STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495270	A. BUILDING _____ B. WING _____	C 05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER VA BEAC	3750 SENTARA WAY VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments	E 000		

An unannounced Emergency Preparedness survey was conducted 05/22/18 through 05/25/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Four complaint(s) was/were investigated during the survey.

E 007 SS=C EP Program Patient Population
CFR(s): 483.73(a)(3)

[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]

(3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**

*Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.]
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility staff failed to have documentation that strategies were in place to address the needs of at risk or vulnerable residents. And the facility staff failed to have documentation of delegation of authority during an emergency.

The findings included:

During an interview on 5/24/18 at 2:50 P.M. with

E 007

E 007: EP Program Patient Population

1. Staff will be educated on the facility assessment to include the high risk/vulnerable population and on the delegation of authority for emergency disaster events.
2. All residents are at potential risk in the event of an emergency or disaster situation in the absence of delegation of authority.
3. The facility Emergency Operations Plan was revised to include documentation on the facility's at risk and vulnerable residents and an organization chart outlining roles and responsibilities that delineates lines of authority in the absence of facility leadership was developed. Facility Administrator or designee will educate all staff on Emergency Operation Plan to include identification of high risk residents, staff roles and responsibilities during emergent events
4. The facility administrator or designee will audit all new employee records for 60 days to ensure new staff have received education on the Emergency Operations Plan. Findings for the audits will be presented to QAPI for review and recommendations.
5. Compliance Date: July 5, 2018.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/28/18

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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E 007	Continued From page 1 the Administrator, The Director of Nursing (DON) and the Maintenance Director, when asked for documentation of at risk or vulnerable residents, the DON stated, "The facility had not documented the unique vulnerabilities of the facilities population in the event of an emergency or disaster." During an interview with the Administrator, he was asked for documentation that an authorized person has been identified in writing to act in the absence of the administrator or person legally responsible for the operations of the facility. The administrator stated, "No person has been authorized in writing to act in the absence of the administrator during an emergency or a disaster." The facility staff failed to have documentation that identified at risk and vulnerable residents. Also, the facility staff failed to have documentation of a designated staff person in the absence of the administrator.	E 007		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff	E 015		

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E 015	Continued From page 2	E 015		

and patients whether they evacuate or shelter in place, include, but are not limited to the following:
(i) Food, water, medical and pharmaceutical supplies
(ii) Alternate sources of energy to maintain the following:
(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(B) Emergency lighting.
(C) Fire detection, extinguishing, and alarm systems.
(D) Sewage and waste disposal.

*[For Inpatient Hospice at §418.113(b)(6)(iii):]
Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility staff failed to have a fire watch process.

E 015: Subsistence Needs for Staff and Patients

1. The facility Emergency Operations Plan (EOP) was revised to include documentation on the facility's fire watch process and written vendor agreements for sewage disposal. The Resident Council will be educated on the EOP and practice fire watch drills will be conducted.
2. Residents that will be in a shelter in place scenario during an emergency situation have the potential to be affected.
3. The facility Emergency Operations Plan was revised to include documentation on the facility's fire watch process and written agreements for sewage/waste disposal during emergent events. Facility Administrator or designee will educate staff on the fire watch process and vendor arrangements for sewage/waste disposal during shelter in place scenarios as part of the Emergency Operations Plan
4. The facility administrator will audit all new employee records for 60 days to ensure new staff have received education on the Emergency Operations Plan to include fire watch procedures and vendor arrangements for sewage/waste disposal. Findings for the audits will be presented to QAPI for review and recommendations
5. Compliance Date: July 5, 2018.

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E 015	Continued From page 3 The findings included: During an interview on 5/24/18 at 2:56 P.M. with the Administrator, Director of Nursing (DON) and the Maintenance Director, the administrator was asked, for the policies and procedures for fire detection, extinguishing and alarm systems. The administrator stated, the facility had a "Fire Watch Process." When asked for documentation of the fire watch process there were no guidelines or procedures of how the "Fire Watch" would be carried out. During an interview with the Maintenance Director he stated, normally he carried out the "Fire Watch Process" by making rounds every 60 minutes. When asked how would resident get assistance of food water and pharmaceutical supplies during the "Fire Watch Process" the Maintenance Director stated, in that case, I guess we will be evacuating. Also, the facility staff failed to have documentation of written agreement for sewage and waste disposal during an emergency or disaster.	E 015		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]	E 018		

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E 018	Continued From page 4	E 018		

(2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.

*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.

*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.
(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.
(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC,

E 018: Procedures for Tracking of Staff and Patients

1. Master and individual tracking forms were developed for facility to utilize during evacuations. Tracking forms were added to the Emergency Operations Plan binder.
2. Residents that are sent out of the facility during an emergent situation have the potential to be affected.
3. Facility Administrator developed a new emergency preparedness tracking to be utilized in case of facility evacuation of residents. Facility administrator or designee will educate all staff on the use of the emergency preparedness tracking form as part of the Emergency Operations Plan training.
4. The facility administrator or designee will audit all new employee records for 60 days to ensure new staff have received education on the Emergency Operations Plan to include the emergency preparedness tracking form used during facility evacuations to off-site locations. Findings for the audits will be presented to QAPI for review and recommendations
5. Compliance Date: July 5, 2018

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E 018	Continued From page 5 which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation and staff training of Emergency preparedness tracking system. The findings included: During an interview on 5/24/18 at 3:06 P.M. with the Administrator, Director of Nursing (DON) and the Director of Maintenance, the Administrator and the DON were asked if had been trained on the facilities emergency plan for for tracking the location of on-duty staff and residents during an emergency. The Administrator stated, "No" the staff had not been trained on the tracking system. The facility staff failed to have documentation and staff training of the Emergency Preparedness tracking system.	E 018		

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E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)	E 024		

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]

(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to have documentation that policies and procedures addressed the use of volunteers and other staffing strategies.

The findings included:

During an interview on 5/24/18 at 3:25 P.M. with the Administrator, Director of Nursing (DON) and the Maintenance Director, the Administrator was asked for policies and procedures to address the use of volunteers in an emergency or other

E 024 Policies/Procedures - Volunteers and Staffing

1. The Volunteer section of the Emergency Operations Plan was revised to include specific strategies for use of and roles for volunteers and other staff.
2. All residents are at risk for this deficient practice with regards to use of volunteers in an emergency.
3. The facility's Volunteer section of the Emergency Operations Plan was revised to include specific staffing strategies for the use of volunteers and other staff during emergencies. Facility Administrator or designee will educate all staff on the revised Volunteer policy and process as it relates to the Emergency Operations Plan training
4. The facility Administrator or designee will audit all new employee records for 60 days to ensure new staff have received education on the Emergency Operations Plan to include the use of volunteers during emergency events. Findings for the audits will be presented to QAPI for review and recommendations
5. Completion Date: July 5,2018

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E 024	Continued From page 7 emergency staffing strategies. The Administrator stated, "No policies and procedures had been developed for the use of volunteers in an emergency. The facility staff failed to have documentation that policies and procedures address the use of volunteers and other staffing strategies.	E 024		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	E 026	**E 026 Roles Under a Waiver Declared by Secretary** 1. The Emergency Operations Plan was revised to include the Sentara Life Care policy entitled Section 1135 Waiver, and education to staff on facilities role in providing care at off site location will be completed. 2. All residents are at risk if staff are unaware of the facility's role in providing care and treatment at alternate care sites under an 1135 waiver 3. Facility Administrator or designee will educate facility staff on the facility Emergency Operations Plan to include the facility's role in providing care, treatment and resident tracking at alternate care sites under the Section 1135 Waiver Policy 4. The facility Administrator or designee will audit all new employee records for 60 days to ensure new staff have received education on the Emergency Operations Plan. Findings for the audits will be presented to QAPI for review and recommendations. 5. Completion date: July 5, 2018	

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E 026	Continued From page 8 facility staff failed to have documentation that describes the facilities role in providing care and treatment at alternate care sites. The findings included: During an interview on 5/24/18 at 3:40 P.M. with the Administrator, Director of Nursing (DON) and Maintenance Director, the Administrator and the DON were asked for documentation of the facilities staff role in providing care and treatment at an alternate care site. The DON stated, the facility had not developed policies and procedures that describes the facility staffs role in providing care at an alternate care site during emergencies and disaster. The facility staff failed to have documentation that describes the facility's role in providing care and treatment at alternate care sites.	E 026		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set	E 036		

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E 036	Continued From page 9	E 036		

forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to have a written training and testing program.

The findings included:

During an interview on 5/24/18 at 3:47 P.M. with the Administrator, and the Director of Nursing (DON), they were asked for documentation that the facility staff had been trained and tested on the facilities emergency preparedness plan. The administrator stated, the facility had not developed a training and testing program based on the emergency preparedness program.

E 036 EP Training and Testing

1. Staff will be educated on the Emergency Operations Plan regarding staff responsibilities and duties with providing care during an emergency.
2. All residents are at risk if staff are unaware of the facility's role in providing care and services during emergent situations.
3. Facility Administrator or designee will educate facility staff on the facility Emergency Operations Plan to include the facility's role in providing care and individual responsibilities to be provided during emergent situations.
4. The facility administrator or designee will audit all new employee records for 60 days to ensure new staff have received education on the Emergency Operations Plan. Findings for the audits will be presented to QAPI for review and recommendations.
5. Completion date: July 5, 2018

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E 036	Continued From page 10 The facility staff failed to have a written training and testing program.	E 036		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard and complaint survey was conducted 5/22/18 through 5/25/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Four complaints were investigated during the survey.	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, 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)	F 580		

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F 580	Continued From page 11	F 580		

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, closed record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed for one (Resident #379) of 34 residents in the survey sample to notify the responsible party of a fall.

The findings included:

Resident #379 was admitted to the facility on 1/24/17 with diagnoses included but were not limited to cerebral vascular accident (CVA or stroke), COPD (Chronic Obstructive Pulmonary

F 580 Notify of Changes
1. Resident # 379 responsible party was notified of the fall and documentation of notification entered in medical record. Staff will be educated on the policy related to notification of change for residents.
2. Residents who experienced a fall have a potential to be affected.
3. The Staff Development Coordinator or designee will provide education to all licensed nursing, rehabilitation, and social services staff regarding the policy and procedure that governs the standards of practice related to Notification of Changes. Clinical Manager or designee will review the medical record of resident's who were reported to have fallen in the last 24 hours at IDT meeting to validate appropriateness of notification of the responsible party and documentation in electronic medical record.
4. Clinical Manager/ designee will audit medical records of residents who experienced a reported fall weekly for four weeks, then monthly for two months to validate adherence to the established standards governing Notification of Falls. Findings will be reported to QAPI monthly for further review and recommendations.
5. Compliance Date: July 5, 2018

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Disease), major depressive disorder, unspecified injury of head, difficulty in walking, and muscle weakness. Resident #379 was discharged from the facility on 2/10/17.

An initial care plan dated 2/6/17 included, Problems: At risk for falls, Goals: Resident #379 will demonstrate the ability to ambulate/transfer without fall related injuries over the next 90 days, Interventions: Keep areas free from obstruction to reduce the risk of falls or injury, Place call bell within easy reach, Remind Resident #379 to call for assistance before moving from bed-to-chair and from chair-to-bed, Use alarm to monitor attempts to rise, Footwear will fit properly and had on non-skid soles, Provide reminders to use ambulation and transfer assist devices.

On 5/23/18 at 4:30 PM Resident #379's medical record was reviewed. Nurses notes written 1/25/17 at 4:17 AM included "Received resident in bed at start of shift, alert and oriented to self, confusion noted during shift vs [vital signs] wnl [within normal limits] at start of shift resident attempted to get out of bed on her own and fell on floor. " CNA (Certified Nursing Assistant) and LPN (Licensed Practical Nurse) assessed resident vs normal. Resident stood up on her own and got back in bed. Bed alarm was in place. Resident removed battery so not to set off alarm. LPN informed resident importance of not taking apart alarm and need to stay in bed. Resident attempted to get out of bed multiple more times, resident placed in wheelchair at nurse's station during shift. Resident needed to be redirected multiple times. RN made aware of resident fall. MD made aware of resident fall".

1/25/17 2:32 pm nurses note included Resident

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[#379] transported to ED (Emergency Department) for evaluation, husband notified of the above, daughter at facility when resident left.

1/25/17 7:33 PM nurses note read "Patient [#379] returned from the ED [Emergency Department] via family transport CT [computed tomography] scan negative. No paperwork received from hospital, negative result confirmed with nurse in ED. Patient transferred to room (number) closer to nurse's station for safety. Fall mats and bed alarm in place."

A Review of the Incident Report dated 1/25/17 associated with the fall for Resident #379 noted: Date of incident 1/24/17 Date of Report was written on 1/31/18
On 5/24/18 at 2:10 PM Interview with the Director of Nursing (DON) revealed that the practice expected is the nurse who wrote the nurses note should have written the incident report the same day. The DON was asked how it was that the dates of the incident and the date of the report are 7 days apart. The DON stated that incidents are reviewed weekly and if the incident report must not have been written by the nurse, [on the day of the fall] a report was written during that meeting.
The DON was asked if the incident report indicated that Resident #379's representative was notified of the fall and she replied "it's not documented on the form".

On 5/24/18 at 1:20 PM the Medical record and facility documentation were reviewed and there is no documentation that the responsible party was notified about the fall on either the nursing notes or on the incident report.

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F 580	Continued From page 14 On 5/24/18 at 1:42 attempted to call the LPN who wrote the nurse's note about the fall in 1/25/18 the number is not in service. On 5/25/18 at 11:39 AM the Administrator and DON met with the survey team to review the complaint. During the interview they were asked about the nurse's notes and incident report and whether there would be documentation showing the resident's representative was notified of the fall. The DON stated it should be in the notes. On 5/25/18 at approximately 3:45 PM the facility policy regarding change in condition or following an accident was reviewed and included: Life Care - Notification of Changes in Condition, Revised 06/02/2017 stated in part: Required Action Steps 1. The nurse on duty will notify the Practitioner and Resident/Legal Representative/Family Member when there is an occurrence of an accident involving the resident which results in injury and has the potential for requiring physician intervention. On 5/25/18 a pre exit review was conducted with the Administrator, the DON, two corporate representatives where these and other concerns were discussed. No further information was provided. Complaint deficiency.	F 580		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		

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F 657	Continued From page 15 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, the facility staff failed to review and revise the comprehensive care plan for 1 resident (#8) in the survey sample of 34 residents. Facility staff failed to maintain an accurate person centered care plan related to transfer needs for Resident #8. The findings included:	F 657	**F 657 Care Plan Timing and Revision** 1. Resident #8 care plan was revised to include the person centered care for transfer need. 2. All residents have the potential to be affected. 3. The Staff Development Coordinator or designee will provide education to all interdisciplinary staff on the regulation that governs the standards of practice related to individualized Care Planning. 4. MDS Coordinator will audit 10% of residents' medical records weekly for four weeks, then 20% of residents monthly for two months to validate adherence to the established standards governing care planning. Findings will be reported to QAPI monthly for three months for further review and recommendations. 5. Compliance Date: July 5, 2018	

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Resident #8 was admitted to the facility on 2/15/18 with diagnoses that include and are not limited to: Acute post hemorrhagic anemia, cirrhosis of the liver, liver failure, alcohol abuse, coagulation deficit (bleeds easily) and sepsis (infection).

A care plan for Resident #8 prepared 5/14/18 included: Problems: Bathing - Resident #8 requires extensive assistance, Goals: Resident #8 will be bathed/showered with the assistance of 1-2 people, Interventions: Bathe/shower Resident #8 Use lifts/transfer devices.

A quarterly MDS 3.0 (Minimum Data Set) assessment for resident #8 was dated 5/14/18 was coded with a BIMS (Brief Interview for Mental Status) score of 14, indicating cognitively intact. Resident #8's ADL (Activities of Daily Living) status was coded as supervision only needed for self-performance and staff assistance of one staff members for bed mobility, toilet use, and personal hygiene; and supervision for self-performance with supervision with transfers, walking dressing, and eating. The MDS 3.0 dated 5/14/18 section for bathing was coded as "Physical help in part of bathing" needed.

On 5/23/18 9:00 AM an interview was conducted with resident #8. Resident #8 was observed ambulating in his room without the assistance of staff or assistive devices (walker/cane) without any difficulty. When Resident #8 was asked about his need for assistance from staff he stated he needs help with scheduling appointments.

On 05/23/18 at 12:36 PM a record review of the residents care plan included: "needed extensive assistance with his bath, and the intervention

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F 657	Continued From page 17 states Resident uses lifts/transfer devices". Observation of resident #8 found that he ambulated without any assistive devices and did not need the use of mechanical lift devices. On 5/23/18 at 11:05 AM an interview with the unit manager was conducted and the care plan was reviewed. She stated he "needs supervision but has no need for transfer [mechanical lift] assistance". On 5/23/18 at 12:00 PM an interview was conducted with the MDS Registered Nurse (RN#2). RN# 2 stated we take the information form the MDS to formulate the care plan. When asked, the MDS nurse if Resident #379 was physically observed prior to completing the MDS he said "yes, and he is very ambulatory and I will update his care plan." The information was incorrect and we will correct the care plan. On 5/25/18 a pre exit review was conducted with the Administrator, the DON, two corporate representatives where these were discussed. No further information was provided.	F 657		
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	F 690		

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comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews, clinical document and facility documentation review the facility staff failed to maintain proper infection control practices for indwelling Foley catheter maintenance for 2 residents (#23) and (#129) in the survey sample of 34 residents.

1. The facility staff failed to ensure Resident #23's indwelling Foley catheter urine collection bag was not in contact with the floor.

2. The facility staff failed to ensure Resident #129's indwelling catheter bedside drainage bag

F690 Bowel/Bladder Incontinence, Catheter, UTI

1. Resident #23 foley bag was properly secured off the floor and resident #129 foley bag was emptied and secured to ensure bag did not touch floor.
2. Residents who have indwelling catheters have the potential to be affected.
3. The Staff Development Coordinator or designee will provide education to all nursing staff regarding infection control practices for catheter care consistent with professional standards.
4. The Clinical Managers will rounded on all residents with indwelling catheters 5 times per week for 4 weeks, then weekly for 4 weeks to ensure that indwelling catheter are not touching the floor and catheter bags are being emptied appropriately. Findings will be reported weekly to the Standards of Care meeting and to QAPI monthly for further review and recommendations.
5. Compliance date: July 5, 2018

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was emptied and prevented from making contact with the floor.

The findings included:

1. Resident # 23 was admitted to the facility on 12/26/17 with diagnoses that include but are not limited to bladder neck obstruction, CVA (cerebral vascular accident or stroke), unspecified dementia, hypertension, and Alzheimer's disease.

Resident #23's care plan was prepared, reviewed and updated on 5/22/18 and included: Problem: At risk for infection R/T (related to) indwelling catheter. Goals: Res #23 will remain free from urinary tract infections during period of catheterization. Interventions: Change drainage bag, Clean around catheter with soap and water, Keep tubing below the level of the bladder and free from kinks or twists, Record output per shift, Report ant sigh of infection (temperature, pain, urine that looks cloudy, dark, or with blood). Wash hands before and after procedure.

Resident # 23 had a Quarterly MDS 3.0 (minimum data set) was completed on 5/17/18. The assessment coded Resident # 23 with a BIMS (Brief Interview for Mental Status) of 3 which indicated significant cognitive impairment. Resident #23 's ADL (Activities of Daily Living) status was coded as extensive assistance needed for self-performance and staff assistance of one staff member for bed mobility; transfers, dressing, toilet use, and personal hygiene. He needed supervision and set up assistance for eating.

On 05/22/18 11:57 AM observation of Resident #23's Foley catheter bag was on the floor on the

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right side of his bed. A dignity bag was nearby but the Foley urine collection bag was not placed inside the dignity bag.

On 05/23/18 01:32 PM observation noted Resident #23's Foley catheter urine drainage bag was observed placed on the floor and not in a dignity bag.

On 5/23/18 at 1:53 Met with LPN# 2 in Resident #23's room and asked her to observe his catheter bag and she said "it's on the floor and it should be in the bag".

On 05/23/18 at 3:25 PM observed resident in low bed, Foley catheter bag is in a dignity bag yet resting on the floor. Spoke with LPN# 2 who stated he is in a low bed. Asked if she thought there was an increased risk of infection with the catheter and dignity bag on the floor and she said it would be "best practice to have it off the floor".

On 5/25/18 at 11:00 AM a medical record review for Resident #23 was conducted which noted a laboratory report for a urine sample collected on 2/13/18 which had a result of positive for Staphylococcus Aurous (bacteria) greater than 100,000 colony forming units which indicated high bacterial presence in his urine. Findings by the laboratory indicate this was an "Abnormal" result. A review of the physician's orders noted Resident #23 had an order for a Foley 16 French 30 ml (milliliter) balloon started on 4/10/18

The facility was asked for their policy regarding maintenance of Foley catheters and urine collection bags as it related to infection control practices. The DON stated the facility does not use a policy per se, but instead uses Nursing

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Reference Center Plus. The section titled "How to Care for Your Foley Catheter - Male" included (in part):

Steps to Take:
Step 4 To empty the urine bag, open the outlet and drain urine into the toilet, or an appropriate container if you have been asked to measure the urine volume DO NOT let the outlet touch your hand, the urine bag, or the sides of the container. You do not want any germs to get into the bag. After clamping the outlet tube, use an alcohol wipe or mild soap and water to clean it. Do this every time you empty the bag.
Step 5 Be sure the urine bag you are using is always kept lower than your bladder so no germs can travel up the catheter into your body.

On 5/25/18 a pre exit review was conducted with the Administrator, the DON, two corporate representatives where these and other concerns were discussed. No further information was provided.

2. Resident #129 was originally admitted to the nursing facility 5/15/18 from an in-patient Hospice facility has never been discharged from the nursing facility. The current diagnoses included; dementia with major depressive disorder, cerebrovascular disease, contractures and multiple pressure ulcers.

No Minimum Data Set (MDS) assessment had been completed by the nursing facility for

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Resident #129.

Review of the May 2018 Physician's order Summary revealed an order dated 5/16/18 which read; Foley catheter care every shift. 16 french, 10 milliliter (ml) balloon. Change Foley catheter as needed if compromised.

The interim care plan dated, 5/15/18 revealed a care plan problem which read; Elimination related to incontinence. The goal read; Adequate elimination as evidenced by voiding every 6-8 hours, no bladder distension, bowel sounds present, bowel movement every 3 days or normal for the resident. The interventions included; Monitor voiding and stool elimination pattern. Assess for bladder distension as needed. Assess bowel movements. Assess urine and stool for abnormalities. Encourage mobility, Medications/treatments per physician's orders.

Resident #129 was observed during the initial screening of residents on 5/22/18 at approximately 11:40 a.m., in a specialty bed, facing the doorway with her arms extended upwards. The resident's eyes were open and she looked at the surveyor as the surveyor spoke to her but closed her eyes and didn't respond. The indwelling catheter bedside drainage bag was observed inside a dignity bag but it was heavy and touched the floor. Bilateral fall mats were also observed at bedside.

On 5/23/18 at approximately 10:20 a.m., Resident #129 was again observed in a specialty bed facing the doorway with her arms extended

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upwards. The surveyor again introduced herself to the resident and asked her name, slowly the resident stated her name but answered no further questions. Again the bedside drainage bag was observed inside a dignity bag which touched the floor. The bedside drainage bag contained 600 milliliters of cloudy tea colored urine.

On 5/24/18 at approximately 12:10 p.m., Resident #129 was observed in a specialty bed with her back to the door. As the surveyor walked around to face the resident the bedside drainage bag was again observed inside a dignity bag which touched the floor.

An interview was conducted with Registered Nurse (RN) #1 on 5/24/18 at approximately 2:45 p.m. RN #1 stated she was not aware Resident's #129 bedside drainage bag had been touching the floor for the last 3 days but she would follow-up on a resolution because the resident's bed was low to the floor.

An interview was conducted with the Hospice Agency RN on 5/24/18 at approximately 4:25 p.m. The Hospice Agency RN stated the diagnosis for use of the indwelling catheter was unstageable pressure ulcers.

On 5/25/18 at approximately 10:00 a.m., Resident #129 was observed in a specialty bed. The resident faced the door but didn't respond when spoken to. The indwelling catheter's bedside drainage bag was suspended and not touching the floor.

On 5/25/18 at approximately 5:55 p.m. the above information was shared with the Administrator

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and DON. The DON stated they hadn't had a catheter related urinary tract infection in the facility in 2 years and the facility doesn't loop the drainage tubing which can decrease urine flow therefore; preventing the dignity bag from touching the floor poses a problem. The DON strategies if using a basin would be feasible to preventing the bag from touching the floor.

The DON stated the facility does not have a policy on indwelling catheter management but information from the Nursing Reference Center (NRC) is referenced as their Professional Standard. Such information recommended included; keep the bedside drainage bag below the bladder, secure the catheter tubing to the patient's inner thigh using a commercial tube holder, avoid dependent loops or kinks in the tubing.

Other best practice recommendations stated by the Nurse Educator included; Ensure the catheter bag hangs freely without touching the floor and Ensure Foley bags remain less than half full at all times to prevent back flow.

On 5/25/18 at approximately 5:55 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Educator. No additional information was provided.

F 697 SS=D Pain Management
CFR(s): 483.25(k)

§483.25(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,

F 697

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the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility documentation review, clinical record review the facility staff failed to ensure non-pharmacological measures were offered prior to the administration of analgesic medications.

The facility staff failed to ensure non-pharmacological measures were offered prior to the administration of analgesic medications for one Resident (Resident # 11) of 34 residents in the survey sample.

The findings included:

Resident observations were made on the following dates in her room:
5/22/18 at approximately 6 PM: Resident well groomed in her room and without complaints of pain
5/23/18 at approximately 6:30 PM: Resident in her room and without complaints
5/24/18 at approximately 6:45 PM: Resident well groomed and without complaints

Resident #11 was admitted to the facility on 1/17/16. Diagnoses for Resident #11 included but are not limited to Left Shoulder Pain, Alzheimer's Disease, Arthritis, Osteoporosis and Hemiplegia (paralysis) following Cerebral Infarction (Stroke).

Resident #11's Quarterly Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 2/23/18, scored Resident #11

F 697 Pain Management

1. Resident #11 was offered and will continued to be offered non-pharmacological interventions prior to administrating an analgesic.
2. All residents reporting pain or receiving pain medications have a potential to be affected.
3. The Staff Development Coordinator or designee will provide education to all licensed nursing staff on the policy, procedure, and standards of practice related to Medication Administration of pain medications.
4. The Clinical Manager or designee will review 10% of all resident medical records to ensure that staff are providing non-pharmacologic interventions prior to administering pain medications. Audits will be conducted weekly for 4 weeks, then monthly for two month. Findings will be reported to the Standards of Care meeting and QAPI monthly for further review and recommendations.
5. Compliance Date: July 5, 2018

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with a Brief Interview for Mental Status (BIMS) of 15 of a possible 15 indicating no cognitive impairment.

Resident #11's 5/17/18 to present Person Centered Comprehensive Care Plan documented the following:

Focus Area:
Pain Management related to chronic pain, arthritis, migraines and history of fracture

Goal:
The resident's pain will be assessed and managed.

Interventions included but were not limited to:
Implement the following non-pharmacological pain management program, specifically: distraction, massage, imagery, relaxation, aromatherapy, and application of heat or cold.

Resident #11's Current Physician orders included but were not limited to:

1/14/18 Physician ordered Oxycodone 5 milligrams (mg) tablet one tablet orally as needed for pain every six hours.

The May 2018 Medication Administration Record (TAR) documented the following as needed Oxycodone 5 mg given.

5/1/18 14:19 (2:19 PM) Pain level 9 (Pain scale 1-10 with 10 being the worst pain)
5/2/18 2:56 (2:56 AM) Pain level 6
5/2/18 16:08 (4:08 PM) Pain level 5
5/3/18 19:12 (7:12 PM) Pain level 10
5/5/18 19:42 (7:42 PM) Pain level 8

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5/6/18 16:01 (4:01 PM) Pain level 10
5/7/18 14:17 (2:17 PM) Pain level 8
5/7/18 20:19 (8:19 PM) Pain level 10
5/8/18 4:10 (4:10 AM) Pain level 6
5/8/18 19:24 (7:24 PM) Pain level 10
5/9/18 14:05 (2:05 PM) Pain level 8
5/10/18 13:38 (1:38 PM) Pain level 6
5/12/18 15:26 (3:26 PM) Pain level 5
5/13/18 13:00 (1:00 PM) Pain level 9
5/14/18 19:29 (7:29 PM) Pain level 10
5/15/18 16:20 (4:20 PM) Pain level 10
5/18/18 2:39 (2:39 AM) Pain level 7
5/18/18 16:59 (4:59 PM) Pain level 9
5/19/18 3:31 (3:31 AM) Pain level 3
5/19/18 13.24 (1:24 PM) Pain level 13
5/19/18 19:37 (7:37 PM) Pain level 10
5/20/18 4:55 (4:55 AM) Pain level 9
5/20/18 22:03 (10:03 PM) Pain level 10
5/21/18 4:11 (4:11 AM) Pain level 8
5/21/18 15:37 (3:37 PM) Pain level 10
5/22/18 5:25 (5:25 AM) Pain level 9
5/22/18 15:19 (3:19 PM) Pain level 8
5/23/18 18:58 (6:58 PM) Pain level 10
5/24/18 16:12 (2:12 PM) Pain level 10
5/25/18 14:21 (2:21 PM) Pain level 9

All of the above as needed hydrocodone medication administrations were assessed as effective.

The Director of Nursing on 5/25/18 at approximately 2:45 PM that the facility has acknowledged that there are currently no means to document non-pharmacological nursing measures prior to the administration of pain medications. Corporate Educator #4 RN stated on 5/25/18 at approximately 2:50 PM that efforts are being made to add a component into the computer system for nurses to document

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non-pharmacological measures prior to the administration of pain medications.

The Facility Policy titled, "Life Care - Pain Management" with a revision of 1/22/18 documented the following:

Policy Statement: It is the standard of this facility based on the comprehensive assessment to provide a pain management plan of care and treatment in accordance with professional standards of practice, the comprehensive person-centered care plan and residents' goals and preferences.

The Facility Procedure titled, "Life Care - Pain Management Guidelines with a revision date of 1/22/18 documented the following:

Action Steps:

A pain assessment will be completed on each resident upon admission, quarterly, with significant change, and/or onset of new pain or change in condition.

Assessment and intervention will include but not limited to Pain Assessment Tool.

The Facility will provide the patient and/or resident medication per physician order to include but not limited to:
Licensed Nurse will document pain level and assessment prior to medication administration to determine proper treatment.
Upon medication administration the nurse will re-assess medication effectiveness and document assessment findings.

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F 697	Continued From page 29 Nursing and/or physician will provide pain management education to the patient, resident, and/or resident representative as necessary to include but not limited to: ... c. available pain control mechanisms The facility administration was informed of the findings during a briefing on 5/25/18 at approximately 7:15 PM. The facility did not present any further information about the findings.	F 697		
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; §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;	F 758		

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§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 observation, resident interview, staff interview, facility documentation review, clinical record review facility staff failed to ensure 2 residents (Resident #7 and #52) were free from unnecessary psychotropic medications.

1. The facility staff failed to ensure Resident #7's as needed Trazodone was reassessed and extended for another 14 days.

2. The facility staff failed to ensure Resident #52 received gradual dose reductions in an effort to decrease and/or discontinue psychotropic drugs use.

The findings included:

F 758 Free from Unnecessary Psychotropic Drugs

1. Resident #52 received a gradual dose reduction recommendation plan from pharmacy for their psychotropic medication. Resident # 7 was reassessed for the need for psychotropic medication by the physician.
2. Residents receiving psychotropic medications have a potential to be affected.
3. The Staff Development Coordinator or designee will provide education to all licensed nursing staff at facility and at PACE regarding the policy, procedure, and standards of practice for the use of psychotropic medications and gradual dose reductions.
4. The Clinical Manager or designee will review 10% of all resident medical records to ensure that providers are renewing Psychotropic medications within the 14 day timeframe and to ensure gradual dose reduction recommendations are provided by pharmacy to the provider. Audits will be conducted weekly for four weeks, then monthly for two months. Findings will be reported to Standards of Care QAPI monthly for further review and recommendations.
5. Compliance Date: July 5, 2018

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1. Resident #7 was admitted to the facility on 5/2/16. Diagnoses for Resident #7 included but were not limited to Non Alzheimer's Dementia and Depression. Resident #7's Re-entry Quarterly Minimum Data Set (MDS) (an assessment protocol) with an Assessment Reference Date of 5/15/18 scored him with a 15 out of a possible 15 on his Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the Quarterly MDS coded Resident #7 as needing supervision with set up only for Bed Mobility, Toilet Use and Dressing. Review of the MDS did not document behaviors.

Review of the Resident's clinical record did not reveal any Physician orders to extend Resident #7's Trazadone.

The Corporate Educator on 5/27/18 at approximately 1:45 PM after being asked to show any proof that the Physician made any notes or orders to extend the Trazadone for another 14 days, stated that there was no prescribing practitioner orders to extend Resident #7's as needed Trazadone. The Corporate Educator did present the surveyor with Physician Dates of the following stating to continue medications.

The following dates are not every 14 days. She stated that it was something the Facility needed to work on.

12/6/17
1/8/18
2/14/18
3/5/18
3/16/18

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F 758	Continued From page 32 3/28/18 4/12/18 5/1/18 5/3/18	F 758		

The Director of Nursing on 5/27/18 at approximately 4:10 PM presented the surveyor with a 3/18/18 dated document titled, "Ad Hoc QAPI (quality assurance performance improvement) that documented the following:

Identified Opportunity for Improvement/Deficient Practice: F758
The IDT (interdisciplinary team) team has identified an opportunity to promote the highest quality of care and service by validating adherence to the established practice standards for "Unnecessary Drugs and Psychotropic Drugs"
The intent of adherence to the organization's established standards of practice is to ensure that a residents with psychotropic medications are monitored for any adverse drug reactions. The facility will achieve the established threshold for Antipsychotic medications of or less than 3.8 % for Short stay residents and 5.3 % for LTC (Long Term Care) residents.
Immediate Corrective Action for those affected by the deficient practice:
In reviewing processes for giving PRN (as needed) psychotropic medication, revealed that documentation for non-pharmacological interventions were not in place.
The Ad Hoc QAPI 3/18/18 document did not address prn antipsychotic medications being reassessed and either reordered or discontinued by the prescribing practitioner.

The facility's Pharmacy service policy with a revision dated of 10/26/17 read at bullet #5;

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Provide GDR and other recommendations surrounding psychotropic and antipsychotic medications

The facility's Psychoactive Medications policy with a revision date of 1/17/17 read; The facility will develop and maintain a system for assuring the proper use and monitoring of psychoactive agents. Psychoactive agents can only be used on receipt of a physician's order to eliminate or reduce identified behavioral symptoms or to treat a specific diagnosis.

The facility administration was informed of the findings during a briefing on 5/27/18 at approximately 7:15 PM. The facility did not present any further information about the findings.

2. Resident #52 was originally admitted to the facility 5/25/15 and readmitted 6/9/17 after an acute care hospital stay. The current diagnoses included; major depressive disorder, and dementia with behavioral disturbances.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date

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(ARD) of 4/12/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #52 cognitive abilities for daily decision making were intact.

In section; "D" (Mood), the resident was coded without mood problems. In section; "E" (Behaviors), the resident was coded for exhibiting verbal behaviors towards others 1-3 days per week. In section; "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with out of room locomotion, personal hygiene and dressing, extensive assistance of 2 or more persons with bed mobility, transfers, and toileting, and total care with bathing.

The May 2018 Physician's Order summary included orders for the following medications to be administered to Resident #52;

Risperdal (an antipsychotic medication), 0.25 milligrams (mg) two times daily orally for vascular dementia with behavioral disturbances, dated 2/8/18.

Cymbalta (an antidepressant medication) 60 mg delayed release, one time daily orally for a major depressive disorder, dated 12/18/17.

Lorazepam (an antianxiety medication) 0.5 mg orally as needed every 8 hours for vascular dementia with behavioral disturbances, dated 2/14/18.

Resident #52's active care plan dated 4/20/18,

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included a problem which read; Behavioral symptoms: (name of resident) has verbal behavioral symptoms directed towards patient in room. The goal read; Number of verbal incidents will decrease over the next 90 days as evidenced on the medical record, 7/5/18. The interventions included; Encourage activities to participate in activities with (name of resident) separately from other resident to promote positive interactions. Gently remind (name of resident) that screaming/cursing is not appropriate. Respond in a calm voice; maintain eye contact. Remove from area if (name of resident) is verbally abusive to other residents.

Another care plan problem dated 4/20/18 read; (name of resident) has a history of verbally aggressive behaviors as evidenced by chart. The goal read; (name of resident) will remain free of verbally aggressive behaviors over the next 90 days, 7/5/18. The interventions included; Encourage caregivers to participate in activities with (name of resident) to promote positive interactions. Record behaviors, monitor pattern of behaviors (time of day, factors and specific time). Respond in a calm voice, maintain eye contact. Remove resident from area if she becomes verbally abusive. Remind (name of resident) that behaviors are not appropriate.

A care plan problem dated 4/20/18 also read; Risk for adverse reactions related to medication use. (name of resident) is receiving antipsychotic drugs on a regular basis. The goal read; (name of resident) will not cause harm or injury to self or others over the next 90 days, 7/5/18. The interventions include; Administer medication as ordered, noting effectiveness and side effects.

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A final care plan problem related to use of psychotropic medications dated 4/20/18 read; Risk for adverse reactions related to medication use. (name of resident) is receiving antidepressant drugs on a regular basis due to a diagnosis of depression. The goal read; Symptoms of depression will be controlled managed with minimal side effects over the next 90 days, 7/5/18

"Gradual Dose Reduction (GDR)" is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued.

Resident #52 was observed seated in her room 5/24/18 at approximately 6:10 p.m. The resident answered questions appropriately but was easily distracted by sounds coming in from the hallway. The resident responded with commands and cursing.

A Licensed Clinical Social (LCSW), progress note dated 5/25/18 revealed, Resident #52 had been aggressive towards another resident at the Program of All-inclusive Care for the Elderly (PACE) program therefore; a follow-up was necessary. The progress note stated Resident #52 stated "she did not like the person and the resident needed to leave her alone". The LCSW further stated Resident #52 was not awake enough for her to discuss the incident further.

An interview was conducted with the Director of Nursing (DON), on 5/25/18 at approximately 3:15

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p.m., regarding gradual dose reduction attempts for residents residing in the facility. The DON stated those who required GDR didn't get them because they were not doing them. The DON further stated they hadn't had mental health professionals available to provide needed service but recently a new group of provider have been contacted and will begin servicing the facility.

Pharmacy reviews were also requested and were to be faxed to the Office of Licensure and Certification from the nursing facility. I were not available at the time this report was written.

The facility's Pharmacy service policy with a revision dated of 10/26/17 read at bullet #5; Provide GDR and other recommendations surrounding psychotropic and antipsychotic medications

The facility's Psychoactive Medications policy with a revision date of 1/17/17 read; The facility will develop and maintain a system for assuring the proper use and monitoring of psychoactive agents. Psychoactive agents can only be used on receipt of a physician's order to eliminate or reduce identified behavioral symptoms or to treat a specific diagnosis. Page 2 of this policy bullet #7 read; If a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts) within the first year, unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.

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F 758	Continued From page 38 On 5/25/18 at 5:55 p.m., the above findings were shared with the Administrator, Director of Nursing, and Corporate Educator. The DON stated they identified the problem (no GDRs) and presented it in Quality Assurance but had no information to present to the survey team prior to the team exiting the facility.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		

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Based on general observation of the nursing facility, staff interviews, the facility failed to ensure medications were labeled and stored in accordance with currently accepted professional principles in 1 out of 8 facility medication carts.

The facility staff failed to ensure one *Humalog (insulin) vial was dated once open and one Humalog vial was removed from medication cart once expired.

*Humalog is a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours. Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood (https://www.drugs.com/humalog.html).

On 5/22/18 at approximately 12:25 p.m., this surveyor inspected the medication cart on Unit 2 (Front Hall) with LPN #1. During the inspection of the insulin stored inside the medication cart; one Humalog vial was open with no open date and one Humalog vial dated open on 4/20/18 with an expiration date of 5/18/18 remained inside the cart. An interview was conducted with LPN #1 who stated, "The Humalog insulin vial should have been dated once open and the Humalog insulin should have been removed from the medication cart once it had expired."

An interview was conducted with Director of Nursing (DON) on at 5/23/18 at approximately 12:30 p.m., who stated, "I expect for the nurses to date all insulin's once open and to remove expired insulin from the medication cart."

The facility administration was informed of the finding during a briefing on 5/25/18. The facility

F 761 Label/Store Drugs and Biologicals

1. The "Humalog" insulin vial not labeled with an open date was discarded and replaced. The expired "Humalog" vial was removed from the medication care and discarded.
2. Residents receiving insulin have a potential to be affected.
3. The Staff Development Coordinator or designee will provide education to all licensed nursing staff regarding the policy for Drug Labeling, Storage, and Disposal.
4. Clinical Manager/ designee will audit 100% of Medication Carts to ensure that all opened vials of insulin are dated and expired insulin vials are discarded. Audits will be 5 times per week for four weeks, then monthly for two months to validate adherence to the established standards governing Drug labeling, Storage and Disposal. Findings will be reported to QAPI monthly for further review and recommendations.
5. Compliance Date: July 5, 2018

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F 761	Continued From page 40 did not present any further information about the findings. The facility's policy titled Life Care - Storage of Medications (Last Revision 2/15/18). Policy Statement: Medications, treatments, and biological are stored safely, securely, and properly following manufacture's recommendations or facility policy. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. -Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, unlabeled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reorder from the pharmacy if a current order exists The facility's policy titled Life-Care medication: Expiration Dates (9/11/17). -Clarify medications that are dated when opened. -Insulin: once opened, ALL insulin kept in the refrigerator or in the medication cart expires 28 days after opening.	F 761		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice	F 849		

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services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.

F 849 Hospice Services

1. A Hospice Service agreement was obtained between the Hospice Agency and the facility for resident #129.
2. Residents who are receiving Hospice Agency services have the potential to be affected.
3. A written agreement regarding the care and services between the facility and Hospice Agency was initiated and the Emergency Operations Plan was amended to include these services. The Staff Development Coordinator or designee will provide education to all licensed nursing staff on the policy and procedure regarding collaboration and coordination of care between Hospice Agency services and facility during emergent situations.
4. Facility Clinical Manager or designee will audit facility medical records for residents receiving Hospice Agency services weekly for two months to validate adherence to the established standards. Findings will be reported to QAPI monthly for further review and recommendations.
5. Compliance Date: July 5, 2018

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(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown

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source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.

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(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and review of the Hospice policy; the facility staff failed to ensure the Hospice Agency provided a written agreement describing the provision of services for 1 of 34 residents (Resident #129), in the survey sample.

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The facility staff failed to ensure the Hospice Agency provided the facility staff with the coordinated plan of care for Resident #129, to identify which services the Hospice Agency would provide, when the services would be provided, the communication process, and when or why the nursing facility staff should notify the Hospice Agency.

The findings included;

Resident #129 was originally admitted to the nursing facility 5/15/18 from an in-patient Hospice facility has never been discharged from the nursing facility. The current diagnoses included; dementia with major depressive disorder, cerebrovascular disease, contractures and multiple pressure ulcers.

No Minimum Data Set (MDS) assessment had been completed by the nursing facility for Resident #129.

Review of the May 2018 Physician's order Summary revealed an order dated 5/20/18 which read; Admit to (name of the hospice agency) service 5/16/18.

The facility's interim care plan dated 5/15/18 problem read; Adjustment to nursing home placement: transition from hospice house. The goal red; Adjust to nursing home placement as evidenced by positive verbal and non-verbal expressions. The interventions read; Evaluate

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mood by verbal and non-verbal expressions. Monitor for aberrant behavior. Encourage family involvement. Encourage small possessions from home. Medications as ordered by the physician.

Resident #129 was observed during the initial screening of residents on 5/22/18 at approximately 11:40 a.m., in a specialty bed, facing the doorway with her arms extended upwards. The resident's eyes were open and she looked at the surveyor as the surveyor spoke to her but; closed her eyes and didn't respond. The indwelling catheter bedside drainage bag was observed inside a dignity bag but it was heavy and touched the floor. Bilateral fall mats were also observed at bedside.

On 5/23/18 at approximately 10:20 a.m., Resident #129 was again observed in a specialty bed facing the doorway with her arms extended upwards. She was again dressed in a green striped hospital gown with a ponytail on top of her head. The surveyor again introduced herself to the resident and asked her name, slowly the resident stated her name but answered no further questions. Again the bedside drainage bag was observed inside a dignity bag which touched the floor. The bedside drainage bag contained 600 milliliters of cloudy tea colored urine.

An interview was conducted with Registered Nurse (RN) #1 on 5/24/18 at approximately 2:45 p.m. RN #1 stated she was unable to locate in the facility the requested hospice agency documents which describes Resident #129 diagnosis for admission to the hospice program, which disciplines would make visits and what services

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they would provide, the hospice plan of care and treatment plan, how and what the nursing facility staff was to communicate with the hospice staff, when and if to transfer the resident if a change in condition was identified. RN#1 then stated the Hospice Agency had been contacted and the information would arrive soon.

An interview was conducted with the Hospice Agency RN on 5/24/18 at approximately 4:25 p.m. The Hospice Agency RN stated the chief diagnosis for the resident's admission to hospice services was Alzheimer's dementia but upon review of the nursing facility order and diagnosis Alzheimer's dementia was not a diagnosis.

The Hospice Agency RN stated documents should have been available to the facility staff in the nursing facility and that will be done today. She also stated normally a communication book for family is kept at the residents bedside but; upon observation it was not there.

On 5/25/18 at approximately 10:00 a.m., Resident #129 was observed in a specialty bed dressed in a hospital gown with 1 ponytail on top of her head. The resident faced the door but didn't respond when spoken to. The indwelling catheter's bedside drainage bag was suspended and not touching the floor.

An interview was conducted with the Certified Nursing Assistant (CNA) #2 on 5/25/18 at approximately 10:00 a.m. CNA #2 stated she was assigned to Resident #129 that day and this was approximately the third time she was assigned to the resident. CNA #1 stated the resident answered simple questions when she desired to and required total care with all Activities of Daily

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Living (ADLs).

The CNA further stated she was aware the resident received hospice services but she was unaware when the Hospice agency staff would arrive. She further stated she was told by other CNA staff that the hospice CNA visits on the evening shift therefore; when the resident was assigned to her she provided services as she did for all residents.

CNA #2 also stated she was given a dress to put on Resident #129 that day but prior to that she had no clothing in her closet and hospital gowns were what she put on the resident. CNA #2 then stated she was instructed on 5/25/18 to get the resident up out of bed in the recliner chair provided.

The facility's Hospice agreement dated 5/15/18 read under; III. Initiation and Coordination of services:

B. Hospice shall furnish to HOME, at the time of the patient's admission, a copy of the patients plan of care, an assessment of the patient's and family needs, a current physical examination, the last visit note from the attending physician's office, orders for diet, medications, activity and treatments. Under the supervision Hospice, HOME shall implement the plan of care and will promptly communicate to Hospice any changes in the patient's condition which would necessitate a revision or alteration in the plan of care. Hospice shall promptly communicate orally or in writing any changes in the plan of care to HOME.

C. Hospice shall furnish to HOME the most recent plan of care specific to each hospice

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patient; Hospice election form and any advanced directives specific to each patient; physician certification, recertification of the terminal illness specific to each patient, names and contact information for Hospice personnel involved in the hospice care of each patient; instructions on how to access Hospice's 24 hour on call system; Hospice medication information specific to each patient; and Hospice physician and attending physician orders specific to each patient.

On 5/25/18 at approximately 5:55 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Educator. No additional information was provided.