surveyor asked the interim DON when orthostatic blood pressures were ordered what blood pressures should be obtained. The interim DON stated lying, sitting and standing. The interim DON stated after reviewing the clinical record that the order had been placed as "orthostatic blood pressure" but that only the "lying" blood pressure had been obtained. The surveyor requested the facility guidance for obtaining orthostatic blood pressures. The MDS coordinator provided the following to the surveyor	F 684		

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F 684	Continued From page 12 on 4/25/19 at 10:36 a.m. from the National High Blood Pressure Education Program, National Institute of Health (2003) and read "Orthostatic hypotension (postural hypotension) refers to a sudden drop of 25 mm (millimeters) Hg (mercury) in systolic pressure and 10 mm Hg in diastolic pressure when the client moves from a lying to a sitting or a sitting to a standing position. Orthostatic hypotension usually occurs with aging and is a common antiadrenergic side effect of several medications such as chlorpromazine hydrochloride. When measuring orthostatic blood pressure: Place the client in a supine position for 5 minutes to allow for equilibrium of the blood pressure, and measure the pulse and blood pressure. Assist the client to a standing position, and wait 1 minute to obtain a full evaluation of the initial orthostasis, then recheck the pulse and blood pressure. Reassess the vital signs after 2 minutes to allow for an evaluation of the client's mechanisms to compensate for the presence of any orthostasis. (C). The facility staff failed to follow the physician order to notify the physician when the resident gained 3-5 pounds. The April 2019 physician's orders read "Daily weights report weight gain of 3-5 lb. (pound) to Doctor." The surveyor reviewed the April 2019 daily weights. Resident #25 gained from 131.7 pounds on 4/11/19 to 139.7 pounds on 4/12/19-a difference of 8 pounds. The surveyor found no documentation of the weight change reported to the physician in the departmental notes for 4/12/19. There was a note dated 4/12/19 at 5:28 p.m. that the resident was seen by the nurse	F 684		

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F 684	Continued From page 13	F 684		

practitioner on that day with medication changes for anemia but for diuresis.

Resident #25 gained from 130.2 pounds on 4/14/19 to 138.9 pounds on 4/15/19-a difference of 7.7 pounds. The surveyor found no documentation that the physician was made aware of the weight gain. The MD was made aware of that day's laboratory results but there was no documentation about the resident's weight gain as per the physician's orders.

Resident #25 gained from 132.1 pounds on 4/18/19 to 139.8 pounds on 4/19/19 - a difference of 7.7 pounds. The 4/19/19 1:37 p.m. note stated the resident was seen on rounds and a new order to increase Lasix to 60 mg (milligrams) q am (every morning).

Resident #25 gained weight from 132.1 pounds on 4/20/19 to 139.1 pounds on 4/21/19-a difference of 7 pounds. There was no documentation in the departmental notes that the physician had been informed of the weight gain.

Resident #25gained from 131.9 pounds on 4/22/19 to 140.3 pounds on 4/23/19-a difference of 8.4 pounds. Resident #25 was seen by the nurse practitioner and changes to the diuretic were made.

The surveyor informed the administrator, the interim director of nursing, the minimum data set coordinator and the corporate registered nurse of the above concern with TED hose, orthostatic blood pressures and failure to document/notify the physician of weight changes on 4/25/19 at 12:51 p.m.

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F 684	Continued From page 14 No further information was provided prior to the exit conference on 4/25/19.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as	F 690	**F690** **Corrective Action(s):** Resident #54's Foley catheter orders have been reviewed and resident #54 now has the correct Foley catheter in place with the correct balloon size. The resident's care plan has been revised to reflect accurate Foley Catheter size and correct catheter balloon size. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with a Foley catheter may have been potentially affected. The DON and or Unit Manager will conduct a 100% review of all residents with a Foley catheter to identify residents at risk. Residents identified will be corrected at time of discovery and disciplinary action with be taken as warranted. a Facility Incident & Accident Form will be for each negative finding.	

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F 690	Continued From page 15 possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow the physician's orders for the size of an indwelling Foley catheter balloon for 1 of 18 residents (Resident #54). The findings included: The facility staff failed to follow physician's orders for the size of the indwelling Foley catheter balloon for Resident #54. The clinical record of Resident #54 was reviewed 4/23/19 through 4/25/19. Resident #54 was admitted to the facility 6/5/15 and readmitted 3/12/19 with diagnoses that included but not limited to acute respiratory failure, hypomagnesemia, protein-calorie malnutrition, urine retention, hydronephrosis, bipolar disorder, major depressive disorder, hypertension, anxiety, arthritis, dorsalgia, and pneumonia. Resident #54's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/19/19 assessed the resident with a BIMS (brief interview for mental status) Summary Score as 14/15. Resident #54 was assessed with inattention, disorganized thinking but without evidence of psychosis or behaviors that affected others. Resident #54's current comprehensive care plan identified the problem of urinary incontinency. Interventions read in part "3/25/19 Clarification Foley cath (catheter) 18 Fr (French) Change every month and as needed (prn)."	F 690	**Systemic Change(s):** The facility Policy and Procedure for Foley/Suprapubic Catheter insertion, usage and care has been reviewed and no changes are warranted at this time. The nursing staff will be inserviced by the DON on the policy and procedures for proper Foley Catheter use and care to include the using the proper catheter balloon size when inserting or changing a physician ordered Foley catheter. **Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON and/or Unit Manager will perform monthly audits of all Foley Catheter's to monitor for compliance. All negative findings will be corrected at time of discovery. Detailed findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: June 7, 2019**	

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F 690	Continued From page 16 The April 2019 physician's orders included an order dated 3/25/19 for Foley cath 18 Fr/10 cc (cubic centimeters) balloon change q (every) month and prn (as needed). The surveyor observed Resident #54 on 4/23/19 at 12:30 p.m. Resident #54 was in bed. Certified nursing assistant #1 was asked to check the resident for anchorage and size of the Foley catheter. C.N.A. #1 stated the Foley catheter was anchored. Both the surveyor and C.N.A. #1 noted the size of the catheter was 18 Fr with a 30 cc balloon-not a 10 cc balloon as ordered. The surveyor and the interim director of nursing checked the indwelling Foley catheter on 4/24/19 at 4:06 p.m. The Foley size was 18 Fr with a 30 cc balloon. The interim DON stated the balloon size was wrong and then stated, "I hope I didn't put it in." The surveyor requested the April 2019 physician's orders, MDS, care plan and the facility policy on Foley catheters. The surveyor informed the administrator, the interim director of nursing, the minimum data set coordinator, and the corporate registered nurse of the above concern on 4/25/19 at 12:51 p.m. The facility policy titled "Foley Catheter Insertion, Female Resident" was reviewed 4/25/19. The policy read in part "Preparation 1. Verify that there is a physician's order for this procedure." No further information was provided prior to the exit conference on 4/25/19.	F 690		

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F 756	Continued From page 17	F 756		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F 756	F756 **Corrective Action(s):** Resident #33 has had their routine and PRN psychotropic medications reviewed by the attending physician and consultant pharmacist. Resident #33's psychotropic medication regime has been clarified to not administer PRN psychotropic medications longer than 14 days without appropriate physician follow up and review. A facility Incident and Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents receiving psychotropic medications may have been potentially affected. The DON and Unit Manager will review all residents receiving routine and PRN psychotropic medications to identify residents at risk. All residents identified at risk will have their psychotropic medications reviewed by the attending physician and/or consultant pharmacists to make corrections and/or adjustments. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The DON and the nursing staff will be inserviced by regional nurse consultant on the revised Federal Regulations for drug regime review and the use of PRN psychotropic medication for no more than 14 days at a time without further review and approval from the attending physician.	

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F 756	Continued From page 18 when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the contracted pharmacist failed to document whether or not there was any change for psychotropic medications ordered for prn (as needed) use for 14 days for 1 of 18 residents (Resident #33). The findings included: Resident #33 was readmitted to the facility on 3/18/19 with the following diagnose of, but not limited to high blood pressure, heart failure, urinary tract infection, diabetes, stroke, anxiety disorder, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/26/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #33 was also coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene and being totally dependent on 2 staff members for bathing. During the clinical record review on 4/25/19, the surveyor noted the following physician order's for Resident #33: o" ...Haldol 1 mg po (by mouth) q (every) 4 hours prn (as needed) anxiety. May repeat X (times) 1 hour o ...Ativan 0.5 mg (milligram) SL (sublingual) q 2 hours prn anxiety may repeat X 1 in 30 minutes if patient remains anxiety ..."	F 756	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or Unit Manager will perform monthly audits of all residents receiving psychotropic medications to ensure that the usage is appropriate and that PRN psychotropics are not used for more than 14 days at a time without physician review and approval for continued use. Any/all negative finding will be corrected at time of discovery and disciplinary action will be taken as needed. Detail findings of this review will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: June 7, 2019**	

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F 756	Continued From page 19 The Hospice physician gave these orders to the facility staff on 3/19/19. The contracted pharmacist performed a Medication Regimen Review on 4/8/19. There was a written in notation that stated "hospice". The surveyor noted no further recommendations from the contracted pharmacist. The surveyor notified the administrative team of the above documented findings on 4/25/19 at 12:50 pm. No further information was provided to the surveyor prior to the exit conference on 4/25/19.	F 756		
F 758 SS=D	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;	F 758	**F758** **Corrective Action(s):** Resident #33 has had their routine and PRN psychotropic medications reviewed by the Hospice physician, the attending physician and consultant pharmacist. Resident #33's regime has been clarified to not administer PRN psychotropic medications longer than 14 days without appropriate physician follow up and review. A facility Incident and Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents receiving Hospice and psychotropic medications may have been potentially affected. The DON and Unit Manager will review all residents receiving routine and PRN psychotropic medications to identify residents at risk. All residents identified at risk will have their psychotropic medications reviewed by the attending physician and/or consultant pharmacists to make corrections and/or adjustments. A facility Incident & Accident form will be completed for each negative finding.	

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F 758	Continued From page 20 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on facility document review, staff interview and clinical record review, the facility staff failed to ensure that 1 of 18 residents in the survey sample was free from receiving prn/as-needed psychotropic medications for longer than 14 days (Resident #33). The findings included: The facility staff failed to ensure Resident #33	F 758	**Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Hospice provider, the DON and the nursing staff have been inserviced by the regional nurse consultant on the revised Federal Regulations for drug regime review and the use of PRN psychotropic medication for no more than 14 days at a time without further review and approval from the Hospice Physician and/or attending physician. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or Unit Manager will perform monthly audits of all Hospice residents receiving psychotropic medications to ensure that usage is appropriate and that PRN psychotropics are not used more than 14 days at a time without physician review and approval for continued use. Any/all negative finding will be corrected at time of discovery. Detailed findings of this review will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: June 7, 2019**	

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F 758	Continued From page 21	F 758		

was free from receiving prn/as-needed psychotropic medications for longer than 14 days. Resident #33 was readmitted to the facility on 3/18/19 with the following diagnose of, but not limited to high blood pressure, heart failure, urinary tract infection, diabetes, stroke, anxiety disorder, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/26/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #33 was also coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene and being totally dependent on 2 staff members for bathing.

During the clinical record review on 4/25/19, the surveyor noted the following physician order's for Resident #33:

" ...Haldol 1 mg po (by mouth) q (every) 4 hours prn (as needed) anxiety. May repeat X (times) 1 hour
...Ativan 0.5 mg (milligram) SL (sublingual) q 2 hours prn anxiety may repeat X 1 in 30 minutes if patient remains anxiety ..."

The Hospice physician gave these orders to the facility staff on 3/19/19.

The Corporate Nurse and DON (director of nursing) was notified of the above documented findings on 4/25/19 at 9:16 am. The surveyor requested and received the facility's policy titled "Antipsychotic Medication Use" which read in part:
" ...Residents will not receive PRN (as needed) doses for psychotropic medications unless that

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F 758	Continued From page 22 medication is necessary to treat a specific condition that is documented in the clinical record ... The need to continue PRN orders for psychotropic medications beyond 14 days unless the healthcare practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of the medication ..." The surveyor notified the administrative team of the above documented findings at 12:50 pm. No further information was provided to the surveyor prior to the exit conference on 4/25/19.	F 758		
F 812 SS=E	Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812	**F812** **Corrective Action(s):** All undated, unlabeled, expired Spices identified in the Dry-storage area during the initial kitchen tour that were not properly labeled or out of date have been removed and disposed of. A facility Incident and Accident form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other food items in may have been potentially affected. The Food Service Manager, and/or Registered Dietician will inspect the kitchen dry storage areas, the walk-in freezer, reach in freezers and refrigerators to identify any negative findings. All negative findings will be corrected at time of discovery. A facility Incident and Accident form will be completed for each negative finding identified.	

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F 812	Continued From page 23 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review and staff interview, the facility staff failed to date spices when opened and failed to discard expired spices. The findings included: The facility staff failed to date spices when opened and failed to discard spices that had expired. The surveyor toured the kitchen on 4/23/19 beginning at 10:15 a.m. with the assistant dietary manager and the dietary manager. The surveyor, the dietary manager and assistant dietary manager observed a shelf with spices. The first spice observed was 28 ounces of Lemon and Pepper spice that had no date when opened. Further observation revealed 6 ounces of Whole Rosemary that had no date when opened. The surveyor asked both dietary staff what their expectations were with dating food when opened. The assistant dietary manager stated food including spices were to be dated and labeled when opened. The surveyor observed the contents of the spice shelf and noted the following: Dill weed-5.5.ounces. No date when opened. Onion powder 20 ounces-No date when opened. Ground oregano 11 ounces. No date when opened. Hungarian Paprika 18 ounces-No date when opened. Garlic powder 20 ounces. No date when opened. Date on the container read "Sent 4/16/19."	F 812	**Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician and/or Dietary manager will inservice the dietary staff on the proper preparing, storing and distribution of food under sanitary conditions, as well as the policy for proper food storage to include proper labeling and dating. The inservice will also include all aspects of infection & sanitation control measures. **Monitoring:** The CDM is responsible for maintaining compliance. The Administrator and/or Food service manager will complete the Dietary audit tool weekly for monitoring and maintaining compliance. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date: June 7, 2019**	

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F 812	Continued From page 24 Seasoning salt 38 ounces. No date when opened. Ginger 15 ounces. No date when opened. Cumin 16 ounces. Dated to be used by 2/9/16. Sage 6 ounces with a use by date of 8/4/18. Ground mustard 15 ounces with a use by date of 7/5/18. Thyme 13 ounces with use by date of 7/1/18. Chili powder 18 ounces. No date when opened. Black pepper 18 ounces. No date when opened. Many of the spices did not have a sticker on them as to when they were sent or the sticker was torn or unreadable. The surveyor requested the facility policy for dating of food from the managers on 4/23/19. The surveyor reviewed the facility policy titled "Section CIII-Food Storage, Policy: Covering, Labeling, Dating Food" on 4/23/19. The policy read in part under Dry Storage "1. All foods are to be dated upon receipt. The date shall reflect when the food has been received. The date upon receipt should be recorded as dd/mm/yy. (03/02/15). 2. Follow manufacturer's "expiration dates" or "use by dates", when available to determine when a food should be discarded. 3. See attached food storage chart for expiration guidelines when the manufacturer does not have the use by date or expiration date clearly labeled on the container or packaging." The surveyor reviewed the "Spices, Herbs, Condiments, Extracts" chart on 4/23/19. "Spices, whole good at room temperature for 1-2 years. Spices, ground at room temperature good for 6 months."	F 812		

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F 812	Continued From page 25 The surveyor informed the administrator, the interim director of nursing, minimum data set coordinator and the corporate registered nurse of the above concern on 4/24/19 at 3:00 p.m. No further information was provided prior to the exit conference on 4/25/19.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842	**F842** **Corrective Action(s):** Resident #25's attending physician has been notified that the facility staff failed to notify and document when resident #25 had daily weight changes per physician order. A facility incident and accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% review of all residents with physician ordered daily weights will be conducted by the DON and/or Unit Manager to identify residents at risk for inappropriate documentation and physician notification. All negative findings will be clarified and/or correct at time of discovery. A facility Incident & Accident form will be completed for each negative finding.	

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F 842	Continued From page 26 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a	F 842	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON or regional nurse consultant on the clinical documentation standards per facility policy and procedure. This inservice will include the standards for proper notification and documentation of physician ordered weight changes. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will audit medical records weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:**	

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F 842	Continued From page 27 complete and accurate clinical record for 1 of 18 residents (Resident #25). The findings included: The facility staff failed to ensure the clinical record of Resident #25 was accurate. The facility staff failed to document in the clinical record when the physician was notified of weight changes for Resident #25. The clinical record of Resident #25 was reviewed 4/23/19 through 4/25/19. Resident #25 was admitted to the facility 11/28/15 and readmitted 3/11/19 with diagnosis that included but not limited to type 2 diabetes mellitus, fracture of right pubis, heart failure, atrial fibrillation, edema, chronic ischemic heart disease, chronic obstructive pulmonary disease, and chronic kidney disease (stage III). Resident #25's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/18/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #25 had no signs or symptoms of delirium, psychosis, or behaviors affecting others. Resident #25's current comprehensive care plan was reviewed. The care plan identified nutrition with weight fluctuations as a risk and approaches were in part to monitor weights, labs, and intakes. The April 2019 physician's orders read "Daily weights report weight gain of 3-5 lb. (pound) to Doctor." The surveyor reviewed the April 2019 daily	F 842		

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weights. Resident #25 gained from 131.7 pounds on 4/11/19 to 139.7 pounds on 4/12/19-a difference of 8 pounds. The surveyor found no documentation of the weight change reported to the physician in the departmental notes for 4/12/19. There was a note dated 4/12/19 at 5:28 p.m. that the resident was seen by the nurse practitioner on that day with medication changes for anemia but for diuresis.

Resident #25 gained from 130.2 pounds on 4/14/19 to 138.9 pounds on 4/15/19-a difference of 7.7 pounds. The surveyor found no documentation that the physician was made aware of the weight gain. The MD was made aware of that day's laboratory results but there was no documentation about the resident's weight gain as per the physician's orders.

Resident #25 gained from 132.1 pounds on 4/18/19 to 139.8 pounds on 4/19/19 - a difference of 7.7 pounds. The 4/19/19 1:37 p.m. note stated the resident was seen on rounds and a new order to increase Lasix to 60 mg (milligrams) q am (every morning).

Resident #25 gained weight from 132.1 pounds on 4/20/19 to 139.1 pounds on 4/21/19-a difference of 7 pounds. There was no documentation in the departmental notes that the physician had been informed of the weight gain.

Resident #25gained from 131.9 pounds on 4/22/19 to 140.3 pounds on 4/23/19-a difference of 8.4 pounds. Resident #25 was seen by the nurse practitioner and changes to the diuretic were made.

The surveyor informed the administrator, the

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F 842	Continued From page 29 interim director of nursing, the minimum data set coordinator and the corporate registered nurse of the above concern with failure to document/notify the physician of weight changes on 4/25/19 at 12:51 p.m. No further information was provided prior to the exit conference on 4/25/19.	F 842		