STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495166	A. BUILDING ______ B. WING ______	C 05/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD HEALTHCARE CENTER	508 RISON STREET DANVILLE, VA 24541

(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 05/29/18 through 05/31/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 05/29/19 through 05/31/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey. The census in this 60 certified bed facility was 55 at the time of the survey. The survey sample consisted of 19 current Resident reviews and 3 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		6/30/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 06/26/2019

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

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F 578	Continued From page 1 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the Virginia Department of Health Durable Do Not Resuscitate (DDNR) form was complete for 1 of 22 residents (Resident #154). The findings included: The facility staff failed to ensure the Virginia Department of Health DDNR was accurate for Resident #154. The clinical record of Resident #154 was	F 578	1. Resident #154s DDNR reviewed and revised on 05/30/2019. 2. Residents that reside in the facility have the potential to be affected by this deficient practice. Director of Nursing and/or Designee completed audit of residents that reside in the facility that have a Virginia Department of Health Durable Do Not Resuscitate (DDNR) form to ensure forms are accurate and complete. 3. Director of Nursing and/or Designee re-educated licensed nursing staff	

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Continued From page 2

reviewed 5/29/19 through 5/31/19. Resident #154 was admitted to the facility 5/22/19 with diagnoses that included but not limited to fracture of parts of lumbosacral spine and pelvis, muscle weakness, gait and mobility abnormalities, cognitive communication deficit, anxiety, major depressive disorder, age-related osteoporosis, rheumatoid arthritis, hypertension, Vitamin D deficiency, kyphosis, atherosclerotic heart disease, and chronic pain.

Resident #154's admission minimum data set (MDS) had not been completed.

The clinical record contained a Virginia Department of Health Durable Do Not Resuscitate form dated 5/22/19. Section 1 and Section 2 were blank.

Section 1 of the DDNR read in part, "I further certify [must check 1 or 2]:
1. The patient is CAPABLE of making an informed decision...
2. The patient is INCAPABLE of making an informed decision..."
The boxes beside #1 and #2 were blank.

Section 2 read "If you checked 2 above, check A, B, or C below:" The three boxes below were blank.

The surveyor asked licensed practical nurse #1 to review Resident #154's DDNR on 5/29/19 at 12:38 p.m. L.P.N. #1 stated nothing was marked on the DDNR.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the chief executive officer of the incomplete

F 578

regarding F 578- Request/Refuse/Discontinue Treatment; Formulate Advances Directives, Code Status Policy and Cardiopulmonary Resuscitation Policy to ensure the Virginia Department of Health Durable Do Not Resuscitate (DDNR) form is complete and accurate for residents who choose to have this in the facility.
4. Director of Nursing and/or Designee will complete audit of resident□s code status one time a week x 3 months to ensure the Virginia Department of Health Durable Do Not Resuscitate (DDNR) form is complete and accurate for residents who choose to have this in the facility. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as necessary.

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F 578	Continued From page 3 DDNR on 5/30/19 at 4:50 p.m. and again prior to exit on 5/31/19 at 6:20 p.m. No further information was provided prior to the exit conference on 5/31/19.	F 578		
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. §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	F 584		6/30/19

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F 584	Continued From page 4 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, resident interview, staff interview, and clinical record review, the facility staff failed to ensure a clean and comfortable homelike environment for 1 of 22 residents (Resident #41). The findings included: The facility staff failed to ensure Resident #41's privacy curtain and air conditioning unit were clean. Resident #41 was admitted to the facility 1/26/18 with diagnoses that included but not limited to frostbite, anxiety, depression, and dementia. Resident #41's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/15/19 assessed the resident with a BIMS (brief interview for mental status) as 9/15. The surveyor interviewed Resident #41 on 5/29/19 at 11:34 a.m. Resident #41 was observed sitting up in bed during the interview. The surveyor sat in a folding chair and the privacy curtain was pulled to separate Resident #41 from the roommate. When the surveyor sat down, a large orange stain was observed at the end of the	F 584	1. Resident #41s privacy curtain and air conditioning unit cleaned on 05/29/2019. 2. Residents that reside in the facility have the potential to be affected by this deficient practice. Housekeeping Supervisor and/or Designee completed audit of residents rooms in facility to ensure clean privacy curtains and air conditioning units. 3. Administrator and/or Designee re-educated housekeeping staff regarding F 584- Safe/Clean/Comfortable/Homelike Environment and Room Cleaning Policy to ensure residents have a clean and comfortable homelike environment while residing in the facility. 4. Administrator and/or Designee will complete audit of resident□s room privacy curtains and air conditioning units once a week x 3 months to ensure residents have a clean and comfortable homelike environment. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as necessary.	

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F 584	Continued From page 5 curtain as well as dark marks throughout the remainder of the curtain. At the end of the interview, Resident #41 asked the surveyor to close the window and turn the air conditioner on 68 degrees. When the surveyor turned the air conditioner on, the surveyor noticed an accumulation of dust on top of the air conditioner in the grill. The surveyor showed the director of nursing of the above concerns on 5/29/19 at 2:00 p.m. The DON stated she would inform the housekeeping staff of the above issue. The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the chief executive officer of the above concern during the end of the day meeting on 5/30/19 at 4:50 p.m. and requested a copy of the housekeeping job duties and informed the administrative staff again on 5/31/19 at 6:20 p.m. of the above concern. No further information was provided prior to the exit conference on 5/31/19.	F 584		
F 622 SS=C	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved	F 622		6/30/19

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F 622	Continued From page 6	F 622		

sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is

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F 622	Continued From page 7 communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to ensure that comprehensive care plan goals were sent with	F 622	1. Unable to correct this issue with resident #6, #12, #19, #31, #32, #40 and #43 as this is already completed.	

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F 622	Continued From page 8 facility residents upon transfer for 7of 22 residents. The findings included: The facility staff failed to ensure that comprehensive care plan goals were sent with facility residents upon transfer. During the course of the survey that was conducted 5/29/19 through 5/31/19, the survey team identified the following Residents did not have comprehensive care plan goals sent upon transfer, Resident # 6, Resident # 12, Resident # 19, Resident # 31, Resident # 32, Resident # 40, and Resident # 43. On 5/31/19 at 6:30 pm, the administrative team was made aware of the findings as stated above, and agreed that it had not been a facility practice to send comprehensive care plan goals with Residents upon transfer. No further information regarding this issue was presented to the survey team prior to the exit conference on 5/31/19.	F 622	2. Resident□s that transfer out of the facility have the potential to be affected by this deficient practice. Director of Nursing and/or Designee completed audit of residents that have been transferred out of facility in the last 30 days to ensure comprehensive care plan goals are sent with facility residents upon transfer. 3. Director of Nursing and/or Designee re-educated licensed nursing staff regarding F 622- Transfer and Discharge Requirements and Discharge/Transfer Policy to ensure comprehensive care plan goas are sent with facility residents upon transfer. 4. Director of Nursing and/or Designee will complete audit one time a week x 3 months to ensure that comprehensive care plan goas are sent with facility residents upon transfer. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as necessary.	
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State	F 623		6/30/19

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F 623	Continued From page 9 Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged;	F 623		

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(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure

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F 623	Continued From page 11 to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide written notice of transfer/discharge to include the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman and documentation in the medical record that the notice was sent to the Ombudsman for 3 of 22 residents (Resident #45, Resident #40, and Resident #6). The findings included: 1. The facility staff failed to provide written notice of transfer to the resident and the resident representative when the resident was transferred to the hospital, failed to provide a statement of the resident's appeal rights, failed to provide information on how to obtain an appeal form and assistance in completion of such and failed to document in the medical record ombudsman notification when Resident #40 was transferred to the hospital.	F 623	1. Unable to correct this issue with resident #45, #46 and #6 as this is already completed. 2. Resident□s that transfer out of the facility have the potential to be affected by this deficient practice. Director of Nursing and/or Designee completed audit of residents that have been transferred out of facility in the last 30 days to ensure ensuring the facility provided written notice of transfer/discharge to include the effective date of transfer/discharge; the location to which the resident is transferred or discharged; a statement of the resident□s appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman and the documentation in the medical record that the notice was sent to the Ombudsman when residents transfer out of the facility. 3. Director of Nursing and/or Designee re-educated licensed nursing staff regarding F 623- Notice Requirements	

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	495166	A. BUILDING ______ B. WING ______	C 05/31/2019

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Resident #40 was admitted to the facility 2/28/19 and readmitted 5/2/19 with diagnoses that included altered mental status, muscle weakness, symbolic dysfunctions, hypertension, atherosclerotic heart disease, dementia with behavioral disturbances, hemiplegia and hemiparesis following a cerebral infarction and type 2 diabetes mellitus.

Resident #40's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 5/15/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15.

The clinical record's progress notes dated 4/26/19 at 05:17 read "Rsd (resident) admitted to hospital for altered mental status."

The surveyor was unable to locate the above information in Resident #40's clinical record. The clinical record did not contain information about Resident #40's transfer, the location where Resident #40 was transferred, a statement of the appeal rights, and documentation of information sent to the ombudsman.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse, and the chief executive officer of the above information on 5/31/19 at 5:14 p.m. The director of nursing stated the facility was not providing written notice of transfers to the resident and the transfer notice to the resident representatives was incomplete. The facility staff failed to provide the resident and resident representative information about the appeal process. In addition, there was no documentation in the clinical record of ombudsman notification.

F 623

Before Transfer/Discharge and Discharge/Transfer Policy to ensure the facility provides written notice of transfer/discharge to include the effective date of transfer/discharge; the location to which the resident is transferred or discharged; a statement of the resident□s appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman and the documentation in the medical record that the notice was sent to the Ombudsman when residents transfer out of the facility.

4. Director of Nursing and/or Designee will complete audit one time a week x 3 months of residents that transfer out of the facility to ensure ensuring the facility provides written notice of transfer/discharge to include the effective date of transfer/discharge; the location to which the resident is transferred or discharged; a statement of the resident□s appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the

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No further information was provided prior to the exit conference on 5/31/19.

2. The facility staff failed to provide written notice of transfer to the resident and the resident representative when the resident was transferred to the hospital, failed to provide a statement of the resident's appeal rights, failed to provide information on how to obtain an appeal form and assistance in completion of such and failed to document in the medical record ombudsman notification when Resident #6 was transferred to the hospital.

The clinical record of Resident #6 was reviewed 5/29/19 through 5/31/19. Resident #6 was admitted to the facility 6/7/16 and readmitted 4/4/19 with diagnoses that included but not limited to metabolic encephalopathy, muscle weakness, dysphagia, hypertension, hypothyroidism, major depressive disorder, gastro-esophageal reflux disease, gastrostomy status, aphasia following cerebral infarction, and hemiplegia and hemiparesis following cerebral infarction.

Resident #6's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/8/19 assessed the resident with short-term memory problems, long-term memory problems, and severely impaired cognitive skills for daily decision-making.

A progress note dated 4/1/19 at 0914 read "Spoke with dr (doctor) re: residents ahr (unable to determine) and he gave orders to send to er (emergency room), ems (emergency medical services) took him at 0855 attempted to call wife and daughter in law with no answer to either, left

F 623

State Long-Term Care Ombudsman and the documentation in the medical record that the notice was sent to the Ombudsman when residents transfer out of the facility. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as necessary.

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msg (message) for wife to call me."

The surveyor was unable to locate a written notice of transfer/discharge given to the resident and resident representative, written documentation of ombudsman notification, and the appeal process.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse, and the chief executive officer of the above information on 5/31/19 at 5:14 p.m. The director of nursing stated the facility was not providing written notice of transfers to the resident and the transfer notice to the resident representatives was incomplete. The facility staff failed to provide the resident and resident representative information about the appeal process. In addition, there was no documentation in the clinical record of ombudsman notification.

No further information was provided prior to the exit conference on 5/31/19.

3. The facility staff failed to provide written notice of transfer to the resident and the resident representative when the resident was transferred to the hospital, failed to provide a statement of the resident's appeal rights, failed to provide information on how to obtain an appeal form and assistance in completion of such and failed to document in the medical record ombudsman notification when Resident #45 was transferred to the hospital.

The clinical record of Resident #45 was reviewed 5/29/19 through 5/31/19. Resident #45 was admitted to the facility 10/1/18 and readmitted 5/9/19 with diagnoses that included but not limited

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to schizophrenia, osteomyelitis in ankle and foot, type 2 diabetes mellitus, morbid obesity, obstructive and reflux uropathy, hypertension, hyperlipidemia, peripheral vascular disease, and chronic kidney disease, stage 3.

Resident #45's significant change in assessment minimum data set (MDS) with an assessment reference date (ARD) of 5/16/19 assessed the resident with a BIMS (brief interview for mental status) as 13/15.

The surveyor was unable to locate documentation in the clinical record of the above information when Resident #45 was admitted to the hospital on 5/1/19 from a medical doctor's appointment.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse, and the chief executive officer of the above information on 5/31/19 at 5:14 p.m. The director of nursing stated the facility was not providing written notice of transfers to the resident and the transfer notice to the resident representatives was incomplete. The facility staff failed to provide the resident and resident representative information about the appeal process. In addition, there was no documentation in the clinical record of ombudsman notification.

No further information was provided prior to the exit conference on 5/31/19.

****During the end of the day meeting on 5/31/19 at 5:14 p.m. with the administrator, the director of nursing, the corporate registered nurse and the chief executive officer, the administrative staff stated the facility was not providing the required information to the resident/resident

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F 623	Continued From page 16 representative, the appeals process information, and the written documentation of ombudsman notification when residents are sent to the hospital. No further information was provided prior to the exit conference on 5/31/19.	F 623		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625		6/30/19

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F 625	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review, the facility staff failed to provide written notice of bed hold upon transfer or discharge for 8 of 22 residents.. The findings included The facility staff failed to provide documentation that a written notice of bed hold was issued to facility residents upon transfer or discharge. During the course of the survey that was conducted 5/29/19 through 5/31/19, the survey team identified the following Residents did not have documentation that a written notice of bed hold was issued upon transfer or discharge, Resident # 6, Resident # 12, Resident # 19, Resident # 31, Resident # 32, Resident # 40, Resident # 43, and Resident #45. The "Discharge/Transfer Letter Policy," contained documentation that included but was not limited to; ..."4. A copy of the completed bed hold notice will be scanned into PCC under document manager and filed in business file with certified receipt attached if applicable, with copy of the discharge/transfer letter." ... On 5/31/19 at 6:30 pm, the administrative team was made aware of the findings as stated above, and agreed that it had not been a facility practice to maintain documentation that a written notice of bed hold was issued with Residents upon transfer or discharge. No further information regarding this issue was	F 625	1. Unable to correct this issue with resident #6, #12, #19, #31, #32, #40, #43 and #45 as this is already completed. 2. Residents that transfer out of the facility have the potential to be affected by this deficient practice. Director of Nursing and/or Designee completed audit of residents that have been transferred out of facility in the last 30 days to ensure the facility provided written notice of bed hold to residents upon transfer. 3. Director of Nursing and/or Designee re-educated licensed nursing staff regarding F 625- Notice of Bed Hold Policy Before/Upon Transfer and Discharge/Transfer Policy to ensure the facility staff provide written notice of bed hold to residents upon transfer. 4. Director of Nursing and/or Designee will complete audit one time a week x 3 months to ensure to ensure the facility provides written notice of bed hold to residents upon transfer. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as necessary.	

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F 625	Continued From page 18 presented to the survey team prior to the exit conference on 5/31/19.	F 625		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)	F 645		6/30/19

§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.

§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:
(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-

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F 645	Continued From page 19 (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the PASSARs (Pre-Admission Screening and Resident Review) were complete for 2 of 22 residents (Resident #45 and Resident #7).	F 645	1. Resident #7 & #45s PASARR reviewed and revised on 05/30/2019. 2. Residents that reside in the facility have the potential to be affected by this deficient practice. Administrator and/or Designee completed audit of residents in	

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The findings included:

1. The facility staff failed to ensure the PASSAR was complete for Resident #45.

The clinical record of Resident #45 was reviewed 5/29/19 through 5/31/19. Resident #45 was admitted to the facility 10/1/18 and readmitted 5/9/19 with diagnoses that included but not limited to schizophrenia, osteomyelitis in ankle and foot, type 2 diabetes mellitus, morbid obesity, obstructive and reflux uropathy, hypertension, hyperlipidemia, peripheral vascular disease, and chronic kidney disease, stage 3.

Resident #45's significant change in assessment minimum data set (MDS) with an assessment reference date (ARD) of 5/16/19 assessed the resident with a BIMS (brief interview for mental status) as 13/15.

During the survey process, the record review asked if a Level II PASSAR had been completed. All sections of the PASSAR had been completed except there was no signature or date as to who completed the assessment.

The surveyor was informed by the director of nursing on 5/30/19 that the social worker was responsible for the completion of the form.

The surveyor interviewed the facility social worker on 5/30/19 at 11:14 a.m. The social worker reviewed the form and stated she completed the form but just didn't sign it.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse, and the chief executive officer of the above

F 645

the facility to ensure current residents have a PASARR (Pre-Admission Screening and Resident Review) and it is complete.
3. Administrator and/or Designee re-educated Director of Social Services and Admissions Director regarding F 645- PASARR Screening for MD & ID and State PASARR policy to ensure the PASARR (Pre-Admission Screening and Resident Review) are complete for residents that reside in the facility.
4. Administrator and/or Designee will complete audit of new admissions to facility one time a week x 3 months to ensuring the PASARR (Pre-Admission Screening and Resident Review) are in place and complete for newly admitted residents in the facility. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as necessary.

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concern on 5/30/19 at 4:50 p.m. and again on 5/31/19 at 6:20 p.m.

No further information was provided prior to the exit conference on 5/31/19.

2. The facility staff failed to ensure the Pre-Admission Screening and Resident Review (PASSAR) was competed for Resident #7.

The clinical record of Resident #7 was reviewed 5/28/19 through 5/31/19. Resident #7 was admitted to the facility 7/29/16 with diagnoses that included but not limited to anemia, anxiety, depression, dementia, psychosis, diabetes mellitus, pneumonia, hypertension, orthostatic hypotension, and obstructive uropathy.

Resident #7's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/10/19 assessed the resident with a BIMS (brief interview for mental status) as 12/15.

During the clinical record review, the long-term care process asked about PASSARs. The surveyor reviewed the PASSAR in the clinical record. Under Section 5, it stated either a or b must be checked. Neither one of these were checked. The surveyor informed the director of nursing of the above concern on 5/30/19 at 11:10 a.m. At 11:25 a.m., the surveyor interviewed the social worker and informed the social worker of the concern. The social worker circled 5b and stated, "I just made a mistake."

The surveyor informed the administrator, the director of nursing, the corporate registered nurse, and the chief executive officer of the above concern on 5/30/19 at 4:50 p.m. and again on

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F 645	Continued From page 22 5/31/19 at 6:20 p.m. No further information was provided prior to the exit conference on 5/31/19.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		6/30/19

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future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to develop care plans for psychotropic medication (Zyprexa and Restoril) and insomnia for 1 of 22 residents (Resident #40).

The findings included:

The facility staff failed to develop a care plan for the use of psychotropic medications, failed to develop a care plan for insomnia, and failed to develop a care plan for diabetes for Resident #40.

The clinical record of Resident #40 was reviewed 5/29/19 through 5/31/19. Resident #40 was admitted to the facility 2/28/19 and readmitted 5/2/19 with diagnoses that included but not limited to symbolic dysfunction, insomnia, muscle weakness, hypertension, atherosclerotic heart disease, unspecified dementia with behavioral disturbances, cerebrovascular disease, anxiety disorder, major depressive disorder, hyperlipidemia, type 2 diabetes mellitus, and unspecified psychosis.

Resident #40's quarterly minimum data set (MDS) assessment with an assessment

F 656

1. Resident #40s comprehensive care plan reviewed and revised on 05/30/2019.
2. Residents that reside in the facility have the potential to be affected by this deficient practice. Director of Nursing and/or Designee completed audit comprehensive care plans of residents in the facility to ensure resident□s comprehensive care plans are accurate and complete.
3. Director of Nursing and/or Designee to educate licensed nursing staff regarding F 656- Develop/Implement Comprehensive Care Plan and Care Plan Policy to ensure residents in the facility have comprehensive care plans that are accurate and complete.
4. Director of Nursing and/or Designee to complete audit of 5 resident comprehensive care plans one time a week x 3 months to ensure resident□s care plans are accurate and complete. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as necessary.

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reference date (ARD) of 3/15/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #40 was not interviewable.

The May 2019 physician's orders were reviewed and included orders that read "Restoril 15 mg (milligrams) Give 1 capsule by mouth at bedtime for insomnia, Seroquel Tablet 25 mg Give 1 tablet at bedtime for BPSD (bipolar disorder) and Zyprexa 2.5 mg give 1 tablet by mouth one time a day for psychosis." In addition, Resident #40 had physicians orders for Lantus15 units at bedtime-start date 5/11/19 and Novolog FlexPen Inject as per sliding scale: If 150-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units, 351-400=10 units, subcutaneously before meals and at bedtime for DM II (diabetes mellitus type 2). If BS (blood sugar) > (greater than) 400, call MD (medical doctor). Start Date 5/11/19.

Resident #40's current comprehensive care plan initiated 3/4/19 did not include a care plan for behaviors and the use of psychotropic medications or a care plan for insomnia. Resident #40 does have a care plan initiated 3/8/19 for a focus area of chronic/progressive decline in intellectual functioning characterized by deficit in memory, judgement, decision making and thought processes, per family and through interviews related to dx (diagnosis) of dementia/hx (history of) CVA (cerebrovascular accident) AEB (as evidenced by) inability to participate on BIMS/PHQ sections of MDS. Interventions: Break tasks/activities into manageable subtasks. In addition, the current comprehensive care plan did not have a care plan for the care and management of the diabetic resident.

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F 656	Continued From page 25 The surveyor informed the administrator, director of nursing, the corporate registered nurse and the chief executive officer of the above concern on 5/30/19 at 4:50 p.m. and again on 5/31/19 at 6:20 p.m. The surveyor requested the facility policy on psychotropic medication management. No further information was provided prior to the exit conference on 5/31/19.	F 656		
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 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	F 657		6/30/19

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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 2 of 22 Residents in the survey sample, Resident # 31 and Resident # 7.

The findings included

1. The facility staff failed to review and revise the plan of care for Resident # 31 to reflect refusal of insulin.

Resident # 31 was a 77-year-old-female who was originally admitted to the facility on 4/18/15, with a readmission date of 1/21/19. Diagnoses included but were not limited to; type 2 diabetes mellitus, hypertension, anemia, and heart failure.

The clinical record for Resident # 31 was reviewed 5/30/19 at 3:38 pm. The most recent MDS (minimum data set) assessment for Resident # 31 was an annual assessment with an ARD (assessment reference date) of 5/5/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 31 had a BIMS (brief interview for mental status) score of 13 out of 15, which indicated that Resident # 31 was cognitively intact.

The current plan of care for Resident # 31 was reviewed and revised on 5/10/19. The facility staff documented a focus area for Resident # 31 as, "At risk for skin breakdown related to: decreased mobility, weakness, edema, diagnosis of DM

F 657

1. Resident #31 and #7s comprehensive care plan reviewed and revised on 05/31/2019.
2. Residents that reside in the facility have the potential to be affected by this deficient practice. Director of Nursing and/or Designee completed audit of comprehensive care plans of residents in the facility to ensure resident□s comprehensive care plans are reviewed and revised by facility staff.
3. Director of Nursing and/or Designee re-educated licensed nursing staff regarding F 657- Care Plan Timing and Revision and Care Plan Policy to ensure residents in the facility have comprehensive care plans that are reviewed and revised by facility staff.
4. Director of Nursing and/or Designee to complete audit of 5 resident comprehensive care plans one time a week x 3 months to ensure resident□s care plans are reviewed and revised. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as necessary.

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(diabetes mellitus), O2 (oxygen) tubing prn (as needed)." Interventions included but were not limited to, "Notify MD (medical doctor) prn with any changes." The surveyor did not observe any documentation of insulin refusals on the care plan for Resident # 31.

Resident # 31 had orders that included but were not limited to, "Lantus SoloStar Solution Pen-injector 100 unit/ml (milliliter) Inject 35 unit subcutaneously at bedtime for diabetes," which was initiated by the physician on 3/9/19.

The surveyor reviewed the clinical record for Resident # 31 and observed that the facility staff had documented that Resident # 31 had refused Lantus 35 units at 8:00 pm, and the physician had not been notified. The dates identified were:
5/5/19
5/11/19
5/14/19
5/15/19
5/17/19
5/18/19
5/20/19
5/21/19
5/22/19
5/24/19
5/25/19
5/26/19
5/29/19

On 5/31/19 at 6:30 pm, the administrative team was made aware of the findings as stated above, and agreed that the plan of care for Resident # 31 did not reflect that Resident # 31 refused insulin at times.

No further information regarding this issue was

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presented to the survey team prior to the exit conference on 5/31/19.

The findings included

2. The facility staff failed to review and revise the plan of care to include Resident specific behaviors of depression associated with the use of Remeron for Resident # 7.

Resident # 7 was an 83-year-old-female who was originally admitted to the facility on 8/5/15, with a readmission date of 11/5/17. Diagnoses included but were not limited to; major depressive disorder, anxiety, heart failure, and type 2 diabetes mellitus.

The clinical record for Resident # 7 was reviewed on 5/30/19 at 11:00 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/10/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 7 had a BIMS (brief interview for mental status) score of 12 out of 15, which indicated that Resident # 7's cognitive status was moderately impaired.

The current plan of care for Resident # 7 was reviewed and revised on 1/14/19. The facility staff documented a focus area for Resident # 7 as, "At risk for adverse effects r/t (related to) psychoactive medication use: anxiety, depression, BSPD (behavioral and psychological symptoms of dementia), psychosis." Interventions included but were not limited to, "Monitor of s/s (signs and symptoms) of depression," "Monitor medications for effectiveness," and "Monitor for med side effects: sedation, hypotension, EPS

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F 657	Continued From page 29 (extrapyramidal symptoms), anticholinergic sx (symptoms) H/A (headache), insomnia, anorexia, constipation." The surveyor did not observe and Resident specific documented behaviors of depression on the plan of care for Resident # 7. Resident # 7 had orders that included but were not limited to, "Remeron tablet 30 mg (milligram) Give 1 tablet by mouth at bedtime for depression," which was initiated by the physician on 12/13/18. On 5/31/19 at 9:42 am, the surveyor reviewed the May 2019 medication administration record for Resident # 7. The surveyor did not observe behavior monitoring, or monitoring for side effects and effectiveness associated with the use of Remeron for Resident # 7. On 5/31/19 at 6:20 pm, the administrative team was made aware of the findings as stated above, and agreed that the facility failed to review and revise the care plan for Resident # 7 to include Resident specific behaviors associated with the use of Remeron . No further information regarding this issue was presented to the survey team prior to the exit conference of 5/31/19.	F 657		
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	F 684		6/30/19

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F 684	Continued From page 30 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 staff interview, clinical record review, and during a medication pass and pour observation, the facility staff failed to ensure the highest practicable well-being for 7 of 22 Residents, Resident #43, #31, #19, #34, #4, #40, and #22. The findings included: 1. For Resident #43, the facility staff failed to administer the Residents medication per the physician's orders. The medication renvela was not administered with meals or any food item. The clinical record review revealed that Resident #43 had been admitted to the facility 09/29/16 and was readmitted 05/08/19. Diagnoses included, but were not limited to, hypertension, end stage renal disease, gout, gastro-esophageal reflux disease, cognitive communication deficit, and metabolic encephalopathy. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/15/19 included a BIMS (brief interview for mental status) summary score of 12 out of a possible 15 points. The Residents clinical record included a physicians order for renvela 800 mg give by mouth with meals. On 05/29/19 beginning at approximately 11:10	F 684	1. MD made aware of medication error for resident #43 on 05/29/2019, no new orders. MD made aware of resident #4s refusal of insulin on 05/31/2019, no new orders. MD made aware of resident #19s blood sugar levels on 05/31/2019, no new orders. MD made aware of resident #34s refusals of insulin on 05/31/2019, no new orders. MD made aware of resident #31s refusals of insulin and the failure of obtaining a urinalysis on 05/31/2019, no new orders. MD made aware of resident #40s failure to follow physician□s orders for insulin administration on 5/31/2019, no new orders. MD made aware of facility□s failure to follow physician□s orders for resident #22 on 05/31/2019, no new orders. 2. Residents that reside in the facility with diabetes and have physicians orders for Renvela have the potential to be affected by this deficient practice. Director of Nursing and/or Designee completed audit of residents in the facility with diabetes and receive Renvela to ensure the facility residents receive the highest practicable well-being. 3. Director of Nursing and/or Designee re-educated licensed nursing staff regarding F 684- Quality of Care, Resident Change in Condition Policy and Medication Error policy ensure facility staff are providing facility residents with the highest practicable well-being.	

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F 684	Continued From page 31 a.m., the surveyor observed LPN (licensed practical nurse) #2 prepare and administer Resident #43's renvela for administration. This medication was not administered with a meal or with any type of food. When interviewing LPN #2, LPN #2 stated the order pops up at 11:00 a.m. I think we are going to tweak the order. On 05/29/19 at 12:30 p.m., the DON (director of nursing) and corporate nurse were made aware of the issues regarding the Residents medication. Per the website www.renvela.com this medication is known as a phosphate binder. It should be taken three times a day with meals to help control phosphorous levels in your body. No further information regarding this issue was shared with the surveyor. 2. The facility staff failed to notify the physician of refusal of insulin for Resident # 4. Resident # 4 was an 87-year-old-male who was originally admitted to the facility on 2/1/11, and was readmitted to the facility on 1/30/19. Diagnoses included but were not limited to; type 2 diabetes mellitus, heart failure, hypertension, and end stage renal disease. The clinical record for Resident # 4 was reviewed on 5/30/19 at 9:25 am. The most recent MDS (minimum data set) assessment for Resident # 4 was a quarterly assessment with an ARD (assessment reference date) of 3/13/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 4 had a BIMS (brief interview for	F 684	4. Director of Nursing and/or Designee to complete audit of residents who receive insulin one time a week x 3 months to ensure facility residents are provided the highest practicable well-being. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as necessary.	

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mental status) score of 12 out of 15, which indicated that Resident # 4's cognitive status was moderately impaired. Section N of the MDS assesses medications. In Section N0350, the facility staff documented that Resident # 4 had insulin injections on 2 days during the look back period for the 3/13/19 ARD.

The current plan of care for Resident # 4 was reviewed and revised on 2/25/19. The facility staff documented a focus area for Resident # 4 as, "The resident is at times resistive to care r/t (related to) noncompliance with taking medication and daily routine AEB (as evidenced by) refusing medication and getting out of bed." Interventions included but were not limited to; "Educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care."

Resident # 4 had orders that included but were not limited to; "Levemir Solution 100 unit/ml (milliliter) Inject 12 unit subcutaneously one time a day for DM II (type 2 diabetes mellitus)," which was initiated by the physician on 1/30/19, and "Levemir Solution 100 unit/ml Inject 5 unit subcutaneously at bedtime for DM II," which was initiated by the physician on 1/30/19.

On 5/31/19 at 8:02 am, the surveyor reviewed the May 2019 medication administration record for Resident # 4. The surveyor observed that the facility staff documented that Resident # 4 had refused Levemir Solution 100 unit/ml Inject 12 unit subcutaneously one time a day on the following dates for the 6:00 am dose,
5/1/19
5/2/19
5/3/19

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F 684	Continued From page 33 5/4/19 5/5/19 5/6/19 5/7/19 5/8/19 5/9/19 5/10/19 5/11/19 5/12/19 5/13/19 5/14/19 5/16/19 5/17/19 5/18/19 5/19/19 5/20/19 5/21/19 5/22/19 5/23/19 5/24/19 5/25/19 5/26/19 5/27/19 5/28/19 5/29/10 5/30/19 The surveyor observed that the facility staff documented that Resident # 4 had refused Levemir Solution 100 unit/ml Inject 5 unit subcutaneously at bedtime on the following dates for the 8:00 pm dose, 5/2/19 5/5/19 5/8/19 5/9/19 5/12/19 5/13/19 5/15/19	F 684		

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5/16/19
5/17/19
5/18/19
5/19/19
5/21/19
5/24/19
5/25/19
5/27/19
5/29/19
5/30/19

The surveyor reviewed the clinical record further for Resident # 4 and did not observe documentation that the physician and had been made aware that Resident # 4 had refused Levemir on the dates and times listed above.

On 5/31/19 at 11:08 am, the surveyor informed the director of nursing that there was no documentation that the physician had been made aware of Resident # 4's refusal of Levemir on the dates and times listed above. The director of nursing stated that she would look into it.

The facility "Change in Resident Condition" policy contained documentation that included but was not limited to; ..." 5. The Resident/Physician/Family/Responsible Party will be notified when there has been:
f. Refusal of treatment or medications for on 3 consecutive times." ...

On 5/31/19 at 6:30 pm, the administrative team was made aware of the findings as stated above and agreed that the physician had not been made aware of Resident # 4's refusals of Levemir.

No further information regarding this issue was presented to the survey team prior to the exit

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conference on 5/31/19.

3. The facility staff failed to notify the physician of blood sugar levels above 450 for Resident # 19.

Resident # 19 was an 83-year-old-male who was originally admitted to the facility on 10/2/15, with a readmission date of 5/29/19. Diagnoses included but were not limited to; type 2 diabetes mellitus, hypertension, cognitive communication deficit, and peripheral vascular disease.

The clinical record for Resident # 19 was reviewed on 5/29/19 at 11:51 am. The most recent MDS (minimum data set) assessment for Resident # 19 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 # 19 had a BIMS (brief interview for mental status) score of 5 out of 15, which indicated that Resident # 19's cognitive status was severely impaired. Section N of the MDS assesses medications. In Section N0350, the facility staff documented that Resident # 19 had insulin injections for 7 days during the look back period for the 4/4/19 ARD.

The current plan of care for Resident # 19 was reviewed and revised on 3/15/19. The facility staff documented a focus area for Resident # 19 as, "At risk for skin breakdown related to decreased mobility, weakness, diagnosis of DM (diabetes mellitus) edema, incontinent of bowel and bladder, PVD (peripheral vascular disease), application of prosthetic to left leg, surgical wound to right leg." Interventions included but were not limited to, "Meds/labs/treatment as ordered."

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Resident # 19 had orders that included but were not limited to; "Call MD (medical doctor) if bs (blood sugar) greater than 450," which was initiated by the physician on 4/26/19, and "Novolog flexpen solution pen-injector 100 unit/ml (milliliter) Inject 15 unit subcutaneously before meals for dm (diabetes mellitus)," which was initiated by the physician on 4/26/19.

On 5/30/19 at 2:42 pm, the surveyor reviewed the May 2019 medication administration record for Resident # 19. The surveyor observed that Resident # 19 had blood sugar levels above 450 on the following dates and times:
5/2/19 at 4:30 pm - 454
5/3/19 at 4:30 pm - 477
5/5/19 at 4:30 pm - 472
5/11/19 at 4:30 pm - 452
5/16/19 at 4:30 pm - 493
5/18/19 at 4:30 pm - 497
5/26/19 at 4:30 pm - 494

The surveyor reviewed the clinical record for Resident # 19 and did not observe any documentation that reflected that the physician was made aware of blood sugars levels greater than 450 on the dates and times listed above.

On 5/31/19 at 11:08 am, the director of nursing was made aware that the surveyor did not locate documentation that supported that the physician had been made aware of blood sugars greater than 450 on the dates and times listed above.

On 5/31/19 at 6:30 pm, the administrative team was made aware of the findings as stated above and agreed that the physician was not notified of blood sugars greater than 450 for Resident # 19.

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No further information regarding this issue was presented to the survey team prior to the exit conference on 5/31/19.

4. The facility staff failed to notify the physician of insulin refusals for Resident # 34.

Resident # 34 was an 80-year-old-male who was originally admitted to the facility on 3/17/16, with a readmission date of 7/19/18.
Diagnoses included but were not limited to; obstructive and reflux uropathy, chronic kidney disease, hypertension, and type 2 diabetes mellitus.

The clinical record for Resident # 34 was reviewed on 5/29/19 at 10:59 am. The most recent MDS (minimum data set) assessment for Resident # 34 was a quarterly assessment with an ARD (assessment reference date) of 5/9/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 34 had a BIMS (brief interview for mental status) score of 7 out of 15, which indicated that Resident # 34's cognitive status was severely impaired. Section N of the MDS assesses medications. In Section N0350, the facility staff documented that Resident # 34 had insulin injections on 5 days during the look back period for the 5/9/19 ARD.

The current plan of care for Resident # 34 was reviewed and revised on 5/14/19. The facility staff documented a focus area for Resident # 34 as, "Resident is noncompliant with taking his insulin in the a.m. R/T (related to) his right of choice." Interventions included but were not limited to, "Inform MD (medical doctor)/physician, if applicable of non-compliance."

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Resident # 34 had orders that included but were not limited to, "Lantus Solution 100 unit/ml (milliliter) Inject 14 unit subcutaneously at bedtime for diabetes," which was initiated by the physician on 7/19/18, and "Lantus Solution 100 unit/ml Inject 16 unit subcutaneously in the morning for diabetes before breakfast," which was initiated by the physician on 7/19/18.

On 5/29/19 at 11:44 am, the surveyor reviewed the May 2019 medication administration record for Resident # 34. The surveyor observed that the facility staff documented that Resident # 34 refused Lantus 100 unit/ml 16 unit subcutaneous for the 6:30 am dose, and the physician was not notified on the following dates:
5/1/19
5/2/19
5/3/19
5/5/19
5/6/19
5/7/19
5/8/19
5/9/19
5/10/19
5/11/19
5/12/19
5/13/19
5/16/19
5/17/19
5/19/19
5/20/19
5/21/19
5/22/19
5/23/19
5/24/19
5/25/19
5/26/19

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5/27/19
5/29/19

The surveyor observed that Lantus 100 unit/ml Inject 14 unit subcutaneously at bedtime for the 8:00 pm was refused by Resident # 34 and the physician was not notified on the following dates:
5/2/19
5/6/19
5/9/19
5/12/19
5/15/19
5/16/19
5/17/19
5/19/19
5/21/19
5/28/19

The facility "Change in Resident Condition" policy contained documentation that included but was not limited to; ..." 5. The Resident/Physician/Family/Responsible Party will be notified when there has been:
f. Refusal of treatment or medications for on 3 consecutive times." ...

On 5/31/19 at 6:30 pm, the administrative team was made aware of the findings as stated above and agreed that the physician had not been made aware of Resident # 34's refusals of Lantus.

No further information regarding this issue was presented to the survey team prior to the exit conference on 5/31/19.

5(a). The facility staff failed to notify the physician of insulin refusals for Resident # 31.

Resident # 31 was a 77-year-old-female who was

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originally admitted to the facility on 4/18/15, with a readmission date of 1/21/19. Diagnoses included but were not limited to; type 2 diabetes mellitus, hypertension, anemia, and heart failure.

The clinical record for Resident # 31 was reviewed 5/30/19 at 3:38 pm. The most recent MDS (minimum data set) assessment for Resident # 31 was an annual assessment with an ARD (assessment reference date) of 5/5/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 31 had a BIMS (brief interview for mental status) score of 13 out of 15, which indicated that Resident # 31 was cognitively intact.

The current plan of care for Resident # 31 was reviewed and revised on 5/10/19. The facility staff documented a focus area for Resident # 31 as, "At risk for skin breakdown related to: decreased mobility, weakness, edema, diagnosis of DM (diabetes mellitus), O2 (oxygen) tubing prn (as needed)." Interventions included but were not limited to, "Notify MD (medical doctor) prn with any changes." The surveyor did not observe any documentation of insulin refusals on the care plan for Resident # 31.

Resident # 31 had orders that included but were not limited to, "Lantus SoloStar Solution Pen-injector 100 unit/ml (milliliter) Inject 35 unit subcutaneously at bedtime for diabetes," which was initiated by the physician on 3/9/19.

The surveyor reviewed the clinical record for Resident # 31 and observed that the facility staff had documented that Resident # 31 had refused Lantus 35 units at 8:00 pm, and the physician had

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not been notified. The dates identified were:
5/5/19
5/11/19
5/14/19
5/15/19
5/17/19
5/18/19
5/20/19
5/21/19
5/22/19
5/24/19
5/25/19
5/26/19
5/29/19

The facility "Change in Resident Condition" policy contained documentation that included but was not limited to; ..." 5. The Resident/Physician/Family/Responsible Party will be notified when there has been:
f. Refusal of treatment or medications for on 3 consecutive times." ...

On 5/31/19 at 6:30 pm, the administrative team was made aware of the findings as stated above, and agreed that the physician was not notified that Resident # 31 had refused Lantus on the dates and times listed above.

No further information regarding this issue was presented to the survey team prior to the exit conference on 5/31/19.

5(b). The facility staff failed to obtain a urinalysis within a timely manner for Resident # 31.

On 5/30/19 at 3:21 pm, the surveyor observed a nursing note in Resident # 31's clinical record

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dated 5/24/19 at 10:47 pm. The nursing note was documented as, "Seen by (Physician's name withheld) today orders given to start loratadine 10 mg (milligram) by mouth daily and collect UA/C&S (urine analysis with culture and sensitivity)." The surveyor observed that the urinalysis was to be obtained on the next available void. Upon review of the lab results, the surveyor observed that the urinalysis was not obtained until 5/27/19. The surveyor asked the regional nurse consultant if she could look into why the urinalysis was not obtained until 3 days later when it was to be obtained on the next available void.

On 5/31/19 at 6:30 pm, the administrative team was made aware of the findings as stated above, and agreed that the facility staff did not obtain the physician ordered urinalysis for Resident # 31 within a timely manner.

No further information regarding this issue was presented to the survey team prior to the exit conference on 5/31/19.

6. The facility staff failed to follow the physician's orders for insulin administration that included holding of long acting insulin (Lantus) without a physician order, not following physician's orders to obtain accuchecks, and no notification to physician when Resident #40 refused both Humalog (short-acting insulin) and Lantus (long-acting insulin).

The clinical record of Resident #40 was reviewed 5/29/19 through 5/31/19. Resident #40 was admitted to the facility 2/28/19 and readmitted 5/2/19 with diagnoses that included but not limited to symbolic dysfunction, insomnia, muscle weakness, hypertension, atherosclerotic heart

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disease, unspecified dementia with behavioral disturbances, cerebrovascular disease, anxiety disorder, major depressive disorder, hyperlipidemia, type 2 diabetes mellitus, and unspecified psychosis.

Resident #40's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/15/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #40 was not interviewable.

There was not a comprehensive care plan that addressed diabetes.

The surveyor reviewed the April 2019 physician's orders and the May 2019 physician's orders. Resident #40 had insulin orders that read Humalog Inject 5 units subcutaneously one time a day for DM (diabetes mellitus)-start date 3/3/19 and Lantus (Insulin Glargine) Inject 25 units one time a day for DM II (diabetes mellitus type 2) start date-3/1/19.

A review of the April 2019 electronic medication administration record (eMAR) revealed the following:
In the entry for Lantus on 4/4/19 at 0600-There was an "X" in the box for the blood sugar at 0600 and the number "19" and initials ls.
In the entry for Lantus on 4/6/19, there was an "X" in the box for blood sugar at 0600 and the number "12" and initials ls.
In the entry for Lantus on 4/8/19, there was an "X" in the box for blood sugar at 0600 and the number "12" and initials ls.

In the entry for Humalog on 4/6/19 at 0630, there

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was a "12" and the initials ls.
In the entry for Humalog on 4/8/19 at 0630, there was a "12" and the initials lc.
In the entry for Humalog on 4/9/19 at 0630, there was a "19" and the initials vhc.
In the entry for Humalog on 4/12/19 at 0630, there was a "12" and the initials ls.
In the entry for Humalog on 4/15/19 at 0630, there was a "16" and the initials vhc.

Based on the chart codes/follow-up codes, 12=drug refused, 16=Hold/See Nurse Notes, 17=Hospitalized, and 19=Other/See Nurse Notes.

The 4/4/19 06:51 progress note read "Lantus SoloStar Solution pen-injector 100 unit/ml (milliliter) Inject 25 unit subcutaneously one time a day for DM II rsd (resident) BS (blood sugar) 133 insulin not given." The surveyor was unable to locate a physician order to hold the insulin, physician notification that the insulin was held, or any physician orders with hold parameters.

The 4/6/19 05:14 progress note read "Lantus SoloStar Solution pen-injector 100 unit/ml (milliliter) Inject 25 unit subcutaneously one time a day for DM II rsd (resident) BS (blood sugar) 133 insulin not given." The surveyor was unable to locate a physician order to hold the insulin, physician notification that the insulin was held, or any physician orders with hold parameters.

The 4/6/19 05:35 progress note read, "Humalog KwikPen Solution Pen-injector 100 unit/ml Inject 5 units subcutaneously one time a day for DM rsd refused admin. (administration) of insulin. The surveyor was unable to physician notification that the insulin was refused by the resident.

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There was not a progress note for 4/8/19 as to the reason Humalog and Lantus were not administered at 0630.

The 4/9/19 05:35 progress note read, "Humalog KwikPen Solution Pen-injector 100 unit/ml Inject 5 units subcutaneously one time a day for DM held, long acting insulin given. Unable to determine resident appetite at this time. Resting quietly with eyes closed, refused snack at this time. The surveyor was unable to locate a physician order to hold the Humalog insulin and physician notification that the insulin was not administered by the nurse.

There was not a progress note for 4/12/19 as to the reason Humalog was not administered at 0630. The chart code for Lantus not administered on 4/12/19 at 0600 was refusal by the resident per the chart codes. However, there was no documentation that the physician had been made aware of the insulin refusal.

The 4/15/19 05:59 progress note read, "Humalog KwikPen Solution Pen-injector 100 unit/ml Inject 5 units subcutaneously one time a day for DM blood sugar 126, fast acting insulin held. The surveyor was unable to locate a physician order to hold the Humalog insulin and physician notification that the insulin was not administered by the nurse.

The May 2019 physician's orders read "Lantus Inject 10 unit subcutaneously one time a day for Diabetes-start date 5/6/19."

The entry for Lantus on 5/9/19 at 0600 read "3" and initials l1s.
The entry for Lantus on 5/10/19 at 0600 read "12"

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and initials I1s.

The chart codes for 3=No insulin required and 12=drug refused.

The surveyor was unable to locate a blood sugar result for 5/9/19 at 0600.

The progress note dated 5/10/19 at 06:53 read "Lantus SoloStar Solution Pen-injector 100 unit/ml Inject 10 unit subcutaneously one time a day for DM II rsd refused insulin d/t (due to) BS (blood sugar) 113. However, there was no documentation that the physician had been made aware of the insulin refusal.

The May 2019 physician's orders, in addition, included orders for Novolog Flex Pen subcutaneously before meals and at bedtime for DM II.
Inject as per sliding scale:
If 151-200=2 units
201-250=4 units
251-300=6 units
301-350=8 units
351-400=10 units
If BS > (greater than) 400, call MD (medical doctor). Start dated 5/11/19.

On 5/17/19 at 0600, there was no recorded blood sugar. The box read "7" and initials of C1M. The chart codes for 7=vitals outside of parameters. The progress noted dated 5/17/19 at 05:47 did not have a documented blood sugar result.

The 5/18/19 2000 (8:00 p.m.) blood sugar was 404. The box had "19" and the initials HC. The chart code for 19=Other/See Nurse Note. The 5/18/19 at 19:29 (7:29 p.m.) did not have

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documentation the physician was notified of the 404 blood sugar.

On 5/20/19 at 2000, there was no recorded blood sugar. The box read "X" and initials of JCM. There was not a progress note dated 5/20/19 for blood sugars.

The 5/25/19 4:00 p.m. (1600) blood sugar was 443 and the chart code "19". 19=Other/See Nurse Notes. The 5/25/19 8:00 p.m. blood sugar was 419 and the chart code "19". The chart code for 19=Other/See Nurse Notes. The surveyor reviewed the 5/25/19 nurses notes and found no documentation that the physician was informed of the blood sugar greater than 400.

The 5/26/19 4:00 p.m. (1600) blood sugar was 427 and the chart code "19". 19=Other/See Nurse Notes. The 5/26/19 8:00 p.m. blood sugar was 433 and the chart code "19". The chart code for 19=Other/See Nurse Notes. The surveyor reviewed the 5/26/19 nurses notes and found no documentation that the physician was informed of the blood sugar greater than 400.

The surveyor informed the director of nursing of the above concern on 5/31/19 at 11:24 a.m. and requested the facility policy on diabetes management and physician notification.

The surveyor reviewed the facility policy titled "Caring for the Diabetic Date Revised October 15, 2015" on 5/31/19. The policy read in part "PROCEDURE: g) The physician will authorize pertinent periodic evaluations such as ophthalmology and nephrology, as indicated. The physician will order desired parameters for monitoring and reporting information related to

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diabetes or blood sugar management. i. The staff will incorporate such parameters into the Medication Administration Record and care plan."

The surveyor reviewed the facility policy titled "Change in Resident Condition Date Revised: July 2015." The policy read in part "5. The Resident/Physician/Family/Responsible Party will be notified when there has been: e. A need to alter the resident's medical treatment."

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above issue on 5/31/19 at 6:20 p.m.

No further information was provided prior to the exit conference on 5/31/19.

7. The facility staff failed to follow the physician's orders for medication administration for Resident #22. The facility staff failed to administer Humalog and Lantus as ordered by the physician and failed to notify the physician of insulin refusals.

The clinical record of Resident #22 was reviewed 5/28/19 through 5/31/19. Resident #22 was admitted to the facility 4/26/11 and readmitted 4/27/19 with diagnoses that included but not limited to type 2 diabetes mellitus, end-stage renal disease, morbid obesity, post-menopausal bleeding, hypertension, hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side, contracted elbow, contracted left hand, and chronic pain.

Resident #22's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/13/19 assessed the

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resident with a BIMS (brief interview for mental status) as 15/15.

Resident #22's current comprehensive care plan date initiated 8/18/2015 and revised 5/14/19 identified non-compliance with medication/insulin. Interventions: Notify MD (medical doctor) of non-compliance per routine and prn (whenever necessary).

The May 2019 physician's orders were reviewed. Resident #22 had orders for Humalog (Insulin Lispro) Inject 12 units subcutaneously three times a day for DM (diabetes mellitus) and Lantus (insulin Glargine) Inject 62 units subcutaneously at bedtime for DM.

The surveyor reviewed the May 2019 electronic medication administration records (eMARs).

The entry that read "Humalog (insulin Lispro) Inject 12 unit subcutaneously three times a day for DM" revealed Resident #22 was not administered Humalog on the following days/times:

5/2/19 at 0600 (chart code 12), 1100 (chart code=14), and 1700 (5:00 p.m.)(chart code=3).

Chart codes:
3=No insulin required
12=Drug refused
14=Absent from home
15-Away from home with meds

A review of the 5/2/19 progress notes did not have documentation as to why the medication was not administered or the physician had been informed of the insulin refusal.

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F 684	Continued From page 50 5/3/19 at 0600=12 marked 5/3/19 at 1100=12 marked 5/4/19 at 0600=12 marked 5/4/19 at 1100=13 marked 5/7/19 at 0600=12 marked 5/7/19 at 1100=14 marked 5/8/19 at 0600=12 marked 5/8/19 at 1100=15 marked 5/9/19 at 0600=12 marked 5/9/19 at 1100=13 marked 5/9/19 at 1700=3 marked 5/10/19 at 0600=12 marked 5/10/19 at 1100=12 marked 5/11/19 at 1100=14 marked 5/11/19 at 1700=12 marked 5/12/19 at 0600=12 marked 5/14/19 at 0600=12 marked 5/14/19 at 1100=13 marked 5/14/19 at 1700=12 marked 5/15/19 at 0600 and 1100=12 marked 5/16/19 at 0600=12 marked 5/16/19 at 1100=13 marked 5/16/19 at 1700=12 marked 5/17/19 at 0600=3 marked 5/18/19 at 0600=12 marked 5/19/19 at 0600=12 marked 5/20/19 at 0600=12 marked 5/20/19 at 1100=14 marked 5/21/19 at 0600-12 marked 5/22/19 at 0600=12 marked 5/22/19 at 1700=14 marked 5/23/19 at 0600=12 marked 5/23/19 at 1100=13 marked 5/24/19 at 0600=12 marked 5/25/19 at 0600 and 1700=12 marked 5/25/19 at 1100=14 marked 5/26/19 at 0600=12 marked 5/27/19 at 0600 and 1100=12 marked	F 684		

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5/28/19 at 0600 and 1700=12 marked
5/28/19 at 1100=13 marked
5/29/19 at 0600=12 marked
5/30/19 at 0600=12 marked
5/30/19 at 1100=14 marked
5/31/19 at 1100=12 marked

The entry for Lantus Inject 62 unit subcutaneously at bedtime for DM-start date 4/27/19 was reviewed. The entry for 5/22/19 at 2000 (8:00p.m.) was marked with 12 (drug refused).

The May 2019 progress notes were reviewed. Only two progress notes (one dated 5/19/19 at 0604 and a second one dated 5/20/19 at 0559) had documentation why the resident refused the insulin. However, there was no documentation the physician was notified of Resident #22's insulin refusals and the physician orders for insulin not followed.

The surveyor informed the MDS/RN (registered nurse) of the above concern on 5/31/19 at 4:42 p.m. and requested the facility policy on diabetes management and physician notification.

The surveyor reviewed the facility policy titled "Caring for the Diabetic Date Revised October 15, 2015" on 5/31/19. The policy read in part "PROCEDURE: g) The physician will authorize pertinent periodic evaluations such as ophthalmology and nephrology, as indicated. The physician will order desired parameters for monitoring and reporting information related to diabetes or blood sugar management. i. The staff will incorporate such parameters into the Medication administration Record and care plan."

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F 684	Continued From page 52 The surveyor reviewed the facility policy titled "Change in Resident Condition Date Revised: July 2015." The policy read in part "5. The Resident/Physician/Family/Responsible Party will be notified when there has been: e. A need to alter the resident's medical treatment." The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above issue on 5/31/19 at 6:20 p.m. No further information was provided prior to the exit conference on 5/31/19.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		6/30/19

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F 690

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(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, clinical record review, staff interview, Resident interview, and facility document review, the facility staff failed to provide services to prevent urinary tract infections for 1 of 22 Residents in the survey sample, Resident 34.

The findings included

The facility staff failed to ensure that Foley catheter tubing for Resident # 34 was secured.

Resident # 34 was an 80-year-old-male who was originally admitted to the facility on 3/17/16, with a readmission date of 7/19/18. Diagnoses included but were not limited to; obstructive and reflux uropathy, chronic kidney disease, hypertension, and type 2 diabetes mellitus.

The clinical record for Resident # 34 was reviewed on 5/29/19 at 11:44 am. The most recent MDS (minimum data set) assessment for Resident # 34 was a quarterly assessment with an ARD (assessment reference date) of 5/9/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff

F 690

1. Foley catheter tubing for resident #34 secured on 05/30/2019.
2. Resident�s that have a urinary catheter in place have the potential to be affected by this deficient practice. Director of Nursing and/or Designee completed audit of residents in the facility with foley catheters to ensure catheter tubing is secured.
3. Director of Nursing and/or Designee re-educated licensed nursing staff regarding F 690- Bowel/Bladder Incontinence, Catheter, UTI and Foley Catheter Care Policy to ensure that foley catheter tubing is secured for residents that have an indwelling catheter.
4. Director of Nursing and/or Designee will audit resident�s that have foley catheters in place one time a week x 3 months to ensure the facility staff ensure resident�s with foley catheter tubing have tubing secured. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as

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documented that Resident # 34 had a BIMS (brief interview for mental status) score of 7 out of 15, which indicated that Resident # 34's cognitive status was severely impaired. Section H of the MDS assesses bladder and bowel. In Section H0100, the facility staff documented that Resident # 34 had an indwelling catheter.

The current plan of care for Resident # 34 was reviewed and revised on 5/14/19. The facility staff documented a focus area for Resident # 34 as, "Resident is at risk for infection r/t (related to) Foley catheter r/t BPH (benign prostatic hyperplasia), obstructive uropathy, peg tube, hx (history) of uti (urinary tract infections), hx pna (pneumonia), hx cellulitis, hx of osteomyelitis, areas to legs and toes." Interventions included but were not limited to; "Foley cath care as ordered."

Resident # 34 had orders that included but were not limited to; "16F (French) (30cc (cubic centimeter) balloon) indwelling Foley catheter d/t (due to) obstructive uropathy," which was signed by the physician on 5/2/19.

On 5/30/19 at 9:18 am, the surveyor was in Resident # 34's room conducting a Resident interview. The surveyor asked Resident # 34 if she could observe his Foley catheter. Resident # 34 pulled back his bed covers, and the surveyor observed that Resident # 34's Foley catheter tubing was not secured.

On 5/30/19 at 10:34 am, the surveyor and LPN # 1 (licensed practical nurse) went into Resident # 34's room to observed his Foley catheter. The surveyor and LPN # 1 observed Resident # 34's Foley catheter tubing was not secured. The

Provider's plan of correction (F 690): necessary.

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surveyor asked LPN # 1 if the catheter should be secured. LPN # 1 replied, "Yes he used to have one but he keeps pulling them off." "We tried both kinds." The surveyor asked Resident # 34 if he would like to have something on his leg that would help keep his catheter from pulling. Resident # 34 stated, "You can try it if you want to."

On 5/30/19 at 10:45 am, the surveyor reviewed the clinical record for Resident # 34. The surveyor did not observe any documentation in Resident # 34's clinical record that stated that Resident # 34 would pull off or refuse supplies utilized to secure his Foley catheter.

On 5/31/19 at 11:05 am, the director of nursing provided the surveyor with the facility standard of practice for "Management of the Patient with an Indwelling (self-retaining) Catheter and Closed Drainage system." The standard of practice contained documentation that included but was not limited to; ..."Nursing Action
2. Secure the indwelling catheter to the patient's thigh using tape, strap, adhesive anchor, or other securement device." ...

Nettina, S. M., & Brunner, L. S. (2019). Lippincott manual of nursing practice (10th ed.). Philadelphia:
Wolters Kiuwer.

On 5/31/19 at 6:30 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 5/31/19.

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F 697	Continued From page 56	F 697		
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, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to utilize non-pharmacological interventions prior to the use of pain medication for 1 of 22 residents (Resident #154). The findings included: The facility staff failed to utilize non-pharmacological interventions prior to the use of pain medication for Resident #154. The clinical record of Resident #154 was reviewed 5/29/19 through 5/31/19. Resident #154 was admitted to the facility 5/22/19 with diagnoses that included but not limited to fracture of parts of lumbosacral spine and pelvis, muscle weakness, gait and mobility abnormalities, cognitive communication deficit, anxiety, major depressive disorder, age-related osteoporosis, rheumatoid arthritis, hypertension, Vitamin D deficiency, kyphosis, atherosclerotic heart disease, and chronic pain. Resident #154's admission minimum data set (MDS) had not been completed. Resident #154's careplan initiated 5/23/19	F 697	1. Non-Pharmacological Interventions identified and implemented for resident #154 on 05/31/2019. 2. Resident□s in facility receiving pain medication have the potential to be affected by this deficient practice. Director of Nursing and/or Designee completed audit of residents in the facility receiving pain medication to ensure non-pharmacological interventions are in place and used prior to the use of pain medications. 3. Director of Nursing and/or Designee re-educated licensed nursing staff regarding F 697- Pain Management and Non-Pharmacological Pain Management policy to ensure non-pharmacological interventions are in place and attempted prior to the administration of pain medications. 4. Director of Nursing and/or Designee will audit resident□s in the facility that have pain medications in place one time a week x 3 months to ensure non-pharmacological interventions are in place and used prior to the use of pain medications. Results of Audit will be brought to monthly Quality Assurance and	6/30/19

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F 697	Continued From page 57 identified actual pain as a focus area r/t (related to) decreased mobility/function and weakness, dx (diagnosis) chronic pain, spinal compression fracture with long history of back issues including multiple kyphoplastys, RA (rheumatoid arthritis), sacral fracture, lumbar fracture, and abdominal pain. Interventions: Assist with positioning for comfort, provide distractions prn (as needed) such as television, or activities, interaction with others, reading material as able, assess for increase or decrease in pain, and meds (medications) as ordered. Resident #154's May 2019 admission physician's orders included Oxycodone 5 mg (milligram) 1 tablet by mouth every 6 hours as needed for pain and Tylenol 1000 mg every 8 hours as needed for pain fever. A review of the May 2019 electronic medication administration record revealed Resident #154 was administered oxycodone 5 mg eighteen times and Tylenol 1000 mg twice since admission on 5/22/19. A review of the May 2019 progress notes did not reveal any non-pharmacological interventions were utilized prior to the administration of each of the Oxycodone 5 mg tablets or Tylenol. Resident #154's pain assessment each shift ranged from 0-8 with 0 being no pain and 8 being the highest. The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the chief executive officer of the above concern during the end of the day meeting on 5/31/19 at 6:20 p.m. No further information was provided prior to the exit conference on 5/31/19.	F 697	Performance Improvement (QAPI) Meetings for review and revisions as necessary.	
F 758	Free from Unnec Psychotropic Meds/PRN Use	F 758		6/30/19

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F 758 SS=E		F 758		

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CFR(s): 483.45(c)(3)(e)(1)-(5)

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

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

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

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

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

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is

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F 758	Continued From page 59 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure 6 of 22 residents were free of an unnecessary psychotropic medication (Resident #6, Resident #40, Resident #154, Resident #19, Resident #53, and Resident # 7). The findings included: 1. The facility staff failed to identify and monitor resident specific target behaviors and identify non-pharmacological interventions for the administration of prn Ativan for Resident # 154. The clinical record of Resident #154 was reviewed 5/29/19 through 5/31/19. Resident #154 was admitted to the facility 5/22/19 with diagnoses that included but not limited to fracture of parts of lumbosacral spine and pelvis, muscle weakness, gait and mobility abnormalities, cognitive communication deficit, anxiety, major depressive disorder, age-related osteoporosis, rheumatoid arthritis, hypertension, Vitamin D deficiency, kyphosis, atherosclerotic heart disease, and chronic pain. Resident #154's admission minimum data set	F 758	1. Specific target behaviors identified and non-pharmacological interventions identified and implemented for resident #6, #40, #154, #19, #53 and #7 on 05/31/2019. 2. Residents that reside in the facility and receive psychotropic medications have the potential to be affected by this deficient practice. Director of Nursing and/or Designee completed audit of residents in the facility receiving psychotropic medications to ensure specific target behaviors identified and non-pharmacological interventions are identified and implemented. 3. Director of Nursing and/or Designee re-educated licensed nursing staff regarding F 758- Free from Unnecessary Psychotropic Medications/PRN Use and Behavior Management Policy to ensure residents are free from unnecessary psychotropic medications and those receiving psychotropic medication have non-pharmacological interventions in place and the specific target behaviors are identified. 4. Director of Nursing and/or Designee will	

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(MDS) had not been completed.

Resident #154's current comprehensive care plan initiated 5/23/19 identified the resident was at risk for adverse effects r/t (related to) psychoactive medication use: Anxiety, Depression. Interventions: Encourage expressions of feelings, interaction with others, oor (out of room) activity, monitor for s/s (signs and symptoms) of anxiousness, monitor for s/s of depression, report changes in mood.

Resident #154's May 2019 physician's orders read in part "Ativan tablet 0.5 mg (milligrams) (Lorazepam) Give 1 tablet by mouth as needed for anxiety for 14 days." The orders for Paxil and Trazodone (both antidepressants had been discontinued 5/22/19.

A review of the May 2019 electronic medication administration record revealed Resident #154 was administered Ativan 0.5 mg 10 times from 5/22/19 through 5/29/19. The surveyor found no non-pharmacological interventions prior to the use of Ativan or specific targeted behaviors identified for the use of the medication or behavior monitoring sheets for Ativan.

The surveyor informed the director of nursing (DON) of the above concern on 5/30/19 at 9:54 a.m. The DON stated the nurses fill out the behavior sheets. The DON stated the resident was a readmission and probably already had a care plan that addressed the use of psychotropic medications.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the chief executive officer of the above

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audit resident□s in the facility that have psychotropic medications in place one time a week x 3 months to to ensure residents are free from unnecessary psychotropic medications and those receiving psychotropic medication have non-pharmacological interventions in place and the specific target behaviors are identified. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as necessary.

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concern in the end of the day meeting on 5/30/19 at 4:50 p.m. and requested the facility policy on the management of psychotropic medication, Resident #154's May 2019 physician orders, care plan, May 2019 medication administration record and May 2019 nurse's progress notes.

The surveyor reviewed the facility policy titled "Psychotropic Medication Documentation and Review" revised November 2015. The policy read in part
"A. Residents receiving psychotropic medication will have a behavior/Intervention Monthly Flow Record (BFR) initiated on admission or whenever psychotropic meds are ordered.
a. Each psychotropic medication will be entered on BFR.
b. Resident specific behaviors related to medication use will be entered.
c. Diagnosis for the reason psychotropic medication is being given will be documented in medical record.
d. BFR record will be placed in front of the resident medication administration record (MAR).
B. Nurse will document on the following every shift:
a. Number of behavior episodes
b. Specific non-medication interventions used-entered code as indicated on BFR.
c. Outcome of interventions-use code key listed on BFR
i. Behavior interventions-individualized non-pharmacological approaches (including direct care and activities) that are provided as part of a supportive physical and psychological environment, and are directed toward preventing, relieving, and/or accommodating a resident's distressed behavior.
d. Any side effects (observed) -use code key

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listed on BFR
D. The resident's Plan of Care (POC) will be reviewed and updated with any changes in behavior and/or treatment."

No further information was provided prior to the exit conference on 5/31/19.

2. The facility staff failed to identify and monitor resident specific target behaviors and identify non-pharmacological interventions for the administration of Ativan and Zoloft for Resident #6.

The clinical record of Resident #6 was reviewed 5/29/19 through 5/31/19. Resident #6 was admitted to the facility 6/7/16 and readmitted 4/4/19 with diagnoses that included but not limited to metabolic encephalopathy, muscle weakness, dysphagia, hypertension, hypothyroidism, major depressive disorder, gastro-esophageal reflux disease, gastrostomy status, aphasia following cerebral infarction, and hemiplegia and hemiparesis following cerebral infarction.

Resident #6's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/8/19 assessed the resident with short term memory problems, long term memory problems, and severely impaired cognitive skills for daily decision making.

Resident #6's current comprehensive care plan initiated 6/21/16 and revised 3/20/19 identified a focus area that the resident was at risk for adverse effects r/t (related to) psychoactive medications use: depression/anxiety. Interventions: Encourage interaction with others or activity, monitor for s/s (signs/symptoms) of

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anxiousness, monitor for s/s depression, monitor medications for effectiveness.

Resident #6's May 2019 physician's orders read in part "Ativan tablet 0.5 mg (milligrams) (Lorazepam) Give 1 tablet via G-tube at bedtime related to anxiety disorder and Zoloft tablet 25 mg (Sertraline HCL) give 12.5 mg via G-tube one time a day for depression."

The surveyor was unable to locate specific behavior monitoring sheets for Ativan and Zoloft or identified targeted behaviors for the use of Ativan and Zoloft.

The surveyor interviewed licensed practical nurse #2 on 5/30/19 at 3:07 p.m. about behavior monitoring for Resident #6. L.P.N. #2 stated the forms are usually kept in the notebook with the narcotic sheets. The narcotic book was checked and L.P.N. #2 was unable to locate any behavior monitoring sheets. The surveyor informed the administrator and the director of nursing of the above issue. The unit secretary reviewed Resident #6's closed record and stated the record did not have any behavior monitoring sheets for Ativan or Zoloft upon the resident's return from a hospital stay in April 2019.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the chief executive officer of the above concern in the end of the day meeting on 5/30/19 at 4:50 p.m. and again on 5/31/19 at 6:20 p.m. The surveyor requested the facility policy on the management of psychotropic medications.

The surveyor reviewed the facility policy titled "Psychotropic Medication Documentation and

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Review" revised November 2015. The policy read in part
"A. Residents receiving psychotropic medication will have a behavior/Intervention Monthly Flow Record (BFR) initiated on admission or whenever psychotropic meds are ordered.
a. Each psychotropic medication will be entered on BFR.
b. Resident specific behaviors related to medication use will be entered.
c. Diagnosis for the reason psychotropic medication is being given will be documented in medical record.
d. BFR record will be placed in front of the resident medication administration record (MAR).
B. Nurse will document on the following every shift:
a. Number of behavior episodes
b. Specific non-medication interventions used-entered code as indicated on BFR.
c. Outcome of interventions-use code key listed on BFR
i. Behavior interventions-individualized non-pharmacological approaches (including direct care and activities) that are provided as part of a supportive physical and psychological environment, and are directed toward preventing, relieving, and/or accommodating a resident's distressed behavior.
d. Any side effects (observed) -use code key listed on BFR
D. The resident's Plan of Care (POC) will be reviewed and updated with any changes in behavior and/or treatment."

No further information was provided prior to the exit conference on 5/31/19.

3. The facility staff failed to identify and monitor

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resident specific target behaviors and identify non-pharmacological interventions for the administration of Restoril, Zyprexa and Seroquel for Resident #40.

The clinical record of Resident #40 was reviewed 5/29/19 through 5/31/19. Resident #40 was admitted to the facility 2/28/19 and readmitted 5/2/19 with diagnoses that included but not limited to symbolic dysfunction, insomnia, muscle weakness, hypertension, atherosclerotic heart disease, unspecified dementia with behavioral disturbances, cerebrovascular disease, anxiety disorder, major depressive disorder, hyperlipidemia, type 2 diabetes mellitus, and unspecified psychosis.

Resident #40's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/15/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #40 was not interviewable.

The May 2019 physician's orders were reviewed and included orders that read "Restoril 15 mg (milligrams) Give 1 capsule by mouth at bedtime for insomnia, Seroquel Tablet 25 mg Give 1 tablet at bedtime for BPSD (bipolar disorder) and Zyprexa 2.5 mg give 1 tablet by mouth one time a day for psychosis."

Resident #40's current comprehensive care plan initiated 3/4/19 did not include a care plan for behaviors and the use of psychotropic medications. Resident #40 does have a care plan initiated 3/8/19 for a focus area of chronic/progressive decline in intellectual functioning characterized by deficit in memory,

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judgement, decision making and thought processes, per family and through interviews related to dx (diagnosis) of dementia/hx (history of) CVA (cerebrovascular accident) AEB (as evidenced by) inability to participate on BIMS/PHQ sections of MDS. Interventions: Break tasks/activities into manageable subtasks.

The clinical record did reveal a behavior monitoring sheet for May 2019 for the use of Seroquel. The behavior sheet identified verbal and physical aggression but no identified interventions or outcomes. However, there were no behavior monitoring sheets for the use of Zyprexa or Restoril, identified target behaviors or a care plan developed and implemented for either Zyprexa or Restoril.

The surveyor informed the administrator, director of nursing, the corporate registered nurse and the chief executive officer of the above concern on 5/30/19 at 4:50 p.m. and again on 5/31/19 at 6:20 p.m. The surveyor requested the facility policy on psychotropic medication management.

The surveyor reviewed the facility policy titled "Psychotropic Medication Documentation and Review" revised November 2015. The policy read in part
"A. Residents receiving psychotropic medication will have a behavior/Intervention Monthly Flow Record (BFR) initiated on admission or whenever psychotropic meds are ordered.
a. Each psychotropic medication will be entered on BFR.
b. Resident specific behaviors related to medication use will be entered.
c. Diagnosis for the reason psychotropic medication is being given will be documented in

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medical record.
d. BFR record will be placed in front of the resident medication administration record (MAR).
B. Nurse will document on the following every shift:
a. Number of behavior episodes
b. Specific non-medication interventions used-entered code as indicated on BFR.
c. Outcome of interventions-use code key listed on BFR
i. Behavior interventions-individualized non-pharmacological approaches (including direct care and activities) that are provided as part of a supportive physical and psychological environment, and are directed toward preventing, relieving, and/or accommodating a resident's distressed behavior.
d. Any side effects (observed) -use code key listed on BFR
D. The resident's Plan of Care (POC) will be reviewed and updated with any changes in behavior and/or treatment."

No further information was provided prior to the exit conference on 5/31/19.
4(a). The facility staff failed to document appropriate rationale for prn (as needed) Lorazepam for Resident # 19 that exceeded 14 days.

4(b). The facility staff failed to implement non-pharmacological interventions prior to the use of prn Lorazepam for Resident # 19.

Resident # 19 was an 83-year-old-male who was originally admitted to the facility on 10/2/15, with a readmission date of 5/29/19. Diagnoses included but were not limited to; type 2 diabetes mellitus, hypertension, cognitive communication deficit,

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and peripheral vascular disease.

The clinical record for Resident # 19 was reviewed on 5/29/19 at 11:51 am. The most recent MDS (minimum data set) assessment for Resident # 19 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 # 19 had a BIMS (brief interview for mental status) score of 5 out of 15, which indicated that Resident # 19's cognitive status was severely impaired.

The current plan of care for Resident # 19 was reviewed and revised on 3/21/19. The facility staff documented a focus area for Resident # 19 as, "Resident has a psychosocial well being issue (potential) r/t (related to) recent health issues/additional amputation of right stump AEB (as evidenced by) loss of independence." Interventions included but were not limited to; "Administer meds as ordered by physician, monitor for effectiveness. Report adverse reactions/ineffectiveness to physician for further f/u (follow up)," and "Encourage activity distraction."

Resident # 19 had orders for "Lorazepam tablet 1 mg (milligram) Give 1 tablet by mouth as needed for agitation two times daily," which was initiated by the physician on 5/11/19.

On 5/29/19 at 12:02 pm, the surveyor reviewed the May 2019 medication administration record for Resident # 19. The surveyor observed that Resident # 19 had a prn order for Lorazepam that had been active for 18 days. The surveyor reviewed the clinical record and did not observe

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any documentation from the physician to provide a rationale that warranted the use of prn Lorazepam for longer than 14 days. The surveyor also did not observe any documentation of non-pharmacological interventions attempted prior to the administration of prn Lorazepam for Resident # 19.

The facility policy for "Psychotropic Medication Documentation and Review" contained documentation that included but was not limited to,
..." Policy: All residents receiving psychotropic medication will have their behaviors, effectiveness of interventions (pharmacological and non-pharmacological) and potential for gradual dose reduction of psychotropic medication monitored and documented." ...

On 5/31/19 at 6:30 pm, the administrative team was made aware of the findings as stated above, and agreed that there was no documentation to support the use of prn Lorazepam for more than 14 days for Resident # 19. The administrative team also agreed that there were no non-pharmacological interventions documented prior to the use of prn Lorazepam for Resident # 19.

No further information regarding this issue was provided to the survey team prior to the exit conference on 5/31/19.

5. The facility staff failed to monitor side effects and effectiveness associated with the use of Ambien and Sertraline for Resident # 53.

Resident # 53 was a 67-yer-old-male who was originally admitted to the facility on 5/19/14, with a

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readmission date of 11/27/15. Diagnoses included but were not limited to; major depressive disorder, anxiety, insomnia, and type 2 diabetes mellitus.

The clinical record for Resident # 53 was reviewed on 5/31/19 at 9:35 am. The most recent MDS (minimum data set) assessment for Resident # 53 was a quarterly assessment with an ARD (assessment reference date) of 5/23/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 53 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 53 was cognitively intact. Section N of the MDS assesses medications. In Section N0410, the facility staff documented that Resident # 53 had hypnotic and antidepressant medications for 7 days during the look back period for the 5/23/19 ARD.

The current plan of care for Resident # 53 was reviewed and revised on 5/22/19. The facility staff documented a focus area for Resident # 53 as, "At risk for adverse effects r/t (related to) psychoactive medication use, dx (diagnosis) of depression, insomnia, anxiety." Interventions included but were not limited to, "Monitor for med side effects: sedation hypotension, EPS (extrapyramidal symptoms), anticholinergic sx (symptoms) H/A (headache) insomnia, anorexia, constipation," and "Monitor medications for effectiveness."

Resident # 53 had orders that included but were not limited to; "Ambien tablet 10 mg (milligram) Give 1 tablet by mouth at bedtime related to insomnia," and "Sertraline HCI tablet 50 mg Give 1 tablet by mouth one time a day for depression."

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On 5/31/19 at 9:43 am, the surveyor observed the May 2019 medication administration record for Resident # 53. The surveyor did not observe any documentation for monitoring of side effects and effectiveness associated with the use of Ambien and Sertraline for Resident # 53. The surveyor interviewed the director of nursing and asked if she could provide documentation of monitoring of side effects and effectiveness associated with the use of Ambien and Sertraline for Resident # 53. The director of nursing informed the surveyor that the facility had not been documenting side effects and effectiveness on antidepressants and hypnotics and that the facility had been focused on monitoring the antipsychotic medications.

The facility policy for "Psychotropic Medication Documentation and Review" contained documentation that included but was not limited to,
..." Policy: All residents receiving psychotropic medication will have their behaviors, effectiveness of interventions (pharmacological and non-pharmacological) and potential for gradual dose reduction of psychotropic medication monitored and documented." ...

On 5/31/19 at 6:30 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 5/31/19.

6. The facility staff failed to monitor for side effects and effectiveness and failed to identify and monitor behaviors associated with the use of Remeron for Resident # 7.

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Resident # 7 was an 83-year-old-female who was originally admitted to the facility on 8/5/15, with a readmission date of 11/5/17.
Diagnoses included but were not limited to; major depressive disorder, anxiety, heart failure, and type 2 diabetes mellitus.

The clinical record for Resident # 7 was reviewed on 5/30/19 at 11:00 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/10/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 7 had a BIMS (brief interview for mental status) score of 12 out of 15, which indicated that Resident # 7's cognitive status was moderately impaired.

The current plan of care for Resident # 7 was reviewed and revised on 1/14/19. The facility staff documented a focus area for Resident # 7 as, "At risk for adverse effects r/t (related to) psychoactive medication use: anxiety, depression, BSPD (behavioral and psychological symptoms of dementia), psychosis." Interventions included but were not limited to, "Monitor of s/s (signs and symptoms) of depression," "Monitor medications for effectiveness," and "Monitor for med side effects: sedation, hypotension, EPS (extrapyramidal symptoms), anticholinergic sx (symptoms) H/A (headache), insomnia, anorexia, constipation." The surveyor did not observe and Resident specific documented behaviors of depression on the plan of care for Resident # 7.

Resident # 7 had orders that included but were not limited to, "Remeron tablet 30 mg (milligram) Give 1 tablet by mouth at bedtime for

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F 758	Continued From page 73	F 758		

depression," which was initiated by the physician on 12/13/18.

On 5/31/19 at 9:42 am, the surveyor reviewed the May 2019 medication administration record for Resident # 7. The surveyor did not observe behavior monitoring, or monitoring for side effects and effectiveness associated with the use of Remeron for Resident # 7.

The facility policy for "Psychotropic Medication Documentation and Review" contained documentation that included but was not limited to,
..." Policy: All residents receiving psychotropic medication will have their behaviors, effectiveness of interventions (pharmacological and non-pharmacological) and potential for gradual dose reduction of psychotropic medication monitored and documented.
Procedure:
A. Residents receiving psychotropic medication will have a Behavior/Intervention Monthly Flow Record (BFR) (Form 4.11) initiated on admission or whenever psychotropic meds are ordered.
b. Resident specific behaviors related to medication use will be entered on BFR." ...

On 5/31/19 at 6:20 pm, the administrative team was made aware of the findings as stated above, and agreed that the facility failed to document Resident specific behaviors and monitor side effects and effectiveness associated with the use of Remeron for Resident # 7.

No further information regarding this issue was presented to the survey team prior to the exit conference of 5/31/19.

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F 760	Continued From page 74	F 760		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Stratford F tag 760 E Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure 2 of 22 residents were free of a significant drug error (Resident #40 and Resident #22). The findings included: 1. The facility staff failed to administer physician ordered insulin to Resident #40. The clinical record of Resident #40 was reviewed 5/29/19 through 5/31/19. Resident #40 was admitted to the facility 2/28/19 and readmitted 5/2/19 with diagnoses that included but not limited to symbolic dysfunction, insomnia, muscle weakness, hypertension, atherosclerotic heart disease, unspecified dementia with behavioral disturbances, cerebrovascular disease, anxiety disorder, major depressive disorder, hyperlipidemia, type 2 diabetes mellitus, and unspecified psychosis. Resident #40's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/15/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #40 was not interviewable.	F 760	1. MD notified of facility□s failure to follow physician order for resident # 40 and #22, no new orders. 2. Residents that reside in the facility have the potential to be affected by this deficient practice. Director of Nursing and/or Designee completed audit of medication administration records in the facility to ensure the residents are free of significant medication errors. 3. Director of Nursing and/or Designee re-educated licensed nursing staff regarding F 760- Residents are Free of Significant Med Errors and Change in Resident Condition Policy to ensure proper medication administration and ensuring to follow physicians orders as well as to ensure the residents are free of significant medication errors. 4. Director of Nursing and/or Designee to audit 10 medication administration records one time a week x 3 months to ensure the residents that resident in facility are free from medication errors. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as necessary.	6/30/19

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There was not a comprehensive care plan that addressed diabetes.

The surveyor reviewed the April 2019 physician's orders and the May 2019 physician's orders. Resident #40 had insulin orders that read Humalog Inject 5 units subcutaneously one time a day for DM (diabetes mellitus)-start date 3/3/19 and Lantus (Insulin Glargine) Inject 25 units one time a day for DM II (diabetes mellitus type 2) start date-3/1/19.

A review of the April 2019 electronic medication administration record (eMAR) revealed the following:
In the entry for Lantus on 4/4/19 at 0600-There was an "X" in the box for the blood sugar at 0600 and the number "19" and initials ls.
In the entry for Lantus on 4/6/19, there was an "X" in the box for blood sugar at 0600 and the number "12" and initials ls.
In the entry for Lantus on 4/8/19, there was an "X" in the box for blood sugar at 0600 and the number "12" and initials ls.

In the entry for Humalog on 4/6/19 at 0630, there was a "12" and the initials ls.
In the entry for Humalog on 4/8/19 at 0630, there was a "12" and the initials lc.
In the entry for Humalog on 4/9/19 at 0630, there was a "19" and the initials vhc.
In the entry for Humalog on 4/12/19 at 0630, there was a "12" and the initials ls.
In the entry for Humalog on 4/15/19 at 0630, there was a "16" and the initials vhc.

Based on the chart codes/follow-up codes, 12=drug refused, 16=Hold/See Nurse Notes, 17=Hospitalized, and 19=Other/See Nurse Notes.

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F 760	Continued From page 76 The 4/4/19 06:51 progress note read "Lantus SoloStar Solution pen-injector 100 unit/ml (milliliter) Inject 25 unit subcutaneously one time a day for DM II rsd (resident) BS (blood sugar) 133 insulin not given." The surveyor was unable to locate a physician order to hold the insulin, physician notification that the insulin was held, or any physician orders with hold parameters. The 4/6/19 05:14 progress note read "Lantus SoloStar Solution pen-injector 100 unit/ml (milliliter) Inject 25 unit subcutaneously one time a day for DM II rsd (resident) BS (blood sugar) 133 insulin not given." The surveyor was unable to locate a physician order to hold the insulin, physician notification that the insulin was held, or any physician orders with hold parameters. The 4/6/19 05:35 progress note read, "Humalog KwikPen Solution Pen-injector 100 unit/ml Inject 5 units subcutaneously one time a day for DM rsd refused admin. (administration) of insulin. The surveyor was unable to physician notification that the insulin was refused by the resident. There was not a progress note for 4/8/19 as to the reason Humalog and Lantus were not administered at 0630. The 4/9/19 05:35 progress note read, "Humalog KwikPen Solution Pen-injector 100 unit/ml Inject 5 units subcutaneously one time a day for DM held, long acting insulin given. Unable to determine resident appetite at this time. Resting quietly with eyes closed, refused snack at this time. The surveyor was unable to locate a physician order to hold the Humalog insulin and physician notification that the insulin was not administered	F 760		

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by the nurse.

There was not a progress note for 4/12/19 as to the reason Humalog was not administered at 0630. The chart code for Lantus not administered on 4/12/19 at 0600 was refusal by the resident per the chart codes. However, there was no documentation that the physician had been made aware of the insulin refusal.

The 4/15/19 05:59 progress note read, "Humalog KwikPen Solution Pen-injector 100 unit/ml Inject 5 units subcutaneously one time a day for DM blood sugar 126, fast acting insulin held. The surveyor was unable to locate a physician order to hold the Humalog insulin and physician notification that the nurse did not administer the insulin.

The May 2019 physician's orders read, "Lantus Inject 10 unit subcutaneously one time a day for Diabetes-start date 5/6/19."

The entry for Lantus on 5/9/19 at 0600 read "3" and initials l1s.
The entry for Lantus on 5/10/19 at 0600 read "12" and initials l1s.

The chart codes for 3=No insulin required and 12=drug refused.

The progress note dated 5/10/19 at 06:53 read "Lantus SoloStar Solution Pen-injector 100 unit/ml Inject 10 unit subcutaneously one time a day for DM II rsd refused insulin d/t (due to) BS (blood sugar) 113. However, there was no documentation that the physician had been made aware of the insulin refusal.

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The surveyor informed the director of nursing of the above concern on 5/31/19 at 11:24 a.m. and requested the facility policy on diabetes management and physician notification.

The surveyor reviewed the facility policy titled "Caring for the Diabetic Date Revised October 15, 2015" on 5/31/19. The policy read in part "PROCEDURE: g) The physician will authorize pertinent periodic evaluations such as ophthalmology and nephrology, as indicated. The physician will order desired parameters for monitoring and reporting information related to diabetes or blood sugar management. i. The staff will incorporate such parameters into the Medication Administration Record and care plan."

The surveyor reviewed the facility policy titled "Change in Resident Condition Date Revised: July 2015." The policy read in part "5. The Resident/Physician/Family/Responsible Party will be notified when there has been: e. A need to alter the resident's medical treatment."

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above issue on 5/31/19 at 6:20 p.m.

No further information was provided prior to the exit conference on 5/31/19.

2. The facility staff failed to follow the physician's orders for insulin administration for Resident #22. The facility staff failed to administer Humalog and Lantus as ordered by the physician and failed to notify the physician of insulin refusals.

The clinical record of Resident #22 was reviewed 5/28/19 through 5/31/19. Resident #22 was

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admitted to the facility 4/26/11 and readmitted 4/27/19 with diagnoses that included but not limited to type 2 diabetes mellitus, end-stage renal disease, morbid obesity, post-menopausal bleeding, hypertension, hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side, contracted elbow, contracted left hand, and chronic pain.

Resident #22's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/13/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

Resident #22's current comprehensive care plan date initiated 8/18/2015 and revised 5/14/19 identified non-compliance with medication/insulin. Interventions: Notify MD (medical doctor) of non-compliance per routine and prn (whenever necessary).

The May 2019 physician's orders were reviewed. Resident #22 had orders for Humalog (Insulin Lispro) Inject 12 units subcutaneously three times a day for DM (diabetes mellitus) and Lantus (insulin Glargine) Inject 62 units subcutaneously at bedtime for DM.

The surveyor reviewed the May 2019 electronic medication administration records (eMARs).

The entry that read "Humalog (insulin Lispro) Inject 12 unit subcutaneously three times a day for DM" revealed Resident #22 was not administered Humalog on the following days/times:

5/2/19 at 0600 (chart code 12), 1100 (chart

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F 760	Continued From page 80 code=14), and 1700 (5:00 p.m.)(chart code=3). Chart codes: 3=No insulin required 12=Drug refused 14=Absent from home 15-Away from home with meds A review of the 5/2/19 progress notes did not have documentation as to why the medication was not administered or the physician had been informed of the insulin refusal. 5/3/19 at 0600=12 marked 5/3/19 at 1100=12 marked 5/4/19 at 0600=12 marked 5/4/19 at 1100=13 marked 5/7/19 at 0600=12 marked 5/7/19 at 1100=14 marked 5/8/19 at 0600=12 marked 5/8/19 at 1100=15 marked 5/9/19 at 0600=12 marked 5/9/19 at 1100=13 marked 5/9/19 at 1700=3 marked 5/10/19 at 0600=12 marked 5/10/19 at 1100=12 marked 5/11/19 at 1100=14 marked 5/11/19 at 1700=12 marked 5/12/19 at 0600=12 marked 5/14/19 at 0600=12 marked 5/14/19 at 1100=13 marked 5/14/19 at 1700=12 marked 5/15/19 at 0600 and 1100=12 marked 5/16/19 at 0600=12 marked 5/16/19 at 1100=13 marked 5/16/19 at 1700=12 marked 5/17/19 at 0600=3 marked 5/18/19 at 0600=12 marked 5/19/19 at 0600=12 marked	F 760		

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5/20/19 at 0600=12 marked
5/20/19 at 1100=14 marked
5/21/19 at 0600-12 marked
5/22/19 at 0600=12 marked
5/22/19 at 1700=14 marked
5/23/19 at 0600=12 marked
5/23/19 at 1100=13 marked
5/24/19 at 0600=12 marked
5/25/19 at 0600 and 1700=12 marked
5/25/19 at 1100=14 marked
5/26/19 at 0600=12 marked
5/27/19 at 0600 and 1100=12 marked
5/28/19 at 0600 and 1700=12 marked
5/28/19 at 1100=13 marked
5/29/19 at 0600=12 marked
5/30/19 at 0600=12 marked
5/30/19 at 1100=14 marked
5/31/19 at 1100=12 marked

The entry for Lantus Inject 62 unit subcutaneously at bedtime for DM-start date 4/27/19 was reviewed. The entry for 5/22/19 at 2000 (8:00p.m.) was marked with 12 (drug refused).

The May 2019 progress notes were reviewed. Only two progress notes (one dated 5/19/19 at 0604 and a second one dated 5/20/19 at 0559) had documentation why the resident refused the insulin. However, there was no documentation the physician was notified of Resident #22's insulin refusals and the physician orders for insulin not followed.

The surveyor informed the MDS/RN (registered nurse) of the above concern on 5/31/19 at 4:42 p.m. and requested the facility policy on diabetes management and physician notification.

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F 760	Continued From page 82 The surveyor reviewed the facility policy titled "Caring for the Diabetic Date Revised October 15, 2015" on 5/31/19. The policy read in part "PROCEDURE: g) The physician will authorize pertinent periodic evaluations such as ophthalmology and nephrology, as indicated. The physician will order desired parameters for monitoring and reporting information related to diabetes or blood sugar management. i. The staff will incorporate such parameters into the Medication administration Record and care plan." The surveyor reviewed the facility policy titled "Change in Resident Condition Date Revised: July 2015." The policy read in part "5. The Resident/Physician/Family/Responsible Party will be notified when there has been: e. A need to alter the resident's medical treatment." The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above issue on 5/31/19 at 6:20 p.m. No further information was provided prior to the exit conference on 5/31/19.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		6/30/19

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F 761	Continued From page 83 §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 medications on two of two halls. The findings included: The facility staff failed to dispose of expired medications. On 05/29/19 at 9:35 a.m., the surveyor checked medication cart #2 on the 100 hall with LPN (licensed practical nurse) #1. This cart included an opened bottle of 1000-tablet multivitamins with an expiration date of 03/19 and a victoza (insulin) flex pen with an open date of 04/14/19. The label on this flex pen read to discard after 30 days. LPN #1 checked the medications with the surveyor, confirmed they were out of date disposed of the flex pen, and returned the bottle of multivitamins to the medication room to be returned to the pharmacy.	F 761	1. Expired medications found on both medication cart #1 and #2 immediately removed from medication carts and disposed of on 05/29/2019. 2. Residents that reside in the facility have the potential to be affected by this deficient practice. Director of Nursing and/or Designee completed audit of medication carts in the facility to ensure there were no expired medications on medication carts in facility. 3. Director of Nursing and/or Designee re-educated licensed nursing staff regarding F 761- Label/Store Drugs & Biologicals and Medication Storage Guidance Policy to ensure there are no expired medications on facility medication carts and the proper process of removal and disposal from medication carts. 4. Director of Nursing and/or Designee will audit medication carts one time a week x 3 months to ensure that there are no	

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F 761	Continued From page 84 On 05/29/19 at 10:10 a.m., the surveyor checked medication cart #1 on the 200 hall with LPN #2. This cart included an opened bottle of 100-tablet zinc sulfate 220 mg with a use by date of 09/18 and a victoza flex pen dated 04/28/19. The label on this flex pen read to discard after 30 days. LPN #2 checked the medications with the surveyor confirmed they were out of date and stated she would dispose of them. On 05/29/19 at 12:30 p.m., the DON (director of nursing) and corporate nurse were made aware of the issues regarding the expired medications. No further information regarding this issue was shared with the surveyor.	F 761	expired medications on medication carts in facility and to ensure to dispose of expired medications. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as necessary.	
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record, the facility staff failed to obtain a physician ordered laboratory test for 1 of 22 residents (Resident #40). The findings included: The facility staff failed to obtain a CMP	F 770	1. MD notified of facility□s failure to obtain a CMP (comprehensive metabolic panel) for resident #40 on 05/30/2019, no new orders. 2. Residents that reside in the facility have the potential to be affected by this deficient practice. Director of Nursing and/or Designee completed audit of lab	6/30/19

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F 770 Continued From page 85

(comprehensive metabolic panel) for Resident #40.

The clinical record of Resident #40 was reviewed 5/29/19 through 5/31/19. Resident #40 was admitted to the facility 2/28/19 and readmitted 5/2/19 with diagnoses that included but not limited to symbolic dysfunction, insomnia, muscle weakness, hypertension, atherosclerotic heart disease, unspecified dementia with behavioral disturbances, cerebrovascular disease, anxiety disorder, major depressive disorder, hyperlipidemia, type 2 diabetes mellitus, and unspecified psychosis.

Resident #40's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/15/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #40 was not interviewable.

The surveyor reviewed the March 2019 physician's orders. The 3/2/19 orders read "Hgb, A1C, CMP, Lipid panel, urine micro albumin one time only for 1 day."

A review of the laboratory section revealed no results for the CMP ordered.

The surveyor informed the director of nursing of the above laboratory test results not found.

After researching the order, the DON stated the nurse had not marked the lab test (CMP) on the lab requisition sheet.

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

F 770

orders in facility for the last 30 days to ensure there were no failures to obtain labs per physicians orders.
3. Director of Nursing and/or Designee re-educated licensed clinical staff regarding F 770- Laboratory Services and Lab Order Protocol Policy to ensure facility staff properly obtain physician ordered laboratory tests.
4. Director of Nursing and/or Designee will audit laboratory orders for residents in the facility one time a week x 3 months to ensure the facility obtains physician ordered laboratory tests. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as necessary.

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F 770	Continued From page 86 chief executive officer of the above concern on 5/30/19 at 4:50 p.m. and again on 5/31/19 at 6:20 p.m. No further information was provided prior to the exit conference on 5/31/19.	F 770		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record, the facility staff failed to obtain a physician order prior to obtaining laboratory tests for 1 of 22 residents (Resident #40). The findings included: The facility staff failed to obtain a physician order before obtaining an albumin level, a urine and urine for culture and sensitivity, and a CBC (complete blood count) for Resident #40 on 3/4/19. The clinical record of Resident #40 was reviewed	F 773	1. MD notified of facility□s failure to obtain a physician order before obtaining an albumin level, a urine, and a urine culture and sensitivity, and a CBC (complete blood count) for resident #40 on 05/30/2019, no new orders. 2. Residents that reside in the facility have the potential to be affected by this deficient practice. Director of Nursing and/or Designee completed audit of lab orders in facility for the last 30 days to ensure there were no laboratory diagnostic testing without physician orders.	6/30/19

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F 773 Continued From page 87

5/29/19 through 5/31/19. Resident #40 was admitted to the facility 2/28/19 and readmitted 5/2/19 with diagnoses that included but not limited to symbolic dysfunction, insomnia, muscle weakness, hypertension, atherosclerotic heart disease, unspecified dementia with behavioral disturbances, cerebrovascular disease, anxiety disorder, major depressive disorder, hyperlipidemia, type 2 diabetes mellitus, and unspecified psychosis.

Resident #40's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/15/19 assessed the resident with a BIMS (brief interview for mental status) as 3/15. Resident #40 was not interviewable.

The surveyor reviewed the March 2019 physician's orders. The 3/2/19 orders read "Hgb, A1C, CMP, Lipid panel, urine micro albumin one time only for 1 day."

A review of the laboratory section revealed the results for the CBC, albumin level and a urine and urine for culture and sensitivity dated 3/4/19 but a physician order was unable to be located.

The surveyor informed the director of nursing of the above laboratory test results found but unable to find a physician order.

After researching the order, the DON stated the nurse had marked the lab tests on the lab requisition sheet incorrectly. CBC, Albumin, urine and urine culture were marked incorrectly but not ordered by the physician.

The surveyor informed the administrator, director

F 773

3. Director of Nursing and/or Designee re-educated licensed nursing staff regarding F 773 Lab Services Physician Order/ Notify of Results and Lab Order Protocol Policy to ensure physicians orders are obtained prior to conducting laboratory diagnostic testing.
4. Director of Nursing and/or Designee will audit laboratory orders for residents in the facility one time a week x 3 months to ensure the facility staff obtains a physician order prior to obtaining laboratory tests. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as necessary.

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F 773	Continued From page 88 of nursing, the corporate registered nurse and the chief executive officer of the above concern on 5/30/19 at 4:50 p.m. and again on 5/31/19 at 6:20 p.m. No further information was provided prior to the exit conference on 5/31/19.	F 773		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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	F 880		6/30/19

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F 880	Continued From page 89 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable 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, staff interview, facility document review, and clinical record review, the	F 880	1. LPN # 2 immediately educated on 05/30/2019 regarding failure to clean the	

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F 880

Continued From page 90

facility staff failed to clean scissors before use or after use for 1 of 22 residents (Resident #45).

The findings included:

The facility staff failed to clean the scissors used in wound care for Resident #45.

The clinical record of Resident #45 was reviewed 5/29/19 through 5/31/19. Resident #45 was admitted to the facility 10/1/18 and readmitted 5/9/19 with diagnoses that included but not limited to schizophrenia, osteomyelitis in ankle and foot, type 2 diabetes mellitus, morbid obesity, obstructive and reflux uropathy, hypertension, hyperlipidemia, peripheral vascular disease, and chronic kidney disease, stage 3.

Resident #45's significant change in assessment minimum data set (MDS) with an assessment reference date (ARD) of 5/16/19 assessed the resident with a BIMS (brief interview for mental status) as 13/15. Section K Skin Conditions assessed the resident with a surgical wound and surgical wound care.

Resident #45's current comprehensive care plan initiated 10/4/18 and revised 5/22/19 identified the resident to be at risk for skin breakdown related to weakness, decreased mobility, diagnosis of DM (diabetes mellitus), incontinent of bowel, PVD (peripheral vascular disease), actual surgical area to scrotum/penis. Interventions: meds/labs/treatment (medications/laboratory) as ordered.

During the interview with Resident #45 on 5/29/19 at 10:46 a.m., the resident was asked if the surveyor could observe doing wound care.

F 880

scissors used during wound care for resident #45.
2. Residents in facility receiving wound care have the potential to be affected by this deficient practice. Director of Nursing and/or Designee completed audit of clinical staff in the facility to ensure clinical staff use proper infection prevention and control protocol following the competency checklist for Clean Dressing Application per facility protocol.
3. Director of Nursing and/or Designee re-educated licensed nursing staff in the facility regarding F 880- Infection Prevention & Control, Skin and Wound Care Guidelines and Clean Dressing Application Policy to ensure clinical staff use proper infection prevention and control protocol following the competency checklist for Clean Dressing Application per facility protocol.
4. Director of Nursing and/or Designee to audit clinical staff in facility using competency checklist for Clean Dressing Application one time a week x 3 months to ensure facility staff use proper infection and prevention protocol. Results of Audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) Meetings for review and revisions as necessary.

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F 880	Continued From page 91 Resident #45 stated yes. The surveyor observed wound care to Resident #45 on 5/30/19 at 2:44 p.m. with licensed practical nurse #2. L.P.N. #2 washed hands, returned to the treatment cart, removed a bottle of Saf-Clens from cart, and sprayed gauze with saf-clens. L.P.N. #2 pulled an ABD pad and opened it. L.P.N. #2 put gloves on, removed one q-tip from a multi-package, and placed the qtip in a cup. L.P.N. #2 pulled a strip of iodoform from the cart, opened the bottle and cut a long strip. Scissors were not cleaned before cutting the strip. L.P.N. #2 placed the scissors on the top of the uncleaned cart. Knocked on door and entered room. Placed wax paper on over the bed table. Washed hands and put gloves on. Old dressing removed (had seen urologist today). Gloves off and washed hands. New gloves on and cleaned scrotal area with safe clens soaked gauze. Gloves off and hands washed. Gloves on and placed iodoform gauze in scrotal area. Placed ABD over scrotum and covered the resident with a sheet. Removed soiled trash can lining and discarded. Gloves off and washed hands. L.P.N. #2 placed the scissors in the uniform pocket and left the room. In the end of the day meeting on 5/30/19 at 4:50 p.m., the surveyor requested the facility policy on dressing changes. The surveyor reviewed the competency checklist for Clean Dressing Application provided by the director of nursing on 5/31/19 at 2:55 p.m. The competency read in part "6. Remove and discard gloves. Wash bandage scissors with soap and water if used during soiled part of	F 880		

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procedure. 10. Wash hands. Wash bandage scissors, if used."

The surveyor interviewed L.P.N. #2 on 5/31/19 at 2:37 p.m. about the wound care observations. L.P.N. #2 was informed that the scissors were not cleaned prior to cutting the iodoform strip. L.P.N. #2 stated she always cleans her scissors. L.P.N. #2 stated the scissors were cleaned before the surveyor's observations. However, the surveyor did not observe scissors cleaned before or after use.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse, and the chief executive officer of the above concern on 5/31/19 at 6:20 p.m.

No further information was provided prior to the exit conference on 5/31/19.