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	495349	A. BUILDING _____ B. WING _____	C 06/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT CENTER	990 HOLSTON RD WYTHEVILLE, VA 24382

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/4/19 through 6/7/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/4/10 through 6/7/19. Corrections are required for compliance with the following Federal Long Term Care requirements. Complaints were investigated during the course of the survey. The Life Safety Code survey/report will follow. The census in this 137 certified bed facility was 99 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 3 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		7/19/19

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

Electronically Signed | 07/05/2019

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide a dignified dining experience for 3 of 25 residents (Resident # 87, Resident #62, and Resident #40) and failed to knock or announce themselves before entering residents rooms for 1 of 25 residents (Resident #17). The findings included: 1. The facility staff failed to provide a dignified dining experience for Resident #87. Resident	F 550	1. Nursing and Dietary staff were re-educated by Director of Nursing (DON) on 6/24/19 regarding the centers process of serving meals to residents who need assistance with feeding to ensure residents are served their meals at the same time as their roommate to enhance a dignified dining experience. Identified residents were interviewed on their dining location preference and accommodations were made. Current staff were also re-educated on Centers process of serving meals simultaneously to	

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F 550	Continued From page 2 #87's roommate (Resident # 105) was served breakfast 30 minutes before Resident #87 received his tray. Resident #87's roommate completed breakfast before the resident received his breakfast tray. Resident #87 stated the breakfast was cold when the tray arrived. The clinical record of Resident #87 was reviewed 6/4/19 through 6/7/19. Resident #87 was admitted to the facility 5/3/17 with diagnoses that included but not limited to flaccid hemiplegia affecting right dominant side, epilepsy, quadriplegia, chronic pain, anemia, hyperlipidemia, dementia without behavioral disturbances, and seborrheic dermatitis. Resident #87's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/7/19 assessed the resident with a BIMS (brief interview for mental status) as 6/15. No signs or symptoms of delirium, psychosis, or behaviors that affected others. Resident #87 was totally dependent on one person for eating and had impairments in range of motion in all 4 extremities. Resident #87's current comprehensive care plan identified the potential for weight changes due to varied intakes r/t (related to) dx (diagnosis) hemiplegia, dementia initiated 5/9/19. Approaches: Assist me with meals prn (as needed). The surveyor observed the nursing staff deliver resident's breakfast trays on 6/5/19 beginning around 7:30 a.m. The surveyor observed Resident #87's roommate had already received his breakfast at 7:30 a.m. and was in the process of eating. The surveyor interviewed licensed	F 550	roommates to enhance a dignified dining experience by Food Services Manager on 7/3/19. (b) CNA #1 was re-educated by the DON on 6/10/19 on resident rights and dignity to include knocking and announcing themselves prior to entering any resident□s room. No negative clinical outcome has been identified for Resident #17. 2. Quality Monitoring completed by the DON/designee of residents requiring assistance with feeding on 6/10/2019 to ensure staff are serving both roommates meals simultaneously and providing any assistance as needed with feeding to provide an enhanced dining experience. Follow up as indicated. (b) Quality Monitoring completed by the DON/designee of current resident rooms to ensure staff are knocking and announcing themselves prior to entering the resident□s room to ensure the preservation of resident□s rights and dignity. Follow up as indicated. 3. DON or designee to re-educated current nursing and dietary staff on proper meal delivery service process to ensure a dignified dining service program. (b) Administrator or designee re-educated current center staff on resident□s rights and dignity to include knocking on doors and announcing their selves prior to entering.	

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F 550	Continued From page 3 practical nurse #1 on 6/5/19 at 7:34 a.m. and asked where Resident #87's tray was and she responded, "He is a feeder." At 8:00 a.m., Resident #87 had not received the breakfast tray and the roommate was finished with breakfast. At 8:04 a.m., Resident #87 received the breakfast tray. Certified nursing assistant #1 (C.N.A. #1) did ask what the resident wanted first but stood at the bedside towering over him. Resident received large portions of scrambled eggs, hash browns, tomatoes, oatmeal with sugar, milk and water. Resident #87 requested coffee with the meal. At 8:15 a.m., when C.N.A. #1 returned with the coffee, she assisted the resident with the meal. The surveyor asked Resident #87 about the meal and the response "Food is cold." No offer was made to reheat the food. Resident #87's diet orders included mechanical soft diet with mighty shakes at lunch and dinner. The unit secretary provided the surveyor with a list of residents who need assistance with feeding on 6/6/19 at 4:44 p.m. Resident #87 was listed. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above observation and concern on 6/7/19 at 12:00 p.m. No further information was provided prior to the exit conference on 6/7/19. 2. The facility staff failed to provide a dignified dining experience for Resident #40. Resident #40's roommate was served breakfast before the resident received her breakfast tray. Resident	F 550	4. Administrator/designee conduct Dignity Observation monitoring to ensure staff are knocking and introducing themselves prior to entering resident rooms 5 times weekly x4 weeks, weekly x 8 weeks then monthly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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#40 observed the roommate eat breakfast while she waited for the tray to be served.

The clinical record of Resident #40 was reviewed 6/4/19 through 6/7/19. Resident #40 was admitted to the facility 1/18/17 and readmitted 2/17/19 with diagnoses that included but not limited to hemiplegia affecting left non-dominant side, mood disorder, type 2 diabetes mellitus, major depression, anxiety, sacral pressure ulcer, stage 4, urinary tract infection with extended spectrum beta lactamase resistance (ESBL), subacute osteomyelitis of left ankle and foot, hypertension, iron deficiency anemia, peripheral vascular disease, conduct disorder, and edema.

Resident #40's significant change in assessment minimum data set (MDS) with an assessment reference date (ARD) of 3/4/19 assessed the resident with a BIMS (brief interview for mental status) as 13/15 and without signs or symptoms of delirium, or behaviors affecting others or psychosis.

Resident #40's current comprehensive care plan identified the focus area of the need for a therapeutic diet of CCD (consistent carbohydrate diet) related to DM2 (diabetes mellitus type 2). Approaches: Assist with meals prn (as needed).

Resident #40's June 2019 diet orders read "Mechanical soft, no added salt, CCD, divided plate, weighted utensils, Sipper cup."

The surveyor observed the staff deliver the breakfast trays on 6/5/19 beginning at 7:30 a.m. Resident #40 was observed around 7:35 a.m. and the breakfast tray had not yet been delivered. At 7:48 a.m., the unit secretary delivered the

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roommate's tray and began feeding the roommate. Resident #40 did not have a breakfast tray. Resident #40 stated the food will probably be cold. It usually is.

06/05/19 08:02 AM The unit secretary finished feeding the roommate, left the room, walked down the hall and returned with Resident's 40's tray.

Resident #40 received her breakfast tray at 8:09 a.m. and the unit secretary began feeding the resident. The resident stated the food was cold and she didn't like hash browns. No offer was made to reheat the food.

The unit secretary provided the surveyor with a list of residents who need assistance with feeding on 6/6/19 at 4:44 p.m. Resident #40 was listed.

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above observation and concern on 6/7/19 at 12:00 p.m.

No further information was provided prior to the exit conference on 6/7/19.

3. The facility staff failed to provide a dignified dining experience for Resident #62. Resident #62's roommate was served breakfast before the resident's tray was delivered. Resident #62 observed the roommate eat breakfast while she waited for her tray to be served.

The clinical record of Resident #62 was reviewed 6/4/19 through 6/7/19. Resident #62 was admitted to the facility 11/18/11 and readmitted 8/26/17 with diagnoses that included but not

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limited to pulmonary embolism, mild protein malnutrition, gastro-esophageal reflux disease, anxiety, depression, hypokalemia, chronic obstructive pulmonary disease, irritable bowel syndrome, constipation, and chronic kidney disease, stage 3.

Resident #62's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/18/19 assessed the resident with a BIMS (brief interview for mental status) as 13/15. No signs or symptoms of behaviors affecting others, delirium, or psychosis. Resident #62 was assessed to need supervision of one person for eating.

Resident #62's current comprehensive care plan identified the resident's BMI (body mass index) indicated obesity with expected weight and fluid fluctuations while on diuretics. Has a history of stomach ulcers and can't eat spicy foods. Approaches: Assist with meals prn (as needed).

The surveyor observed Resident #62 on 6/5/19 at 7:37 a.m. Resident #62 was sitting in bed and waiting for breakfast. During the interaction, the surveyor observed Resident #62's roommate had already received a tray and was eating with 50% already eaten.

The surveyor observed the admission coordinator deliver Resident #62's tray at 7:51 AM. Resident #62 received a regular diet of prunes, mixed fruit, and dry cereal and milk. All food items were in bowls. Roommate had finished breakfast by the time Resident #62 received her breakfast tray.

The unit secretary provided the surveyor with a list of residents who need assistance with feeding

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on 6/6/19 at 4:44 p.m. Resident #62 was listed.

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above observation and concern on 6/7/19 at 12:00 p.m.

No further information was provided prior to the exit conference on 6/7/19.

4. The facility staff failed to knock on the door or announce themselves prior to entering Resident #17's room.

The clinical record of Resident #17 was reviewed 6/4/19 through 6/7/19. Resident #17 was admitted to the facility 3/23/18 with diagnoses that included but not limited to multiple sclerosis, urinary tract infection, cellulitis and abscess of the mouth, major depressive disorder, chronic pain syndrome, anxiety, insomnia, slow transit constipation, tobacco use, nicotine dependence, iron deficiency anemia, and dysuria.

Resident #17's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/12/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

The surveyor was interviewing Resident #17 on 6/5/19 at 2:55 p.m. During the interview, certified nursing assistant #1 entered the room, asked the resident if she had seen another staff member and then exited the room. C.N.A. #1 did not knock on announce self before entering the resident's room. Resident #17 stated that happened all the time and that it was a concern.

The concern of staff not knocking on resident's

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F 550	Continued From page 8 doors before entering was discussed with the administrator, the director of nursing, and the corporate registered nurse on 6/7/19 at 12:00 p.m. Each stated staff should knock before entering a resident's room. No further information was provided prior to the e exit conference on 6/7/19.	F 550		
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) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		7/19/19

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F 580	Continued From page 9 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 and clinical record review the facility staff failed to notify the physician of a change in condition and failed to inform a resident that he would not receive ferrous sulfate during his morning medication pass for 2 of 25 residents in the survey sample (Residents #17 and #59). The findings included: 1. The facility staff failed to inform the physician of a change in condition when medication (Methadone) was not available for Resident #17. The clinical record of Resident #17 was reviewed 6/4/19 through 6/7/19. Resident #17 was admitted to the facility 3/23/18 with diagnoses,	F 580	1. Resident #17□s physician was notified on 6/7/19 by the DON regarding missed doses of medication (Methadone) as identified in the 2567 with no new orders noted. Resident #59 was notified on 6/5/19 that he did not receive his ferrous sulfate and that his physician was also notified. Resident #59 was notified physician gave an order to hold medication during morning med pass on 6/5/19. LPN #1 was re-educated by the DON on 6/7/19 on resident□s rights to be informed of any changes to the resident plan of care. 2. Quality review of the clinical reports	

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F 580	Continued From page 10 that included but not limited to multiple sclerosis, urinary tract infection, cellulitis and abscess of the mouth, major depressive disorder, chronic pain syndrome, anxiety, insomnia, slow transit constipation, tobacco use, nicotine dependence, iron deficiency anemia, and dysuria. Resident #17's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/12/19 assessed the resident with a BIMS (brief interview for mental status) Summary Score as 15/15. Resident #17's current comprehensive care plan identified the resident to be at risk for pain and/or discomfort initiated 4/2/18. Approaches: My nurse will administer and monitor effectiveness and for possible side effects from medication I receive. During the interview with Resident #17 on 6/5/19, the resident stated there had been times when methadone ordered was not available to give. The resident was unable to recall the exact dates but stated the incident had occurred recently. The surveyor reviewed the March 2019, April 2019 and May 2019 progress notes and the March 2019 medication administration records (MARs), April MARs and May MARs. The April 2019 Methadone 10 mg (milligrams), MAR had "N" in the box dated 4/18/19 at 6:00 a.m. and 1:00 p.m. The administrative notes dated 4/18/19 6:17 a.m. read "Methadone HCl 10 mg tablet Give 2 tablet ...scheduled for 04/18/2019 6:00 a.m. Not available from the pharmacy and the note dated 4/18/19 at 2:06 p.m. read "Methadone HCl 10 mg tablet Give 2 tablet ...scheduled for 04/18/19 1:00 PM was not administered."	F 580	for the previous 72 hours (6/25/19 through 6/28/19) were completed by the DON/designee for compliance with physician notification of unavailable medications. Follow up as indicated. (b) Quality review of the clinical report for the previous 72 hours has been completed by the DON/designee (6/25/2019 through 6/28/19) to evaluate compliance with documentation of resident and/or resident representative notification related to medication hold orders. Follow up as indicated. 3. DON or designee re-educated current licensed nursing staff on the requirement to notify physician, or nurse practitioner for changes in resident condition to include unavailable medications for administration. (b) DON or designee re-educated current licensed nursing staff on requirements to notify resident and/or resident representative for any changes of condition to include orders to hold medication(s). 4. Quality monitoring to be completed by the DON/designee regarding reviewing the clinical report during the morning clinical meeting 5 times weekly x4 weeks, then weekly and PRN as indicated to ensure physician or nurse practitioner, resident and/or resident representative is notified of changes in condition to include unavailable medications. Findings to be reported to QAPI committee monthly and	

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F 580	Continued From page 11 A review of the April 2019 progress notes did not reveal that the physician was made aware of the medication not administered. The surveyor interviewed the director of nursing (DON) on 6/6/19 at 10:29 a.m. about notification to the physician when Methadone was not available for administration on 4/18/19. The DON was asked if Resident #17's pain physician was informed that Methadone was not available on 4/18/19 for two (2) administrations of missed Methadone. The DON stated the staff usually call the facility physician because "we can get orders for breakthrough pain." The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above issue on 6/7/19 at 12:00 p.m. and requested the facility policy on change of condition. The surveyor reviewed the facility policy titled "Change in a Resident's Condition or Status" on 6/7/19. The policy 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." No further information was provided prior to the exit conference on 6/7/19. 2. The facility staff failed to inform Resident # 59 that he would not receive ferrous sulfate during his morning medication pass. Resident # 59 was a 94-year-old male who was admitted to the facility on 10/23/13, with a readmission date of 1/10/17. Diagnoses included	F 580	updated as indicated. Quality monitoring schedule modified based on findings.	

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but were not limited to, hypertension, hypokalemia, failure to thrive, and bronchitis.

The clinical record for Resident # 59 was reviewed on 6/5/19 at 11:23 am. The most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 4/16/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 59 had a BIMS (brief interview for mental status) score of 8 out of 15, which indicated that Resident # 59's cognitive status was moderately impaired.

The current plan of care for Resident # 59 was reviewed and revised on 4/19/19. The facility staff documented a focus area for Resident # 59 as, "I have a diagnosis of anemia." Interventions included but were not limited to, "Administer my medication per medical order."
The current orders for Resident # 59 was signed by the physician on 6/3/19. Resident # 59 had current orders that included but was not limited to, "Ferrous sulfate 325 mg (milligram) tablet one by mouth everyday."

On 6/5/19 at 8:07 am, the surveyor was conducting a medication pass observation with LPN # 1 (licensed practical nurse). During the medication pass observation for Resident # 59, LPN # 1 stated, "I don't have his ferrous sulfate." "I need to call the doctor."

On 6/5/19 at 8:15 am, the surveyor observed LPN # 1 as she called the physician for Resident # 59 and made the physician aware that Resident # 59 was out of ferrous sulfate. LPN # 1 was given a telephone order to hold ferrous sulfate until it

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F 580	Continued From page 13 came in. On 6/5/19 at 8:20 am, the surveyor entered Resident # 59's room along with LPN # 1. The surveyor observed LPN # 1 as she administered medications to Resident # 59. The surveyor observed that LPN # 1 did not inform Resident # 59 that his ferrous sulfate had been put on hold until it came into the facility. On 6/5/19 at 4:36 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 6/7/19.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		7/19/19

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F 584	Continued From page 14 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure a clean, comfortable, homelike environment for 1of 25 residents (Resident #26). The findings included: The facility staff failed to ensure Resident #26's Broda chair was clean. The clinical record of Resident #26 was reviewed 6/4/19 through 6/7/19. Resident #26 was admitted to the facility 12/30/15 with diagnoses that included but not limited to Alzheimer's disease, orthostatic hypotension, pain, anxiety, syncope and collapse, adult failure to thrive,	F 584	1. Resident #26□s broda chair was thoroughly cleaned on 6/7/19 as well as all other wheelchairs and specialty chairs that were identified as needing to be cleaned. 2. Residents who require the use of wheelchairs, broda chairs and specialty chairs were checked on 6/5/2019 through 6/6/2019 by the Unit Managers (UMs) and Maintenance Director to ensure equipment is clean, free of rust and in good repair. Follow up as indicated. Equipment cleaning list was reviewed for accuracy Administrator/Designee and included current resident equipment in	

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F 584	Continued From page 15 irritable bowel syndrome without diarrhea, and unspecified mood. Resident #26's quarterly 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 2/15. The surveyor observed Resident #26 during the initial tour on 6/4/19 at 2:30 p.m. The resident was observed sitting in the dining room in a Broda chair. The surveyor observed both armrests with food debris on them. The surveyor observed Resident #26 during breakfast on 6/5/19 at 8:00 a.m. Resident #26 was feeding self in the dining room from bowls where the food was placed. Licensed practical nurse #2 was in attendance. The surveyor observed Resident #26 sitting in the Broda chair on 6/5/19 at 9:06 a.m. Both armrests had multiple areas of dried food and white spots were observed on the right armrest near the end. During the observation, the surveyor observed the resident spit multiple times on the floor. Dried food particles observed on the lower right side of the chair and in the seat. Resident #26 was observed in bed on 6/5/19 at 4:20 p.m. A second surveyor observed dried cheerios on top of the seat cushion along with some type of mashed up food, white spots on the right armrest and dried brown food on the right lower side of the chair. Both sides of the upper Broda frame appear to have rust like discoloration.	F 584	center. 3. The Administrator/designee re-educated current nursing and maintenance department staff on the center process for cleaning resident equipment to include list of equipment specifying when and by whom it will be cleaned. 4. The Administrator / designee to perform quality monitoring of equipment cleanliness of resident□s wheelchairs, broad chairs, and specialty chairs weekly x4 weeks then monthly and PRN as indicated to ensure equipment is clean and in good repair. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 584	Continued From page 16 Resident #26 was observed on 6/6/19 at 8:04 a.m. in the dining room. Breakfast had been completed. Broda chair remained dirty with dried food located on right side of chair (lower part), dirty armrests, and rusted areas on right upper frame. The surveyor showed the Broda chair with the dried food on the armrests, the dried food on the right lower side and the rust appearing areas on both sides of the upper chair frame to MDS/LPN #2 on 6/06/19 at 8:17 a.m. The surveyor asked the unit secretary on 6/06/19 at 8:32 a.m. if there was a facility list for the cleaning of resident's equipment. The unit secretary provided the surveyor with a cleaning list for wheelchairs and walkers. Resident #26's day for cleaning was Tuesday. The unit secretary stated 11-7 was responsible for cleaning the wheelchairs and walkers. The unit secretary stated it looked like that wasn't done this week. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 6/7/19 at 12:00 p.m. No further information was provided prior to the e exit conference on 6/7/19.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		7/19/19

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F 641	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to ensure accuracy of Minimum Data Set assessments for 2 of 26 residents in the survey sample (Resident #104 and supplemental resident #1). 1. For Resident #104, facility staff failed to ensure the admission minimum data set assessment accurately documented hospice and hemodialysis status. Resident #104 was admitted to the facility on 6/05/19 04:05 PM. Diagnoses included hypertension, end stage Alzheimer's disease, malnutrition, anxiety, and depression. On the admission Minimum Data Set assessment with Assessment Reference Date 5/20/19, the resident was assessed with short and long-term memory deficits, severely impaired decision-making ability, fluctuating signs of delirium, and without signs of psychosis or delirium. The resident was admitted with an order for hospice (5/9/19). The MD'S was not coded for hospice. The MD'S was coded for dialysis. The resident did not have an order for hemodialysis or a renal failure diagnosis. The administrator and director of nursing were notified of the concern during a summary meeting on 6/7/19. 2. For Supplemental resident #1, facility staff failed to submit a discharge Minimum Data Set assessment.	F 641	1. Resident #104□s MDS was corrected and submitted on 6/7/19 by the MDS Coordinator. (b) A discharge minimum data set assessment for supplemental resident #1 was completed and submitted on 6/7/29 by the MDS Coordinator. 2. Quality review of Admission minimum data set assessments on or after June 1, 2019 completed by the MDS Coordinator for section O accuracy with any corrections needed completed and submitted accordingly. Follow up as indicated. (b) Quality review of residents discharged on or after June 1, 2019 MDS□s completed by the Regional Director of Reimbursement on 6/10/2019 to ensure a discharge minimum data set assessment has been completed and submitted accordingly. Follow up as indicated. 3. The Regional Director of Reimbursement/designee re-educated current MDS Coordinator□s regarding the accuracy of completion of minimum data set assessment section O; special treatments, procedure□s, and programs. (b) The Regional Director of Reimbursement/designee re-educated the current MDS Coordinator□s regarding the need to complete and submit a minimum data set assessment upon discharge.	

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F 641	Continued From page 18 The resident was admitted on 1/6/19 and discharged on 1/10/19. Minimum Data Set entry assessment was submitted for 1/6/19 and another entry assessment was entered on 1/10/19. The administrator and director of nursing were notified of the concern during a summary meeting on 6/7/19.	F 641	4. The MDS Director/designee to conduct quality monitoring of MDS Admission Assessments of newly admitted residents weekly x4 weeks then monthly and PRN as indicated to ensure admission minimum data set assessments are coded correctly in section O. (b) The MDS Director/designee to conduct quality monitoring of resident□s MDS Discharge Assessments weekly x 4 weeks then monthly and PRN as indicated to ensure discharge minimum data set assessments are completed and submitted timely. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	
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- (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	F 657		7/19/19

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F 657	Continued From page 19 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 clinical record review and staff interview, the facility staff failed to review and revise the comprehensive plan of care for 1 of 26 Residents in the survey sample, Resident # 41. The findings included: The facility staff failed to review and revise the comprehensive plan of care for Resident # 41 to include port-a-cath. Resident # 41 was a 78-year-old-female who was admitted to the facility on 12/15/17, with a readmission date of 5/31/18. Diagnoses included but were not limited to, chronic kidney disease, vitamin E deficiency, atrial fibrillation, and heart failure. The clinical record for Resident # 41 was reviewed on 6/4/19 at 1:37 pm. The most recent MDS (minimum data set) assessment for Resident # 41 was a quarterly assessment with an ARD (assessment reference date) of 4/4/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 41 had a BIMS (brief	F 657	1. Resident #41□s care plan was revised and updated on 6/6/19 by the MDS Coordinator to include porta-cath. 2. Quality review of current residents with a central venous access in place was conducted on 6/10/2019 by the DON to ensure the care plan is accurate and reflects access currently present. Follow up as indicated. 3. Regional Director of Reimbursement re- educated current MDS staff on care plan creation, revision and updating to reflect the presence of any type of central venous device. (b) DON/designee re-educated current licensed nursing staff on the proper policy and procedure for updating and revising resident care plans to reflect the presence of any type of central venous catheter. 4. Director of MDS/designee to conduct	

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F 657	Continued From page 20 interview for mental status) score of 12 out of 15, which indicated that Resident # 41's cognitive status was moderately impaired. Resident # 41 had orders that included but were not limited to, "Flush port every month on," which was signed by the physician on 5/2/19. The surveyor observed that the order did not specify what to flush the port with, the amount that was to be flushed, or the date that the port was supposed to be flushed. The current plan of care for Resident # 41 was reviewed and revised on 4/5/19. Upon review of the plan of care for Resident # 41, the surveyor observed that the current plan of care for Resident # 41 did not address that Resident # 41 had a port-a-cath. On 6/6/19 at 3:57 pm, the surveyor and MDS nurse # 1 reviewed the plan of care for Resident # 41 along with the surveyor. MDS nurse # 1 agreed that the plan of care for Resident # 41 did not address that Resident # 41 had a port-a-cath. On 6/6/19 at 4:36 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/7/19.	F 657	quality monitoring of 10 care plans to include residents with central venous catheters weekly x 4 weeks then monthly and PRN as indicated to ensure current physician orders and interventions are reflected in the care plan. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		7/19/19

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F 677	Continued From page 21 by: Based on observation, resident interview, family interview, staff interview and clinical record review, the facility staff failed to provide nail care to 1 of 25 dependent residents (Resident #62). The findings included: The facility staff failed to provide nail care to Resident #62. The clinical record of Resident #62 was reviewed 6/4/19 through 6/7/19. Resident #62 was admitted to the facility 11/18/11 and readmitted 8/26/17 with diagnoses that included but not limited to pulmonary embolism, mild protein malnutrition, gastro-esophageal reflux disease, anxiety, depression, hypokalemia, chronic obstructive pulmonary disease, irritable bowel syndrome, constipation, and chronic kidney disease, stage 3. Resident #62's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/18/19 assessed the resident with a BIMS (brief interview for mental status) Summary Score as 13/15. No signs or symptoms of behaviors affecting others, delirium, or psychosis. Resident #62 was assessed to require extensive assistance of one person for personal hygiene and was dependent on one staff for bathing. Resident #62's current comprehensive care plan identified the resident to need assistance with self-care. Required extensive assistance with ADLs (activities of daily living). Approaches: Staff will assist me with ADLs prn (as needed) for safety/task completion. In the margin was	F 677	1. Resident #62 fingernails were cleaned and trimmed on 6/5/19 by the Unit Manager. 2. DON and Unit mangers conducted a quality review of current resident□s nails on 6/28/19 to ensure fingernails were trimmed and cleaned. Follow up as indicated. 3. Director of Nursing/designee re-educated current licensed nurses and certified nursing staff on fingernail care to include proper assessment of nails and regarding cleaning and trimming as indicated. 4. DON/designee to conduct quality monitoring of resident□s finger nail care weekly x 8 weeks then monthly and PRN as indicated to ensure fingernails are clean and trimmed. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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written: "Poorly motivated in self-care". Initialed by someone but not dated.

The surveyor interviewed Resident #62 on 6/5/19 at 9:40 a.m. She stated that she usually gets bed baths instead of showers. Described an incident where she hurt after the male certified nursing assistant helped her with a shower. The surveyor observed Resident #62's nails on both hands. Under each fingernail, the surveyor observed brown debris. The surveyor was unclear as to what the brown debris might be.

The surveyor observed Resident #62 again on 6/5/19 at 10:20 a.m. Resident's nails remain with dark brown debris under each nail.

Resident #62's nails checked again on 6/5/19 prior to lunch. Nails remain with brown debris under each nail.

Resident #62 observed on 6/5/19 at 4:05 p.m. Resident #62 stated the staff had given her a bed bath. Resident #62 was asked if the aide had cleaned her nails. She looked at them and said "no." The surveyor observed the resident had a change of clothes but each nail remained with the brown debris under the nails.

The surveyor interviewed certified nursing assistant #3 and certified nursing assistant #4 on 6/5/19 at 4:06 p.m. The C.N.A.s were asked what was done when a resident received a complete bed bath. C.N.A. #3 stated hair shampooed, perineum washed, and nail care done. C.N.A. #1 stated Resident #62 was given a bed bath after lunch. Her hair was washed, perineum, back, and nails cut and cleaned. C.N.A. #3 was asked to check Resident #62's

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(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 677	Continued From page 23 nails with the surveyor. C.N.A. #3 stated she hadn't done the nails. C.N.A. #5 was supposed to do the nails. The surveyor showed the daughter Resident #62's nails. The daughter stated that her mother ate a lot of chocolate and messes with her bowels. "Could be either?" she stated. The surveyor discussed and showed the nails to the unit manager on 6/05/19 4:08 p.m. The unit manager had no comment. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 6/7/19 at 12:00 noon. No further information was provided prior to the exit conference on 6/7/19.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to follow the bowel protocol for 1 of 25 residents (Resident #17).	F 684	1. Resident #17 had a bowel movement on 6/5/2019 and has had regular bowel movements since. There were no negative clinical outcomes identified.	7/19/19

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F 684	Continued From page 24 The findings included: The facility staff failed to follow the bowel protocol for bowel management for Resident #17. The clinical record of Resident #17 was reviewed 6/4/19 through 6/7/19. Resident #17 was admitted to the facility 3/23/18 with diagnoses, that included but not limited to multiple sclerosis, urinary tract infection, cellulitis and abscess of the mouth, major depressive disorder, chronic pain syndrome, anxiety, insomnia, slow transit constipation, tobacco use, nicotine dependence, iron deficiency anemia, and dysuria. Resident #17's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/12/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Section H assessed that the resident was always incontinent of bowel. Bowel Patterns was marked that constipation was present. Resident #17's current comprehensive care plan identified the focus area that read, "I am at risk for constipation." Approaches: Initiate standing orders for constipation on the third day of no bowel movement. Record bowel movements as occurs. The surveyor interviewed Resident #17 on 6/5/19 at 2:51 p.m. The resident was asked if she were on a bowel-training program. The resident stated she was not but was incontinent of bowel but thought she might benefit from using a bedside commode instead. The surveyor reviewed the March 2019 through	F 684	2. DON and Unit managers conducted a quality review of current residents on 6/28/19 to ensure residents have not gone greater than 3 days without a bowel movement and that a proper medical intervention has been implemented per bowel management protocol. 3. DON/designee re-educated current licensed nursing staff beginning on the Bowel management program and following appropriate physician orders for residents who have not had a bowel movement in greater than 3 days. 4. DON/designee to conduct quality monitoring of clinical Bowel Movement report documentation during morning clinical meeting daily 5 times weekly x 8 weeks, 3x weekly x4 weeks then weekly and PRN as indicated to ensure residents who are identified as having no bowel movement for greater than 3 days have had proper medical intervention. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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May 2019 bowel movement detail report. The report documented Resident #17 did not have a bowel movement from 3/11/19 through 3/20/19-a total of 10 days; from 3/25/19 through 3/31/19-a total of 7 days; from 4/2/19 through 4/5/19-a total of 4 days; from 4/30/19 through 5/8/19-a total of 9 days; and from 5/27/19 through 6/1/19-a total of 6 days.

The surveyor reviewed the March 2019 electronic medication administration record (eMAR), the April 2019 eMAR, and the May 2019 eMAR. There was no documentation that Resident #17 received any of the standing order options or the orders the resident had for constipation on the physician's orders (Dulcolax 10 mg suppository 1 supp rectally every day as needed-start date 6/20/18).

The surveyor requested the bowel protocol from the director of nursing (DON) on 6/5/19 at 9:51 a.m. The DON stated to ask licensed practical nurse #3 for the bowel protocol.

The surveyor interviewed L.P.N. #3 on 6/6/19 at 9:52 a.m. about the bowel movement protocol. L.P.N. #3 stated if no BM x 3 days, give MOM then stated she would bring the protocol to the surveyor.

The surveyor received the bowel protocol from L.P.N. #3 on 6/6/19 at 10:09 AM. L.P.N. #3 stated the BM list was checked every day. "These are old school nurses they should know."

The surveyor reviewed the Physician Standing Orders on 6/6/19. The standing orders included one for GI (gastrointestinal) problems and read "Constipation: These are the steps to follow in

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F 684	Continued From page 26 the order given: If no bowel movement in 3 days: 1. MOM (milk of magnesia) 30 cc (cubic centimeters) po (by mouth) qd (every day) prn (as need) for constipation-If no results within 8-12 hours, do suppository. 2. Bisacodyl 10 mg (milligrams) suppository (Dulcolax) 1 PR (per rectum) qd prn for constipation if no results within 8-12 hours do enema. 3. Notify MD (medical doctor) for further instructions after steps 1 and 2 if unsuccessful." The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 6/7/19 at 12:00 p.m. No further information was provided prior to the exit conference on 6/7/19.	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;	F 690		7/19/19

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F 690	Continued From page 27 (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 interview, facility document review, and clinical record review, the facility staff failed to follow the physician's orders for 1 of 25 residents (Resident #40) for the care of an indwelling Foley catheters. The findings included: The facility staff failed to ensure Resident #40 received the appropriate size of Foley catheter. The clinical record of Resident #40 was reviewed 6/4/19 through 6/7/19. Resident #40 was admitted to the facility 1/18/17 and readmitted 2/17/19 with diagnoses that included but not limited to hemiplegia affecting left non-dominant side, mood disorder, type 2 diabetes mellitus, major depression, anxiety, sacral pressure ulcer, stage 4, urinary tract infection with extended	F 690	1. Resident #40 Foley catheter inserted per physician order on 6/7/19 by a licensed Charge Nurse. 2. Quality review of current residents with physician orders for Foley catheters completed 6/28/19 by DON and Unit Manger to ensure bulb size and size of the Foley catheter was present per physician order. Follow up as indicated. 3. DON/designee re-educated current licensed nursing staff on Foley catheter insertion per physician order to include ensuring available supplies prior to changing or inserting a new Foley catheter.	

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F 690	Continued From page 28 spectrum beta lactamase resistance (ESBL), subacute osteomyelitis of left ankle and foot, hypertension, iron deficiency anemia, peripheral vascular disease, conduct disorder, and edema. Resident #40's significant change in assessment minimum data set (MDS) with an assessment reference date (ARD) of 3/4/19 assessed the resident with a BIMS (brief interview for mental status) as 13/15 and without signs or symptoms of delirium, or behaviors affecting others or psychosis. Section H was coded for the presence of an indwelling catheter. The current comprehensive care plan identified the focus area that read "I was admitted with indwelling catheter [dx (diagnosis): neurogenic bladder]. Approaches: Change my catheter tubing/bag as appropriate." The surveyor interviewed Resident #40 on 6/4/19 at 3:17 p.m. The resident stated she had a Foley catheter because of the sacral ulcer. The surveyor requested to watch wound care. Resident #40 stated she did not want the surveyor to observe. When asked if the Foley was anchored, Resident #40 stated yes. The surveyor asked Resident #40 if the nurse could check the size of the catheter to which she stated yes. The surveyor and licensed practical nurse #4 checked the size of the Foley catheter. L.P.N. #4 and the surveyor checked the size of the Foley catheter. Neither L.P.N. #4 nor the surveyor were able to read the size. The only number visible was a "1". L.P.N. #4 stated the Foley catheter was changed 6/3/19 because L.P.N. #4 had done the change.	F 690	4. DON/designee to conduct quality monitoring of Foley Catheters weekly x4 weeks then monthly and PRN as indicated to ensure residents with Foley catheters have appropriate size inserted per physician orders. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 690	Continued From page 29	F 690		

The June 2019 physician's orders were reviewed. Resident #40's orders read, "Foley catheter, 16 Fr (French) with 10 cc (cubic centimeters) balloon to be changed as needed due to leakage or being dislodged."

L.P.N. #4 stated the Foley catheter insertion kits in the supply rooms were 18 Fr/5 cc balloon and insert 10 cc sterile water into the balloon. L.P.N. #4 stated the 18 Fr/5cc insertion kit was used when Resident #40's Foley was changed 6/3/19. The surveyor and L.P.N. #4 checked the cabinets and drawers. There was a variety of catheter sizes but the balloon size was 5 cc-no 10 cc. The surveyor asked L.P.N. #4 if a charge had been made. L.P.N. #4 stated no. The 6/3/19 progress note written by L.P.N. #4 did not address the size of the catheter or the balloon size.

The surveyor and registered nurse #3 checked the supply room again on 6/5/19 at 12:15 p.m. The supply room had 2 insertion kits for Foley catheters that were 18Fr/5cc balloon. There were no insertion kits for 10 cc.

The surveyor interviewed the central supply clerk certified nursing assistant #1 on 6/5/19 at 12:30 p.m. The central supply clerk stated the supply rooms have 18 Fr/5 cc insertion kits but various sizes of catheters.

The surveyor interviewed the director of nursing (DON) on 6/7/19 at 8:45 a.m. The DON didn't quite understand what the issue was. The surveyor explained to the DON that Resident #40's June 2019 physician's orders were for the resident to have 16 Fr/10 cc balloon. The only insertion kits available were 18Fr/5cc balloon.

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F 690	Continued From page 30 The DON stated she understood and stated the facility probably was given a box of Foley insertion kits and they were using them up. The surveyor requested the facility policy on Foley catheters. The surveyor reviewed the facility policy titled "Orders for Indwelling Urinary Catheters and Catheter Care" on 6/7/19. Details of order: 2. The physician's order for an indwelling urinary catheter will be based on an appropriate medical justification, and will specify the type (Foley, suprapubic, 3-way), catheter size, and balloon capacity (in cubic centimeters) and other parameters, as indicated." The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 6/7/19 at 12:00 p.m. No further information was provided prior to the exit conference on 6/7/19.	F 690		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review, the facility staff failed to ensure that 1 of 26 Residents in the survey sample received port-a-cath care	F 694	1. Resident #41□s port-a Cath was assessed and flushed on 6/6/19 by a Registered Nurse. LPN #2 was counseled and re-educated on 6/6/19 by the	7/19/19

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F 694	Continued From page 31 consistent with professional standards of practice, Resident # 41. The findings included: a. The facility staff failed to follow physician's order to flush port-a-cath every month for Resident # 41. b. The facility staff failed to ensure that the port-a-cath for Resident # 41 was accessed and flushed by a Registered Nurse. c. The facility staff failed to ensure that Resident # 41's port-a-cath orders specified what the port-a-cath was to be flushed with, the amount that was to be flushed, and the date the port-a-cath was to be flushed on. Resident # 41 was a 78-year-old-female who was admitted to the facility on 12/15/17, with a readmission date of 5/31/18. Diagnoses included but were not limited to, chronic kidney disease, vitamin E deficiency, atrial fibrillation, and heart failure. The clinical record for Resident # 41 was reviewed on 6/4/19 at 1:37 pm. The most recent MDS (minimum data set) assessment for Resident # 41 was a quarterly assessment with an ARD (assessment reference date) of 4/4/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 41 had a BIMS (brief interview for mental status) score of 12 out of 15, which indicated that Resident # 41's cognitive status was moderately impaired. Resident # 41 had orders that included but were not limited to, "Flush port every month on," which was signed by the physician on 5/2/19. The	F 694	Regional Director of Operations regarding scope of practice for LPN□s and facility policy and procedure regarding MAR documentation. LPN #2 also counseled and re-educated on 6/6/19 by the Regional Director of Operations regarding port-a-Cath flushes, scope of practice, including policy titled Administering Medications. (b) Resident #41□s physician was notified by the Director of Nursing on 6/6/2019. Orders were obtained and updated on 6/6/19 to included what to flush port-a-cath with and specific date and time to be flushed. 2. Quality review of current Resident□s with venous implanted catheters, port-a caths was conducted on 6/28/19 by the DON to ensure physician orders for flushes were present to include date. Follow up as indicated. (b) Quality review of current Medication Administration Records (MARS) of residents with port-a caths conducted by the Director of Nursing to ensure that port-a-caths have been accessed only by RN□s. Follow up as indicated. (c) Quality review of physician orders for current residents with port-a caths completed by the DON to ensure the physician order is complete and specifies what the port-a-cath is to be flushed with, the amount that is to be flushed, and the date the port-a-cath is to be flushed with all irregularities addressed. Follow up as indicated.	

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F 694	Continued From page 32 surveyor observed that the order did not specify what to flush the port with, the amount that was to be flushed, or the date that the port was supposed to be flushed. The current plan of care for Resident # 41 was reviewed and revised on 4/5/19. Upon review of the plan of care for Resident # 41, the surveyor observed that the current plan of care for Resident # 41 did not address that Resident # 41 had a port-a-cath. On 6/4/19 at 1:59 pm, the surveyor reviewed the February 2019 medication administration record for Resident # 41. The documentation on the February 2019 medication administration record for Resident # 41 reflected that Resident # 41's port-a-cath had not been flushed during the month of February 2019. The surveyor reviewed the March 2019 medication administration record for Resident # 41. Upon review of the medication administration record for Resident # 41, the surveyor observed documentation that supported that Resident # 41's port-a-cath had been flushed two times during the month of March, on 3/1/19 and 3/31/19. The surveyor also observed the port-a-cath flush administration had been documented by a LPN (licensed practical nurse) on 3/1/19 and 3/31/19. The surveyor reviewed the April 2019 medication administration record for Resident # 41. Upon review of the medication administration record for Resident # 41, the surveyor observed that documentation reflected that Resident # 41's port-a-cath flush administration had been documented by LPN # 2 on 4/30/19.	F 694	3. DON/designee re-educated current licensed nursing staff on the facility policies Implanted Venous Port Accessing and Administering Medications. (b) DON/designee re-educated current licensed nursing staff regarding the Virginia Nurse Practice Act and the scope of practice for RNs (registered nurses) and LPNs regarding porta-cath access and medication administration. (c) DON/ designee re-educated current licensed nursing staff regarding writing/transcribing complete physician orders for the care and maintenance of port-a-cath sites and access. 4. DON/designee to conduct quality monitoring of medication administration records (MARS) of residents with port-acaths 5x weekly x 4 weeks, weekly x4 weeks, the monthly and PRN as indicated to ensure port-a-caths are flushed per physician order. (b) DON/designee to conduct quality monitoring of medication MARS of residents with port-acaths 5x weekly x4 weeks, weekly x4 weeks, then monthly and PRN as indicated to ensure a Registered Nurse access port-a-caths. (c) DON/ designee to conduct quality monitoring of physician orders for resident with port-a caths daily 5 x weekly x4 weeks, weekly x4 weeks, then monthly and PRN as indicated to ensure the physician order specifies what the port-a-cath is to be flushed with, the amount that is to be flushed, and the date	

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F 694	Continued From page 33 On 6/5/19 at 3:05 pm, the surveyor and LPN # 2 reviewed the April 2019 medication administration record for Resident # 41. The surveyor asked LPN # 2 if she had documented the port-a-cath flush administration for Resident # 41 on 4/30/19. LPN # 2 verified that the initials documented for Resident # 41's port-a-cath flush administration were her initials. LPN # 2 stated, "But I didn't flush it." The facility policy on "Administering Medications" contained documentation that included but was not limited to, ..."1. Only persons licensed or permitted by the state to prepare, administer, and document the administration of medications may do so. 22. The individual administering the medication initials the resident's MAR (medication administration record) on the appropriate line after giving each medication and before administering the next ones." ... The facility policy on "Implanted Venous Port-Accessing" contained documentation that included but was not limited to, ..."General Guidelines 1. Verify with state Nurse Practice Act the scope of practice for RNs (registered nurses) and LPNs regarding this procedure. Documentation 2. Document the flushing agent(s) and amount(s), medication or solution infused, and any topical anesthetic in the medication administration record." ... On 6/6/19 at 4:37 pm, the administrative team was made aware of the findings as stated above.	F 694	the port-a-cath is to be flushed on. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT CENTER	990 HOLSTON RD WYTHEVILLE, VA 24382

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F 694	Continued From page 34 No further information regarding this issue was presented to the survey team prior to the exit conference on 6/7/19.	F 694		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, Resident interview, facility document review, and clinical record review the facility staff failed to properly maintain oxygen equipment or to deliver the ordered dose for 3 of 26 Residents, Resident #52, Resident #59. and Resident #62). The findings included: 1. For Resident #52 the facility staff failed to ensure the Resident's C-PAP (continuous-positive airway pressure) mask was covered/bagged when not in use. Resident #52 was admitted to the facility on 01/30/18 and readmitted on 07/20/18. Diagnoses included but not limited to hypertension, urinary tract infection, diabetes mellitus, anxiety, depression, bipolar disorder, constipation, gastroesophageal reflux disease, sleep apnea, and obsessive-compulsive disorder.	F 695	1. Resident #52□s C-PAP mask was cleaned, bagged, and labeled per facility policy on 6/7/19 by the Assistant Director of Nursing (ADON). (b) On 6/5/19, Resident #59 nebulizer mask was replaced, bagged, and labeled by the Unit manager. Resident #59 was properly assessed prior to next scheduled administration of medication on 6/5/19. LPN #1 was re-educated on the proper administration of Pulmicort and resident assessment and on proper nebulizer mask cleaning and care per facility policy on 6/6/2019 before next medication pass by the Regional Director of Clinical Operations. (c) Resident #62 was examined and verified by DON to be set at 2LPM as per physician order on 6/7/19.	7/19/19

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F 695	Continued From page 35 The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/12/19 coded the Resident as 14 out of 15 in section C, cognitive patterns. This is a quarterly MDS. Surveyor spoke with Resident #52 on 06/04/19 at approximately 1400. Surveyor noticed C-PAP mask lying uncovered on Resident's nightstand. Surveyor asked Resident if this is how the C-PAP mask is stored and she stated, "yeah, they leave it laying there on the nightstand". Surveyor again observed C-PAP mask lying on nightstand, uncovered on 6/05/19 at approximately 0855 and 06/06/19 at approximately 0735. Surveyor spoke with the ADON (assistant director of nursing)/infection control nurse regarding Resident #52's C-PAP mask. ADON stated the mask should be covered/bagged when not in use. The RNC (regional nurse consultant) provided the surveyor with a copy of a facility policy entitled "Departmental (Respiratory Therapy)-Prevention of Infection" on 06/06/19. This policy read in part "The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilator, among Resident and staff", and "7. Store the circuit in plastic bag, marked with date and Resident's name, between uses". The concern of not keeping the C-PAP mask covered when not in use was discussed with the administrative staff during a meeting on 06/07/19 at approximately 1430. No further information provided prior to exit. 2. The facility staff failed to properly maintain	F 695	2. Quality review of current residents with CPAP□s completed 6/7/19 by DON and UMs to confirm that C-PAP masks were bagged, labeled, and stored per Departmental (Respiratory Therapy) Prevention of Infection policy when not in use. Follow up as indicated. (b) LPN #1 Hand held nebulizer competency was conducted by the Clinical Regional Director and was observed properly assessing resident prior to nebulizer treatment, administering nebulizer per order, and conducting proper cleaning of equipment per manufacturers recommendations post treatment. Follow up as indicated. (c) Quality review completed 6/28/19 of current residents with physician orders for oxygen by the UMs to ensure 02 was being administered per physician orders. Follow up as indicated. 3. Director of Nursing / designee re-educated current licensed nursing staff regarding the proper care of C-PAP masks when not in use and on the Departmental (Respiratory Therapy) Prevention of Infection. (b) DON/designee re- educated current licensed nursing staff on the proper administration of nebulizer treatments to include resident assessment and care of nebulizer equipment. (c) DON/designee re-educated current licensed nursing staff regarding the administration of oxygen per physician orders including the facility policy Oxygen Administration.	

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F 695	Continued From page 36 nebulizer mask for Resident # 59. Resident # 59 was a 94-year-old male who was admitted to the facility on 10/23/13, with a readmission date of 1/10/17. Diagnoses included but were not limited to, hypertension, hypokalemia, failure to thrive, and bronchitis. The clinical record for Resident # 59 was reviewed on 6/5/19 at 11:23 am. The most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 4/16/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 59 had a BIMS (brief interview for mental status) score of 8 out of 15, which indicated that Resident # 59's cognitive status was moderately impaired. The current plan of care for Resident # 59 was reviewed and revised on 4/19/19. The facility staff documented a focus area for Resident # 59 as, "I have a diagnosis of COPD (congestive obstructive pulmonary disorder)." Interventions included but were not limited to, "Treatments as ordered." The current orders for Resident # 59 were signed by the physician on 6/3/19. Resident # 59 had orders that included but were not limited to, "Pulmicort 0.25 mg/ml (milligrams per milliliter) inhale 1 unit dose vial via nebulization every morning." On 6/5/19 at 9:57 am, the surveyor observed LPN # 1 (licensed practical nurse) as she administered Pulmicort 0.25 mg/ml via nebulizer to Resident # 59. The surveyor observed that LPN # 1 did not	F 695	4. DON/designee to conduct quality monitoring through random facility rounds 5x weekly x4 weeks, weekly x4 weeks, then monthly and PRN as indicated to ensure proper storage of C-PAP masks. (b) DON/designee to conduct quality monitoring of Nebulizer Treatment Competency to include lung sounds assessment, instillation of medications. Proper cleaning and storage of equipment 5 x weekly x 4 weeks, Weekly x 4 weeks, then monthly and PRN as indicated to ensure the resident is assessed prior to nebulizer administration, correctly administers nebulizer treatment, and properly cleans and maintains nebulizer equipment following use. (c) DON/designee to conduct quality monitoring of oxygen administration 5x weekly x 4 weeks, weekly x4 weeks, then monthly and PRN as indicated to ensure residents with physician orders for the administration of oxygen are receiving per physician order. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 695	Continued From page 37	F 695		

conduct an assessment on Resident # 59 prior to the administration of Pulmicort 0.25 mg/ml. LPN # 1 administered Pulmicort 0.25 mg/ml to Resident # 59 and stayed at Resident # 59's bedside for the duration of the treatment. The surveyor observed LPN # 1 remove Resident # 59's nebulizer mask and place the nebulizer mask in a plastic bag. The surveyor did not observe LPN # 1 clean the nebulizer mask following the Pulmicort administration to Resident # 59.

The manufacturer's instruction for "Budesonide Inhalation Suspension (Pulmicort)" has documented instructions that included but was not limited to
..."How to use budesonide suspension"
7. Throw away the empty vial. See the cleaning of equipment section below
Cleaning of Equipment
The nebulizer cup and mouthpiece or face mask should be cleaned according to the instructions supplied by the manufacturer." ...

The manufacturer's instructions for the nebulizer mask contained documentation that included but was not limited to,
..." Cleaning Instructions
Unscrew the nebulizer cap and bottle. Remove the one-piece jet by pulling and twisting the jet off the jet stem. Wash all components in warm soapy water and rinse well. Air dry or hand dry with a clean, lint free cloth. Reset the jet by placing the jet over the jet stem and snap into place. Reattach the nebulizer stem and bottle. Device will withstand 50 cleaning cycles." ...

On 6/5/19 at 4:36 pm, the administrative team was made aware of the findings as stated above.

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F 695	Continued From page 38	F 695		

No further information regarding this issue was presented to the survey team prior to the exit conference on 6/7/19.
3. The facility staff failed to follow the physician's orders for oxygen administration for Resident #62.

The clinical record of Resident #62 was reviewed 6/4/19 through 6/7/19. Resident #62 was admitted to the facility 11/18/11 and readmitted 8/26/17 with diagnoses that included but not limited to pulmonary embolism, mild protein malnutrition, gastro-esophageal reflux disease, anxiety, depression, hypokalemia, chronic obstructive pulmonary disease, irritable bowel syndrome, constipation, and chronic kidney disease, stage 3.

Resident #62's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/18/19 assessed the resident with a BIMS (brief interview for mental status) Summary Score as 13/15. No signs or symptoms of behaviors affecting others, delirium, or psychosis. Section O was marked for oxygen therapy

Resident #62's current comprehensive care plan identified the resident to have diagnosis of cardiopulmonary disease with onset date of 12/12/2014. Approaches: Administer O2 (oxygen) as ordered if I need it. Notify my physician if I have any SOB (shortness of breath)."

The surveyor interviewed Resident #62 on 6/5/19 at 9:55 a.m. Resident #62 was resting in bed and was using oxygen via nasal cannula. The oxygen concentrator was set on 2 and ½ liters.

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F 695	Continued From page 39 The surveyor observed Resident #62 again on 6/06/19 at 4:40 p.m. Resident #62's oxygen concentrator was set at 2 and ½ liters per minute. The surveyor asked registered nurse #3 to check the setting for the oxygen. R.N. #3 stated, "It looks like 2 and ½ liters." The surveyor and R.N. #3 reviewed the June 20119 physician's orders. The June 2019 orders read "O2 at 2 LPM (liters per minute) via nasal cannula as needed for SOB r/t (related to) COPD (chronic obstructive pulmonary disease)." After reviewing the physician's orders, R.N. #3 adjusted the oxygen setting to 2 liters per minute. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 6/7/19 at 12:00 p.m. and requested the facility policy on oxygen administration. The surveyor reviewed the facility policy titled "Oxygen Administration" on 6/7/19. The policy read in part "1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration." No further information was provided prior to the exit conference on 6/7/19.	F 695		
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		7/19/19

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F 697	Continued From page 40 the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide pain management to 1 of 25 residents (Resident #17). The findings included: The facility staff failed to administer pain medications per physician orders to Resident #17. The clinical record of Resident #17 was reviewed 6/4/19 through 6/7/19. Resident #17 was admitted to the facility 3/23/18 with diagnoses, that included but not limited to multiple sclerosis, urinary tract infection, cellulitis and abscess of the mouth, major depressive disorder, chronic pain syndrome, anxiety, insomnia, slow transit constipation, tobacco use, nicotine dependence, iron deficiency anemia, and dysuria. Resident #17's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/12/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Section J Health Conditions was marked that Resident #17 received scheduled pain medication and prn (as needed) pain medication. Resident #17 did not receive non-medication interventions for pain. Resident #17's pain frequency was almost constantly, made it difficult to sleep, and limited day-to-day activities because of pain. Pain was rated 6/10. Resident #17's current comprehensive care plan	F 697	1. Resident #17□s medication administration record reviewed by the DON on 6/7/2019 and no further doses of pain medication have been unavailable. 2. Quality review of current residents completed by the DON/designee to ensure pain medication(s) are administered per physician order. Follow up as indicated. 3. DON/designee re-educated current licensed nursing staff regarding center policy that includes ordering medications from the pharmacy, notification of physician when medications need reordering, notification of pharmacy, use of back up pharmacy as needed. Current Licensed nursing staff re-educated by the DON/designee regarding physician notification of unavailable medication for physician to provide alternative orders as indicated. 4. DON/designee to conduct quality monitoring r/t medication compliance/availability reports through morning clinical meeting 5 x weekly x4 weeks, weekly x4 weeks, then monthly and PRN as indicated to ensure medications are available as ordered by the Physician. Findings to be reported to	

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F 697	Continued From page 41 identified the focus area dated 4/2/18 that read, "I am at risk for pain and/or discomfort. Approaches: My nurse will administer and monitor effectiveness and for possible side effects from medication I receive; I will be invited, encouraged, reminded, and escorted to preferred activities with my interests as a diversion from my pain; My physician will order a consultation as indicated; my nurse will educate me and my representative about comfort measures, analgesic medication, and discuss fears/concerns regarding pain, comfort, and disease process; My nurse will notify my physician if I do not state/demonstrate relief or reduction of pain after one hour of receiving the first intervention; and my nurse will monitor for s/s (signs/symptoms) of constipation and administer bowel protocol prn." The surveyor interviewed Resident #17 on 6/5/19 at 2:51 p.m. During the interview, Resident #17 stated the facility runs out of her medication every month. Resident #17 stated it was an issue between the facility and the pharmacy. Resident #17 stated her pain level usually stays around 6. Resident #17's June 2019 physician's orders were reviewed. Resident #17 orders included Oxycodone HCl 10 mg (milligram) tablet Give one tablet by mouth three times a day start 7/10/18 and Methadone HCl 10 mg tablet Give 2 tablets (20 mg) by mouth three times a day-start date 6/4/18. The surveyor reviewed the March 2019 electronic medication administration records. Methadone HCl 20 mg (milligrams) was not administered 3/9/19 at 6:00 a.m. and 1:00 p.m. Methadone was coded "N" for 6:00 a.m. and 1:00 p.m. on the 3/9/19 eMAR. The surveyor was unable to locate	F 697	QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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a reason on the eMAR administrative notes why Methadone was not administered at 6:00 a.m. and 1:00 p.m.

A review of the departmental note for 3/9/19 at 2:47 read that the facility was currently out of Methadone.

The April 2019 eMARs were reviewed. Methadone 20 mg was not administered on 4/18/19 at 6:00 a.m. and 1:00 p.m. Both administration boxes had an "N".

A review of the April 2019 administrative notes documented the medication was not available from the pharmacy for the 6:00 a.m. dose and for the 1:00 p.m. dose, the notes read "was not administered." There were not a progress note on 4/18/19 that addressed the reason Methadone was not administered.

The May 2019 eMARs were reviewed. Oxycodone 10 mg on 5/24/19 at 6:00 a.m. and 1:00 p.m. had "N" in the administration box and Methadone 20 mg had "N" on 5/24/19 at 6:00 a.m., 1:00 p.m., 8:00 p.m. and 5/25/19 at 6:00 a.m. and 1:00 p.m.

The administrative notes for 5/24/19 at 6:00 a.m. for Oxycodone and Methadone read "Not available from pharmacy", the 1:00 p.m. dose of Oxycodone and Methadone read "was not administered", and Methadone 20 mg 8:00 p.m. dose read "not available from pharmacy they advise it was in the next shipment." The 6:00 a.m. Methadone 20 mg administrative note read "Not available from pharmacy" and the 1:00 p. Methadone administrative note read "was held."

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The 5/24/19 progress note written at 3:01 p.m. read in part, "Resident has been very upset since speaking to administrator today concerning vape. Resident stated that she hopes that (sic) kick her out of this place because she hates it here. Awaiting arrival from pharmacy for methadone and oxycodone d/t (due to) awaiting insurance approval. Attempting to retrieve oxycodone from cubex. Several staff have explained to resident that we are awaiting the arrival from pharmacy. Resident yelling and screaming she can't stand it anymore. Resident calling up to nurse's station stating multiple times she just can't take it anymore."

Pain scale indicated 5/10 on 5/24/19 at 2:45 p.m. Resident #17 was not offered non-pharmacological interventions or an alternate medication for pain control when the scheduled Methadone and Oxycodone were not administered per the physician's order.

The surveyor informed the director of nursing (DON) of the above concerns on 6/6/19 at 10:29 a.m. and requested the facility policy on pain management.

The policy "Pain-Clinical Protocol and Pain Assessment and Management" were reviewed 6/7/19. Neither policy addressed when the medication prescribed was unavailable for administration regarding pain control.

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 6/7/19 at 12:00 p.m.

No further information was provided prior to the

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F 697	Continued From page 44 exit conference on 6/7/19.	F 697		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview,	F 755	1. Resident #17, the physician was	7/19/19

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F 755	Continued From page 45 clinical record review, and facility document review, failed to ensure physician ordered medications were available for 1 out of 25 residents (Resident #17). 1. The facility staff failed to ensure physician ordered medications were available for Resident #17. Methadone, Oxycodone, and a Nicoderm patch were not available for administration. The clinical record of Resident #17 was reviewed 6/4/19 through 6/7/19. Resident #17 was admitted to the facility 3/23/18 with diagnoses, that included but not limited to multiple sclerosis, urinary tract infection, cellulitis and abscess of the mouth, major depressive disorder, chronic pain syndrome, anxiety, insomnia, slow transit constipation, tobacco use, nicotine dependence, iron deficiency anemia, and dysuria. Resident #17's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/12/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The surveyor interviewed Resident #17 on 6/5/19 at 2:51 p.m. During the interview, Resident #17 stated the facility runs out of her medication every month. Resident #17 stated it was an issue between the facility and the pharmacy. Resident #17 stated her pain level usually stays around 6. Resident #17's March 2019 through June 2019 physician's orders were reviewed. Resident #17 orders included Oxycodone HCl 10 mg (milligram) tablet Give one tablet by mouth three times a day start 7/10/18, Methadone HCl 10 mg tablet Give 2 tablets (20 mg) by mouth three times a day-start date 6/4/18 and Nicoderm CQ 14 mg/24 hr (hour) patch apply patch daily for	F 755	notified by Director of Nursing/designee of medication not give on 6/7/19 with no new orders and no negative outcomes noted. Resident #17 received all medications per physician order since 6/7/19. The contracting pharmacy was notified with a resolution reached on 6/8/19. 2. Quality review of current Medications (MAR to Cart) completed by the DON/designee to ensure medications were available and administered per physician order. 3. DON designee re-educated current licensed nursing staff beginning regarding Medication Administration according to the Physician orders, medication ordering and communication with pharmacy; to include Physician notification of medication discrepancies and reordering needs. 4. DON/designee to conduct quality monitoring of MARS and Med Carts 3x weekly x 4 weeks, twice weekly x 4 weeks, then monthly and PRN as indicated to ensure medications are being administered per physician order. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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three weeks (start date 5/23/19).

The surveyor reviewed the March 2019 electronic medication administration records. Methadone HCl 20 mg (milligrams) was not administered 3/9/19 at 6:00 a.m. and 1:00 p.m. Methadone was coded N for 6:00 a.m. and 1:00 p.m. on the 3/9/19 eMAR. The surveyor was unable to locate a reason on the eMAR administrative notes why Methadone was not administered at 6:00 a.m. and 1:00 p.m.

A review of the departmental note for 3/9/19 at 2:47 read that the facility was currently out of Methadone.

The April 2019 eMARs were reviewed. Methadone 20 mg was not administered on 4/18/19 at 6:00 a.m. and 1:00 p.m. Both administration boxes had an "N".

A review of the April 2019 administrative notes documented the medication was not available from the pharmacy for the 6:00 a.m. dose and for the 1:00 p.m. dose, the notes read "was not administered." There were not a progress note on 4/18/19 that addressed the reason Methadone was not administered.

The Nicoderm CQ 14 mg/24 hr patch daily for three weeks had an "N" in the boxes for 5/23/19 and 5/24/19 on the May 2019 eMAR. The administrative notes were reviewed and read "not administered-not available."

The May 2019 eMARs were reviewed. Oxycodone 10 mg on 5/24/19 at 6:00 a.m. and 1:00 p.m. had "N" in the administration box and Methadone 20 mg had N on 5/24/19 at 6:00 a.m.,

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F 755	Continued From page 47 1:00 p.m., 8:00 p.m. and 5/25/19 at 6:00 a.m. and 1:00 p.m. The administrative notes for 5/24/19 at 6:00 a.m. for Oxycodone and Methadone read "Not available from pharmacy", the 1:00 p.m. dose of Oxycodone and Methadone read "was not administered", and Methadone 20 mg 8:00 p.m. dose read "not available from pharmacy they advise it was in the next shipment." The 6:00 a.m. Methadone 20mg administrative note read "Not available from pharmacy" and the 1:00 p. Methadone administrative note read "was held." The surveyor informed the director of nursing (DON) of the above concerns on 6/6/19 at 10:29 a.m. and requested the facility policy on obtaining medications from the pharmacy. The facility policy titled "Pharmacy Services Overview" read in part "4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner." The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 6/7/19 at 12:00 p.m. No further information was provided prior to the exit conference on 6/7/19.	F 755		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental	F 758		7/19/19

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processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs 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.

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F 758	Continued From page 49 §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 staff interview, facility document review, and clinical record review, the facility staff failed to ensure 4 of 25 residents were free of an unnecessary psychotropic medication (Resident #87, Resident #26, Resident #62, and Resident #105). The findings included: 1. The facility staff failed to identify and monitor resident specific target behaviors, identify non-pharmacological interventions, and monitor for effectiveness associated with the use of Trazodone for Resident # 87. The clinical record of Resident #87 was reviewed 6/4/19 through 6/7/19. Resident #87 was admitted to the facility 5/3/17 with diagnoses that included but not limited to flaccid hemiplegia affecting right dominant side, epilepsy, quadriplegia, chronic pain, anemia, hyperlipidemia, dementia without behavioral disturbances, and seborrheic dermatitis. Resident #87's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/7/19 assessed the resident with a BIMS (brief interview for mental status) as 6/15. No signs or symptoms of delirium, psychosis, or behaviors that affected others. Resident #87's current comprehensive care plan	F 758	1. Resident #87, Resident #26, Resident #62, and Resident #105 records have been reviewed and were revised on 6/7/19 by the DON to include monitoring for specific target behaviors, identification of nonpharmacological interventions, and monitoring for effectiveness associated with the use of and administration of psychotropic medications. 2. Quality review of current residents receiving psychotropic medication(s) completed 6/8/19 by the DON and Ums regarding monitoring for specific target behaviors, identification of nonpharmacological interventions, and monitoring for effectiveness associated with the use of and administration of psychotropic medications. Follow up as indicated. 3. DON/designee re-educated current licensed nursing staff on psychotropic drug monitoring and required documentation to also include nonpharmacological interventions associated with the administration of psychotropic drugs.	

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F 758	Continued From page 50 had the focus area that read, "I have dx (diagnosis) of depression dated 7/17/18. Approaches: Document behaviors." A second care plan dated 7/17/17 identified a problem that read "I am at risk for side effects of psychotropic medications (receiving antidepressant). Approaches: Observe for any adverse drug-related symptoms and to report to my physician any troublesome symptoms that could be associated with the use of the drug. There were no targeted behaviors identified on the care plan or non-pharmacological interventions identified. The June 2019 physician's orders included orders for Trazodone 50 mg (milligrams) tablet give one-half tablet to equal 25 mg at bedtime. The surveyor reviewed the May 2019 and June 2019 electronic medication administration records. The surveyor was unable to locate behavior monitoring of Trazodone. The surveyor informed the corporate registered nurse of the above concern on 6/6/19 at 4:52 p.m. The corporate registered nurse informed the surveyor that antianxiety medications, antidepressants and hypnotic behavior monitoring had not been implemented. The corporate registered nurse stated she had set-up a template for psychotropic medication monitoring but the facility was only monitoring antipsychotic medication. The surveyor requested the facility policy on psychotropic medications. The surveyor received the policy titled "Antipsychotic Medication Use" on 6/7/19 from the corporate registered nurse. The surveyor did	F 758	4. DON/designee to conduct quality monitoring of residents receiving psychotropic medication(s) 5 x weekly in the morning clinical meeting x 4 weeks, weekly x4 weeks, then monthly and PRN as indicated to identify residents with new orders for psychotropic medications to ensure appropriate monitoring and documentation is being initiated and completed. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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not receive a policy on psychotropic medications.

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 6/7/19 at 12:00 p.m.

No further information was provided prior to the exit conference on 6/7/19.

2. The facility staff failed to identify and monitor resident specific target behaviors, identify non-pharmacological interventions, and monitor for effectiveness associated with the use of Depakote for Resident #26. Depakote was ordered for a mood disorder.

The clinical record of Resident #26 was reviewed 6/4/19 through 6/7/19. Resident #26 was admitted to the facility 12/30/15 with diagnoses that included but not limited to Alzheimer's disease, orthostatic hypotension, pain, anxiety, syncope and collapse, adult failure to thrive, irritable bowel syndrome without diarrhea, and unspecified mood.

Resident #26's quarterly 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 2/15. Resident #26 was assessed to have inattention and disorganized thinking, no evidence of psychosis, or behaviors that affected others.
The June 2019's physician's orders read in part "Depakote 125 mg (milligrams) tablet by mouth every morning for mood disorder and Depakote 250 mg tablet by mouth at bedtime for mood disorder."

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Resident #26's current comprehensive care plan identified the focus area of anxiety with problem onset dated 1/11/16 with approaches listed as document behaviors. A second care plan with date of onset of 1/11/16 read "I am at risk for side effects of psychotropic medications. Approaches: Alert MD (medical doctor) to any significant change in behaviors, document my behavior, and will try to redirect me as appropriate for behaviors."

There were no specific targeted behaviors identified on the care plan or non-pharmacological interventions identified. The May 2019 and June 2019 electronic medication administration records were reviewed. The surveyor was unable to locate any behavior monitoring for Depakote.

The surveyor informed the corporate registered nurse of the above concern on 6/6/19 at 4:52 p.m. The corporate registered nurse informed the surveyor that antianxiety medications, antidepressants and hypnotic behavior monitoring had not been implemented. The corporate registered nurse stated she had set-up a template for psychotropic medication monitoring but the facility was only monitoring antipsychotic medication. The surveyor requested the facility policy on psychotropic medications.

The surveyor received the policy titled "Antipsychotic Medication Use" on 6/7/19 from the corporate registered nurse. The surveyor did not receive a policy on psychotropic medications.

The surveyor informed the administrator, the director of nursing, and the corporate registered

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nurse of the above concern on 6/7/19 at 12:00 p.m.

No further information was provided prior to the exit conference on 6/7/19.

3. The facility staff failed to identify and monitor resident specific target behaviors, identify non-pharmacological interventions, and monitor for effectiveness associated with the use of Cymbalta and Buspar for Resident #62.

The clinical record of Resident #62 was reviewed 6/4/19 through 6/7/19. Resident #62 was admitted to the facility 11/18/11 and readmitted 8/26/17 with diagnoses that included but not limited to pulmonary embolism, mild protein malnutrition, gastro-esophageal reflux disease, anxiety, depression, hypokalemia, chronic obstructive pulmonary disease, irritable bowel syndrome, constipation, and chronic kidney disease, stage 3.

Resident #62's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/18/19 assessed the resident with a BIMS (brief interview for mental status) Summary Score as 13/15. No signs or symptoms of behaviors affecting others, delirium, or psychosis.

Resident #62's June 2019 physician's orders were reviewed and read in part "Cymbalta (Duloxetine) 20 mg (milligrams) capsule one by mouth everyday-start date 9/28/18 and Buspirone (Buspar) HCl 10 mg tablet one tablet by mouth two times per day."

Resident #62's current comprehensive care plan

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identified the resident had an area of focus that read "I have a diagnosis of anxiety and depression with onset date of 12/12/14. Approaches: Staff will document my behaviors." A second care plan read "I have episodes of inappropriate behavior with onset date of 4/22/18. Approaches: Notify MD (medical doctor) of any significant change in behaviors and document resident behaviors." A third care plan read "I am at risk for side effects related to psychotropic medications with onset date of 9/8/17. Approaches: Report to my physician any troublesome symptoms that could be associated with the use of the drug and observe for any adverse drug-related symptoms."

The current comprehensive care plan did not identify any specific targeted behaviors or non-pharmacological interventions.

The surveyor reviewed the May 2019 and June 2019 electronic medication administration records. The surveyor was unable to locate behavior monitoring of Buspar and Cymbalta.

The surveyor informed the corporate registered nurse of the above concern on 6/6/19 at 4:52 p.m. The corporate registered nurse informed the surveyor that antianxiety medications, antidepressants and hypnotic behavior monitoring had not been implemented. The corporate registered nurse stated she had set-up a template for psychotropic medication monitoring but the facility was only monitoring antipsychotic medication. The surveyor requested the facility policy on psychotropic medications.

The surveyor received the policy titled "Antipsychotic Medication Use" on 6/7/19 from

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the corporate registered nurse. The surveyor did not receive a policy on psychotropic medications.

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 6/7/19 at 12:00 p.m.

No further information was provided prior to the exit conference on 6/7/19.

4. The facility staff failed to identify and monitor resident specific target behaviors, identify non-pharmacological interventions, and monitor for effectiveness associated with the use of Klonopin and Sertraline for Resident #105.

The clinical record of Resident #105 was reviewed 6/4/19 through 6/7/19. Resident #105 was admitted to the facility on 5/14/19 with diagnoses that included hypertension, intervertebral disc replacement, legal blindness, unspecified retinal break, bilateral, major depressive disorder, anxiety disorder, chronic pain, and gastro-esophageal reflux disease.

Resident #105's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/22/19 assessed the resident with a BIMS (brief interview for 13/15. Resident #105 had no assessed signs or symptoms of delirium, psychosis, or behaviors that affected others.

Resident #105's current comprehensive care plan identified an area of focus that read "I have diagnosis of anxiety/depression with onset date of 5/24/19. Approaches: Document behaviors." A second care plan identified a focus area that read

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"I am at risk for medication side effects related to psychotropic medications use with onset date of 5/24/19. Approaches: Observe for any adverse drug-related symptoms, observe for any adverse drug-related symptoms, and to report to my physician any troublesome symptoms that could be associated with the use of the drug."

There were no specific targeted behaviors identified on the care plan or identified non-pharmacological interventions.

The June 2019 physician's order included the following: Sertraline HCl 100 mg (milligrams) tablet give one and half tablets to equal 150 mg by mouth at bedtime and Klonopin 0.25 mg tablet twice a day.

The surveyor reviewed the June 2019 electronic medication administration records and was unable to locate any behavior monitoring for the Sertaline and the Klonopin.

The surveyor informed the corporate registered nurse of the above concern on 6/6/19 at 4:52 p.m. The corporate registered nurse informed the surveyor that antianxiety medications, antidepressants and hypnotic behavior monitoring had not been implemented. The corporate registered nurse stated she had set-up a template for psychotropic medication monitoring but the facility was only monitoring antipsychotic medication. The surveyor requested the facility policy on psychotropic medications.

The surveyor received the policy titled "Antipsychotic Medication Use" on 6/7/19 from the corporate registered nurse. The surveyor did not receive a policy on psychotropic medications.

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F 758	Continued From page 57 The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 6/7/19 at 12:00 p.m. No further information was provided prior to the exit conference on 6/7/19.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on clinical record review, and medication pass and pour observation the facility staff failed to ensure a medication error rate of less than 5%. There were 3 errors in 31 opportunities resulting in a medication error rate of 9.68 %. Medication errors affected Resident # 76, Resident # 83, and Resident # 59. The findings included The facility staff had a 9.68% medication error rate following medication pass and pour observation. On 6/5/19 at 7:36 am, the surveyor conducted a medication pass and pour observation with LPN # 2 (licensed practical nurse). The surveyor observed LPN # 2 as she prepared and administered medications to Resident # 76 (unsampled). The surveyor observed LPN # 2 as	F 759	1. Resident #76 responsible party and physician were notified that resident did not receive medication in yogurt as ordered by charge nurse on 6/5/19. Resident #83 responsible party and physician notified resident did not receive aspirin per order by charge nurse on 6/5/19. Resident #59 physician and responsible party notified that Pulmicort not administered per manufacturer□s recommendation on 6/6/ 2019 by the DON. No new orders were received for any resident physician notification and there were no negative clinical outcomes noted. 2. Quality review completed by the DON/designee of current residents to ensure medications are available as per	7/19/19

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F 759	Continued From page 58 she prepared Apriso 0.375 gm (gram) 4 capsules. The surveyor observed LPN # 2 as she opened the 4 capsules of Apriso and sprinkled the contents of the capsules in applesauce. The surveyor observed LPN # 2 as she administered the medications to Resident # 76. After the medication administration observation the surveyor utilized Resident # 76's clinical record to reconcile the medication administered. The surveyor observed that Resident # 76 had current orders that were initiated by the physician on 5/1/19. Orders for Resident # 76 included but were not limited to, "Apriso ER (extended release) 0.375 gram capsule. Take 4 caps by mouth every day open up med and sprinkle in yogurt." On 6/5/19 at 7:50 am, the surveyor observed LPN # 2 as she prepared medications for Resident # 83 (unsampled). The surveyor observed LPN # 2 prepare and administer Aspirin EC (enteric coated) 81 mg (milligram) to Resident # 83. After the medication administration observation the surveyor utilized Resident # 83's clinical record to reconcile the medication administered. The surveyor observed that Resident # 83 had current orders that were signed by the physician on 6/3/19. Orders for Resident # 83 included but were not limited to, "Aspirin 81 mg by mouth daily." On 6/5/19 at 9:57 am, the surveyor observed LPN # 1 (licensed practical nurse) as she prepared and administered Pulmicort 0.25 mg/ml via nebulizer to Resident # 59. The surveyor observed that LPN # 1 did not conduct an assessment on Resident # 59 prior to the administration of Pulmicort 0.25 mg/ml. LPN # 1 administered Pulmicort 0.25 mg/ml to Resident #	F 759	physician order. Follow up as indicated. (b) Quality review completed of residents ordered to receive meds in yogurt to ensure that it was administered accurately on 6/7/2019 by the UMs. Follow up as indicated. (c) Quality review of current residents completed by the DON/UMs to ensure Aspirin is administered in the correct form per physician order. Follow up as indicated. (d) Quality review of current residents receiving Pulmicort completed by the DON/UMs to ensure the resident is assessed prior to administration and their mouth is rinsed following administration. Follow up as indicated. 3. DON/designee re-educated current licensed nursing staff on Medication Administration Policy, administrating medication per physician orders and per manufacturers guidelines when indicated. 4. DON/designee to conduct quality monitoring of current licensed nurses to ensure medications are available as per physician order 3 x weekly x 4 weeks, twice weekly x 2 weeks then twice monthly and PRN as indicated. (b) DON/designee to conduct quality monitoring of current licensed nurses to ensure residents ordered to receive meds in yogurt to ensure that it was administered accurately 3 x weekly x 4 weeks, twice weekly x 2 weeks then twice monthly and PRN as indicated.	

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F 759	Continued From page 59 59 and stayed at Resident # 59's bedside for the duration of the treatment. The surveyor observed LPN # 1 remove Resident # 59's nebulizer mask and place the nebulizer mask in a plastic bag. The surveyor observed that LPN # 1 did not instruct or assist Resident # 59 to rinse his mouth after Pulmicort administration. After the medication administration observation the surveyor utilized Resident # 59's clinical record to reconcile the medication administered. The surveyor observed that Resident # 59 had current orders that were signed by the physician on 6/3/19. Resident # 59 had orders that included but were not limited to, "Pulmicort 0.25 mg/ml (milligrams per milliliter) inhale 1 unit dose vial via nebulization every morning." The surveyor also observed documentation on the medication administration record for Resident # 56 documented an assessment of 18 respirations per minute for Resident # 59 at the time of Pulmicort administration. The facility policy on "Administering Medications" contained documentation that included bit were not limited to, ..."4. Medications are administered in accordance with prescriber's orders, including the required time frame." ... The manufactures instructions for Budesonide Inhalation Suspension (Pulmicort) contained documentation that included but was not limited to, ..."Advise patient to rinse mouth after inhalation." ... On 6/5/19 at 5:30 pm, the administrative team was made aware of the findings as stated above.	F 759	(c) DON/designee to conduct quality monitoring of current licensed nurses to ensure Aspirin is administered in the correct form per physician order 3 x weekly x 4 weeks, twice weekly x 2 weeks then twice monthly and PRN as indicated. (d) DON/designee to conduct quality monitoring of current licensed nurses to ensure the resident is assessed prior to administration and their mouth is rinsed following administration 3 x weekly x 4 weeks, twice weekly x 2 weeks then twice monthly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 759	Continued From page 60 No further information regarding this issue was presented to the survey team prior to the exit conference on 6/7/19.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure three of 26 Residents were free of significant medication errors, Resident #33, Resident #25 and Resident #40. The findings included: 1. For Resident #33 the facility staff held the long acting insulin, Levimir, without a physician's order. Resident #33 was admitted to the facility on 02/12/16 and readmitted on 08/24/18. Diagnoses included but not limited to hypertension, peripheral vascular disease, gastroesophageal reflux disease, diabetes mellitus, Alzheimer's disease, dementia and malnutrition. The most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 03/22/19 assigned the Resident a BIMS (brief interview for mental status) score of 3 out of 15 points in section C, cognitive patterns. Resident #33's CCP (comprehensive care plan) was reviewed and contained a care plan for "I	F 760	1. Resident #33□s responsible party and physician was notified on 6/7/19 by the DON that insulin was held without order. Resident #25 responsible party and physician were notified on 6/7/19 by the DON that insulin was held without physician order. Resident #40 responsible party and physician were notified on 6/7/19 that insulin was administered outside of physician orders by the Director of Nursing. No new orders were received for Resident #33, #25, or #40 and no adverse clinical outcome was noted. 2. Quality review of current residents receiving insulin completed by the DON/UM to ensure residents receive the correct dose of insulin per physician order. Follow up as indicated. Medication pass observation completed as indicated. 3. DON/designee re- educated current licensed nursing staff on proper insulin administration, medication administration	7/19/19

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F 760	Continued From page 61 have diabetes". Approaches for this care plan include "Administer medications as ordered". Resident #33's clinical record contained a physician's order summary for the month of June 2019, which read in part "Levimir flextouch 100 unit/ml 10 units subcutaneously every 12 hours". This order has a start date of 06/06/19. Previous order read in part "Levemir 100 units/ml vial 18 units subcutaneously every HS (bedtime)". Resident #33's eMAR (electronic medication administration record) for the month of May 2019 contained an entry which read in part, "Levemir 100 units/ml vial 18 units subcutaneously every HS (bedtime)". This entry was coded "N" on 05/11/19. The notes section of the eMAR contained a note, which read in part "10:16 PM, 5/11/19 (scheduled : 8:00PM, 5/11/19; Levemir 100 Unit/ml vial) 18 units scheduled for 05/11/2019 8:00 PM was held. special requirement not met". The Resident's eMAR for June 2019 contained an entry which read in part, "Levemir Flextouch 100 unit/ml 10 units subcutaneously every twelve hours". This entry was coded "N" on 06/07/19 at 6 AM. The notes section of the eMAR contained a note which read in part "5:52 06/07/19 (Scheduled: 6:00AM, 6/7/19; Levemir Flextouch 100 unit/ml) Levemir flextouch 100 unit/ml 10 units s...scheduled for 06/07/2019 6:00 AM was held. bs (blood sugar)116". The concern of holding the Resident's insulin without a physician's order was discussed with the administrative team during a meeting on 06/07/19 at approximately 1430.	F 760	per physician order, and facility policy regarding diabetic management. 4. DON/designee to conduct quality monitoring of residents who receive insulin to ensure the correct dose is administered per physician order 3 x weekly x 4 weeks, twice weekly x 2 weeks then twice monthly and PRN as indicated. Medication pass observation completed as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 760	Continued From page 62 No further information was provided prior to exit. 2. For Resident #25 the facility staff held the long acting insulin, Lantus without a physician's order. Resident #25 was admitted to the facility on 05/04/17 and readmitted on 03/10/19. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, diabetes mellitus, hyperlipidemia, Alzheimer's disease, dementia, depression, chronic obstructive pulmonary disease, and gastroesophageal reflux disease. The most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 05/15/19 assigned the Resident a BIMS (brief interview for mental status) score of 12 out of 15 in section C, cognitive patterns. Resident #25's clinical record contained a signed physician's order summary for the month of May 2019, which read in part "Lantus Flexpen 48 units every day". Resident #25's eMAR (electronic medication administration record) for the month of May contained an entry, which read in part "Lantus Flexpen 100 units/ml subcutaneously every day AM". This entry was coded with "N" on 05/22/19 and 05/25/19. The notes section on the eMAR contained a note, which read in part "10:05 5/22/19 (Scheduled 9:00AM, 5//22/19; Lantus solostar 100 units/ml) Lantus Flexpen 100 units/ml Give 48 units...schedules for 05/22//2019 9:00AM. BS (blood sugar) 91". The surveyor could not locate corresponding notes for 05/25/19. The concern of holding the Resident's insulin without a physician's order was discussed with	F 760		

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F 760	Continued From page 63	F 760		

the administrative team during a meeting on 06/07/19 at approximately 1430.

No further information was provided prior to exit.
3. The facility staff failed to follow physician's orders for insulin administration for Resident #40.

The clinical record of Resident #40 was reviewed 6/4/19 through 6/7/19. Resident #40 was admitted to the facility 1/18/17 and readmitted 2/17/19 with diagnoses that included but not limited to hemiplegia affecting left non-dominant side, mood disorder, type 2 diabetes mellitus, major depression, anxiety, sacral pressure ulcer, stage 4, urinary tract infection with extended spectrum beta lactamase resistance (ESBL), subacute osteomyelitis of left ankle and foot, hypertension, iron deficiency anemia, peripheral vascular disease, conduct disorder, and edema.

Resident #40's significant change in assessment minimum data set (MDS) with an assessment reference date (ARD) of 3/4/19 assessed the resident with a BIMS (brief interview for mental status) as 13/15 and without signs or symptoms of delirium, or behaviors affecting others or psychosis.

Resident #40's current comprehensive care plan dated 1/30/17 identified the problem that read, "I have diagnosis of diabetes. Approaches: Administer my medications as ordered."

The May 2019 and June 2019 physician's orders read in part "Novolog 100 unit/ml (milliliter) Flexpen Give 8 units subcutaneously with meals. Hold if blood sugar is < (less than) 160."

A review of the May 2019 electronic medication

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F 760	Continued From page 64	F 760		

administration record (eMAR) revealed Novolog insulin was administered when the medication should have been held.
5/4/19 06:30 a.m. blood sugar was 121. Novolog insulin 8 units was administered.
5/4/19 11:30 a.m. blood sugar was 121. Novolog insulin 8 units was administered.
5/10/19 06:30 a.m. blood sugar was 73. Novolog insulin 8 units was administered.
5/10/19 11:30 a.m. blood sugar was 126. Novolog insulin 8 units was administered.
5/13/19 06:30 a.m. blood sugar was 150. Novolog insulin 8 units was administered.
5/13/19 11:30 a.m. blood sugar was 152. Novolog insulin 8 units was administered.
5/15/19 11:30 a.m. blood sugar was 142. Novolog insulin 8 units was administered.
5/16/19 11:30 a.m. blood sugar was 144. Novolog insulin 8 units was administered.
5/18/19 6:30 a.m. blood sugar was 105. Novolog insulin 8 units was administered.
5/18/19 11:30 a.m. blood sugar was 150. Novolog insulin 8 units was administered.
5/20/19 6:30 a.m. blood sugar was 128. Novolog insulin 8 units was administered.
5/25/19 4:30 p.m. blood sugar was 126. Novolog insulin 8 units was administered.
5/28/19 6:30 a.m. blood sugar was 103. Novolog insulin 8 units was administered.
5/28/19 11:30 a.m. blood sugar was 157. Novolog insulin 8 units was administered.
5/28/19 4:30 p.m. blood sugar was 159. Novolog insulin 8 units was administered.

The surveyor and the unit manager registered nurse #1 reviewed the blood sugar results with the insulin administered on 6/7/19 at 10:48 a.m.

The surveyor informed the director of nursing of

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F 760	Continued From page 65 the above concern on 6/7/19 at 10:51 a.m. and requested the facility policy on diabetic management. No further information was provided prior to the exit conference on 6/7/19.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to dispose of expired	F 761	1. Expired meds were disposed of on 6/5/19 by the UMs. Pace skilled med carts	7/19/19

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F 761	Continued From page 66 medications on 2 of 2 units. The findings included: 1. The facility failed to dispose of expired medications on unit B. The surveyor checked cart #1 on the B unit on 06/05/19 at 3:44 p.m. with LPN #10. This medication cart included 1 opened box of culturelle that contained 15 capsules. The expiration date on the box was 05/2019. LPN #10 stated she was going to discard this medication. The surveyor and LPN #10 then checked the medication room. The medication room included 2-30 capsule boxes of culturelle with an expiration date of 05/2019, 4-60 soft gel bottles of flaxseed oil 1000 mg with an expiration date of 03/2018, 9-100 tablet bottles of vitamin D with a use by date of 01/2019, and 1-10 ounce bottle of mag citrate with an expiration date of 03/2019. LPN #10 stated she would discard this medication. The administrative staff were notified of the issue with the expired medications on 06/05/19 at approximately 4:45 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. The facility staff failed to ensure that medications in medication carts were properly labeled and discarded on the pace and skilled units. On 6/5/19 at 1:00 pm, the surveyor checked the medication cart on the skilled unit with LPN # 2	F 761	checked 6/8/19 by the DON/UMs. Medications were properly labeled and there were no meds to be discarded. 2. Quality review of current medication rooms, medication carts and central storage were completed on 6/7/19 by the DON/UMs. Follow up as indicted. (b) Quality review completed on 6/8/19 by the DON/UM to ensure the med carts are free from expired medications. Follow up as indicated. 3. Director of Nursing/designee re-educated current licensed nursing staff on the proper disposal of expired meds timely and the Storage of Medications policy. (b) DON/designee re-educated current licensed nursing staff on proper storage of meds in medication cart and the Storage of Medication and Administration of Medications policy. 4. DON/designee to conduct quality monitoring of med carts to ensure expired medications are stored properly and disposed of timely 3 x weekly x 4 weeks, twice weekly x 2 weeks then weekly and PRN as indicated. (b) DON/designee to conduct quality monitoring of medication carts to ensure required medications are labeled and meds discarded as needed 3 x weekly x 4 weeks, twice weekly x 2 weeks then weekly and PRN as indicated. Findings to	

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F 761	Continued From page 67 (licensed practical nurse). Upon checking the medication cart, the surveyor observed a bottle of sterile water that had been opened. The surveyor observed that there was no documentation on the bottle of sterile water that reflected what date the bottle of sterile water had been opened. The surveyor observed an expiration date of 1/5/19 documented on the label. The surveyor and LPN # 2 observed the bottle of sterile water and LPN # 2 agreed that the bottle of sterile water did not have a date opened documented on the bottle and that the bottle of sterile water had expired and was on the medication cart available for use. On 6/5/19 at 1:03 pm, the surveyor checked the medication cart on the pace unit with LPN # 1. Upon checking the medication cart, the surveyor observed a bottle of Bisacodyl 5 mg (milligram) tablets that had an expiration date of 1/19 printed on the bottle. The surveyor also observed an opened package of Budesonide Inhalation Suspension 0.25 mg/2mL that had been opened and was not dated. The surveyor and LPN # 1 observed the bottle of Bisacodyl 5 mg and the package of Budesonide Inhalation Suspension and LPN # 1 agreed that the bottle of Bisacodyl 5 mg had expired and was in the medication cart available for use, and that the package of Budesonide Inhalation Suspension had been opened and was not dated. The facility policy on "Administering Medications" contained documentation that included but was not limited to, ..."12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container."...	F 761	be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 761	Continued From page 68 The manufacturer's instructions for Budesonide Inhalation Suspension contained documentation that included but was not limited to, ..." Record the date that you open the foil on the front of the envelope in the space provided. Throw away budesonide inhalation suspension vials if not used within 2 weeks of opening the protective aluminum foil envelope." ... The facility policy on "Storage of Medications" contained documentation that included but was not limited to, ..."5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed." ... On 6/5/19 at 5:30 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 6/7/19.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 804	1. Food service manager adjusted the	7/19/19

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F 804	Continued From page 69 interview, and clinical record review, the facility staff failed to ensure food was palatable and served at an appetizing temperature on one of two units (unit B). The findings included: The facility staff failed to provide palatable foods at an appropriate temperature to residents on unit B. During the survey from 6/4/19 through 6/7/19, three resident interviews were completed with Resident #40, Resident #87, and Resident #17. Resident #40 stated the food was always cold. Resident #87 stated the food was cold. Resident #17 stated the food was terrible and the menu was a lie. "We get soup every day." The surveyor conducted a lunch test tray on 6/6/19 beginning at 11:26 a.m. Food temperatures obtained at 11:26 a.m. were as follows: Coffee-133 degrees Iced tea-36.8 degrees Milk-33.4 degrees Creamed green beans (pureed)-176 degrees Green beans-200 degrees Mashed potatoes-179 degrees Pureed sloppy joes-191 degrees Pork chops-175 degrees Sloppy joe-167 degrees Gravy-175 degrees Strawberry shortcake-39.8 degrees Cream of broccoli soup-158.4 degrees Macaroni salad-38.5 degrees 11:39 a.m. First cart left the kitchen and headed	F 804	time trays leave dietary to ensure residents who require assistance with feeding and are served in room receive meal within 10-20 minutes of cart leaving dietary department. Additionally, new enclosed delivery cart was ordered which will be used for tray delivery on this unit. Food service manager has also seasoned green beans for those residents that their diet allows per resident request. 2. Quality review conducted by the Food service manager/(FSM) to ensure residents who require assistance with meals are receiving meals within acceptable time frame. Follow up as indicated. 3. FSM/DON/designee re-educated current dietary and nursing staff on appropriate temperature of food, timely assistance and delivery of trays to resident rooms. 4. FSM to conduct quality monitoring of meals through random test trays 5x week for 4 weeks, 2x week for 4 weeks, then weekly and PRN as indicated to ensure meals are appetizing and the temperature is palatable. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 804	Continued From page 70	F 804		

to PACE. The surveyor observed the tray carts to be open. Kitchen aide covered the first cart with a large clear plastic bag prior to the cart leaving the kitchen and did this as each cart left the kitchen area.
11:40 a.m. First cart arrived on PACE.
11:42 a.m. First resident served tray.

12:17 p.m. Last cart left kitchen at 1217 and arrived on unit at 12:19 p.m.

Last tray arrived at Resident #40's room at 12:46 p.m.

Temperature of test tray checked with the food services manager (FSM) at 12:47 p.m.
Macaroni salad-55.6 degrees
Sloppy joe sandwich-139.2 degrees
Green beans-114 degrees
Strawberry shortcake-62.6 degrees
Milk-51.9 degrees

The food service manager ate the sloppy joe and stated the sandwich was good. The surveyor agreed. The sandwich had good flavor and was warm enough to eat.

The macaroni salad needed salt and was a little warm. The macaroni salad would require more chilling to make it palatable.

The FSM stated she didn't like frozen green beans and that's what was served. The FSM did not eat the green beans. The FSM stated the canned green beans were better but not served to residents because of the salt content. The surveyor tasted the green beans and found them to be cold and without flavor or seasoning. The green beans were at a temperature that would

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F 804	Continued From page 71 have required reheating and seasoning to make them palatable. The milk was warm and the strawberry shortcake was warm. The milk was too warm to drink per the FSM. Both the strawberry shortcake and milk needed to be chilled. The food services manager stated the food was at or above temperature when the carts leave the kitchen but the trays sit on the floor until those residents who need assistance with meals are fed. Today the tray cart arrived on the floor at 12:19 p.m. and Resident #40 was served at 12:46 p.m. The surveyor interviewed the unit B manager registered nurse #1 on 6/6/19 at 1:00 p.m. The surveyor asked what was the staffing for the day and she stated there were 4 CNAs, 2 nurses, and a wound care nurse on the floor. The unit secretary was off the floor with a resident appointment. The surveyor interviewed licensed practical nurse #4 and registered nurse #3 on 6/6/19. Both stated they did not feed any residents at lunch. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above observation and concern on 6/7/19 at 12:00 p.m. No further information was provided prior to the exit conference on 6/7/19.	F 804		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		7/19/19

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F 880	Continued From page 72 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 73 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review facility staff failed to ensure infection treatment as ordered for 1 of 26 residents in the survey sample (Resident #77) and proper hand-washing. Resident #77 Infections (not UTI or Respiratory)	F 880	1. Resident #77's Physician and responsible party made aware of antibiotics not administered as ordered by the Physician by the DON on 6/6/2019. No new orders and no negative clinical outcome noted for Resident #77. LPN #1 Received coaching/counseled and re-educated on Handwashing/Hand Hygiene policy and Cleaning and disinfection of Resident care Items and Equipment policy on 6/5/19 by Regional	

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F 880	Continued From page 74 06/05/19 11:36 AM resident reported that staff had run out of his antibiotic while he was here. He is on nafcillin 2 gm in 50 ml ns at 50 ml/hr every 4 hours for 8 weeks from 4/22-6/14. MAR indicated 'N' on 6/2 at 9AM, 1 PM, 5 PM, and 9 PM and on 6/3 at 1 AM; in May MAR indicated 'N' on 5/7 at 5 PM, and many other times. Notes indicate the medication will be administered when meds are available or that the medication was not available. During an interview on 6/6/19, the assistant director of nursing reported that, in her role as infection control nurse, she does not track whether resident receive antibiotics as ordered. 2. The facility staff failed to implement proper handwashing practices during medication pass and pour observation and failed to clean durable medical equipment after Resident use. On 6/5/19 at 8:07 am, the surveyor observed LPN # 1 (licensed practical nurse) as she prepared and administered medications to Resident # 59. The surveyor observed that LPN # 1 did not wash or sanitize her hands after medication administration to Resident # 59 and proceeded to prepare medications to administer to Resident # 1 (unsampled). On 6/5/19 at 8:30 am, the surveyor observed LPN # 1 as she prepared to administer medications to Resident # 1. LPN # 1 stated, "I need to take his blood pressure." The surveyor observed LPN # 1 as she retrieved a blood pressure cuff and stethoscope from the medication cart. LPN # 1 applied the blood pressure cuff to Resident # 1's right arm and assessed the blood pressure using the blood pressure cuff and stethoscope. The surveyor observed LPN # 1 as she removed the	F 880	director of Operation. 2. Quality review of current residents who were ordered antibiotics on or after 6/7/19 completed by the DON/UM to ensure there were no missed doses due to medications being unavailable. Follow up as indicated. 3. DON/designee re-educated current licensed nursing staff regarding infection prevention guidelines including but not limited to Medication administration policy and handwashing/Hand Hygiene policy. Current Licensed nursing staff re-educated by the DON/designee regarding pharmacy notification and procedures for unavailable medications. 4. DON/designee to conduct quality monitoring of resident□s medication administration records with antibiotic orders to ensure antibiotics are administered per physician order 3 x weekly x 4 weeks, twice weekly x 2 weeks then weekly and PRN as indicated. (b) DON/designee to conduct Handwashing observation of 5 employees weekly x4, weeks and 10 employees□ monthly and PRN as indicated ensure proper handwashing technique per policy when providing direct resident care. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 880	Continued From page 75	F 880		

blood pressure cuff from Resident # 1's right arm and placed the blood pressure cuff and stethoscope in the medication cart. The surveyor observed that LPN # 1 did not clean the blood pressure cuff and stethoscope after it had been utilized with Resident # 1. The surveyor observed LPN # 1 as she prepared and administered medications to Resident # 1. After Resident # 's medications were administered, the surveyor observed LPN # 1 as she turned on the faucet, washed her hands, turned off the faucet, then dried her hands with a clean paper towel.

The facility policy on "Handwashing Hand/Hygiene" contained documentation that included but was not limited to,
..."7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:
c. Before preparing or handling medications.
Washing hands
1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature. Hot water is unnecessarily rough on hands.
2. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside of sink.
3. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel." ...

The facility policy on "Cleaning and Disinfection of Resident-Care Items and Equipment contained documentation that included but was not limited to,

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F 880	Continued From page 76 ..."d. Reusable items are cleaned and disinfected or sterilized between residents (e. g., stethoscopes, durable medical equipment)." ... On 6/5/19 at 5:30 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 6/7/19.	F 880		