STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495391	A. BUILDING _____ B. WING _____	C 09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBURNIE REHAB & NURSING CENTER	1901 LIBBIE AVE RICHMOND, VA 23226

(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 09/10/19 through 09/12/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to evidence documentation of the patient population that would be at risk during an emergency event and strategies the facility has put into place to address the needs of at-risk or vulnerable patient populations. The findings include:	E 007	Corrective Action: On 10/6/19, documentation was completed to support identify the patient population that would be at risk during an emergency event and strategies put in place to address the needs of at-risk or vulnerable populations.	10/27/19

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

Electronically Signed | 10/08/2019

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E 007	Continued From page 1 On 09/12/19 at 3:55 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence documentation of the patient population that would be at risk during an emergency event and strategies the facility has put into place to address the needs of at-risk or vulnerable patient populations. ASM # 1 stated, "We don't have the documentation." No further information was provided prior to exit.	E 007	Other Potential Residents Affected: Other residents not identified as at risk or a vulnerable population during an emergency event had the potential to be affected. Systematic Changes: On 9/30/19, Administrator, Director of Nursing, Director of Social Services, Medical Director and the Director of Rehabilitation Services were educated regarding the importance of completing documentation that would identify the patient population that would be at risk during an emergency event and strategies the facility will put in place to address the needs of at-risk or vulnerable patient population. Monitoring System: Beginning 10/7/19, a weekly audit of the vulnerability tool will be conducted by the Senior Administrator and/or her designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month.	

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E 007	Continued From page 2	E 007	Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.	E 015		10/27/19

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E 015	Continued From page 3 *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to provide documentation that the emergency plan included policies and procedures for waste disposal. The findings include: On 09/12/19 at 3:55 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the	E 015	Corrective Action: On 10/6/19, the emergency Preparedness plan was updated to include policies and procedures for waste disposal. Other Potential Residents Affected: Other residents requiring waste disposal during an	

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E 015	Continued From page 4 facility's emergency preparedness plan failed to evidence documentation that the emergency plan included policies and procedures for waste disposal. ASM # 1 stated, "We don't have the documentation." No further information was provided prior to exit.	E 015	emergency event had the potential to be affected. Systematic Changes: On 9/30/19, the Administrator, Director of Nursing, Director Of Rehabilitation, Medical Director, Maintenance Director and Environmental Services Director were educated regarding the importance of maintaining policies and procedures in the emergency preparedness plan for waste disposal. Monitoring System: Beginning 10/7/19, a weekly audit of the emergency preparedness plan for the waste disposal policy and procedure will be conducted by the Senior Administrator and/or her designee will be conducted for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate.	

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E 015	Continued From page 5	E 015	Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.	E 026	Corrective Action: On 10/6/19, the emergency plan was updated to describe	10/27/19

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E 026	Continued From page 6 Facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. The findings include: On 09/12/19 at 3:55 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence policies and procedures that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. ASM # 1 stated, "We don't have the documentation." No further information was provided prior to exit.	E 026	how the facility will provide care and treatment at altered care sites under a 1135 waiver. Other Potential Residents Affected: Other residents had the potential to be affected if care and treatment at an altered care under a 1135 waiver had to be provided. Systematic Changes: On 9/30/19, the Administrator and Director of Nursing, Director of Rehabilitation and Medical Director, and Maintenance were educated regarding the importance of how the facility will provide care and treatment at altered care sites under a 1135 waiver. Monitoring System: Beginning 10/7/19, a weekly audit of the emergency preparedness plan for evidence of how the facility will provide care and treatment at altered care sites under a 1135 waiver will be conducted by the	

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E 026	Continued From page 7	E 026	Senior Administrator and/or her designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual,	E 039		10/27/19

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E 039	Continued From page 8	E 039		

facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.
(ii) Conduct an additional exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based.
(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:
(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as

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E 039	Continued From page 9 needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to provide evidence of any documentation of the exercise analysis and response and how the facility updated the emergency program based on the exercise analysis. The findings include: On 09/12/19 at 3:55 p.m. a review of the facility's emergency preparedness plan was conducted and interview with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence of documentation of the exercise analysis and response and how the facility updated its emergency program based on the exercise analysis. ASM # 1 stated, "We don't have the documentation." No further information was provided prior to exit.	E 039	On 10/6/19, the Emergency preparedness plan was updated to include documentation of the drill/exercise, analysis and response of how the facility revised the emergency plan based on the drill/exercise analysis. Other Potential Residents Affected: Other residents had the had the potential to be affected. Systematic Changes: On 9/30/19, the Administrator, Director of Nursing, Director of Rehabilitation, Medical Director and Maintenance Director were educated regarding the importance of maintaining evidence of an actual drill and analysis of such in the emergency preparedness plan. Monitoring System: Beginning 10/7/19, a weekly audit of the emergency preparedness plan for evidence of an	

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E 039	Continued From page 10	E 039	actual drill and analysis of such in the emergency preparedness plan will be conducted by the Senior Administrator and/or her designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.	E 041		10/27/19

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E 041	Continued From page 11 §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource	E 041		

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E 041	Continued From page 12 Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document	E 041	Corrective Action:	

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E 041	Continued From page 13 review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to provide evidence documentation that the facility maintains the onsite fuel source in accordance with NFPA 110 for their generator and documentation of a plan for how to keep the generator operational during an emergency unless they plan to evacuate. The findings include: On 09/12/19 at 3:55 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence documentation that the facility maintains the onsite fuel source in accordance with NFPA 110 for their generator and documentation of a plan for how to keep the generator operational during an emergency unless they plan to evacuate. ASM # 1 stated, "We don't have the documentation." No further information was provided prior to exit.	E 041	On 10/6/19, the emergency preparedness plan was updated to include how the facility will maintain the onsite fuel source for the generator and how it will keep the generator operational during an emergency unless it plans to evacuate. Other Potential Residents Affected: Other residents had the potential to be affected during an emergency event. Systematic Changes: On 9/30/19, the Maintenance Director and other Maintenance staff were educated regarding The importance of maintaining evidence of how the facility will maintain the onsite fuel source for the generator and how it will keep the generator operational during an emergency unless it plans to evacuate. Monitoring System: Beginning 10/7/19, a weekly Audit of the emergency Preparedness plan for evidence of how the facility will	

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E 041	Continued From page 14	E 041	maintain the onsite fuel source for the generator and how it will keep the generator operational during an emergency unless it plans to evacuate. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it	F 557	Corrective Action:	10/27/19

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F 557	Continued From page 15 was determined that the facility staff failed to treat a resident with respect and dignity for one of 48 residents in the survey sample, Resident #45. A staff nurse addressed Resident #45 as "Baby" three times on 9/12/19. The findings include: Resident #45 was admitted to the facility on 7/1/19 with diagnoses including, but not limited to, COPD (chronic obstructive pulmonary disease) (1) and a history of falls. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/8/19, Resident #45 was coded as being cognitively intact, having scored 14 out of 15 on the BIMS (brief interview for mental status). Skilled Nursing Notes dated 8/30/19, 8/31/19, 9/2/19, 9/3/19, 9/4/19, and 9/9/19 documented: "Patient is alert and responsive with periods of confusion." On 9/10/19 at 12:37 p.m., Resident #45 was observed up in a wheelchair beside her bed. She was confused to time, place, and situation. On 9/10/19 at 2:16 p.m., Resident #45 was observed sitting up in a wheelchair beside her bed. She was staring straight ahead and would not respond to questions. On 9/12/19 at 10:14 a.m., Resident #45 was observed sitting in a wheelchair by the nurses' station. She asked LPN (licensed practical nurse) #8 to make a phone call for her. LPN #8 stated, "Baby, just wait a minute. I'll be with you in a	F 557	On 9/19/19, the staff member was immediately re-educated regarding the importance of treating residents with respect and dignity with regard to the name by which they prefer to be called. In addition, the staff member apologized to resident #45. Other Potential Residents Affected: Other residents not being addressed by the name they prefer to be called had the potential to be affected. Systematic Changes: Beginning week of 9/30/19, refresher in-service training was conducted with facility staff regarding the importance of treating residents with respect and dignity regarding the name by which they prefer to be called. Monitoring System: Beginning 10/7/19, a weekly random audit of 10% of the resident current census will be conducted by the Director of Nursing and/or her designee to ensure they are being	

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F 557	Continued From page 16 minute." Resident #45 stated, "I want you to call [not understandable]. Do it now." LPN #8 replied, "I told you, baby, I will be right with you. Just hold on, baby." On 9/12/19 at 10:19 a.m., LPN #8 was interviewed. When asked why she referred to Resident #45 as "baby," LPN #8 stated, "I call all of them 'baby.' It's just a habit. I know I probably shouldn't. But most of them don't want me calling them Mr. or Mrs. They get mad at us when we do that. I just call them that." When asked if she thought this practice promotes a resident's feelings of respect and dignity, LPN #8 stated, "Well, no, I guess not." On 9/12/19 at 11:12 a.m., LPN #4, the assistant unit manager was interviewed. When asked her response to a staff member using the term "baby" to speak to a resident, LPN #4 stated, "It is not okay. We cannot call them that." When asked why this is a concern, LPN #4 stated, "Well, we don't know if it's okay with the resident. We really don't know how it makes them feel." A review of Resident #45 ' s care plan dated 7/2/19 revealed no information regarding the name by which she preferred staff to address her. On 9/12/19 at 12:43 p.m., ASM (administrative staff member) #1, the administrator, was interviewed. When informed that a staff member used the term "baby" to speak to a resident, ASM #1 stated, "They should not do that. Absolutely not. It is a dignity issue." When asked about staff members addressing residents in a casual way, ASM #1 stated, "If it is the resident's preference to be called something other than Mr. or Mrs., it should be care planned. But I believe I would still	F 557	treated with respect and dignity regarding the name by which they prefer to be called for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	

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F 557	Continued From page 17 ask the staff not to do that." At this time, ASM #1 was informed of the concern regarding LPN #8 addressing Resident #45 as "baby." A review of the facility policy, "Quality of Life - Dignity," revealed in part the following: "1. Residents shall be treated with dignity and respect at all times. 2. 'Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth...7. Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not 'labeling' or referring to the resident by his or her room number, diagnosis, or care needs." No further information was provided prior to exit. (1) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 557		
F 578 SS=E	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.	F 578		10/27/19

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F 578	Continued From page 18 §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 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, facility document review and clinical record review, it was determined that the facility staff failed to evidence information for advanced directives was provided on admission and/or a periodic review was conducted for seven of 48 residents in the survey sample, Residents #68, #18, #4, #50, #54, #22, and #53. The findings include:	F 578	Corrective Action: On 10/7/19, the Advance Directive for resident #68, that was completed upon admission was located and uploaded to the current EMR.	

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F 578	Continued From page 19 1.The facility staff failed to evidence documentation that information for advanced directives was provided on admission for Resident #68. Resident #68 was admitted to the facility on 3/16/16. Resident #68's diagnoses included but were not limited to osteomyelitis of vertebra and sacral region (infection of bone and bone marrow of the spinal column) (1), paraplegia (paralysis of the lower limbs) (2), unstable angina (intermittent chest pain occurring with increasing frequency and intensity) (3). Resident #68's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/16/19, coded the resident's BIMS (brief interview for mental status) score as "14" indicating the resident was capable of making daily cognitive decisions. Review of Resident #68's clinical record revealed no evidence of advanced directive review on the date of resident's admission to the facility 3/16/16. On 09/11/19 at 5:00 p.m., an interview was conducted with OSM [other staff member] # 8, the admissions coordinator. When asked to describe the process for obtaining a resident's advance directive and providing information on developing an advance directive if they don't have one, OSM # 8 stated, "The "Advance Directive Acknowledgement" form is part of the resident's admission packet and it is completed at the time of admission." A review of the form was conducted with OSM # 8. The form documented in part, "PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS: I HAVE executed	F 578	On 10/7/19, a periodic review of Advance Directives for resident #18 was conducted with the resident and/or RP. On 10/7/19, the Advance Directive for resident #4 was located and uploaded to the EMR. On 10/7/19, a periodic review of Advance Directives for resident #50, was conducted with the resident and/or RP. On 10/7/19, a periodic review of the Advance Directives for resident #54, was conducted with the resident and/or RP. A corrective action regarding a review of the Advance Directives upon admission for resident #22 could not be completed as the resident was re-admitted on 7/11/17. On 10/7/19, a periodic review of Advanced Directives for resident #22, was conducted with the resident and/or RP. On 10/7/19 a periodic review of Advanced Directives for resident #53, was conducted with the resident and/or RP. Other Potential Residents	

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F 578	Continued From page 20 an Advance Directive; I HAVE NOT executed an Advance Directive." OSM #8 was asked to provide evidence of the "Advance Directive Acknowledgement" form for Resident #68. There was no admission advanced directive found by OSM #8 in the EMR (electronic medical record). An interview was conducted with OSM (other staff member) #8, the admissions coordinator, on 9/12/19 at 8:04 AM. When asked where the advanced directive acknowledgement would be located in the chart, OSM #8 stated "If not scanned into the EMR (electronic medical record), it may have been thinned out and filed on the second floor". When ask for evidence of Resident #68 advanced directive acknowledgment on admission, OSM #8 stated "We will look for it upstairs." On 9/12/19 at 9:49 AM, ASM (administrative staff member) #4, the regional clinical coordinator, stated, "We are still looking for this resident's admission advanced directive acknowledgement." On 9/12/19 at 12:30 PM, ASM #4 informed this surveyor that they were unable to locate an "Advanced Directive Acknowledgement" form for Resident #68. ASM #4 stated that without the "Advanced Directive Acknowledgement" form they could not verify if Resident #68 had an advance directive or if information was provided to develop one on admission. On 9/12/19 at 12:30 PM, ASM (administrative staff member) #1 (administrator), #2 (director of nursing), #3 (medical director), #4 (regional clinical coordinator), #5 (director of nursing for another facility) and #6 (regional quality	F 578	Affected: Other residents admitted without an Advanced Directive being reviewed upon admission and/or periodically had the potential to be affected. Systemic Changes: 9/30/19 and 10/6/19, Admission and Social Services staff were educated Regarding the importance of reviewing Advance Directives with residents and/or RP's upon admission and conducting periodic reviews. In addition, Social Services staff were educated to complete the care conference note in the EMR to reflect a periodic review of Advanced Directives was completed. Monitoring System: Beginning 10/7/19, a weekly random audit of 10% of the current resident census will be conducted by the Administrator and/or her designee for	

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F 578	Continued From page 21 assurance director) were made aware of the above concern. The facility document titled, "Advanced Directives" documented, "Advance directives will be respected in accordance with state law and facility policy. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. The interdisciplinary team will conduct ongoing review of the resident's decision-making capacity and communicate significant changes to the resident's legal representative. Such changes will be made during the annual assessment process and recorded on the resident assessment instrument (MDS)." No further information was presented prior to exit. References: 1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 421. 2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 432. 3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 34. 2. The facility staff failed to evidence documentation of periodic reviews for the advanced directives for Resident #18. Resident #18 was admitted to the facility on 10/11/17. Resident #18's diagnoses included but were not limited to altered mental status (inability of person to function intellectually) (1), and lack of coordination (body muscles not performing	F 578	compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	

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together) (2).

Resident #18's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/21/19, coded the resident's BIMS (brief interview for mental status) score as "13" indicating the resident was capable of making daily cognitive decisions.

Review of Resident #18's clinical record failed to evidence periodic review of advanced directive in the annual MDS assessment dated 10/11/18.

An interview was conducted with OSM (other staff member) # 8, the admissions coordinator, on 09/11/19 at 5:00 p.m. When asked to describe the process for obtaining a resident's advance directive and providing information on developing an advance directive if they don't have one OSM # 8 stated, "The "Advance Directive Acknowledgement" form is part of the resident's admission packet and it is completed at the time of admission." A review of the form was conducted with OSM # 8. The form documented in part, "PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS: I HAVE executed an Advance Directive; I HAVE NOT executed an Advance Directive."

An interview was conducted with OSM (other staff member) # 4, the director of social services, on 09/11/19 at 5:08 p.m. When asked if they conduct periodic reviews of a resident's advance directive and periodic review to develop an advance directive if the resident does not have one, OSM # 2 stated, "Yes." OSM # 4 further stated that the review is documented on the "Care Conference Note." When asked who was responsible for conducting periodic reviews of a

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resident's advance directive and periodic review to develop an advance directive if the resident does not have one, OSM #4 stated, "That would be the social worker's role."

An interview was conducted with OSM (other staff member) #8, the admissions coordinator, on 9/12/19 at 8:04 AM. When asked where the advanced directive would be located in the chart, OSM #8 stated "If not scanned into the EMR (electronic medical record), it may have been thinned out and filed on the second floor." When ask for evidence of Resident #18 advanced directive on admission, OSM #8 stated "We will look for it upstairs."

On 9/12/19 at 9:49 AM, ASM (administrative staff member) #4, the regional clinical coordinator, stated "We have found this resident's admission advanced directive, here is your copy."

On 9/12/19 at 12:30 PM, ASM (administrative staff member) #1 (administrator), #2 (director of nursing), #3 (medical director), #4 (regional clinical coordinator), #5 (director of nursing for another facility) and #6 (regional quality assurance director) were made aware of the above concern regarding the lack of periodic reviews of advanced directives for Resident #18.

On 9/12/19 at 2:55 PM, OSM #4, (director of social services) stated that they were unable to locate any documentation regarding periodic reviews of advance directives for Resident #18.

No further information was presented prior to exit.

References:
1. Barron Dictionary of Medical Terms, 7th

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edition, Rothenberg and Kaplan, page 363.
2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 137.

3. The facility staff failed to evidence documentation that information for advanced directives was provided on admission for Resident #4.

Resident #4 was admitted to the facility on 3/11/18. Resident #4's diagnoses included but were not limited to end stage renal disease (inability of the kidneys to excrete wastes and function in the maintenance of electrolyte balance (1), cerebral infarction (abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and loss of ability to move a body part) (2) and high blood pressure.

Resident #4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/18/16/19, coded the resident's BIMS (brief interview for mental status) score as "14" indicating the resident was capable of making daily cognitive decisions.

Review of Resident #4's clinical record revealed no evidence of advanced directive review on the date of resident's admission to the facility 3/11/18.

On 09/11/19 at 5:00 p.m., an interview was conducted with OSM (other staff member) # 8, the admissions coordinator. When asked to describe the process for obtaining a resident's advance directive and providing information on developing an advance directive if they don't have

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one
OSM # 8 stated, "The "Advance Directive Acknowledgement" form is part of the resident's admission packet and it is completed at the time of admission." A review of the form was conducted with OSM # 8. The form documented in part, "PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS: I HAVE executed an Advance Directive; I HAVE NOT executed an Advance Directive." OSM #8 was asked to provide evidence of the "Advance Directive Acknowledgement" form for Resident #4. There was no admission advanced directive found by OSM #8 in the EMR (electronic medical record).

An interview was conducted with OSM (other staff member) #8, the admissions coordinator, on 9/12/19 at 8:04 AM. When asked where the advanced directive acknowledgement would be located in the chart, OSM #8 stated "If not scanned into the EMR (electronic medical record), it may have been thinned out and filed on the second floor." When ask for evidence of Resident #68 advanced directive acknowledgement on admission, OSM #8 stated "We will look for it upstairs."

On 9/12/19 at 9:49 AM, ASM (administrative staff member) #4, the regional clinical coordinator, stated "We are still looking for Resident #4's admission advanced directive."

On 9/12/19 at 12:30 PM, ASM #4 informed this surveyor that they were unable to locate an "Advanced Directive Acknowledgement" form for Resident #4. ASM #4 stated that without the "Advanced Directive Acknowledgement" form they could not verify if Resident #4 had an advance directive or if information was provided

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to develop one on admission.

On 9/12/19 at 12:30 PM, ASM (administrative staff member) #1 (administrator), #2 (director of nursing), #3 (medical director), #4 (regional clinical coordinator), #5 (director of nursing for another facility) and #6 (regional quality assurance director) were made aware of the above concern.

No further information was presented prior to exit.

References:
1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 498.
2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 111.

4. The facility staff failed to evidence periodic review of advanced directives with Resident #50.

Resident #50 was admitted to the facility on 9/15/14 with diagnoses that included but are not limited to: congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) [1], diabetes, high blood pressure, and osteoarthritis (Characterized by degenerative changes in the joints, pain, stiffness and swelling can develop after exercise) [2].

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 7/25/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring limited to extensive assistance of one or more

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staff members for all of her activities of daily living.

Review of the clinical record failed to evidence documentation that advanced directives were periodically reviewed with Resident #50.

A request was made on 9/11/19 at approximately 10:30 a.m. of administrative staff member (ASM) #1, the administrator, for the evidence of the periodic review of the advance directives with Resident #50 and/or her resident representative.

The medical records clerk, OSM #14 provided a document titled, "Clinical Assessment" dated, 7/30/18, documented in part, "Psychosocial Admission Assessment: Discussion CPR (cardiopulmonary resuscitation) Preference - 1. Yes, and discussion occurred. Discussion of Other Life-Sustaining Tx (treatments) 1. Yes, and discussion occurred. Discussion Hospitalization - 1. Yes, and discussion occurred." There was no further evidence that the advanced directive had been reviewed since 7/30/18.

On 09/11/19 at 5:00 p.m., an interview was conducted with OSM [other staff member] # 8, admissions coordinator. regarding advaced directives obtaining a copy of and or providing information to newly admitted residents. OSM # 8 stated, "The "Advance Directive Acknowledgement" form is part of the resident's admission packet and it is completed at the time of admission." A review of the form was conducted with OSM # 8. The form documented in part, "PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS: I HAVE executed an Advance Directive; I HAVE NOT executed an Advance Directive." When asked who was

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responsible for conducting periodic reviews of a resident's advance directive and periodic review to develop an advance directive if the resident does not have one OSM # 8 stated, "That would be the social worker."

On 09/11/19 at 5:08 p.m., an interview was conducted with OSM [other staff member] # 4, director of social services. When asked if they conduct periodic reviews of a resident's advance directive and periodic review to develop an advance directive if the resident does not have one OSM # 2 stated, "Yes." OSM # 4 further stated that the review is documented on the "Care Conference Note."

ASM #1, the administrator, ASM #3, the medical director, ASM #4, the regional clinical coordinator, and ASM #5, a director of nursing from another facility, were made aware of the above concerns on 9/12/19 at 9:45 a.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 422.

5. The facility staff failed to evidence documentation of the periodic review of the advanced directives for Resident #54.

Resident #54 was admitted to the facility on 3/15/17 with diagnoses that include but were not limited to: diabetes, high blood pressure, absence

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of left great toe, asthma, and gastroparesis (a condition that reduces the ability of the stomach to empty its contents. It does not involve a blockage (obstruction) (1).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/5/19, coded the resident as having a BIMS (brief interview for mental status) score of "14" indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living.

Review of the clinical record failed to evidence documentation that advanced directives were periodically reviewed with Resident #54.

A request was made on 9/11/19 at approximately 10:30 a.m. of administrative staff member (ASM) #1, the administrator, for the evidence of the periodic review of the advance directives with Resident #54 and/or her resident representative.

The facility provided a documented, dated, 5/8/17, "Advance Directive Acknowledgement." The form documented in part, "PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS." A checkmark was documented next to "I HAVE NOT executed and Advance Directive." No further information was provided evidencing period reviews of advanced directives had been completed with Resident #54 and or her resident representative.

On 09/11/19 at 5:08 p.m., an interview was conducted with OSM [other staff member] # 4, director of social services. When asked if they

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conduct periodic reviews of a resident's advance directive and periodic review to develop an advance directive if the resident does not have one OSM # 2 stated, "Yes." OSM # 4 further stated that the review is documented on the "Care Conference Note."

ASM #1, the administrator, ASM #3, the medical director, ASM #4, the regional clinical coordinator, and ASM #5, a director of nursing from another facility, were made aware of the above concerns on 9/12/19 at 9:45 a.m.

No further information was provided prior to exit to evidence the advanced directive was periodically reviewed for Resident #54.

(1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000297.htm 6. The facility staff failed to evidence information was provided to develop an advance directive and periodic review was conducted to provide Resident # 22 and/or their resident representative with the opportunity to develop an advance directive.

Resident # 22 was originally admitted to the facility on 01/10/14 and was readmitted on 07/11/17, with diagnoses that included but were not limited to, difficulty swallowing, high blood pressure and heart failure.

Resident # 22's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 06/27/19, coded Resident # 22 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition

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for making daily decisions.

The clinical record and the EHR (electronic health record) for Resident # 22 failed to evidence an advance directive or the facility's "Advance Directive Acknowledgement.

On 09/11/19 at 5:00 p.m., an interview was conducted with OSM [other staff member] # 8, admissions coordinator. When asked to describe the process for obtaining a resident's advance directive and providing information on developing advance directives, OSM # 8 stated, "The "Advance Directive Acknowledgement" form is part of the resident's admission packet and it is completed at the time of admission." A review of the form was conducted with OSM # 8. The form documented in part, "PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS: I HAVE executed an Advance Directive; I HAVE NOT executed an Advance Directive." When asked who was responsible for conducting periodic reviews of a resident's advance directive and periodic review to develop an advance directive if the resident does not have one, OSM# 8 stated, "That would be the social worker." OSM # 8 was asked to provide evidence of the "Advance Directive Acknowledgement" form for Resident # 22.

On 09/11/19 at 5:08 p.m., an interview was conducted with OSM [other staff member] # 4, director of social services. When asked if they conduct periodic reviews of a resident's advance directive and periodic review to develop an advance directive if the resident does not have one OSM # 2 stated, "Yes." OSM # 4 further stated that the review is documented on the "Care Conference Note." OSM # 4 was asked to

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provide evidence of periodic reviews of a resident's advance directive and periodic review to develop an advance directive.

On 09/12/19 at 11:55 a.m., OSM # 8 informed this surveyor that they were unable to locate an "Advance Directive Acknowledgement" form for Resident # 22. OSM # 8 further stated that without the "Advance Directive Acknowledgement" form they could not verify if Resident # 22 had an advance directive or if information was provided to develop one.

On 09/12/19 at 2:55 p.m., OSM # 4 stated that they were unable to locate any documentation regarding periodic review of an advance directive or offering of information on developing an advance directive for Resident # 22.

On 09/12/19 at approximately 12:30 p.m., ASM [administrative staff member] #1, the administrator, ASM #4, regional clinical coordinator, ASM #5, the director of nursing for another facility and ASM #6, regional quality assurance director were made aware of the findings.

No further information was provided prior to exit.

7. The facility staff failed to evidence periodic reviews were conducted regarding Resident # 53's advance directive.

Resident # 53 was admitted to the facility on 01/07/15 with diagnoses that included but were not limited to swallowing difficulty, high blood pressure and a stroke.

Resident # 53's most recent MDS (minimum data

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set), a quarterly assessment with an ARD (assessment reference date) of 08/04/19, coded Resident # 53 as scoring a two on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions.

Review of the clinical record and the EHR (electronic health record) for Resident # 53 revealed an advance directive but failed to evidence periodic reviews of the advance directive.

On 09/11/19 at 5:00 p.m., an interview was conducted with OSM [other staff member] # 8, admissions coordinator. When asked who was responsible for conducting periodic reviews of a resident's advance directive and periodic review to develop an advance directive if the resident does not have one, OSM# 8 stated, "That would be the social worker."

On 09/11/19 at 5:08 p.m., an interview was conducted with OSM [other staff member] # 4, director of social services. When asked if they conduct periodic reviews of a resident's advance directive and periodic review to develop an advance directive if the resident does not have one OSM # 2 stated, "Yes." OSM # 4 further stated that the review is documented on the "Care Conference Note." OSM # 4 was asked to provide evidence of periodic reviews of Resident # 53's periodic review of their advance directive.

On 09/12/19 at 2:55 p.m., OSM # 4 stated that they were unable to locate any documentation regarding periodic review of Resident # 53's advance directive.

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F 578	Continued From page 34 On 09/12/19 at approximately 12:30 p.m., ASM [administrative staff member] #1, the administrator, ASM #4, regional clinical coordinator, ASM #5, the director of nursing for another facility and ASM #6, regional quality assurance director were made aware of the findings. No further information was provided prior to exit.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as	F 583		10/27/19

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F 583	Continued From page 35 provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined facility staff failed to provide privacy during medication administration for one of six residents in the medication administration observation by administering medications to Resident #67 during a music performance activity in the main lobby of the facility with other residents, staff and visitors in attendance. The findings include: Resident #67 was admitted to the facility on 09/26/2014. Resident #67's diagnoses included but were not limited to major depressive disorder (1) and unspecified dementia (2). Resident #67's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/17/19, coded Resident #67 as scoring a 7 (seven) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 7- being severely impaired for making daily decisions. On 9/10/19 at 4:40 p.m., RN (registered nurse) #1 was observed during medication administration to Resident #67. RN #1 placed the medication cart outside of Resident #67's room in the hallway and prepared the following medications for Resident #67. -Calcium 600mg (milligram) 1 tablet (vitamin	F 583	Corrective Action: On 9/11/19, the staff member was re-educated regarding the importance of providing privacy and confidentiality during medication administration, regardless of cognition. Other Potential Residents Affected: Other residents administered medication during an activity had the potential to be affected. Systematic Changes: Beginning 9/30/19, licensed nurse staff were re-educated regarding the importance of providing privacy and confidentiality during medication administration, regardless of cognition.	

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F 583	Continued From page 36 supplement) -Gabapentin 100mg 2 capsules (used to treat seizures or nerve pain) -Vitamin C 500mg 1 tablet. (Vitamin supplement) RN #1 entered Resident #67's room and discovered that she was not in the room. RN #1 asked another staff member in the hallway if the whereabouts of Resident #67 was. The other staff member stated that Resident #67 was probably in the activity in the lobby. RN #1 carried the medication cup containing the medication and a cup of water to Resident #67 in the front lobby of the facility. Resident #67 was observed sitting in a wheelchair in the front of the lobby with five other residents seated in wheelchairs in a row in front of a visitor who was performing music on a keyboard instrument. Two staff members, two residents in chairs, two visitors sitting with residents and the musician playing a keyboard instrument at the front of the residents seated in the wheelchairs, was also observed in the lobby. RN #1 proceeded to go to the front of the lobby and told Resident #67 that she had her medicine for her. RN #1 administered the medication to Resident #67 and then returned to the unit medication cart. Review of the POS (physician order summary) for Resident #67 on 9/11/2019 at 1:45 p.m. revealed orders for the medications documented above. On 9/11/19 at 3:30 p.m., an interview was conducted with RN #1 regarding the medication observation on 9/10/19 at 4:40 p.m. When asked if residents are given medications in group activities with other residents, staff and visitors present, RN #1 stated that normally it is not done, staff give medications in the room unless the resident request them somewhere else. When	F 583	Monitoring System: Beginning 10/7/19, a random weekly medication administration observation will be conducted by the Director of Nursing and/or her designee for compliance with providing privacy and confidentiality regardless of cognition for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month for. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	

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asked why the staff give medications in the room, RN #1 stated to provide privacy. When asked if a group musical activity is private, RN #1 stated, "No." RN #1 stated that she would move residents if giving breathing treatments or injections but thinking about it now she should have moved the resident to a private area to give her the medication. When asked what the normal practice is for medication administration, RN #1 stated that she would tell the resident that it is time for their medication and take them to a private place or their room. When asked if cognitive status matters when offering privacy with medication administration, RN #1 stated, "No, cognition does not matter."

The facility policy "Resident Rights. CO Edited 05/02/2018" documented in part, "1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: t. privacy and confidentiality."

The facility policy "Confidentiality of Information and Personal Privacy. Revised October 2017" documented in part, "Our facility will protect and safeguard resident confidentiality and personal privacy. 2. The facility will strive to protect the resident's privacy regarding his or her: b. medical treatment."

On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 4, regional clinical coordinator, ASM # 5, the director of nursing for another facility and ASM # 6, regional quality assurance director were made aware of the findings.

No further information was provided prior to exit.

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F 583	Continued From page 38 References: 1. Major depressive disorder Major depression is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm. 2. Dementia A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.	F 583		
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	F 584		10/27/19

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F 584	Continued From page 39 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 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 and staff interview it was determined that facility staff failed to maintain a homelike environment in seven of 32 rooms on the Linden Unit of the facility. On the Linden Unit, facility staff failed to provide undamaged windowsills in the resident rooms to promote a homelike environment. The findings include: On 9/10/19 at 1:35 p.m., an observation of the windowsill in resident room 211 revealed an area of missing paint with the plaster exposed below measuring approximately four and a half inches length by two and a half inches width, the	F 584	Corrective Action: On 9/23/19, the windowsills in rooms #211, #213, #217, #224, #222, #210 and #205 were repaired. Other Potential Residents Affected: Other residents with damaged windowsills had the potential to be affected.	

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F 584	Continued From page 40 surrounding edges were observed to be peeling. On 9/11/19 at 2:30 p.m., an additional observation of the windowsill in resident room 211 revealed the findings above. On 9/10/19 at 1:37 p.m., an observation of the windowsill in resident room 213 revealed an area of missing paint with the plaster exposed measuring approximately 24 inches length by 10 inches width, the surrounding edges were observed to be peeling. On 9/11/19 at 2:35 p.m., an additional observation of the windowsill in resident room 213 revealed the findings above. On 9/10/19 at 1:40 p.m., an observation of the windowsill in resident room 217 revealed an area of missing paint with the plaster exposed measuring approximately three inches length by one inch width, the surrounding edges were observed to be peeling. A second area was observed measuring approximately one-inch length by one half inch width, the surrounding edges were observed to be peeling. On 9/11/19 at 2:40 p.m., an observation of the windowsill in resident room 217 revealed the findings above. On 9/12/19 at 11:30 a.m., an observation of the windowsill in resident room 224 revealed an area of missing paint with the plaster exposed measuring approximately one-inch length by two inches width, the surrounding edges were observed to be peeling. A second area was observed measuring approximately eight inches length by four inches width, the surrounding	F 584	Systematic Changes: On 9/23/19, the Maintenance Director and other maintenance staff were educated regarding the importance of maintaining a homelike environment with regards to providing undamaged windowsills in resident rooms. On 9/23/19, environmental observation rounds for windowsill damage and exposed peeling paint was added to the facility Preventive Maintenance schedule prevention and/or repair. Monitoring System: Beginning 10/7/19, a Weekly random audit of 10% of resident room windowsills will be conducted by the Maintenance Director and/or his designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies	

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F 584	Continued From page 41 edges were observed to be peeling. On 9/12/19 at 11:35 a.m., an observation of the windowsill in resident room 222 revealed an area of missing paint with the plaster exposed measuring approximately 24 inches length by six inches width, the surrounding edges were observed to be peeling. On 9/12/19 at 11:40 a.m., an observation of the windowsill in resident room 210 revealed five areas of missing paint with the plaster exposed and the edges observed to be peeling. The areas measured approximately one-inch length by one inch width, four inches length by one inch width, four inches length by two inches width, three inches length by two inches width and six inches length by six inches width. On 9/12/19 at 11:30 a.m., an observation of the windowsill in resident room 224 revealed an area of missing paint with the plaster exposed measuring approximately six inches length by 12 inches width, the surrounding edges were observed to be peeling. The residents observed in the rooms during the survey dates were assessed to be moderately impaired and could not be interviewed about the windowsills. On 9/12/19 at 8:05 a.m., an interview was conducted with OSM (other staff member) #5, the director of maintenance. When asked about the process for receiving maintenance requests, OSM #5 stated that if staff or family have concerns they fill out a request to have the issue looked at. OSM #5 stated that maintenance staff and nursing staff periodically inspect the resident	F 584	will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	

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rooms and nursing puts in maintenance requests when issues are found. When asked if there were any active requests for the Linden unit, OSM #5 stated that there were none. OSM #5 stated he had only one request this morning about a toilet. When asked if he had any requests regarding the windowsills in the resident rooms on the Linden unit, OSM #5 stated that he had not had any lately. OSM #5 stated that he had a problem with a window leaking on one side and they had fixed the issue a while back. OSM #5 observed the windowsills in resident rooms 211 and 217 and stated that they had not seen these issues in their inspections and would check the windows to see if they had been leaking to cause the damage to the windowsills. OSM # 5 observed several white towels rolled up in the window base and asked the resident in the room who put the towels in the windowsill; the resident stated that the nurses had put them there. OSM #5 stated to the resident that they would caulk and repair the areas. OSM #5 agreed that the peeling paint exposing the plaster underneath on the windowsills did not create a homelike environment.

On 9/12/19 at 8:15 a.m., an interview was conducted with CNA (certified nursing assistant) #5. When asked about the process staff follow for maintenance requests, CNA #5 stated that staff go to the maintenance book on the unit and fill out a form or if she see's someone from maintenance she will tell them what the issue is and also fill out a form. CNA #5 stated that maintenance checks the book regularly. When asked about the windowsills in the resident rooms on the Linden unit observed during survey, CNA #5 stated that they had repaired the window in room 205 because it was leaking but she hadn't

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noticed anything with the others. When asked if peeling paint exposing the plaster underneath created a homelike environment for residents, CNA #5 stated, "No." At 8:30 a.m., the maintenance book on the Linden unit was reviewed with CNA #5 and LPN (licensed practical nurse) #7, it was observed that there were no active maintenance requests in the book.

On 9/12/19 at 8:35 a.m., an interview was conducted with LPN #7, the unit manager. When asked the process for maintenance requests, LPN #7 stated that staff submit a maintenance slip or go directly to the maintenance director with the issue. LPN #7 stated that the request slip is placed in the maintenance book on the unit and it is checked by maintenance daily. When asked about the peeling paint on the windowsills in the observed resident rooms exposing the plaster underneath, LPN #7 stated that staff have noticed rain coming in the windows and have reported it to maintenance. LPN #7 stated that someone was at the facility to look at it about a month ago and they are still working on it.

On 9/12/19 at 10:30 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked how staff submit maintenance requests, ASM #2 stated that there are forms to fill out and a book that is kept on the unit to put them in. When asked if staff do periodic inspections of the resident's room and report issues ASM #2 stated, "Yes." When asked what staff do when issues are observed ASM #2 stated that maintenance is notified to investigate the issue. When asked if peeling paint with exposed plaster on the windowsills creates a homelike environment ASM #2 stated, "No."

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F 584	Continued From page 44 The facility policy "Maintenance Service" documented "2. Functions of maintenance personnel include, but are not limited to: b. maintaining the building in good repair and free from hazards." On 09/12/19 at approximately 1:25 p.m., ASM (administrative staff member) # 1, the administrator, ASM #2, the director of nursing, ASM # 6, the regional quality assurance director and ASM #3, the medical director were made aware of the findings. No further information was provided prior to exit.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview and facility document review it was determined facility staff failed to ensure one of 48 sampled	F 600	Corrective Action: No corrective action was	10/27/19

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residents, (Resident #451), was free from abuse. Resident #451 was hit in the stomach by Resident #82 on 11/21/2018.

The findings include:

Resident #451 was admitted to the facility on 8/18/2018, and was discharged on 12/27/2018. Resident #451's diagnoses included but were not limited to schizoaffective disorder (1), and major depressive disorder (2). Resident #451's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/01/18, coded Resident #451 as scoring a 2 (two) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 2- being severely impaired for making daily decisions.

Resident #82 was admitted to the facility on 05/17/2018 with a readmission on 06/12/2018. Resident #82's diagnoses included but were not limited to, bipolar disorder (3) and anxiety. (4) Resident #82's most recent MDS (minimum data set), a quarterly assessment ,with an ARD (assessment reference date) of 8/25/19, coded Resident #82 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions.

The Facility Reported Incident dated 11/21/18 documented, "[Name of Resident #451] backed his wheelchair into [Name of Resident #82's] wheelchair. [Name of Resident #82] hit [Name of Resident #451] in stomach, [Name of Resident #451] then hit [Name of Resident #82] in her right upper arm. Both residents were immediately separated and assessed. No injury or pain

completed at this time as such was completed for resident #451 and #82 immediately following the incident on 11/21/18.

Other Potential Residents Affected:

Other residents had the potential to be affected.

Systematic Changes:

On 9/30/19, facility staff received a re-fresher education inservice regarding the Abuse policy, resident to resident abuse, prevention and reporting.

Monitoring System:

Beginning 10/7/19, weekly random interviews of 10% of the residents will be conducted by Director of Nursing and/or her designee compliance.

Audits will be conducted for four weeks and then monthly thereafter for one month.

Identified discrepancies will be addressed accordingly and as

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F 600	Continued From page 46 voiced at this time. RP's (responsible parties) aware." The comprehensive care plan for Resident #451 documented, "CANCELLED: At risk for behavior symptoms related to Mental illness ... Date Initiated: 08/19/2018. Revision on: 12/27/2018." Under "Goals" it documented, "Will reduce risk of behavioral symptoms Date Initiated: 08/19/2018. Revision on 12/27/2018." The comprehensive care plan for Resident #82 documented, "Verbal/physical agitation & aggression related to Cognitive impairment. Date Initiated 06/28/2018. Revision on: 06/28/2018." Under "Goals" it documented, "Will not harm self or others. Date Initiated: 06/28/2018." Review of Resident #451's record revealed a nursing progress note dated "11/21/2018 16:09" (4:09 p.m.), it documented "Resident observed rolling wheelchair into another resident's wheelchair, at that time resident observed being hit by the resident and [Name of Resident #451] was witnessed swinging his arm and hitting her back. Both residents immediately separated and assessed. No injuries noted at this time. No complaints of pain/discomfort ...Will continue to monitor." Review of Resident #82's record revealed a nursing progress note dated "11/21/2018 16:19" (4:19 p.m.), it documented "Resident's wheelchair ran into by another resident's wheelchair. Resident then hit the resident and the other resident was observed hitting her back. Both residents immediately separated and assessed. No injuries noted at this time ... Will continue to monitor."	F 600	appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	

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On 9/11/19 at 4:40 p.m., an interview was conducted with Resident #82 regarding the incident of Resident #82 hitting Resident #451 in the stomach on 11/21/18. When asked about the incident Resident #82 became tearful and stated, "I hit a resident, it won't happen again. She was saying mean things and I slapped her, I felt real bad, I love her, she doesn't have any legs. I was so sorry I have repented. I won't do it again."

On 9/12/2019 at approximately 11:00 a.m., ASM (administrative staff member) #1, the administrator stated that the LPN (licensed practical nurse) who witnessed the incident no longer worked at the facility.

On 9/12/19 at 8:15 a.m., an interview was conducted with CNA (certified nursing assistant) #5. When asked how staff are trained for abuse, CNA #5 stated that staff are trained when hired and about every 2-3 months afterwards. When asked who staff are trained to report abuse to, CNA #5 stated they report to the charge nurse, then the unit manager and up the chain of command. When asked what the staff do to prevent resident to resident abuse, CNA #5 stated that they immediately separate them. When asked if there are specific interventions used for residents known to show aggression, CNA #5 stated that staff monitor those residents more closely and try to keep them active. When asked if the occurrence is resident to resident is it still considered abuse, CNA #5 stated, "Yes." When asked about the incident when Resident #82 hit Resident #451 in the stomach on 11/21/18, CNA #5 stated that she did not witness that incident but Resident #82 still has some outburst but she has never witnessed her hit

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anyone. CNA #5 stated that Resident #82 has gotten better lately.

On 9/12/19 at 8:35 a.m., an interview was conducted with LPN (licensed practical nurse) #7, the unit manager. When asked how staff are trained on abuse, LPN #7 stated that they have quarterly in-services, annual in-services and after any incident that is reported. When asked whom abuse is reported to, LPN #7 stated that it is reported to the director of nursing and the administrator as soon as it is reported to them. When asked about the process staff follows for resident-to-resident abuse, LPN #7 stated that they immediately separate the residents and start an investigation. LPN #7 stated that they figure out what happened, what triggered the incident, do medication reviews if needed and do a care plan conference including the family. When asked if the occurrence is resident to resident is it still considered abuse, LPN #7 stated, "Yes." When asked about the incident of Resident #82 hitting Resident #451 in the stomach on 11/21/19, LPN #7 stated that they have been doing different things with Resident #82 including having her family be more involved with her and getting her to be more active. LPN #7 stated that Resident #82's behavior has gotten much better; she occasionally has loud outbursts but has not had any other incidents of hitting since the episode on 11/21/19.

On 9/12/19 at 10:30 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked how staff are trained on abuse, ASM #2 stated that staff are trained at least quarterly, annually and as needed. When asked who staff report abuse to, ASM #2 stated that abuse is

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reported immediately to their supervisor, then to the assistant director of nursing, director of nursing or the administrator. ASM #2 stated that the chain of command is followed. When asked about the time frame for reporting incidents, ASM #2 stated, "Immediately." When asked what is done to prevent resident-to-resident abuse, ASM #2 stated that staff immediately intervene and try to diffuse the situation any way possible. ASM #2 stated that the expectation is for staff to intervene before it becomes physical. ASM #2 stated they separate the persons involved and perform a head to toe assessment and follow up on what happened. ASM #2 stated that an investigation is started immediately. ASM #2 stated that they also talk to staff members and family that may be involved or witnesses. When asked if the occurrence is resident to resident is it still considered abuse, ASM #2 stated, "Yes."

The facility policy "Resident Rights. CO Edited 05/02/2018" documented, "Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: c. be free from abuse, neglect, misappropriation of property, and exploitation ..."

The facility policy "Abuse and Neglect-Clinical Protocol. Revised March 2018" documented, "Cause Identification 1. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. 4. The physician and staff will address appropriately causes of problematic resident behavior where possible, such as mania, psychosis, and mediation side effects."

On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) #1, the

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administrator, ASM #4, regional clinical coordinator, ASM #5, the director of nursing for another facility and ASM #6, regional quality assurance director were made aware of the findings.

No further information was provided prior to exit.

References:

1. Schizoaffective disorder
A mental condition that causes both a loss of contact with reality [psychosis] and mood problems [depression or mania]. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000930.htm.

2. Major depressive disorder
Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

3. Bipolar disorder
A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

4. Anxiety
Fear. This information was obtained from the

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F 600	Continued From page 51 website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. .	F 600		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the	F 622		10/27/19

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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 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:

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F 622	Continued From page 53 (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 staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to evidence that all required documentation was provided to the hospital upon transfer for one of 48 residents in the survey sample, Resident #26. The facility staff failed to evidence that the comprehensive care plan goals and medication list were provided to the hospital upon a transfer to the emergency room on 7/15/19 for Resident #26. The findings include: Resident #26 was admitted to the facility on 3/15/19. Diagnoses include, but are not limited to, dysphagia, tachycardia, anxiety disorder, and stroke. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/4/19 coded the resident as being intact in ability to make daily life decisions. The resident was coded as requiring extensive care for all areas of activities of daily living. A review of the clinical record revealed a nurse's	F 622	Corrective Action: No corrective action for resident #26 was performed as the hospital transfer date has passed and the resident returned to the facility. Other Potential Residents Affected: Other residents transferred to the hospital without a copy of the comprehensive care plan goals and medication list to the hospital upon transfer to the emergency room had the potential to be affected. Systematic Changes:	

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F 622	Continued From page 54 note dated 7/15/19 that documented, "....change in condition noted related this am (morning) vomiting up dark substance, abd (abdomen) soft and bs (bowel sounds) are active, med (medium) bm (bowel movement) this am. This change in condition started on 7/15/19....Evidence of GI (gastrointestinal) bleed present (i.e., bloody stool/vomitus). Has had episodes of nausea/vomiting. Vomiting up dark colored substance....Non-emergent transfer to hospital....Emergency contact....was notified on 7/15/19 at 10:20 AM...." A review of the "SNF/NF (skilled nursing facility/nursing facility) To Hospital Transfer Form" dated 7/15/19 included the following information: demographics, diagnoses, responsible party, facility contact, physician contact, clinical information, functional status, mental status, allergies, treatments, isolation precautions, devices, risk alerts, skin/wound care, immunizations, and therapy status. The form did not evidence that the comprehensive care plan goals and medication list were provided. On 9/11/19 at 5:00 PM, an interview was conducted with RN #2 (Registered Nurse). When asked what is sent with the resident when they are transferred from the facility, RN #2 stated, "In an emergency we call the hospital and get the resident on their way. We send them the SBAR (situation, background, assessment, recommendation) and fax them the care plan, facesheet, labs (laboratory tests) or diagnostics, bed hold notification and the H&P (history and physical) (if the physician asks for it)". When asked where staff document what was provided to the hospital, RN #2 stated, "The documentation would be in the progress note or	F 622	Beginning 9/30/19, licensed nurse staff were re-educated regarding the importance of providing a copy of the comprehensive care plan goals and medication list to the hospital upon transfer to the emergency room and documenting such on the SNF/NF to Hospital Transfer Form or within the EMR. Monitoring System: Beginning 10/7/19, a weekly audit of residents transferred to the hospital will be conducted by the Director of Nursing and/or her designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	

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SBAR".

On 9/12/19 at 9:26 AM, an interview was conducted with LPN #4, (Licensed Practical Nurse). When asked what documentation is sent to the hospital when a resident is transferred to the emergency room (ER), LPN #4 stated, "The transfer form, face sheet, copy of medications, bed hold policy, notes and labs as needed." When asked if the comprehensive care plan goals are sent, LPN #4 stated, "No, I've never sent the care plan goals." When asked where staff document the other items sent, LPN #4 stated, "The other items are not duplicate forms, so there is no evidence they were sent. They are just printed off the computer and sent there is no checklist or pre-prepared packets."

On 9/12/19 at 9:45 AM, an interview was conducted with LPN #7. When asked what is sent with the resident when they are transferred from the facility, LPN #7 stated "We send the notice of transfer, bed hold notification, care plan, facesheet, SBAR, medical diagnostic results, lab results and H&P. If it's an emergency, we would print the paperwork and fax to the hospital". When asked where staff document what was provided to the hospital, LPN #7 stated, "The documentation should be found in the progress note or SBAR".

A review of the facility policy, "Transfer or Discharge Documentation" documented, "Should a resident be transferred or discharged for any reason, the following information will be communicated to the receiving facility or provider:....b. Contact information of the practitioner responsible for the care of the resident; c. Resident representative information

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F 622	Continued From page 56 including contact information; d. Advance Directive information; e. All special instructions or precautions for ongoing care, as appropriate; f. Comprehensive care plan goals; and g. All other necessary information, including a copy of the residents discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care." On 9/12/19 at 11:45 AM, the Administrator, Director of Nursing, and Medical Director (ASM #1, #2, and #3 respectively - Administrative Staff Members) were made aware of the concerns. No further information was provided by the end of the survey.	F 622		
F 623 SS=E	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 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	F 623		10/27/19

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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;
(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

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F 623	Continued From page 58 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 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 resident interview, staff interview and facility document review it was determined facility staff failed to evidence that the ombudsman and/or the resident or their representative were	F 623	Corrective Action: On 10/7/19, written notification of a hospital transfer for	

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F 623	Continued From page 59 provided with the required written notification of a hospital transfer for six of 48 residents in the survey sample, Resident #7, #34, #88, #81, #68 and @26. The findings include: 1. The facility staff failed to provide written notification of transfer to Resident #7 and/or the resident's responsible party, for a facility initiated hospital transfer of Resident #7 on 6/28/19. Resident #7 was admitted to the facility 03/24/2018 with a readmission on 06/29/2019 with diagnoses that included but were not limited to fracture of femur (1) and rheumatoid arthritis (2). Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/10/19, coded Resident #7 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. On 9/10/19 at 1:30 p.m., an interview was conducted with Resident #7. When asked if he had been hospitalized recently Resident #7 stated that he was in the hospital in June when he broke his leg. When asked if he received a written notification of transfer from the facility when he was sent to the hospital Resident #7 stated that he did not remember getting anything but maybe his wife did. The progress note dated 06/28/2019 for Resident #7 documented "[Name of Nurse Practitioner] called order to send to ER (emergency room) for	F 623	residents #7, #34, #88, #81, #68 and #26 were provided to the resident, resident representative and/or Ombudsman as applicable. Other Potential Residents Affected: Other residents transferred to the hospital without written notification of such to them, their representative and/or the Ombudsman had the potential to be affected. Systematic Changes: On 9/30/19 and 10/6/19, Licensed nurse and social services staff were educated regarding the need to provide written notification to the resident, resident representative and ombudsman of transfer to the hospital as well as use of the appropriate form to document such. In addition, the facility policy and procedure was updated to include criteria for notifying the resident's family and the Ombudsman in writing of the hospital transfer.	

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F 623	Continued From page 60 evaluation." Review of the record revealed a copy of the facility transfer form sent to the hospital dated 06/28/2019 but failed to evidence documentation of written notification to Resident #7 or Resident #7's responsible party. Review of the clinical record and the EHR (electronic health record) for Resident #7 failed to evidence documentation that Resident #7 and/or Resident #7's representative were provided written notification of Resident #7's transfer to the hospital on 06/28/2019. On 9/12/19 at 9:26 AM, in an interview with LPN #4 (Licensed Practical Nurse), when asked if written notification of transfer is provided to the resident or resident's representative upon transfer to the hospital, LPN #4 stated that she does not provide written notification to the family. On 9/12/19 at 9:42 a.m., an interview was conducted with OSM (other staff member) #6, the social worker and ASM (administrative staff member) #4, the Regional Clinical Coordinator. When asked about written notification to the resident or resident's representative, ASM #4 stated that written notification was not being done at the facility. ASM #4 stated that the company has the form for it but they have not been doing it." On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, regional clinical coordinator, ASM #5, the director of nursing for another facility and ASM #6, regional quality assurance director were made aware of the findings.	F 623	Monitoring System: Beginning 10/8/19, a weekly audit of residents transferred to the hospital will be conducted by the Director of Nursing and/or her designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate.	

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No further information was provided prior to exit.

References:

1. Femur fracture
You had a fracture (break) in the femur in your leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm.

2. Rheumatoid arthritis
A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm.

2. The facility staff failed to provide written notification of transfer to Resident #34 and/or Resident #34's representative for a facility initiated transfer on 8/9/19 for Resident #34.

Resident # 34 was admitted to the facility 05/02/2016 with a readmission on 08/13/2019 with diagnoses, that included but were not limited to hemiplegia (1) and weakness.

Resident # 34's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/11/2019, coded Resident #34 as scoring a 11 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 11- being moderately impaired for

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making daily decisions.

On 9/10/19 at 1:15 p.m., an interview was conducted with Resident #34. When asked if he had been hospitalized recently Resident #34 stated that he was in the hospital recently because he was bleeding. When asked if he received a written notification of transfer from the facility when he was sent to the hospital Resident #34 stated that he did not know.

Review of the nurse's "Progress Notes," dated 08/09/2019 documented, "Large amount of blood noted in urine [Name of Physician] notified. Order to send to er (emergency room)." Review of the record revealed a copy of the facility transfer form sent to the hospital dated 08/09/2019 but failed to evidence documentation of written notification to Resident #34 or Resident #34's responsible party.

Review of the clinical record and the EHR (electronic health record) for Resident #34 failed to evidence documentation that Resident #34 and/or Resident #34's representative were provided written notification of Resident #34's transfer to the hospital on 08/09/2019.

On 9/12/19 at 9:26 AM, in an interview with LPN #4 (Licensed Practical Nurse), when asked what documentation is sent to the hospital when a resident is transferred to the hospital, she stated, "The transfer form, face sheet, copy of medications, bed hold policy, notes and labs as needed." When asked if written notification of transfer is provided to the resident or resident's representative upon transfer LPN #4 stated that she does not provide written notification to the family.

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On 9/12/19 at 9:42 a.m., an interview was conducted with OSM (other staff member) #6, the social worker and ASM (administrative staff member) #4, the Regional Clinical Coordinator. When asked about written notification to the resident or resident's representative, ASM #4 stated that written notification was not being done at the facility. ASM #4 stated that the company has the form for it but they have not been doing it."

On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, regional clinical coordinator, ASM #5, the director of nursing for another facility and ASM #6, regional quality assurance director were made aware of the findings.

No further information was provided prior to exit.

References:

1. Hemiplegia
Also called: Hemiplegia, Palsy, Paraplegia, and Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

3. The facility staff failed to provide Resident # 88 and the resident's representative written notification of the resident's facility-initiated

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transfer to the hospital on 06/25/19.

Resident # 88 was admitted to the facility on 03/26/2019. Resident #88 was readmitted to the facility on 06/30/2019 with diagnoses that included but were not limited to swallowing difficulty, low iron, and high blood pressure.

Resident # 88's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 08/24/19, coded Resident # 88 as scoring a three on the staff assessment for mental status (BIMS) of a score of 0 - 15, three- being severely impaired of cognition for making daily decisions.

The facility's "Progress Notes" for Resident # 88 dated 06/25/2019 documented, "Resident was assessed by NP [nurse practitioner]. Resident noted to have altered mental status, Resident has had a significant mental event, Contacted [Name of Hospital] to schedule a CT [computerized tomography] [1]1scan, nurse instructed that resident had to go through ER [emergency room] to obtain a CT scan. Unable to send resident to [Name of Hospital] instructed to send to nearest ER due to transportation purposes. Nurse called in report to [Name of Hospital] ER spoke with [Name of Registered Nurse]. Resident being transferred by [Name of Transport Company], Bed hold, notice of transfer and care plan goals and education sent with resident. R/R [resident representative], Resident made aware."

Review of the clinical record and the EHR (electronic health record) for Resident # 88 failed to evidence that a written notification of discharge was provided to the resident and resident's representative for the facility-initiated transfer on

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6/25/19 for Resident # 88.

On 9/12/19 at 9:26 AM, in an interview with LPN #4 (Licensed Practical Nurse), when asked if written notification of transfer is provided to the resident or resident's representative upon transfer LPN #4 stated that she does not provide written notification to the family.

On 9/12/19 at 9:42 a.m., an interview was conducted with OSM (other staff member) #6, the social worker and ASM (administrative staff member) #4, the Regional Clinical Coordinator. When asked about written notification to the resident or resident's representative, ASM #4 stated that written notification was not being done at the facility. ASM #4 stated that the company has the form for it but they have not been doing it."

On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, regional clinical coordinator, ASM #5, the director of nursing for another facility and ASM #6, regional quality assurance director were made aware of the findings.

No further information was provided prior to exit.

References:

[1]A computerized tomography (CT) scan combines a series of X-ray images taken from different angles around your body and uses computer processing to create cross-sectional images (slices) of the bones, blood vessels and soft tissues inside your body. CT scan images provide more-detailed information than plain

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X-rays do. This information was obtained from the website: https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675.

4. The facility staff failed to provide Resident # 81 and the resident's representative written notification of a facility-initiated transfer of the resident to the hospital on 07/08/2019 and 08/12/2019.

Resident # 81 was admitted to the facility on 09/26/2011. Resident #81 was readmitted on 08/16/2019 with diagnoses that included but were not limited to swallowing difficulty, low iron, and high blood pressure.

Resident # 81's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 08/23/19, coded Resident # 81 as scoring a three on the staff assessment for mental status (BIMS) of a score of 0 - 15, three- being severely impaired of cognition for making daily decisions.

The facility's "Progress Notes" for Resident # 81 dated 07/08/19 at 1:27 p.m. documented, "Resident assessed by [Name of Nurse Practitioner] requested to send resident out for further evaluation and treat to [Name of Hospital] by [Name of Transport Company]." The facility's "Progress Notes" for Resident # 81 dated 07/08/19 at 1:55 p.m. documented, "Bed hold, notice of transfer and care plan goals and education sent with resident. R/R [resident representative], Resident made aware."

The facility's "Progress Notes" for Resident # 81 dated 08/12/19 at 8:00 a.m. documented in part,

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"Change in condition noted related to resident noted with right side of neck, red swollen and hard to touch, blood noted in and around mouth, no noted injury of mouth noted [Name of Nurse Practitioner] notified, note order to send to [Name of Hospital] for evaluation."

Review of the clinical record and the EHR (electronic health record) for Resident # 81 failed to evidence that written notification of the transfers above was provided to the resident and resident's representative.

On 9/12/19 at 9:26 AM, in an interview with LPN #4 (Licensed Practical Nurse), when asked if written notification of transfer is provided to the resident or resident's representative upon transfer LPN #4 stated that she does not provide written notification to the family.

On 9/12/19 at 9:42 a.m., an interview was conducted with OSM (other staff member) #6, the social worker and ASM (administrative staff member) #4, the Regional Clinical Coordinator. When asked about written notification to the resident or resident's representative, ASM #4 stated that written notification was not being done at the facility. ASM #4 stated that the company has the form for it but they have not been doing it."

On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, regional clinical coordinator, ASM #5, the director of nursing for another facility and ASM #6, regional quality assurance director were made aware of the findings.

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No further information was provided prior to exit.
5. The facility staff failed to evidence written notification of transfer to Resident #68 and/or their representative for a facility initiated transfer to the hospital on 8/7/19.

Resident #68 was admitted to the facility on 3/16/16. Resident #68's diagnoses included but were not limited to osteomyelitis of vertebra and sacral region [infection of bone and bone marrow of the spinal column (1)], paraplegia [paralysis of the lower limbs (2)], unstable angina [intermittent chest pain occurring with increasing frequency and intensity]. (3)

Resident #68's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/16/19, coded that the resident's BIMS (brief interview for mental status) score was "14" indicating the resident was capable of making daily cognitive decisions.

A nurse's note dated 8/7/19 at 10:50 AM documented, "Resident was transferred to the hospital on 8/7/19 with unstable angina". Further review of Resident #68 clinical record failed to reveal documentation to evidence the resident and/or representative was provided written notification regarding this transfer.

On 9/12/19 at 9:26 AM, in an interview with LPN #4 (Licensed Practical Nurse), when asked if written notification of transfer is provided to the resident or resident's representative upon transfer LPN #4 stated that she does not provide written notification to the family.

On 9/12/19 at 9:42 a.m., an interview was

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conducted with OSM (other staff member) #6, the social worker and ASM (administrative staff member) #4, the Regional Clinical Coordinator. When asked about written notification to the resident or resident's representative, ASM #4 stated that written notification was not being done at the facility. ASM #4 stated that the company has the form for it but they have not been doing it."

On 9/12/19 at 12:30 PM, ASM (administrative staff member) #1 (administrator), #2 (director of nursing), #3 (medical director), #4 (regional clinical coordinator), #5 (director of nursing for another facility) and #6 (regional quality assurance director) were made aware of the above concern.

No further information was presented prior to exit.

References:
1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 421.
2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 432.
3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 34.

6. The facility staff failed to evidence that the required written notification was provided to the Ombudsman and resident representative regarding a hospital transfer on 7/15/19 for Resident #26.

Resident #26 was admitted to the facility on 3/15/19 with the diagnoses of but not limited to dysphagia, tachycardia, anxiety disorder, and stroke. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of

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7/4/19 coded the resident as being intact in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 7/15/19 that documented, "....change in condition noted related this am vomiting up dark substance, abd (abdomen) soft and bs (bowel sounds) are active, med (medium) bm (bowel movement) this am. This change in condition started on 7/15/19....Evidence of GI bleed present (i.e., bloody stool/vomitus). Has had episodes of nausea/vomiting. Vomiting up dark colored substance....Non-emergent transfer to hospital....Emergency contact....was notified on 7/15/19 at 10:20 AM...."

Further review failed to reveal any evidence that the resident representative and Ombudsman were provided with written notification of the hospital transfer.

On 9/12/19 at 9:26 AM, in an interview with LPN #4 (Licensed Practical Nurse), she stated that she does not provide written notification to the family or Ombudsman.

On 9/12/19 at 9:35 AM, in an interview with OSM #6 (Other Staff Member, the social worker), when asked about Ombudsman notification, she stated, "We print the list from the computer program of the discharges. It is not something I compile." She then looked for the discharge information for Resident #26. She stated the system does not show that he was transferred on 7/15/19.

At this time, she consulted with ASM #4 (Administrative Staff Member) the Regional Clinical Coordinator. On 9/12/19 at 9:42 AM, ASM #4 stated, "Nursing did not take him out of

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F 623	Continued From page 71 the system. Nursing is supposed to "ATD" them out of the system. They have not been consistent about that." When asked about written Ombudsman and family notification, ASM #4 stated, "The Ombudsman was supposed to be notified. Written notification to the family was not done either. This facility has not been doing it. The company has the form for it but the facility hasn't been doing it." A review of the facility policy, "Transfer or Discharge, Emergency" documented, "Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures:....e. Notify the representative (sponsor) or other family member...g. Others as appropriate or necessary..." The policy did not specify that the resident family should be notified in writing; and did not include criteria for notifying the Ombudsman. A review of the facility policy, "Transfer or Discharge, Documentation" did not include any criteria for notifying the resident's family in writing or for notifying the Ombudsman of the hospital transfer. On 9/12/19 at 11:45 AM, the Administrator, Director of Nursing, and Medical Director (ASM #1, #2, and #3 respectively) were made aware of the concerns. No further information was provided by the end of the survey.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		10/27/19

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F 641	Continued From page 72 resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate MDS (minimum data set) assessment for one of 48 residents in the survey sample, Resident # 101. The facility staff failed to accurately code Resident # 101's discharge statue to community on the discharge assessment MDS (minimum data set) with an ARD (assessment reference date) of 08/10/19. Instead, the resident's discharge was coded as 'Acute hospital." The findings include: Resident # 101 was admitted to the facility on 07/24/19 with diagnoses that included but were not limited to right knee pain, repeated falls and high blood pressure. Resident # 101's MDS (minimum data set), a discharge assessment with an ARD (assessment reference date) of 08/10/19, coded Resident # 101 as "03 (three) - Acute hospital" under section "A2100 Discharge Status." The facility's "Progress Notes" dated 08/10/2019 documented, "Patient discharged home via [by] daughter in car with [Name of Home Health] in place, all belongings with patient, remaining medication sent with patient self administering medication instructions understood per daughter/patient, skin assess [assessment] prior to discharge remain intact." On 09/12/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #	F 641	Corrective Action: On 9/12/19, a modification to a prior assessment was completed for corrective action resident #101 to accurately reflect his discharge status to the community. Other Potential Residents Affected: Other residents requiring a MDS discharge assessment had the potential to be affected. Systematic Changes: On 9/12/19, MDS Coordinators were re-educated regarding the importance of accurate coding of section A2100 - Discharge Status of the MDS discharge assessment. Monitoring System: Beginning 10/7/19, a weekly random audit of 10% of section A2100 of the MDS Discharge Assessments will be conducted by the	

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F 641	Continued From page 73 9, MDS coordinator. LPN #9 was asked if Resident # 101's "Discharge Return Not Anticipated" MDS dated 08/10/2019 was coded correctly. After reviewing Resident # 101's nurse's progress note dated 08/10/19 and the discharge MDS assessment, LPN # 9 stated, "It was coded in error. It should have been coded as a discharge to community." On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, regional clinical coordinator, ASM #5, the director of nursing for another facility and ASM #6, regional quality assurance director were made aware of the findings. No further information was provided prior to exit.	F 641	Director of Nursing and/or her designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F 655		10/27/19

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F 655	Continued From page 74 (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to develop a baseline care plan for one of 48 residents in the survey sample, Resident #2. The facility staff failed to address Resident #2's need for glasses and hearing aids on her initial baseline care plan. The findings include: Resident #2 was admitted to the facility on	F 655	Corrective Action: On 9/18/19 the care plan for Resident #2 was update. Other Potential Residents Affected: Other residents with hearing aids and eyeglasses	

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F 655	Continued From page 75 8/30/19 with diagnoses including, but not limited to a history of a stroke, and one-sided weakness after a stroke. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 9/6/19, Resident #2 was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the use of a hearing aid and of corrective lenses (eyeglasses). On 9/10/19 at 3:40 p.m., Resident #2 was observed sitting in a wheelchair in her room. She was wearing glasses. Her eyes were closed. Resident #2's daughter was present, and agreed to an interview. She stated her mother was admitted to the facility for therapy services after suffering a stroke the previous week. During the interview, Resident #2's daughter told the surveyor that the resident wears hearing aids, and that one of the hearing aids had been lost. She stated she had reported this to the facility staff, and that the staff had been very responsive and concerned. The resident's daughter confirmed that her mother needed the glasses to see well. On 9/11/19 at 8:05 a.m., Resident #2 was observed in the therapy gym. A therapist was washing her hands in preparation for helping the resident eat breakfast. The resident was wearing glasses. A review of Resident #2's care plan dated 8/30/19 and updated 9/4/19 revealed no evidence of any information regarding Resident #2's hearing aids or glasses.	F 655	had the potential to be affected. Systematic Change: On 9/30/19, licensed nurse staff were re-educated regarding the importance updating the care plan to accurately reflect the resident. Monitoring System: Beginning 10/7/19, a weekly random audit of 10% of the care plans will be by the Director of Nursing and/or her designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for future review and/or possible revisions to facility protocol.	

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	495391	A. BUILDING _____ B. WING _____	C 09/12/2019

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F 655	Continued From page 76	F 655		

On 9/12/19 at 10:19 a.m., LPN (licensed practical nurse) #8 was interviewed regarding care plan updates. She stated, "Nurses just initiate the care plan on admission. The unit manager goes in and does all the updates."

On 9/12/19 at 11:12 a.m., LPN #4, the assistant unit manager, was interviewed regarding care plan updates. She stated, "It's interdisciplinary. It could be me, the ADON (assistant director of nursing), the dietician. Anyone could update it." When asked the purpose of the care plan, she stated, "It tells us how to take care of the resident." When asked if the facility staff use the care plans, LPN #4 stated, "At times. I'm not sure how much." When asked if a resident's use of hearing aids and glasses should be included on an initial baseline care plan, LPN #4 stated, "Absolutely. We would need to know that." LPN #4 was asked to find these items in Resident #2's care plan. After reviewing the care plan, she stated, "I don't see it in here. It should have been included. I know we are looking for one of the hearing aids, and I know she wears her glasses."

On 9/12/19 at 12:43 p.m., ASM (administrative staff member) #1, the administrator, was notified of these concerns.

A review of the facility policy, "Care Plans, Comprehensive Person-Centered," revealed, in part, the following: "The comprehensive, person-centered care plan will:...Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...Incorporate identified problem areas."

No further information was provided prior to exit.

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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 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	F 656		10/27/19

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F 656	Continued From page 78 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, facility document review and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for one of 48 residents in the survey sample, Resident # 50. The facility staff failed to implement Resident #50's comprehensive care plan for the treatment of pain. The staff failed to administer the medications per the physician order and failed to offer non-pharmacological interventions prior to the administration of pain medication. The findings include: Resident #50 was admitted to the facility on 9/15/14 with diagnoses that included but are not limited to: congestive heart failure [1], diabetes, high blood pressure, and osteoarthritis [2]. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 7/25/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring limited to extensive assistance of one or more staff members for all of her activities of daily living. In Section J - Health Conditions -the resident was coded as receiving as needed pain medication and at the time of the interview stated, she had no pain. The resident was coded in Section J as not receiving any non-medication	F 656	Corrective Action: No corrective action was performed for resident #50 regarding omissions of non-pharmacological documentation as the dates referenced are more than 30 days old. Other Potential Residents Affected: Other residents with non-pharmacological omissions had the potential to be affected. Systematic Change: On 9/30/19, licensed nurse staff were re-educated regarding the importance of performing and documenting non-pharmacological interventions in the EMR prior to the administration of pain medication. Monitoring System: Beginning 10/7/19, a weekly	

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F 656	Continued From page 79 interventions for pain. The comprehensive care plan dated, 8/9/19, documented in part, "Focus: Pain related to diabetic neuropathy, arthritis, lymphedema to leg, muscle spasms." The "Interventions" documented in part, "Administer pain medication per physician orders. Encourage/assist with reposition frequently for comfort as needed. Implement nondrug therapies such as diversion activities, TV etc. to assist with pain and monitor effectiveness." The physician orders dated 5/17/19, documented, "Oxycodone Tab (tablet) (used to treat moderate to severe pain) [3] 5 mg (milligrams); 1 tablet by mouth every 1 -2 hours as needed for severe pain." The physician orders dated 1/14/18, documented, "Acetaminophen Tab (used to treat mild to moderate pain) [4] 325 mg - 2 tablets by mouth every 6 hours as needed for mild to moderate pain." The physician orders for the months of May, June and July 2019 documented the following order: Pain Evaluation Each Shift (key): 0 = no pain 1,2,3,4 = mild pain 5, 6, 7 = moderate pain 8, 9 = severe pain 10 = very severe - horrible pain. The May 2019 Medication Administration Record (MAR) documented the above physician's order for Oxycodone. The medication was documented as administered on the following dates and times and for the following pain scale level:	F 656	random audit of nursing progress notes for residents with current orders for pain medication will be conducted by the Director nursing and/or her designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for future review and/or possible revisions to facility protocol.	

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F 656	Continued From page 80	F 656		

- 5/15/19 at 4:30 p.m. - general pain - pain level 5/10 (five out of 10)
- 5/25/19 at 8:15 a.m. - general pain - pain level 5/10
- 5/26/19 at 8:10 a.m. - general pain - pain level 5/10
- 5/29/19 at 6:00 p.m. - general pain - pain level 5/10
- 5/29/19 at 10:00 p.m. - general pain - pain level 6/10
- 5/30/19 at 8:30 a.m. - general pain - pain level 7/10.

There was no documentation evidencing that non-pharmacological interventions were provided prior to the administration of the Oxycodone for any of the dates above.

Review of the nurse's notes for the above dates, failed to evidence documentation of non-pharmacological interventions.

The Medication Administration Record (MAR) for June 2019 documented the above physician's order. The Oxycodone was documented as administered on the following dates and times and for the following pain levels:
- 6/2/19 at 2:38 p.m. - lower leg pain - no pain scale documented
- 6/5/19 at 9:00 p.m. - bilateral leg pain - 5/10
- 6/10/19 at 11:00 p.m. - general pain - 6/10
- 6/12/19 at 9:30 a.m. - leg pain - 6/10
- 6/12/19 at 9:00 p.m. - leg pain - 5/10
- 6/13/19 at 4:00 p.m. - generalized pain - 6/10
- 6/17/19 at 1:00 a.m. - leg pain - 9/10
- 6/17/19 at 5:00 a.m. - leg pain - 6/10
- 6/17/19 at 6:00 p.m. - leg pain - 6/10
- 6/18/19 at 7:00 a.m. - leg pain - 7/10
- 6/21/19 at 11:00 p.m. - leg pain - 5/10
- 6/20/19 at 9:00 a.m. - general pain - 6/10

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F 656	Continued From page 81	F 656		

- 6/22/19 at 8:00 a.m. - bilateral leg pain - 7/10
- 6/23/19 at 8:30 a.m. - general pain - 6/10
- 6/26/19 at 8:16 p.m. - general pain - 5/10.
There was no documentation evidencing that non-pharmacological interventions were provided prior to the administration of the Oxycodone for any of the dates above.

Review of the nurse's notes for the above dates, failed to evidence documentation of non-pharmacological interventions.

The July 2019 MAR documented the above physician's order for Oxycodone. Oxycodone was documented as administered on the following dates and times and for the following pain levels:
- 7/6/19 at 9:24 a.m. - general pain - no pain level documented
- 7/7/19 at 8:00 a.m. - bilateral leg pain - 6/10
- 7/7/19 at 2:50 p.m. - leg pain - 7/10
- 7/11/19 at 8:00 a.m. - leg pain - 6/10
- 7/15/19 at 9:30 a.m. - leg pain - 6/10
- 7/16/19 at 9:00 a.m. - bilateral leg pain - 6/10
- 7/19/19 at 9:00 a.m. - bilateral leg pain - 6/10
- 7/20/19 at 6:00 a.m. - bilateral leg pain - no pain level documented
- 7/21/19 at 9:30 p.m. - general pains - 6/10
There was no documentation evidencing that non-pharmacological interventions were provided prior to the administration of the Oxycodone for any of the dates above.

Review of the nurse's notes for the above dates, failed to evidence documentation of non-pharmacological interventions.

The review of the May, June and July MARs failed to evidence the Tylenol was administered.

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F 656	Continued From page 82	F 656		

An interview was conducted with LPN (licensed practical nurse) #6 on 9/11/19 at 3:59 p.m. When asked the purpose of the care plan, LPN #6 stated it's to meet the goals and expectation of the resident." When asked if it should be followed, LPN #6 stated, "Yes." The care plan for Resident #50 was reviewed for the pain interventions with LPN #6. When asked if not giving the medications as ordered and not attempting non-pharmacological interventions was following this resident's care plan, LPN #6 stated, "No, it's not."

The facility policy, "Care Plan, Comprehensive Person-Centered" documented in part, "1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident."

ASM (administrative staff member) #1, the administrator, ASM #3, the medical director, ASM #4, the regional clinical coordinator, and ASM #5, a director of nursing from another facility, were made aware of the above concerns on 9/12/19 at 9:45 a.m.

No further information was provided prior to exit.

[1] Congestive Heart Failure: abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138.
[2] Osteoarthritis- Characterized by degenerative changes in the joints, pain, stiffness and swelling can develop after exercise. Barron's Dictionary of

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F 656	Continued From page 83 Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 422. [3] This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682132.html [4] This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html	F 656		
F 657 SS=E	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		10/27/19

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F 657	Continued From page 84 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to review and revise the care plan for five of 48 residents in the survey sample, Residents #75, #2, #7, #34, and #40. The findings include: 1. The facility staff failed to revise Resident #75's comprehensive care plan when he acquired a urinary tract infection (1) and began taking antibiotics. Resident #75 was admitted to the facility on 8/14/19 with diagnoses including, but not limited to, history of knee replacement and arthritis. On the most recent MDS (minimum data set), an admission assessment an ARD (assessment reference date) of 8/21/19, Resident #75 was coded as being moderately impaired for making daily decisions, having scored 10 out of 15 on the BIMS (brief interview for mental status). A review of Resident #75's progress notes revealed the following note, written 9/9/19: "Change in condition noted related to patient has a period of confusion with a temp (temperature) of 101.6. New order for Cipro (Ciprofloxacin, an antibiotic) 500 mg (milligrams) po (by mouth) bid (twice a day) X (for) 7 days." A review of Resident #75's comprehensive care plan dated 8/14/19 failed to reveal any information regarding the resident's urinary tract	F 657	Corrective Action: A corrective action to Resident #75 care plan was not completed as the medical record is now considered a closed record due their discharge. A corrective action for Resident #2 was not Completed as the medical record is now considered a closed record due to their discharge. On 10/4/19, the comprehensive care plan for resident #7 was revised to accurately reflect interventions implemented due to a fall. On 9/12/19, the Care plan for resident #34 was revised to accurately reflect interventions implemented due to a fall.	

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F 657	Continued From page 85 infection or antibiotic treatment. On 9/12/19 at 10:19 a.m., LPN (licensed practical nurse) #8 was interviewed regarding care plan updates. She stated, "Nurses just initiate the care plan on admission. The unit manager goes in and does all the updates." On 9/12/19 at 11:12 a.m., LPN #4, the assistant unit manager, was interviewed regarding care plan updates. She stated, "It's interdisciplinary. It could be me, the ADON (assistant director of nursing), the dietician. Anyone could update it." When asked the purpose of the care plan, LPN #4 stated, "It tells us how to take care of the resident." When asked if the facility staff use the care plans, LPN #4 stated, "At times. I'm not sure how much." When asked if Resident #75's care plan should be updated to include a urinary tract infection and antibiotic treatment, LPN #4 stated, "You know, it should. I will make sure it does." On 9/12/19 at 12:43 p.m., ASM (administrative staff member) #1, the administrator, was notified of these concerns. A review of the facility policy, "Care Plans, Comprehensive Person-Centered," revealed, in part, the following: "The comprehensive, person-centered care plan will:...Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...Incorporate identified problem areas." No further information was provided prior to exit. 2. The facility staff failed to revise Resident #2's	F 657	On 10/4/19, the care plan for resident #40 was revised to accurately reflect interventions implemented to a fall. Other Potential Residents Affected: Other residents with care plans not revised after a fall had the potential to be affected. Systematic Changes: On 9/30/19, the licensed nurse staff was re-educated regarding the importance of completing revisions to the care plan after falls. Monitoring System: Beginning 10/7/19,a weekly random audit of 10% of the care plans for residents with falls will be completed by the Director of Nursing and/or her designee for compliance. Audits will be conducted for four weeks and then	

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F 657	Continued From page 86	F 657		

comprehensive care plan when her order for consistency of liquids at mealtime was changed.

Resident #2 was admitted to the facility on 8/30/19 with diagnoses including, but not limited to a history of a stroke, and one-sided weakness after a stroke. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 9/6/19, Resident #2 was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the use of a hearing aid and of corrective lenses (eyeglasses).

On 9/10/19 at 3:40 p.m., Resident #2 was observed sitting in a wheelchair in her room. She was wearing glasses. Her eyes were closed. Resident #2's daughter was present, and agreed to an interview. She stated her mother was admitted to the facility for therapy services after suffering a stroke the previous week. When asked about the facility's nutrition services, she stated, "I guess the food is okay. They grind it up really find for her. They were giving her thick liquids at first, but I told them to stop that. I told them to give her thin liquids or she would not drink anything. So now, they are giving her the thin liquids. She is doing okay with them."

On 9/11/19 at 8:05 a.m., Resident #2 was observed in the therapy gym. A therapist was washing her hands in preparation for helping the resident eat breakfast. The resident's breakfast tray included pureed eggs and sausage, and it contained thin consistency orange juice and milk.

A review of Resident #2's physician order sheet

monthly thereafter for one month.

Identified discrepancies will be addressed accordingly and as appropriate.

Such will be forwarded to the QAPI Committee for future review and/or possible revisions to facility protocol.

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revealed the following order dated 8/30/19: "Diet: Pureed. Liquids: Nectar." Review also revealed the following order dated 9/3/19: "Discontinue Nectar Liquids. Diet: Liquids: Thin."

A review of Resident #2's care plan dated 8/30/19 and updated 9/4/19 revealed, in part, the following: "Diet. Will tolerate diet texture and fluid consistency without signs and symptoms of aspiration. Intervention/Tasks: Liquid Consistency: Nectar. Liquid Consistency: Thin."

On 9/12/19 at 10:19 a.m., LPN (licensed practical nurse) #8 was interviewed regarding care plan updates. She stated, "Nurses just initiate the care plan on admission. The unit manager goes in and does all the updates."

On 9/12/19 at 11:12 a.m., LPN #4, the assistant unit manager, was interviewed regarding care plan updates. She stated, "It's interdisciplinary. It could be me, the ADON (assistant director of nursing), the dietician. Anyone could update it." When asked the purpose of the care plan, she stated, "It tells us how to take care of the resident." When asked if the facility staff use the care plans, she stated, "At times. I'm not sure how much." When asked to review Resident #2's Diet care plan, LPN #4 stated, "Hmmmm." When asked, according to the care plan, what consistency of liquids Resident #2 was supposed to be receiving, LPN #4 stated, "Well you really can't tell can you?" She stated she was the person who updated the care plan to the thin consistency, but neglected to remove the nectar consistency intervention. LPN #4 stated, "I should have caught that."

On 9/12/19 at 12:43 p.m., ASM (administrative

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staff member) #1, the administrator, was notified of these concerns.

A review of the facility policy, "Care Plans, Comprehensive Person-Centered," revealed, in part, the following: "The comprehensive, person-centered care plan will:...Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...Incorporate identified problem areas."

No further information was provided prior to exit.

3. The facility staff failed to update Resident #7's comprehensive care plan after a fall that occurred on 6/27/19.

Resident #7 was admitted to the facility 03/24/2018 with a readmission on 06/29/2019 with diagnoses that included but were not limited to fracture of femur (1) and rheumatoid arthritis (2).

Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/10/19, coded Resident # 7 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident #7 was coded as requiring extensive of two or more staff members for transfers.

Review of the clinical record revealed Resident #7 had a fall on 6/27/19. A facility document "Fall Investigation" dated 6/27/19 documented, "Recommendations to prevent further falls. Document interventions here and on Care Plan.

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Leave call bell in reach. Answer call light quickly. Make sure clothes are loose and not to [sic] tight."

The comprehensive care plan dated "09/12/2019" for Resident #7 documented, "At risk for falls due to history of falls, impaired balance/poor coordination, side effect of medication. Date Initiated 04/10/2018. Revision on: 04/10/2018." Under Interventions it documented, "Reinforce the need to call for assistance prn (as needed). Date Initiated 04/10/2018. Revision on: 04/10/2018." The care plan further documented, "Have commonly used articles within easy reach. Date Initiated: 04/10/2018." The care plan failed to evidence a revision after the fall that occurred on 06/27/19.

On 9/12/19 at 8:35 a.m., an interview was conducted with LPN (licensed practical nurse) #7, the unit manager. When asked the purpose of a care plan, LPN#7 stated that it is used to update staff on significant changes or occurrences that take place with the resident. LPN #7 stated that the care plan includes interventions to take to decide on their plan of care. When asked when the care plan is updated, LPN #7 stated when there is an occurrence or a significant change in a resident. When asked if a fall is an occurrence, LPN #7 stated, "Yes."

On 9/12/19 at 11:30 a.m., an interview was conducted with LPN (licensed practical nurse) #9, MDS coordinator. When asked about the process for care planning after a fall, LPN #9 stated that care plans should be updated. When asked when the updates are done, LPN #9 stated that it is done with the fall investigation. LPN #9 stated that the interventions put in place from the

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fall investigation should be put on the care plan, if they were already, on there they should be updated. After reviewing Resident #7's care plan, LPN #9 stated that the new interventions should have been added to the care plan and the intervention previously in place, "Reinforce the need to call for assistance prn (as needed)" should have been updated. LPN #9 proceeded to revise the care plan to reflect the date of the fall during interview.

On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 4, regional clinical coordinator, ASM # 5, the director of nursing for another facility and ASM # 6, regional quality assurance director were made aware of the findings.

No further information was provided prior to exit.

References:

1. Femur fracture
You had a fracture (break) in the femur in your leg. It is also called the thighbone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm.

2. Rheumatoid arthritis
A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website:

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https://medlineplus.gov/ency/article/000431.htm.

4. The facility staff failed to update Resident #34's comprehensive care plan after a fall that occurred on 07/20/2019.

Resident #34 was admitted to the facility 05/02/2016 with a readmission on 08/13/2019 with diagnoses, that included but were not limited to hemiplegia (1) and weakness.

Resident #34's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/11/2019, coded Resident # 34 as scoring a 11 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 11- being moderately impaired for making daily decisions. Resident # 34 was coded as requiring extensive of one staff member for transfers.

Review of the clinical record revealed Resident #34 had a fall on 7/20/19. The facility document "Fall Investigation" dated 07/20/2019 documented, "Recommendations to prevent further falls. Document interventions here and on are Care Plan. Teaching on the importance of calling for assistance before getting in and out of bed."

The comprehensive care plan dated "09/12/2019" for Resident #34 documented, "Fall, At risk for further falls due to unsteady gait secondary to CVA(2)/right side weakness ...Date Initiated: 04/02/2016. Revision on: 01/17/2019." Under "Interventions" it documented, "Encourage resident to call for assistance as indicated. Date Initiated: 07/01/2016." The care plan failed to evidence a revision after the fall that occurred on

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07/20/2019.

On 9/12/19 at 8:35 a.m., an interview was conducted with LPN (licensed practical nurse) #7, the unit manager. When asked the purpose of a care plan. LPN#7 stated that it is used to update staff on significant changes or occurrences that take place with the resident. LPN #7 stated that the care plan includes interventions to take to decide on their plan of care. When asked when the care plan is updated, LPN #7 stated when there is an occurrence or a significant change in a resident. When asked if a fall is an occurrence, LPN #7 stated, "Yes."

On 9/12/19 at 11:30 a.m., an interview was conducted with LPN (licensed practical nurse) #9, MDS coordinator. When asked about the process for care planning after a fall, LPN #9 stated that care plans should be updated. When asked when the updates are done, LPN #9 stated that it is done with the fall investigation. LPN #9 stated that the interventions put in place from the fall investigation should be put on the care plan if they were already on there they should be updated. After reviewing Resident #34's care plan, LPN #9 stated that the intervention was already on the care plan but was dated 7/1/2016 and it should have been revised to reflect the date of the fall. LPN #9 proceeded to update the care plan to reflect the date of the fall during interview.

On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 4, regional clinical coordinator, ASM # 5, the director of nursing for another facility and ASM # 6, regional quality assurance director were made aware of the

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findings.

No further information was provided prior to exit.

References:

1. Hemiplegia
Also called: Hemiplegia, Palsy, Paraplegia, and Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

2. CVA-cerebrovascular disease, infarction or accident
A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.
5. The facility staff failed to review/revise Residents # 40's comprehensive care plan following the resident's falls on 05/22/19, 07/30/19 and 08/05/19.

Resident # 40 was admitted to the facility on 12/22/15 and a readmission of 04/05/18 with diagnoses that included but were not limited to repeated falls, lack of coordination and high blood pressure.

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Resident # 40's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 07/18/19, coded Resident # 40 as scoring a six on the brief interview for mental status (BIMS) of a score of 0 - 15, six - being severely impaired of cognition for making daily decisions. Resident # 40 was coded as requiring limited assistance of one staff person for all activities of daily living. Under "G0300 Balance During Transitions and Walking" Resident # 40 was coded as "2 [two] Not steady, only able to stabilize with staff assistance" for moving from seated to standing position, walking, turning around, moving on and off the toilet and surface-to-surface transfer.

The facility's form "REPORT OF INCIDENT/ACCIDENT" DATED "5/22/19" for Resident # 40 documented, "DESCRIPTION OF INCIDENT: Resident observed lying on the floor in his room. Resident is confused and states, "I was going to play my numbers." Level of Injury: None Apparent." Under "RECOMMENDATIONS TO PREVENT FURTHER FALLS" it documented, "Continue with plan of care and continue with frequent monitoring."

The facility's form "REPORT OF INCIDENT/ACCIDENT" DATED "7/30/19" for Resident # 40 documented, "DESCRIPTION OF INCIDENT: Resident found sitting on the floor on buttocks in front of w/c [wheelchair] in front of bathroom door." Level of Injury: None Apparent." Under "RECOMMENDATIONS TO PREVENT FURTHER FALLS" it documented, "Toilet before and after meals. Continue with plan of care."

The facility's form "REPORT OF INCIDENT/ACCIDENT" DATED "8/5/19" for

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Resident # 40 documented, "DESCRIPTION OF INCIDENT: After app [appointment] 9:30 a.m., resident was noted in bathroom getting out of w/c [wheelchair]. Attempted to go assist him but w/c tipped over and resident was laying on his left side on the floor while still in w/c." Level of Injury: Abrasion." Under "RECOMMENDATIONS TO PREVENT FURTHER FALLS" it documented, "Remind resident to ask for staff assist [assistance] with transfers/toileting."

The comprehensive care plan for Resident # 40 with a target date of 10/28/2019 failed to evidence documentation of review or revisions after Resident # 40's falls on 05/22/19, 07/30/19 and 08/05/19.

On 04/16/19 at 12:43 p.m., an interview was conducted with LPN (licensed practical nurse) # 9, MDS coordinator, regarding Resident # 40's fall on 05/22/19, 07/30/19 and 08/05/19. After reviewing the comprehensive care plan for Resident # 40 with a target date of 10/28/2019, LPN # 9 agreed that the care plan was not reviewed or revised following Resident # 40's falls. LPN # 9 stated, "It should be on the care plan." When asked to describe the procedure for updating a resident's care plan following a fall, LPN # 9 stated, "If there is a significant change, decline in status, new fall decrease in ADLs etc. there would be documentation that the care plan was updated or reviewed."

On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, regional clinical coordinator, ASM #5, the director of nursing for another facility and ASM #6, regional quality assurance director were made aware of the

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F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to follow professional standards of practice for two of 48 residents in the survey sample, Residents # 54 and Resident #75, and one of six residents in the medication administration observation, Resident #60. The findings include: 1. a. The facility staff failed to complete the recapitulation of Resident #54's orders at the end of the month from May to June 2019 accurately. Resident #54 was admitted to the facility on 3/15/17 with diagnoses that include but were not limited to: diabetes, high blood pressure, absence of left great toe, asthma, and gastroparesis (a condition that reduces the ability of the stomach to empty its contents. It does not involve a blockage [obstruction]) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an	F 658	Corrective Action: On 9/11/19, a clarification order for resident #54 was obtained from the physician for the Insulin. No corrective action was performed for resident #75 as the medical record is considered a closed record due to discharge On 9/10/19, resident #60, the MD and RP were notified of the medication administration error regarding Tylenol. Other Potential Resident Affected:	10/27/19

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F 658	Continued From page 97 assessment reference date of 8/5/19, coded the resident as having a BIMS (brief interview for mental status) score of "14" indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. The physician order dated, 5/23/19, documented, "Order clarification: D/C (discontinue) Novolin (a short acting insulin) (2) inject 6 units sliding scale for evening and dinner - additional units. Order clarification B/C (blood sugar) checks TID (three times a day)." The May 2019 MAR (medication administration record) documented the order to D/C the Novolin. This entry was hand written, "D/C'd 5/23/19." The resident did not receive any more of the Novolin per the sliding scale through the end of May 2019. The June 2019 POS (physician order summary) documented, "Novolin N 100Unit/ML (milliliter); inject 6 units for blood sugar > (greater than) 200 & < (less than) 249, Inject >249, CALL MD (medical doctor) blood sugar great than 350 for evening and dinner additional units." The nurse practitioner signed the POS on 6/4/19. Review of the June 2019 MAR for Resident #54 documented the above physician's order for Novolin N insulin. The MAR documented the resident received the medication every day at dinner and evening, except one day it was circled as not given. Review of the July and August 2019 POS documented the above physician's order for the	F 658	Other residents that had orders for Tylenol had the potential to be affected. Systematic Changes: On 9/30/19, licensed nurse staff were re-educated regarding the importance of completing the monthly medication change over process accurately and administering the the prescribed dosage as scheduled during the medication administration pass. Monitoring System: Beginning 10/7/19, a weekly Random audit of 10% Of the current resident eMar with orders for Tylenol will be conducted by the Director of Nursing and/or her designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as	

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F 658	Continued From page 98 Novolin N insulin. The physician signed the POS for July on 7/6/19. The August 2019 POS was signed by the physician on 8/3/19. Review of the July and August 2019 MAR documented the above physician's order for Novolin. The MARs evidenced documentation that the medication was administered. The comprehensive care plan dated, 1/15/19 and revised on 7/27/19, documented in part, "Focus: Endocrine System related to DM (diabetes mellitus)." The "Interventions/Tasks" documented in part, "Administer medications per physician's orders. Obtain labs (laboratory tests)/diagnostic testing as ordered notify physician of results. An interview was conducted with LPN (licensed practical nurse) #6 on 9/11/19 at 3:59 p.m., the nurse who completed the monthly recapitulation of the orders. When asked about the process staff follows for the changeover or recapitulation of orders at the end/beginning of the month, LPN #6 stated I get the MAR, the POS and any telephone orders written in the past month and verify that the POS and MARs match." When asked if it was her signature on the June 2019 POS, LPN #6 stated, "Yes, I did that one. I must have missed it." The facility policy, "Medication Orders" documented in part, "d. Renewed or Recapitulated (Recapped) Orders (to continue a medication therapy beyond a previous order with limited duration). 1. The prescriber renews the order either, by repeating the entire order process or with a statement such as 'continue XXX for ten days.' The prescriber writes a new order for continued therapies that require a change in	F 658	appropriate. Such will be forwarded to the QAPI Committee for future review and/or possible revisions to facility protocol.	

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directions, dosage, form or strength." The policy failed to evidence the process the nurse takes at the end/beginning of each month.

On 9/12/19 at 3:20 p.m., ASM # 2, the director of nursing, stated that the facility uses it's policies as their standard of practice.

In Potter-Perry, Fundamentals of Nursing, 6th edition, page 841, a noted standard of practice is: "When medications are first ordered, the nurse compares the medication recording form or computer orders with the prescriber's written orders." On page 852, regarding the administration of oral medications, "Check accuracy and completeness of each MAR or computer printout with prescriber's written medication order."

ASM (administrative staff member) #1, the administrator, ASM #3, the medical director, ASM #4, the regional clinical coordinator, and ASM #5, a director of nursing from another facility, were made aware of the above concerns on 9/12/19 at 9:45 a.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000297.htm.
(2) This information was obtained from the following website: https://medlineplus.gov/ency/patientinstructions/000965.htm

1. b. The facility staff documented medications were administered to Resident #54, when upon interview, the staff stated they did not administer

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the medication and failed to clarify the order.

The June 2019 POS (physician order summary) documented, "Novolin N 100Unit/ML (milliliter); inject 6 units for blood sugar > (greater than) 200 & < (less than) 249, Inject >249, CALL MD (medical doctor) blood sugar great than 350 for evening and dinner additional units." The nurse practitioner signed the POS on 6/4/19.

The "Diabetic Flow Sheet" for June 2019 documented the resident blood sugar readings at 4:30 p.m. to be the lowest at 105 to the highest being documented as 182. Per the physician order, she should not have received the Novolin N at 4:30 p.m. The flow sheet documented the blood sugar at 9:00 p.m. with the lowest reading level of 107 and the highest level as 212.

The June MAR documented the resident received the Novolin insulin every dinner and evening.

The July POS documented the above physician's order for Novolin N.

The "Diabetic Flow Sheet" for July documented the resident's blood sugar reading at 4:30 p.m. with the lowest reading at 86 and the highest documented blood sugar was as 213. Per the physician order, she should have received the Novolin once on 7/9/19 when the blood sugar was 213, all other times it should not have been administered. The flow sheet documented the blood sugar at 9:00 p.m. with the lowest reading at 102 and the highest reading was documented as 175.

The July MAR documented the resident received the Novolin insulin was given every day at 4:30

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p.m. except three days were it was circled and not given. The 9:00 p.m. dose of insulin was documented as given every day except three days.

The August POS documented the above physician's order for Novolin N.

The "Diabetic Flow Sheet" for August documented the resident's blood sugar reading at 4:30 p.m. with the lowest reading at 73 and the highest documented blood sugar level as 177. Per the physician order, she should not have received the insulin at the 4:40 p.m. dose. The blood sugars documented at 9:00 p.m. documented the lowest reading 92 and the highest blood sugar as 167.

The August MAR documented the resident received the Novolin insulin every day at 4:30 p.m. and 9:00 p.m. except five doses were circled as not given.

The September POS documented the above physician's order for Novolin N.

The "Diabetic Flow Sheet" for September documented the resident's blood sugar reading at 4:30 p.m. The lowest level at 86 and the highest documented blood sugar was 198. Per the physician order, she should not receive the Novolin N. The blood sugars documented at 9:00 p.m. documented the lowest level at 99 and the highest documented blood sugar was 180.

The September 2019 MAR documented the Novolin was administered on 9 of 10 opportunities at the 4:30 -p.m. dose and only 2 of 10 opportunities for the 9:00 p.m. dose.

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On 9/11/19 at 3:36 p.m., an interview was conducted with LPN #3, the nurse that works the 3 - 11 shift five days a week and works with Resident #54. When asked to read the order above for the Novolin N insulin, LPN #3 stated, "This order needs to be clarified. It's not clear. "When asked to review the MARs for June, July, August and September, LPN #3 stated, "I don't give her that because her blood sugar in below the range. I swear I don't give it. I only give her, her scheduled two units at that time." When asked what staff are supposed to do if a medication is not administered, LPN #3 stated, "If you don't give a medication you are supposed to circle it and write on the back why it wasn't given." When asked why she didn't circle it, LPN #3 stated, "To be honest, I didn't see it was discontinued and we've been so busy and I didn't follow up on it. I'm responsible. Because I didn't circle it. But I know I didn't give it."

An interview was conducted with ASM (administrative staff member) #4, the regional clinical coordinator, on 9/11/19 at 4:16 p.m. The above Novolin N order was reviewed with ASM #4. ASM #4 stated, "I saw this order earlier and I've already clarified it. It didn't make sense and doesn't match the original order." The order for 5/23/19 was reviewed with ASM #4. ASM #4 stated, "That order shouldn't even be on there, it should have been discontinued." When asked if a nurse should sign off a medication, they did not give, ASM #4 stated, "No, they need to circle it and write it on the back of the MAR. The nurses are in training to learn the medication administration application of the computer program. Hopefully that will correct some of these issues."

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After the nurse administers the medication, the medication administration record (MAR) is completed per agency policy to verify that the medication was given as ordered. Accurate documentation serves as a way for health care providers to communicate with each other. Perry & Potter, Fundamentals of Nursing, 6th edition, page 843

ASM (administrative staff member) #1, the administrator, ASM #3, the medical director, ASM #4, the regional clinical coordinator, and ASM #5, a director of nursing from another facility, were made aware of the above concerns on 9/12/19 at 9:45 a.m.

No further information was provided prior to exit.

1. c. The facility staff failed to clarify the physician order for an as needed high blood pressure medication for Resident #54.

The physician order dated, 9/28/18, documented, "Clonidine (used to treat high blood pressure) (1) Tab (tablet) 0.1 mg (milligram); 1 tablet by mouth every four hours as needed for blood pressure (SBP [systolic blood pressure] > (greater than) 70 or DBP [diastolic blood pressure] > 100."

Review of the May, June, July, August, and September MARs documented the above physician's order. The medication was not documented as administered.

An interview was conducted with LPN #3 on 9/11/19 at 3:36 p.m. LPN #3 was asked to review the Clonidine order. Once reviewed, LPN #3 was asked what Clonidine is used for, LPN #3 stated,

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it's a blood pressure medication for if it's high we give it and if it's low we don't use it. When asked about the order, LPN #3 stated, "It needs to be clarified."

An interview was conducted with LPN #6 on 9/11/19 at 3:59 p.m. LPN #6 reviewed the above Clonidine order. When asked what Clonidine is used for, LPN #6 stated it is for increased blood pressure. When asked if anything with this order for clonidine was incorrect, LPN #6 stated, "It needs to be clarified by the doctor. She's had this order for a long time." When asked who does the end of the month change over, LPN #6 stated, "I do." When asked if the above order should have been identified, LPN #6 stated, "Yes, I definitely should have seen that."

An interview was conducted with ASM (administrative staff member) #4, the regional clinical coordinator; on 9/11/19 at 4:16 p.m., ASM #4 reviewed the above Clonidine order. When asked if this order was correct, ASM #4 stated, "That order is completely wrong." When asked what the medication is used for, ASM #4 stated, "High blood pressure. If you have an order like that then you should be taking the resident's blood pressure every four hours if you have a PRN (as needed) medication like that. But you don't give it for a systolic blood pressure greater than 70, it's normally 170."

According to Fundamentals of Nursing, 6th edition Potter and Perry, 2005, page 846, "A medication order is required for any medication to be administered by a nurse...If the medication order is incomplete, the nurse should inform the prescriber and ensure completeness before carrying out any medication order."

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ASM (administrative staff member) #1, the administrator, ASM #3, the medical director, ASM #4, the regional clinical coordinator, and ASM #5, a director of nursing from another facility, were made aware of the above concerns on 9/12/19 at 9:45 a.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682243.html

2. a. The facility staff failed to clarify Resident #75's order for an as-needed pain medication.

Resident #75 was admitted to the facility on 8/14/19; diagnoses include, but are not limited to, history of knee replacement and arthritis. On the most recent MDS (minimum data set), an admission assessment an ARD (assessment reference date) of 8/21/19, Resident #75 was coded as being moderately impaired for making daily decisions, having scored 10 out of 15 on the BIMS (brief interview for mental status). In section P, he was coded as having pain occasionally during the five days of the look back period.

A review of Resident #75's August 2019 POS (physician order sheet) revealed the following order, dated 8/14/19: "Oxycodone (1) IR (immediate release) 5 mg (milligrams), 1 or 2 tabs (tablets) po (by mouth) every 6 hours as needed for pain."

A review of Resident #75's August 2019 MAR

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(medication administration record) revealed nurses' initials for the administration of the as-needed Oxycodone on the following dates: 8/15/19, 8/16/19, 8/22/19, 8/23/19, and 8/24/19.

On 9/12/19 at 10:19 a.m., LPN (licensed practical nurse) #8 was interviewed. She stated that she frequently takes care of Resident #75. When asked to review the order documented above, LPN #8 stated: "Okay." When asked how many tablets she would give the resident, LPN #8 stated: "I would ask him about his pain level. But you can't really ask him. He can't really tell you most of the time. Personally, for me, he never complained about pain or never indicated in other ways that he was in pain. I don't know. I think the order is too vague. It should have some parameters. But you know orders are never written that way. They leave it up to our discretion or to the resident's discretion about how many they should get."

On 9/12/19 at 11:12 a.m., LPN #4, the assistant unit manager was interviewed. After reviewing the order documented above, LPN #4 stated: "Well, the first thing I would do is clarify how many pills are supposed to be given. It needs to be clarified. It should say how many tablets to give in one case, how many pills to be given in another. The doctor needs to clarify the order."

On 9/12/19 at 12:43 p.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns. When asked about the facility's standard of nursing practice, she stated she would check.

On 9/12/19 at 3:20 p.m., ASM #2, the director of nursing, stated that the facility uses its policies as

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their standard of practice.

A review of the facility policy, "MEDICATION ORDERS," revealed, in part, the following: "The prescriber is contacted by nursing to verify or clarify and order (e.g. [for example], when the resident has allergies to the medication, there are contraindications to the medication, significant drug interactions are present, the directions are confusing)."

No further information was provided prior to exit.

2. b. The facility staff incorrectly discontinued an as-needed pain medication on the resident's MAR (medication administration record) without a provider's order to do so. As a result, the facility staff failed to carry over an order for an as-needed pain medication from the August 2019 POS (physician order sheet) to the September 2019 POS.

A review of Resident #75's August 2019 POS (physician order sheet) revealed the following order, dated 8/14/19: "Oxycodone (1) IR (immediate release) 5 mg (milligrams), 1 or 2 tabs (tablets) po (by mouth) every 6 hours as needed for pain."

A review of Resident #75's August 2019 MAR (medication administration record) revealed the following entry: "Oxycodone (1) IR (immediate release) 5 mg (milligrams), 1 or 2 tabs (tablets) po (by mouth) every 6 hours as needed for pain."

A review of Resident #75's September 2019 POS (physician order sheet) failed to reveal an order for the prn Oxycodone as described above.

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A review of Resident #75's September 2019 MAR revealed the following entry: "Oxycodone (1) IR (immediate release) 5 mg (milligrams), 1 or 2 tabs (tablets) po (by mouth) every 6 hours as needed for pain." This entry had a single line drawn through it. The space beside the entry contained the following: "D/C (discontinue) 8/23/19." No staff initials indicated that the medication had been given at all in September 2019.

A review of Resident #75's care plan dated 8/14/19 revealed, in part, the following: "Administer pain medication per physician orders."

On 9/11/19 at 4:35 p.m., ASM #4, the regional clinical coordinator was asked to provide the surveyor with a copy of the physician's order to discontinue the order for as-needed Oxycodone for Resident #75.

On 9/12/19 at 7:50 a.m., ASM #4 stated: "We don't have that order. There is no order."

On 9/12/19 at 8:45 a.m., Resident #75 was observed in the area near the nurses' station. He was eating breakfast. There were no signs or symptoms evident that the resident was in pain.

On 9/12/19 at 10:19 a.m., LPN (licensed practical nurse) #8 was interviewed. She stated that she frequently takes care of Resident #75. After LPN #8 reviewed the August and September 2019 POS sheets and MARs as described above, LPN #8 stated: "[The as-needed Oxycodone order] should never have been discontinued. I am the one who called the doctor and got him to order a

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scheduled Oxycodone for [Resident #75] so he could be sure to get something every day before he went to therapy. I specifically asked the doctor if he wanted me to discontinue the prn (as needed), [order] and he said to leave it there in case of breakthrough pain. I don't know who stopped it. That is not my writing."

On 9/12/19 at 11:12 a.m., LPN #4, the assistant unit manager was interviewed. After LPN #4 reviewed the August and September 2019 POS sheets and MARs as described above, LPN #4 stated: "I don't know what happened. It looks like we should not have stopped the prn order." When asked who had done the recapitulation/changeover of the orders from August 2019 to September 2019, LPN #4 stated the nurse's name. LPN #4 stated: "She is not here anymore." When asked about the process for the monthly recapitulation of orders, LPN #4 stated: "I look at the previous month's POS and all the telephone orders. I would never just use a MAR. I verify order to order." When asked if any current order should be discontinued without a physician's order, LPN #4 stated: "Absolutely not."

On 9/12/19 at 12:43 p.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns. When asked about the facility's standard of nursing practice, she stated she would check.

On 9/12/19 at 3:20 p.m., ASM #2, the director of nursing, stated that the facility uses its policies as their standard of practice.

A review of the facility policy, "MEDICATION ORDERS," revealed, in part, the following:

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"Renewed or Recapitulated (Recapped) Orders (to continue a medication therapy beyond a previous order with limited duration)...Medication orders are recapped on a monthly basis or as to state guidelines when the prescriber signs the physician order summary. A designated nurse reviews the order summary before giving it to the prescriber to sign."

No further information was provided prior to exit.

(1) "Oxycodone is used to relieve moderate to severe pain... Oxycodone is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682132.html.

3. The facility staff failed to administer the prescribed dosage of the scheduled Acetaminophen (1) during medication administration observation for Resident #60 on 09/10/2019.

Resident #60 was admitted to the facility on 02/01/2019 with a readmission on 07/15/2019. Resident #60's diagnoses included but were not limited to Parkinson's disease (2) and hip fracture. Resident #60's most recent MDS (minimum data set), a thirty day assessment with an ARD (assessment reference date) of 08/12/19, coded Resident #60 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section J coded Resident #60 as not having pain frequently.

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On 9/10/19 at 5:10 p.m., an observation was conducted of RN #1 administering medication to Resident #60. RN #1 prepared the following medications for Resident #60:
-Acetaminophen 325mg (milligram) one tablet (used to treat pain or fever)
-Benztropine 1mg one tablet (used to treat Parkinson's disease)
-Calcium/Vitamin D 500mg/200 IU (international units) one tablet (mineral/vitamin supplement)
-Metformin 1000mg one tablet (used to treat diabetes (3))
-Divalproex 500mg one tablet (used to treat seizures (4) or migraine headaches).
RN #1 proceeded to administer the medications as prepared to Resident #60.

Review of Resident #60's clinical record revealed a physician's order dated "07/15/19 Acetaminophe(n) Tab 325MG 2 (two) tablet(s) (650mg) by mouth every 6 (six) hours for chronic pain."

Review of Resident #60's clinical record revealed an MAR (medication administration record) dated 09/01/2019 through 09/30/2019. The MAR documented, "Acetaminophe(n) tab 325mg 2 (two) tablet(s) (650 mg) by mouth every 6 (six) hours for chronic pain." Further review of the MAR revealed documentation of the Acetaminophen 650mg given on 9/10/19 for the 6 p.m. dose by RN #1.

On 9/11/19 at 3:30 p.m., an interview was conducted with RN #1 regarding the medication administration observation on 9/10/19 at 5:10 p.m. When asked what is checked prior to medication administration, RN #1 stated that the rights are checked, right person, right medication,

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right dose, right route, and right time. When asked what these things are checked with, RN #1 stated the medications are checked with the MAR. When asked about the Acetaminophen administration for Resident #60 on 9/10/19 at 5:10 p.m., RN #1 stated that she was not sure about whether she gave one or two tablets. RN #1 stated that she normally does not work on that unit and is not familiar with the residents there. When asked to clarify the order by looking at the chart, RN #1 stated that she was not on her usual unit and that she may have only given one tablet.

On 9/12/19 at 10:30 a.m., ASM (administrative staff member) #2, the director of nursing was asked what standard of practice is used at the facility.

On 9/12/19 at 3:20 p.m., ASM #2 stated that the facility uses its policies as their standard of practice.

The facility policies provided failed to evidence standards of practice on verifying medications.

According to Basic Nursing, Essentials for Practice, 6th edition (Potter and Perry, 2007, pages 349-360) "To ensure safe medication administration, be aware of the six rights of medication administration. 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation .....Use the MAR to prepare and administer medications. When preparing medications in bottles or containers, compare the label of the medication container with the medication administration order three times: (1) before removing the container from the drawer or shelf, (2) as you remove the amount of

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medication ordered from the container, and (3) before returning the container to storage .....After you administer medications, indicate which medications you gave on your patient's MAR per agency policy to show that you gave the medications as ordered. Inaccurate documentation of medications, such as failing to document giving a medication or documenting an incorrect dose, leads to errors in subsequent decisions about your patient's care."

On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 4, regional clinical coordinator, ASM # 5, the director of nursing for another facility and ASM # 6, regional quality assurance director were made aware of the findings.

No further information was provided prior to exit.

References:

1. Acetaminophen
Nonnarcotic analgesics: Indications for TYLENOL: Minor aches and pain. Fever. This information was obtained from the website: https://www.empr.com/drug/tylenol/

2. Parkinson's disease
A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

3. Diabetes
A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:

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F 658	Continued From page 114 https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 4. Seizures Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.	F 658		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to provide a preferred scheduled activity for one of 48 residents in the survey sample, Resident #42. The findings include: On 2/27/19 the activities staff told residents they were not sure if the scheduled 6:15 p.m. wine and cheese activity was going to occur. Once the	F 679	Corrective Action: A corrective action was not performed for resident #42 as the preferred scheduled activity has passed. Other Potential Residents Affected:	10/27/19

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F 679	Continued From page 115 staff decided to hold the activity, the staff failed to ensure Resident #42 was made aware although this was the resident's preferred activity. Once Resident #42 realized the event was taking place, the resident attempted to attend the event but the event had ended and the resident was not accommodated. Resident #42 was admitted to the facility on 1/20/17. Resident #42's diagnoses included but were not limited to post traumatic stress disorder, major depressive disorder and low back pain. Resident #42's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/19/19, coded the resident as being cognitively intact. Resident #42's comprehensive care plan dated 1/31/17 documented, "(Name of Resident #42) attends all OOR (out of room) activities...Assist to transport to and from activities of choice. Encourage participation in group activities of interest..." Resident #42's annual MDS assessment with an ARD of 1/16/19 documented, "How important is it for you to do things with groups of people? Somewhat important. How important is it for you to do your favorite activities? Very important..." An activity evaluation with an effective date of 1/21/19 documented talking and conversing as one of Resident #42's current interests. Review of the facility activities calendar for February 2019 revealed a wine and cheese activity that was scheduled on 2/27/19 at 6:15 p.m. On 3/12/19, the VDH (Virginia Department of Health) OLC (Office of Licensure and Certification) received a complaint regarding Resident #42. The hand written letter	F 679	Other residents with a preference for this activity had the potential to be affected. Systematic Changes: On 9/30/19, the Activity Staff were educated regarding the importance of informing residents of activity schedule changes and accommodating them if they show up for an activity that ends earlier than usual. Monitoring System: Beginning 10/7/19, a weekly random audit of 10% of all activities with a schedule change will conducted by the Administrator and/or her designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee	

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documented a wine and cheese event as one of Resident #42's favorite activities provided by the facility and documented the resident was not allowed to participate in the event on 2/27/19.

On 4/9/19, the VDH OLC received a FRI (facility reported incident) from the facility that documented, "On 4/9/19 resident (Resident #42) reported to activities assistant that another employee in that department had refused to serve her during a scheduled 'Wine and Cheese' party. Resident states the activity assistant told her party was 'Closed' and she was late although other residents were still eating and drinking. Employee has been suspended..."

An interview conducted by the former administrator and former director of nursing with Resident #42 on 4/9/19 documented, "On April 9, 2019, interview was conducted with resident (name). (Name) stated that there was a 'Wine and Cheese' event in February (according to our calendar it was 2/27/19), in which resident was not allowed to participate. She feels this was deliberate. She further states our activities assistant (name), spoke with her twice throughout the day telling her the event was cancelled, he then came into her room later that evening and told her roommate that he had to go 'do' wine and cheese. (Name of Resident #42) stated she was already in her bed but she went down to the party in her nightgown to participate. She states she arrived while others were still eating, drinking, and having a good time. She stated 'I'm Here Now! Let me have some!' She reports (name of activities assistant) stated 'No our party is closed and we are finished for the night.' Resident stated she became tearful, mad and very upset...She states she 'Loves' the Wine and

for future review and/or possible revisions to facility protocol.

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Cheese events and he knew that. It is something that makes her feel 'Normal.'"

An email submitted from the activities assistant to OSM (other staff member) #3 (the payroll benefits coordinator/human resources) on 4/11/19 documented, "On the day of February 27, 2019 One (sic) this day my scheduled shift was 12-8 (12:00 p.m. to 8:00 p.m.). With the census being low, I was instructed to leave a (sic) hour early (7:00). I carried on with what was on the board to do for the day and let a majority of the CNA's (certified nursing assistants), residents and the front desk employee know that they're (sic) wasn't going to be the night activity due to me having to leave early. Some of the residents, family members, and CNA's were disappointed that there wasn't going to be wine and cheese and expressed how much they enjoyed when I do the wine and cheese. After dinner around 5:45-6pm I went around to talked (sic) to some of the residents and decided to have wine and cheese. Usually wine and cheese is from 6:15 pm-7:45pm but I had it from 6:15pm-6:50pm. I had some of the CNA's help me get some residents who were still up to have wine and cheese. Walking to take one of the residents back one of the CNA's was in a room and asked me what we're doing. I told her I was leaving early and that we had a quick wine and cheese. One of the residents (Resident #42) who was already in the bed expressed that she 'thought they're (sic) was no wine and cheese and I told her I wasn't going to do it at first because I had to leave early but I decided to do what I could. I went back to wine and cheese to start packing everything up because of the time and one of the residents comes down the hallway (Resident #42) and stops me while I'm pushing the wine and cheese cart and takes of (sic) the

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wine bottles off the cart. I stopped and asked her to put the wine bottle back and explained to here (sic) that wine and cheese is over since I have to leave. She than (sic) starts begging and tries to take the wine bottle again in front of some of the CNA's and nurses and tries to pour herself a glass. I told her she can't do that and I take the wine bottle and put them (sic) away. She got really upset and rolled over and drank whatever wine was leftover in the other residents (sic) glasses who weren't there anymore. Afterwards she sat up front with another resident and vented about myself, activities, CNA's and how she 'hates living in this facility'. That very next day I went and briefed one of the activity staff about what happened at wine and cheese and about the resident..."

A statement documented by OSM (other staff member) #1 (another activities assistant) dated 4/9/19 documented, "On April 9, 2019 after lunch in the afternoon resident (Resident #42) came to me in the activity room and reported that she had filed a complaint w/ (with) VHD (Virginia Health Department) regarding a scheduled activity- wine and cheese- that event was held and residents were brought to that event. (Resident #42) reports she was told the event was not going to happen, by (name of activities assistant). He later came to (Resident #42's) room and said to her roommate that he had to get back to wine and cheese. When she went to participate she was told that it was finished and was not allowed to have wine and cheese..."

A witness statement obtained by the former director of nursing from CNA #3 on 4/9/19 documented, "Writer spoke with CNA (name) about a 'wine & cheese' event that happened on

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2/27/19. CNA does not recall any events. When asked specifically about Resident (#42) and any incidents- CNA still does not recall anything unusual."

A witness statement documented by LPN (licensed practical nurse) #2 on 4/11/19 documented, "I saw residents sitting finishing up the wine and cheese. Asked where was (Resident #42) because I did not see her. (Name of activities assistant) was packing up."

A witness statement dated 4/11/19 documented by another nurse who was not available for interview during the survey documented, "During the wine social, (name of activities assistant) was ending packing up the wine. The cheese and crackers were left out. (Resident #42) came to dining room while he was pushing the cart off unit. (Resident #42) started yelling please, please give me a drink. He was down the hallway and the event was over."

A final report submitted to the VDH OLC from the former administrator and former director of nursing on 4/16/19 documented, "Allegation was brought to our attention on 4/9/19 when (Resident #42) reported to the Activities staff that an employee refused to allow her to participate in an event. At the time of reporting the resident reported that employee (name of activities assistant) 'deliberately' kept her from participating in a 'wine and cheese' event. (Resident #42) reports that she asked him several times throughout the day about the even (sic) and he said he didn't know if they were going to have it or not. She reports he then came into her room to speak with her roommate and told her he had to leave to do the event. She reports she got out of

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her bed and immediately went down to the area to participate and other residents were there 'eating and drinking' but (activities assistant) told her it was over and would not give her any. (Activities assistant) was immediately suspended pending outcome of investigation....As part of Investigation it was determined that this event occurred on 2/27/19. Interviews of alert and oriented Residents were inconclusive. In interviewing staff; one staff member recalls the social event and reports that (activities assistant) was packing up the event when (Resident #42) came in and started yelling 'Please, please, give me a drink'. She stated that (activities assistant) proceeded down the hallway and ended the event without serving (Resident #42)..." The activities assistant was terminated from the facility.

Review of facility documentation and Resident #42's clinical record failed to reveal evidence that Resident #42 was made aware the wine and cheese event was going to occur as scheduled and that the event would not last as long as usual due to the need for the activities assistant to leave the facility.

On 9/11/19 at 3:36 p.m., an interview was attempted with Resident #42 but the resident was lying in bed with her eyes closed.

On 9/11/19 at 1:55 p.m., an interview was conducted with OSM #1 (an activities assistant). OSM #1 stated she worked until approximately 4:30 p.m. on 2/27/19. OSM #1 stated she knew there was some question whether the wine and cheese event was going to be held that evening and residents were told that it might not occur that evening. OSM #1 further stated the activities department decided to hold that event and she

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told the former activities assistant who was responsible for holding the event that he could announce that the event was going to occur over the intercom but to her knowledge, he did not do so. OSM #1 was asked how residents are notified of a change in the activities schedule such as a decrease in the usual length of time of a scheduled activity. OSM #1 stated there was a couple of ways that the activities staff notifies the residents such as a posted flyer or documenting the change on a board in the common area. OSM #1 stated she also verbalizes the change to residents, CNAs, nursing staff and the rehab (rehabilitation) staff. OSM #1 was asked if the wine and cheese event was Resident #42's preferred activity. OSM #1 stated it definitely was and the resident has attended the event for as long has she has known. OSM #1 was asked if Resident #42 was made aware that the wine and cheese event was going to occur on 2/27/19. OSM #1 stated she told as many people as she could but could not recall if Resident #42 was told. OSM #1 was asked if she would have ensured Resident #42 was aware the activity was going to occur since it was a preferred activity. OSM #1 stated, "Oh my god yes. I would have said it at dinner and I probably would have gotten her first because she likes to help." When asked how the resident likes to help, OSM #1 stated Resident #42 likes to assist with putting out plates and cups. OSM #1 was asked what should be done if a resident attends late to the wine and cheese event. OSM #1 stated, "They will fuss. If I have served and someone comes, I will still serve. I feel like it might be unfair if I did not."

On 9/11/19 at 2:15 p.m., an interview was conducted with OSM #2 (the activities director). OSM #2 was asked to explain the details

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surrounding Resident #42 and the wine and cheese event held on 2/27/19. OSM #2 stated Resident #42 reported the former activities assistant refused to serve her a glass of wine but the former assistant said he did not do such a thing. OSM #2 was asked if the former activities assistant was told he needed to clock out early because of the facility census. OSM #2 stated the assistant was told that and that is why he held the activity earlier than scheduled. OSM #2 was asked what should occur if an activity is held and going to cease earlier than usual. OSM #2 stated she would let the residents know earlier during that day by posting a flyer and announcing the change in the morning activities. OSM #2 was asked if Resident #42 was made aware of the time change for the wine and cheese activity on 2/27/19 since it was her preferred activity. OSM #2 stated the resident should have been made aware. OSM #2 stated changes in scheduled activities are communicated to residents through the intercom system and by word of mouth. OSM #2 was asked if she could provide evidence that Resident #42 was made aware of the change and that the wine and cheese social would be shorter than usual. OSM #2 stated the resident should have been made aware and the change should have been documented on a flyer but she throws the flyers in the trash at the end of the day. OSM #2 was asked if she knew what time Resident #42 appeared for the wine and cheese social on 2/27/19. OSM #2 stated the former activities assistant told her that Resident #42 appeared after the activity was over and he was packing everything up. OSM #2 was asked if a resident should be accommodated if a scheduled activity is ending earlier than usual and the resident shows up for the activity. OSM #2 stated, "Yes they should. I would stay over." OSM #2 stated

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F 679	Continued From page 123 the former activities assistant would not have been reprimanded if he had stayed to accommodate Resident #42. OSM #2 stated, "This is the resident's home and we are accommodating them first. They come first." OSM #2 was asked how she would feel if she showed up to a preferred activity and the staff was packing up so she was not permitted to participate. OSM #2 stated, "I would feel sad." On 9/11/19 at approximately 4:30 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, "Activity Programs" documented, "Activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident...11. Scheduled activities are posted on the resident bulletin board. Activity schedules are also provided individually to residents who cannot access the bulletin board..." No further information was presented prior to exit.	F 679		
F 697 SS=D	COMPLAINT DEFICIENCY 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:	F 697		10/27/19

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F 697	Continued From page 124 Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed implement a complete pain management program for two of 48 residents in the survey sample, Residents #75 and #50. The findings include: 1. The facility staff failed to attempt non-pharmacological interventions to relieve Resident #75's pain prior to the administration of as-needed pain medication on multiple dates in August, 2019. Resident #75 was admitted to the facility on 8/14/19 with diagnoses including, but not limited to history of knee replacement and arthritis. On the most recent MDS (minimum data set), an admission assessment an ARD (assessment reference date) of 8/21/19, Resident #75 was coded as being moderately impaired for making daily decisions, having scored 10 out of 15 on the BIMS (brief interview for mental status). In section P, he was coded as having pain occasionally during the five days of the look back period. A review of Resident #75's clinical record revealed the following order, dated 8/14/19: "Oxycodone (1) IR (immediate release) 5 mg (milligrams), 1 or 2 tabs (tablets) po (by mouth) every 6 hours as needed for pain." A review of Resident #75's August 2019 MAR (medication administration record) revealed nurses' initials for the administration of the as-needed Oxycodone on the following dates: 8/15/19, 8/16/19, 8/22/19, 8/23/19, and 8/24/19.	F 697	Corrective Action: No corrective action was performed for resident #75 regarding omissions of non-pharmalogical documentation as the medical record is considered a closed record due to discharge. No corrective action was performed for resident #50 regarding omissions of non-pharmacological documentation as the dates referenced are more than 30 days old. Other Potential Residents Affected: Other residents not receiving non-pharmacological interventions prior to receiving pain medication had the potential to be affected. Systematic Changes: On 9/30/19, licensed nurse staff were re-educated regarding the importance of performing and documenting	

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F 697	Continued From page 125 A review of Resident #75's progress notes and the back of the August 2019 MAR failed to reveal evidence that facility staff had attempted any non-pharmacological interventions for pain relief prior to administering as-needed Oxycodone to the resident. A review of Resident #75's care plan dated 8/14/19 revealed, in part, the following: "Pain left knee related to arthritis, recent surgery...Encourage/assist to reposition frequently for comfort as needed." On 9/12/19 at 8:45 a.m., Resident #75 was observed in the area near the nurses' station. He was eating breakfast. There were no signs or symptoms evident that the resident was in pain. On 9/12/19 at 9:30 a.m., Resident #75 was observed sitting a wheelchair near his bed. There were no signs or symptoms evident that the resident was in pain. Resident #75 was asked if he was currently in pain. He stated, "No. I do not think so." When asked if he had been receiving enough pain medication from the staff, he stated, "Yes." Further attempts to determine if the staff members had attempted any non-pharmacological interventions to relieve his pain were unsuccessful. On 9/12/19 at 10:19 a.m., LPN (licensed practical nurse) #8 was interviewed. She stated that she frequently takes care of Resident #75. When asked about the process for administering as-needed pain medications, LPN #8 stated, "I would ask if they needed anything. I would ask their pain level. I always ask on my mourning rounds. They either say yes or no. If they have a prn (as needed) order, I see if they are due. I give	F 697	non-pharmacological interventions in the EMR prior to the administration of pain medication. Monitoring System: Beginning 10/7/19, a weekly random audit of nursing progress notes for residents with current orders for pain medication will be conducted by the Director nursing and/or her designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for future review and/or possible revisions to facility protocol.	

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them the medicine. Then I always go back and reassess them." When asked if she ever attempts any non-pharmacological interventions prior to giving the prn pain medication, LPN #8 stated, "Sometimes I try other things. Sometimes therapy will try some things. Most of the time, those things don't help. They know what they want. They know what works." When asked if she would document any non-pharmacological interventions she attempted, LPN #8 stated, "I probably would not document it all the time. But I should." When asked if she specifically remembered any non-pharmacological interventions for Resident #75, LPN #8 stated, "I couldn't tell you."

On 9/12/19 at 11:12 a.m., LPN #4, the assistant unit manager was interviewed. When asked if staff nurses should be attempting any non-pharmacological interventions to relieve pain prior to administering a prn pain medication to a resident, LPN #4 stated, "Yes. It could be something even like turning on the tv for distraction. Putting something up on a pillow to elevate it. It could be therapy or nursing or activities. It is interdisciplinary. Yes. It should be documented."

On 9/12/19 at 12:43 p.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns.

A review of the facility policy, "Pain - Clinical Protocol," revealed, in part, the following: "Treatment/Management...3. Staff will provide the elements of a comforting environment and appropriate physical and complementary interventions; for example, local heat or ice, repositioning, massage, and the opportunity to

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talk about chronic pain."

No further information was provided prior to exit.

(1) "Oxycodone is used to relieve moderate to severe pain... Oxycodone is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682132.html.

2. The facility staff failed to offer non-pharmacological interventions prior to the administration of pain medication for Resident #50.

Resident #50 was admitted to the facility on 9/15/14 with diagnoses that included but are not limited to: congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) [1], diabetes, high blood pressure, and osteoarthritis (Characterized by degenerative changes in the joints, pain, stiffness and swelling can develop after exercise) [2].

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 7/25/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring limited to extensive assistance of one or more staff members for all of her activities of daily

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living. In Section J - Health Conditions -the resident was coded as receiving as needed pain medication and at the time of the interview, the resident stated she had no pain. The resident was coded in Section J as not receiving any non-medication interventions for pain.

The physician orders dated 5/17/19, documented, "Oxycodone Tab (tablet) (used to treat moderate to severe pain) [3] 5 mg (milligrams); 1 tablet by mouth every 1 -2 hours as needed for severe pain."

The Medication Administration Record (MAR) for June 2019 documented the above physician's order. The Oxycodone was documented as given on the following dates and times:
6/2/19 at 2:38 p.m.
6/5/19 at 9:00 p.m.
6/10/19 at 11:00 p.m.
6/12/19 at 9:30 a.m.
6/12/19 at 9:00 p.m.
6/13/19 at 4:00 p.m.
6/17/19 at 1:00 a.m.
6/17/19 at 5:00 a.m.
6/17/19 at 6:00 p.m.
6/18/19 at 7:00 a.m.
6/21/19 at 11:00 p.m.
6/20/19 at 9:00 a.m.
6/22/19 at 8:00 a.m.
6/23/19 at 8:30 a.m.
6/26/19 at 8:16 p.m.
The reverse side of the MAR documented these dates and times. There was no documentation of non-pharmacological interventions being provided prior to the administration of these medications.

The nurse's notes for the above dates and times failed to evidence documentation of

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non-pharmacological interventions provided prior to the administration of these medications.

The July 2019 MAR documented the above physician's order for Oxycodone. The Oxycodone was documented as being administered on the following dates and times:
7/6/19 at 9:24 a.m.
7/7/19 at 8:00 a.m.
7/7/19 at 2:50 p.m.
7/11/19 at 8:00 a.m.
7/15/19 at 9:30 a.m.
7/16/19 at 9:00 a.m.
7/19/19 at 9:00 a.m.
7/20/19 at 6:00 a.m.
7/21/19 at 9:30 p.m.
The reverse side of the MAR documented these dates and times. There was no documentation of non-pharmacological interventions provided prior to the administration of these medications.

The nurse's notes for July 2019 for the above dates failed to evidence documentation of non-pharmacological interventions provided prior to the administration of these medications.

The comprehensive care plan dated, 8/9/19, documented in part, "Focus: Pain related to diabetic neuropathy, arthritis, lymphedema to leg, muscle spasms." The "Interventions" documented in part, "Administer pain medication per physician orders. Encourage/assist with reposition frequently for comfort as needed. Implement nondrug therapies such as diversion activities, TV etc. to assist with pain and monitor effectiveness."

An interview was conducted with LPN (licensed practical nurse) #6 on 9/11/19 at 5:16 p.m.

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regarding resident complaints of pain. LPN #6 stated the nurse asks where the pain is, what level of pain it is and then go to the MAR and check the orders for pain medication and then based on the level of pain and what the resident has ordered we'd give what was ordered. When asked if staff would try anything non-pharmacological first before medications, LPN #6 stated, "Yes, depending on what and where the pain is." LPN #6 paused, and then stated, "I could try range of motion. I cannot think of anything that doesn't require an order." LPN #6 was not able to state other non-pharmacological interventions without prompts. When asked if anything is offered before the medication, where would that be documented, LPN #6 stated, "On the back of the MAR or chart it in the nurse's notes."

ASM (administrative staff member) #1, the administrator, ASM #3, the medical director, ASM #4, the regional clinical coordinator, and ASM #5, a director of nursing from another facility, were made aware of the above concerns on 9/12/19 at 9:45 a.m.

No further information was provided prior to exit.

[1]Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138.
[2] Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 422.
[3] This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682132.html

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F 698	Continued From page 131	F 698		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive 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, facility document review and clinical record review, it was determined that the facility staff failed to evidence ongoing communication with the dialysis center for one of 48 residents in the survey sample, Resident #4. The findings include: Resident #4 was admitted to the facility on 3/11/18. Resident #4's diagnoses included but were not limited to end stage renal disease [inability of the kidneys to excrete wastes and function in the maintenance of electrolyte balance. (1)], cerebral infarction [abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and loss of ability to move a body part. (2)], and high blood pressure. Resident #4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/18/16/19, coded the resident's BIMS (brief interview for mental status) score as "14" indicating the resident was capable of making daily cognitive decisions. The care plan dated 3/26/19, documented in part,	F 698	Corrective Action: On 9/12/19, the dialysis communication documentation for resident #4, was obtained from their scheduled visit. Other Potential Residents Affected: Other residents with scheduled dialysis appointments had the potential to be affected. Systematic Changes: Beginning 9/30/19, licensed nurse staff were re-educated regarding the importance of obtaining dialysis communication documentation for he residents after	10/27/19

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F 698	Continued From page 132 Focus: "Renal insufficiency related to ESRD (end stage renal disease)/dialysis." The Goal: dated 3/11/28, documented, "Will have no complications related to dialysis devices or treatment." The Interventions/Tasks: dated 3/11/18, documented, "Coordinate dialysis care with the dialysis treatment center." Review of Resident #4's clinical record revealed Resident #4's dialysis treatment schedule was Tuesday, Thursday and Saturday weekly. Further review of the clinical record evidenced communication with dialysis center on the following dates in the last quarter: 6/8/19, 6/13/19, 6/27/19, 7/11/19, 8/6/19 and 9/10/19. The facility failed to evidence communication with the dialysis center from 6/1/19-9/10/19 a total of 37 times. An interview was conducted with LPN (licensed practical nurse) #6, the assistant unit manager, on 9/11/19 at 10:10 AM. When asked what communication/information is provided to the dialysis center, LPN #6 stated, "We send their dialysis book with them. This book has a form completed for each dialysis visit. The top section includes; vital signs, blood sugar, last pain medication time, wound site, special precautions and additional comments are sections we complete. The bottom section includes: pre dialysis weight and vital signs, post dialysis weight and vital signs, duration of treatment, medications administered and comments." When asked about the location of the dialysis communication forms for the last 90 days, LPN # 6 stated, "They will be in the dialysis book or the paper chart." When shown the dialysis communication forms in the dialysis book and the paper chart, LPN #6 stated, "They're not here, I guess they weren't filled out."	F 698	scheduled appointments. Monitoring System: Beginning 10/7/19, a weekly audit will be of residents currently receiving dialysis services will be conducted by the Director of Nursing and/ or her designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	

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F 698	Continued From page 133 On 9/12/19 at 12:30 PM, ASM (administrative staff member) #1 (administrator), #2 (director of nursing), #3 (medical director), #4 (regional clinical coordinator), #5 (director of nursing for another facility) and #6 (regional quality assurance director) were made aware of the above concern. A policy for communicating with Dialysis centers was requested. No further information was presented prior to exit. References: 1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 498. 2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 111.	F 698		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to evidence that one of five employee records reviewed met the minimum requirement for 12 hours of annual training, CNA #4. There was no evidence of 12 hours of annual training for CNA #4.	F 730	Corrective Action: A corrective action was not performed for CNA #4 as they no longer work for the facility. Other Potential Residents Affected:	10/27/19

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F 730	Continued From page 134 The findings include: On 9/12/19 at 3:45 PM, a review of the educational records of five facility certified nursing assistant (CNA) staff was conducted. One staff member, CNA #4, had five documented hours of annual trainings completed. On 9/12/19 at approximately 3:55 PM in an interview with ASM #5 (Administrative Staff Member), a DON (Director of Nursing) from a sister facility who was assisting, ASM #5 stated that she was not able to speak to why this CNA did not get all 12 hours of the required training. She stated that much of the trainings had previously been done on paper and that the facility is transitioning to an electronic educational system that will be tracking training hours in the future. A review of the facility policy, "In-Service Training Program, Nurse Aide" documented, "3. Annual in-services must:...b. Be no less than 12 hours per employment year..." ASM #1 (the Administrator) was present in the room at the time of the review and was aware of the findings. No further information was provided by the end of the survey.	F 730	Other residents had the potential to be affected. Systematic Changes: On 9/23/19, a new facility Educator was hired and started at the facility. Beginning 9/30/19, certified nursing staff were re-educated regarding the minimum requirement to complete 12 hours of annual training. Monitoring System: Beginning 10/7/19, a weekly random audit of 10% of training records for current certified nurse staff members will be completed by the Director of Nursing and/or her designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as	

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F 730	Continued From page 135	F 730	appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure that two of 48 residents in the survey sample and one	F 757	Corrective Action: On 10/6/19, the physician order for	10/27/19

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F 757	Continued From page 136 of six residents in the medication administration observation were free of unnecessary medications, Residents #50, #75 and #11. The findings include: 1. The facility staff failed to administer pain medication to Resident #50 per the physician's ordered pain scale. Staff administered the Oxycodone ordered for severe pain levels when the resident did not rate the pain as severe. Resident #50 was admitted to the facility on 9/15/14 with diagnoses that include but are not limited to: congestive heart failure [abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys. [1]], diabetes, high blood pressure, and osteoarthritis [Characterized by degenerative changes in the joints, pain, stiffness and swelling can develop after exercise]. [2] The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 7/25/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring limited to extensive assistance of one or more staff members for all of her activities of daily living. In Section J - Health Conditions -the resident was coded as receiving as needed pain medication and at the time of the interview, the resident stated she had no pain. The resident was coded in Section J as not receiving any non-medication interventions for pain. The physician orders dated 5/17/19, documented,	F 757	pain medication for resident #50 for dis-continued. A mediation error Report was completed And the RP was notified. A corrective action was not completed for resident #75 regarding omissions of non-pharmacological documentation as his EHR is considered a closed record due to his discharge. On 9/11/19, the Physician and RP for resident #11 was notified of the medication error and that there was no harm to the resident. A medication error report was also completed. Other Potential Residents Affected: Other residents receiving pain medication and with omissions of non-pharmacological documentation interventions had the	

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F 757	Continued From page 137 "Oxycodone Tab (tablet) (used to treat moderate to severe pain) [3] 5 mg (milligrams); 1 tablet by mouth every 1 -2 hours as needed for severe pain." The physician orders dated 1/14/18, documented, "Acetaminophen Tab (used to treat mild to moderate pain) [4] 325 mg - 2 tablets by mouth every 6 hours as needed for mild to moderate pain." The physician orders for the months of May, June and July 2019 documented the following order: Pain Evaluation Each Shift (key): 0 = no pain 1, 2, 3, 4 = mild pain 5, 6, 7 = moderate pain 8, 9 = severe pain 10 = very severe - horrible pain. The May 2019 Medication Administration Record (MAR) documented the above physician's order for Oxycodone. The medication was documented as being given on the following dates and times and for the following pain scale levels: 5/15/19 at 4:30 p.m. - general pain - pain level 5/10 (five out of 10) 5/25/19 at 8:15 a.m. - general pain - pain level 5/10 5/26/19 at 8:10 a.m. - general pain - pain level 5/10 5/29/19 at 6:00 p.m. - general pain - pain level 5/10 5/29/19 at 10:00 p.m. - general pain - pain level 6/10 5/30/19 at 8:30 a.m. - general pain - pain level 7/10. The Medication Administration Record (MAR) for	F 757	potential to be affected. Systematic Changes: Beginning 9/30/19, licensed nurse staff were re-educated regarding the importance of following physician medication orders, attempting non-pharmacolgical interventions and adhering to physician ordered pain scales when administering pain medication. Monitoring System: Beginning 10/7/19, a weekly random audit of 10% of current residents with physician orders with pain scale when administering pain medication and gradual dose reductions will be conducted by the Director of Nursing and/or her designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate.	

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F 757	Continued From page 138 June 2019 documented the above physician's order. The Oxycodone was documented as given on the following dates and times and for the following documented pain levels: 6/2/19 at 2:38 p.m. - lower leg pain - no pain scale documented 6/5/19 at 9:00 p.m. - bilateral leg pain - 5/10 6/10/19 at 11:00 p.m. - general pain - 6/10 6/12/19 at 9:30 a.m. - leg pain - 6/10 6/12/19 at 9:00 p.m. - leg pain - 5/10 6/13/19 at 4:00 p.m. - generalized pain - 6/10 6/17/19 at 1:00 a.m. - leg pain - 9/10 6/17/19 at 5:00 a.m. - leg pain - 6/10 6/17/19 at 6:00 p.m. - leg pain - 6/10 6/18/19 at 7:00 a.m. - leg pain - 7/10 6/21/19 at 11:00 p.m. - leg pain - 5/10 6/20/19 at 9:00 a.m. - general pain - 6/10 6/22/19 at 8:00 a.m. - bilateral leg pain - 7/10 6/23/19 at 8:30 a.m. - general pain - 6/10 6/26/19 at 8:16 p.m. - general pain - 5/10 The July 2019 MAR documented the above physician's order for Oxycodone. The Oxycodone was documented as being administered on the following dates and times with the following pain levels: 7/6/19 at 9:24 a.m. - general pain - no pain level documented 7/7/19 at 8:00 a.m. - bilateral leg pain - 6/10 7/7/19 at 2:50 p.m. - leg pain - 7/10 7/11/19 at 8:00 a.m. - leg pain - 6/10 7/15/19 at 9:30 a.m. - leg pain - 6/10 7/16/19 at 9:00 a.m. - bilateral leg pain - 6/10 7/19/19 at 9:00 a.m. - bilateral leg pain - 6/10 7/20/19 at 6:00 a.m. - bilateral leg pain - no pain level documented 7/21/19 at 9:30 p.m. - general pains - 6/10 The review of the May, June and July 2019 MARs	F 757	Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	

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failed to evidence the Tylenol was administered.

The comprehensive care plan dated, 8/9/19, documented in part, "Focus: Pain related to diabetic neuropathy, arthritis, lymphedema to leg, muscle spasms." The "Interventions" documented in part, "Administer pain medication per physician orders. Encourage/assist with reposition frequently for comfort as needed. Implement nondrug therapies such as diversion activities, TV etc. to assist with pain and monitor effectiveness."

An interview was conducted with LPN (licensed practical nurse) #6 on 9/11/19 at 5:16 p.m. The physician orders for the pain scale and the orders for the Tylenol and Oxycodone were reviewed with LPN #6. When asked if staff use the pain scale documented on the physician orders to give pain medications, LPN #6 stated, "Yes." LPN #6 was asked when the Oxycodone should be administered according to the physician ordered pain scale, LPN #6 stated, "For a pain level of eight or greater." Resident #50's MARs evidencing the Oxycodone was administered for pain levels below eight were reviewed with LPN #6. LPN #6 stated, "That (Oxycodone) should not have been given."

An interview was conducted with ASM (administrative staff member) #3, the resident's physician, on 9/11/19 at 5:39 p.m. The pain scale, Tylenol and Oxycodone orders were reviewed with ASM #3. When asked if the pain medication should be administered according to the pain scale on the physician's orders, ASM #3 stated, "Yes." The MARs were reviewed with ASM #3 showing the administration of Oxycodone for pain levels less than eight, ASM #3 stated, "They

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should have started with the Tylenol."

The facility policy, "Pain - Clinical Protocol" documented in part, "Treatment/Management: 2. The physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain. a. Pain medication should be selected based on pertinent treatment guidelines. Generally, and to the extent possible, an analgesic regimen should utilize the simplest regiment and lowest risk medications before using more problematic or higher risk approaches."

ASM (administrative staff member) #1, the administrator, ASM #3, the medical director, ASM #4, the regional clinical coordinator, and ASM #5, a director of nursing from another facility, were made aware of the above concerns on 9/12/19 at 9:45 a.m.

No further information was provided prior to exit.

[1]Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138.
[2] Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 422.
[3] This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682132.html
[4] This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html
2. The facility staff failed to ensure Resident #75 was free of unnecessary medications by failing to

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attempt non-pharmacological interventions to relieve the resident's pain prior to the administration of as-needed pain medication on multiple dates in August, 2019.

Resident #75 was admitted to the facility on 8/14/19 with diagnoses including, but not limited to history of knee replacement and arthritis. On the most recent MDS (minimum data set), an admission assessment an ARD (assessment reference date) of 8/21/19, Resident #75 was coded as being moderately impaired for making daily decisions, having scored 10 out of 15 on the BIMS (brief interview for mental status). In section P, he was coded as having pain occasionally during the five days of the look back period.

A review of Resident #75's clinical record revealed the following order, dated 8/14/19: "Oxycodone (1) IR (immediate release) 5 mg (milligrams), 1 or 2 tabs (tablets) po (by mouth) every 6 hours as needed for pain."

A review of Resident #75's August 2019 MAR (medication administration record) revealed nurses' initials for the administration of the as-needed Oxycodone on the following dates: 8/15/19, 8/16/19, 8/22/19, 8/23/19, and 8/24/19.

A review of Resident #75's progress notes and the back of the August 2019 MAR failed to reveal evidence that facility staff had attempted any non-pharmacological interventions for pain relief prior to administering as-needed Oxycodone to the resident.

A review of Resident #75's care plan dated 8/14/19 revealed, in part, the following: "Pain left knee related to arthritis, recent

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surgery...Encourage/assist to reposition frequently for comfort as needed."

On 9/12/19 at 8:45 a.m., Resident #75 was observed in the area near the nurses' station. He was eating breakfast. There were no signs or symptoms evident that the resident was in pain.

On 9/12/19 at 9:30 a.m., Resident #75 was observed sitting a wheelchair near his bed. There were no signs or symptoms evident that the resident was in pain. Resident #75 was asked if he was currently in pain. He stated, "No. I do not think so." When asked if he had been receiving enough pain medication from the staff, he stated, "Yes." Further attempts to determine if the staff members had attempted any non-pharmacological interventions to relieve his pain were unsuccessful.

On 9/12/19 at 10:19 a.m., LPN (licensed practical nurse) #8 was interviewed. She stated that she frequently takes care of Resident #75. When asked about the process for administering as-needed pain medications, LPN #8 stated, "I would ask if they needed anything. I would ask their pain level. I always ask on my mourning rounds. They either say yes or no. If they have a prn order, I see if they are due. I give them the medicine. Then I always go back and reassess them." When asked if she ever attempts any non-pharmacological interventions prior to giving the prn pain medication, LPN #8 stated, "Sometimes I try other things. Sometimes therapy will try some things. Most of the time, those things don't help. They know what they want. They know what works." When asked if she would document any non-pharmacological interventions she attempted, LPN #8 stated, "I probably would not

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document it all the time. But I should." When asked if she specifically remembered any non-pharmacological interventions for Resident #75, LPN #8 stated, "I couldn't tell you."

On 9/12/19 at 11:12 a.m., LPN #4, the assistant unit manager was interviewed. When asked if staff nurses should be attempting any non-pharmacological interventions to relieve pain prior to administering a prn pain medication to a resident, LPN #4 stated, "Yes. It could be something even like turning on the tv for distraction. Putting something up on a pillow to elevate it. It could be therapy or nursing or activities. It is interdisciplinary. Yes. It should be documented."

On 9/12/19 at 12:43 p.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns.

A review of the facility policy, "Pain - Clinical Protocol," revealed, in part, the following: "Treatment/Management...3. Staff will provide the elements of a comforting environment and appropriate physical and complementary interventions; for example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain."

No further information was provided prior to exit.

(1) "Oxycodone is used to relieve moderate to severe pain... Oxycodone is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682132.h

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tml.
3. The facility staff failed to hold the 9:00 a.m. dose of Sertraline (1) as ordered for Resident #11 on 09/11/2019 during the medication administration observation.

Resident #11 was admitted to the facility on 02/01/2019 with a readmission on 03/16/2019. Resident #11's diagnoses included but were not limited to dementia with Lewy bodies (2). Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/11/2019, coded Resident #11 as being severely impaired.

Review of Resident #11's clinical record revealed a physician's order dated "05/15/19 N.O. (new order) Sertraline 25mg (milligram) 1 (one) tab (tablet) po (by mouth) only on Monday, Tuesday, Thursday, Friday, Saturday & Sunday Dx. (diagnosis) Depression. N.O. D/C (discontinue) Sertraline 25mg po daily."

The comprehensive care plan for Resident #11 documented "Cognitive loss related to Lewy-body Dementia, Dementia with psychosis. Date Initiated 02/1/2019. Revision on 02/01/2019." Under interventions it documented, "Administer medications per physician orders. Date Initiated: 05/30/2019."

On 9/11/19 at 8:10 a.m., an observation was made of LPN (licensed practical nurse) #1 administering medication Resident #11. LPN #1 positioned the medication cart in the hallway outside of the doorway to Resident #11's room. LPN #1 prepared the following medications for Resident #11:
-Quetiapine 25 mg (milligram) one tablet (used to

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treat mood disorders)
-Sertraline 25 mg one tablet (used to treat depression).
LPN #1 then proceeded to administer the prepared medications to Resident #11.

On 9/11/19 at 3:00 p.m., an interview was conducted with LPN #1 regarding the medication observation on 9/11/19 at 8:10 a.m. When asked how she ensures the medication administered is correct, LPN #1 stated that she compares the medications with the MAR (medication administration record). When asked about the order for the Sertraline for Resident #11, LPN #1 stated that it was supposed to be held but she had overlooked it on the MAR (medication administration record) and had given it. LPN #1 stated that she would notify the physician right away and see if they could hold it on 9/12/19 instead. LPN #1 stated that she did not read the order correctly, that holding the dose on Wednesdays was part of a gradual dose reduction for Resident #11. When asked if administering the medication on a Wednesday was following the physician's orders, LPN #1 stated that it was not and that it was overlooked.

The MAR (medication administration record) dated 09/01/2019-09/30/2019 documented "Sertraline tab 25MG (milligram) 1 (one) tablet(s) by mouth every Monday Tuesday Thursday Friday Saturday and Sunday for Depression." The area on the MAR dated 9/11/19 for 9 AM contained the initials of LPN #1.

On 9/12/19 at 10:30 a.m., ASM (administrative staff member) #2, the director of nursing was asked what standard of practice is used at the facility.

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On 9/12/19 at 3:20 p.m., ASM #2 stated that the facility uses its policies as their standard of practice.

The facility policies provided failed to evidence standards of practice for unnecessary medication administration.

According to Basic Nursing, Essentials for Practice, 6th edition (Potter and Perry, 2007, pages 349-360) "To ensure safe medication administration, be aware of the six rights of medication administration. 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation.....Use the MAR to prepare and administer medications. When preparing medications in bottles or containers, compare the label of the medication container with the medication administration order three times: (1) before removing the container from the drawer or shelf, (2) as you remove the amount of medication ordered from the container, and (3) before returning the container to storage.....After you administer medications, indicate which medications you gave on your patient's MAR per agency policy to show that you gave the medications as ordered. Inaccurate documentation of medications, such as failing to document giving a medication or documenting an incorrect dose, leads to errors in subsequent decisions about your patient's care."

On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 4, regional clinical coordinator, ASM # 5, the director of nursing for another facility and ASM # 6, regional quality

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F 757	Continued From page 147 assurance director were made aware of the findings. No further information was presented prior to exit. References: 1. Sertraline Mood disorders: Indications for ZOLOFT: Depression. Premenstrual dysphoric disorder (PMDD). This information was obtained from the website: https://www.empr.com/drug/zoloft/#mood-disorders 2. Dementia A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.	F 757		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure that two of six residents in the medication administration observation (Residents #60 and #11) were free of a medication error rate of five percent or less. There were two errors out of 29	F 759	Corrective Action: On 9/10/19, RP and MD for resident #60 was notified of the medication error with no new	10/27/19

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F 759	Continued From page 148 opportunities and the medication error rate was 6.9%. The facility staff failed to administer the prescribed dosage of the scheduled Acetaminophen (1) during medication administration observation for Resident #60 on 09/10/2019 and facility staff failed to hold the 9:00 a.m. dose of Sertraline (1) as ordered for Resident #11 on 09/11/2019 during the medication administration observation. The findings include: 1. The facility staff failed to administer the prescribed dosage of the scheduled Acetaminophen (1) during medication administration observation for Resident #60 on 09/10/2019. Resident #60 was admitted to the facility on 02/01/2019 with a readmission on 07/15/2019. Resident #60's diagnoses included but were not limited to hip fracture. Resident #60's most recent MDS (minimum data set), a thirty day assessment with an ARD (assessment reference date) of 08/12/19, coded Resident #60 as being cognitively intact. On 9/10/19 at 5:10 p.m., an observation was conducted of RN #1 administering medication to Resident #60. RN #1 prepared the following medications for Resident #60: -Acetaminophen 325mg (milligram) one tablet (used to treat pain or fever) -Benztropine 1mg one tablet (used to treat Parkinson's disease) -Calcium/Vitamin D 500mg/200 IU (international units) one tablet (mineral/vitamin supplement) -Metformin 1000mg one tablet (used to treat diabetes (3))	F 759	orders given. A medication error was completed as sell. On 9/11/19, the RP and MD for resident #11 were notified of the medication error with no new orders given. A medication error report was also completed. On 9/10/19 and 9/11/19, both Licensed nurses Were re-educated The importance of Following physician Orders and the 6 Rights for Medication administration. Other Potential Residents Affected: Other residents Receiving medications during these Medication observations had the potential to be affected.	

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F 759	Continued From page 149 -Divalproex 500mg one tablet (used to treat seizures (4) or migraine headaches). RN #1 proceeded to administer the medications as prepared to Resident #60. Review of Resident #60's clinical record revealed a physician's order dated "07/15/19 Acetaminophe(n) Tab 325MG 2 (two) tablet(s) (650mg) by mouth every 6 (six) hours for chronic pain." Review of Resident #60's clinical record revealed an MAR (medication administration record) dated 09/01/2019 through 09/30/2019. The MAR documented, "Acetaminophe(n) tab 325mg 2 (two) tablet(s) (650 mg) by mouth every 6 (six) hours for chronic pain." Further review of the MAR revealed documentation of the Acetaminophen 650mg given on 9/10/19 for the 6 p.m. dose by RN #1. On 9/11/19 at 3:30 p.m., an interview was conducted with RN #1 regarding the medication administration observation on 9/10/19 at 5:10 p.m. When asked what is checked prior to medication administration, RN #1 stated that the rights are checked, right person, right medication, right dose, right route, and right time. When asked what these things are checked with, RN #1 stated the medications are checked with the MAR. When asked about the Acetaminophen administration for Resident #60 on 9/10/19 at 5:10 p.m., RN #1 stated that she was not sure about whether she gave one or two tablets. RN #1 stated that she normally does not work on that unit and is not familiar with the residents there. When asked to clarify the order by looking at the chart, RN #1 stated that she was not on her usual unit and that she may have only given one tablet.	F 759	Systematic Changes: Beginning 9/30/19, licensed nurse staff were re-educated regarding the the importance of following physician orders and the 6 Rights for Medication administration. Monitoring System: Beginning 10/7/19, a weekly random medication pass observation per shift will be conducted By the Director of Nursing And/or her designee for Compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	

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On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 4, regional clinical coordinator, ASM # 5, the director of nursing for another facility and ASM # 6, regional quality assurance director were made aware of the findings.

No further information was presented prior to exit.

References:

1. Acetaminophen
Nonnarcotic analgesics: Indications for TYLENOL: Minor aches and pain. Fever. This information was obtained from the website: https://www.empr.com/drug/tylenol/

2. Parkinson's disease
A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

3. Diabetes
A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

4. Seizures
Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.

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2. The facility staff failed to hold the 9:00 a.m. dose of Sertraline (1) as ordered for Resident #11 on 09/11/2019 during the medication administration observation.

Resident #11 was admitted to the facility on 02/01/2019 with a readmission on 03/16/2019. Resident #11's diagnoses included but were not limited to dementia (2). Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/11/2019, coded Resident #11 as being severely impaired.

On 9/11/19 at 8:10 a.m., an observation was made of LPN (licensed practical nurse) #1 administering medication Resident #11. LPN #1 positioned the medication cart in the hallway outside of the doorway to Resident #11's room. LPN #1 prepared the following medications for Resident #11:
-Quetiapine 25 mg (milligram) one tablet (used to treat mood disorders)
-Sertraline 25 mg one tablet (used to treat depression).
LPN #1 then proceeded to administer the prepared medications to Resident #11.

Review of Resident #11's clinical record revealed a physician's order dated "05/15/19 N.O. (new order) Sertraline 25mg (milligram) 1 (one) tab (tablet) po (by mouth) only on Monday, Tuesday, Thursday, Friday, Saturday & Sunday Dx. (diagnosis) Depression. N.O. D/C (discontinue) Sertraline 25mg po daily."

Review of Resident #11's clinical record revealed the MRR (medication regimen review) dated

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05/2019 for Resident #11 documenting a review by the consultant pharmacist showing that the Sertraline had been decreased. Further review of the MRR revealed a note documenting "GDR" (gradual dose reduction) by the consultant pharmacist dated 8/3/19.

Review of Resident #11's clinical record revealed the MAR (medication administration record) dated 9/1/2019 through 9/30/2019. The MAR documented "Sertraline 25mg 1 (one) tablet(s) by mouth every Monday Tuesday Thursday Friday Saturday and Sunday for Depression." Further review of the MAR revealed documentation of the Sertraline 25mg given on 9/11/19 (Wednesday) for 9 a.m. by LPN #1.

On 9/11/19 at 3:00 p.m., an interview was conducted with LPN #1 regarding the medication observation on 9/11/19 at 8:10 a.m. When asked how she ensures the medication administered is correct, LPN #1 stated that she compares the medications with the MAR (medication administration record). When asked about the order for the Sertraline for Resident #11, LPN #1 stated that it was supposed to be held but she had overlooked it on the MAR (medication administration record) and had given it. LPN #1 stated that she would notify the physician right away and see if they could hold it on 9/12/19 instead. LPN #1 stated that she did not read the order correctly, that holding the dose on Wednesdays was part of a gradual dose reduction for Resident #11. When asked if administering the medication on a Wednesday was following the physician's orders, LPN #1 stated that it was not and that it was overlooked.

On 09/12/19 at approximately 12:30 p.m., ASM

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F 759	Continued From page 153 (administrative staff member) # 1, the administrator, ASM # 4, regional clinical coordinator, ASM # 5, the director of nursing for another facility and ASM # 6, regional quality assurance director were made aware of the findings. No further information was presented prior to exit. References: 1. Sertraline Mood disorders: Indications for ZOLOFT: Depression. Premenstrual dysphoric disorder (PMDD). This information was obtained from the website: https://www.empr.com/drug/zoloft/#mood-disorders 2. Dementia A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.	F 759		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		10/27/19

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F 812	Continued From page 154 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to store and prepare food in a sanitary manner in the kitchen. The findings include: Observation was made of the kitchen on 9/10/19 at 12:05 p.m. with other staff member (OSM) #9, the dietary manager. Observation of the rack containing kitchenware that was drying revealed three large metal bowls that were stacked. There was water in the rims of two of the bowls that were observed nestled inside each other, not allowing air to circulate. Observation was made of the three-compartment sink. The sanitizing compartment contained the sanitizing liquid in water with multiple kitchen dishware in the compartment. A request was made of OSM #9 to test the sanitization level in the sink. OSM #9 proceeded to test the water with a test strip, the test strip recorded 50 PPM (parts per million). When asked what the level should be, OSM #9 stated it should be over 200 PPM. The refrigerator was observed. There was a	F 812	Corrective Action: On 9/10/19, the Metal bowls re-washed and positioned on the rack to allow air circulation. On 9/10/19, previously the stocked and used sanitation strips were discarded. The sanitizing compartment of the three compartment sink was re-tested with new sanitation strips. The re-checked reading was above 200 PPM. On 9/10/19, the Cheese was immediately discarded upon observation of only one date. On 9/10/19, the ovens, The glass doors and the	

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F 812	Continued From page 155 package of opened mozzarella cheese wrapped in plastic wrap and an opened package of mild cheddar cheese wrapped in plastic wrap. There was a date of "9/9" documented on a label on both packages. When asked which date is documented, the open or the use by date, OSM #9 stated, it needs to have both the open date and the use by date. OSM #9 proceeded to throw the cheese away. Observation of the ovens revealed the top ovens contained black charred debris on the bottom of the ovens. The glass doors were brown, and visualization into the oven was hardly possible through the glass. The bottom oven had black charred debris and the racks were coated in a brown substance. OSM #9 was asked when the ovens were last cleaned. OSM #9 stated, "I don't know, but I agree they need cleaning." Observation was made at 12:18 p.m. of OSM #10, a dietary aide, in the dish room. OSM #10 had her hair pulled up into a bun on top of her head. The hair covering that she was wearing was only covering her bun and not the rest of her hair. When asked if she helps with food preparation and tray set up, OSM #10 stated, "I put the knives, forks, packages of crackers on the trays. I also will put the cakes on the trays. I'm in training." Observation was made of the dish room. There were trays used to place the resident's food on, on a rack. There was a stack of 10 trays. Five of the trays were stuck inside each other, causing wet nesting and not allowing proper air-drying. Also noted was small bowls drying on a rack. One of the approximately 20 bowls contained yellow debris, what appeared to be dried eggs, on the	F 812	Racks were cleaned. On 9/10/19, the staff member was remind to adjust her hair net to fully cover her entire head. On 9/10/19, the trays were re-washed and positioned on the rack to allow air circulation. The bowls with dried yellow debris were Collected and re-washed. On 9/10/19, Ecolab was immediately called to assess the dishwasher. In the meantime, dishes utensils, pots/pans, etc., were hand-washed in the 3 compartment sink. On 9/11/19, the dishwasher was adjusted, resulting in appropriate temperature being restored. On 9/10/19, the temperatures that had been taken earlier in the day on a supplemental form, were recorded on the appropriate temperature log.	

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F 812	Continued From page 156 rim of the bowl. OSM #13, a dietary aide, was observed coming and taking bowls off the rack. When asked if the bowls on that rack are available for use, OSM #13 stated they were. When shown the bowl with what the yellow debris on it, OSM #13 stated, "That needs to be rewashed. That shouldn't be there." Observation was made of the dish machine at 12:22 p.m. Four cycles of dishes were observed. There were three other racks recently washed dishes at the end of the machine. The final rinse temperature only got to 178 degrees with each cycle run. The temperature logs for September documented the final rinse as 180 degrees for all three meals since 9/1/19. The log was not filled in for 9/10/19. At 12:32 p.m., OSM #9 was asked to observe OSM #10. When asked if her hair restraint was properly in place, OSM #9 stated, "No, it has to cover the whole head." The chemical closet was observed at 12:45 p.m. A wet mop was observed sitting in the bucket. When asked how mops are to be stored, OSM #9 stated they should be hanging up. At this time, OSM #9 was asked what temperature the dish machine final rinse should be at, OSM #9 stated, "At least 180 degrees. On 9/11/19 at 8:50 a.m., OSM #9 requested this surveyor come to the kitchen. OSM #11, the representative from the company that oversees the dish machine and its operation, was in the dish room. He explained that he had to adjust the booster to get the hot water above 180 degrees. He stated he had run the machine also many times and the temperature did not get above 180.	F 812	On 9/10/19, the mop was removed from the mop bucket. Other Potential Residents Affected: Other residents residing at the facility had the potential to be affected. Systematic Changes: On 9/11/19 and 9/30/19, Dining Services Staff were re-educated regarding the importance of positioning items washed on the racks in a manner that will allow for air circulation to prevent wet-nesting, using the proper sanitation strips to test the sanitizing compartment of the three compartment sink, using the open by and use by date method upon opening items, cleaning and keeping oven free of charred and spilled debris, wearing hairnets properly, washing items such as bowls, etc., thoroughly, recording temperatures immediately and on the	

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F 812	Continued From page 157 When asked what the potential is if the final rinse is not at temperature, OSM #11 stated, "The final rinse is the icing on the cake for sanitation. Germs are killed at 160 degrees." When asked does the rinse cycle have to be above 180, OSM #11 stated, "It still has to reach 180 in the rinse according to the code." On 9/11/19 at 9:05 a.m., OSM #9 was asked what the wash and rinse cycle should be, OSM #9 stated, "In my Serv Safe classes, I was taught that the wash has to be greater than 160 and the rinse has to be 180 degrees. OSM #9 was requested to provide the operational manual regarding the dish machine and the documentation out of the Serv Safe regarding dish machine temperatures. ASM #1, the administrator, ASM #3, the medical director, ASM #4, the regional clinical coordinator, and ASM #5, a director of nursing from another facility, were made aware of the above concerns on 9/12/19 at 9:45 a.m. A request was made on 9/12/19 at approximately 1:30 p.m. for the log of when the ovens were last cleaned and policies for the kitchen. At 3:40 p.m., ASM # 4 stated they have no logs on the cleaning of the oven since May 2019. A copy of that log documented in part, "Daily Cleaning Assignments." the Assignment column, did not document the ovens. The facility policy, "Dishwashing Machine Use" documented in part, "2. Dishwashing machines that use hot water to sanitize must maintain the following wash solution temperatures: 3. Dishwashing machine hot water sanitization rinse	F 812	appropriate temperature log, identifying the proper temperature range for the dish machine and what to do if it is not as well as proper storage of mop heads for cleaning. On 9/11/19, a cleaning assignment schedule was for the oven was posted for use/reference in the kitchen area. Monitoring System: Beginning 10/7/19, a weekly random audit of kitchen to include the above noted areas will conduced by the Administrator and/or her designee for compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	

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temperatures may not be more that 194 degrees, or less than 180 degrees for all other machines."

The facility policy, "Sanitization" documented in part, "2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning....Procedure for Oasis 146 Use in Third Compartment Sink: a. Fill sink 3 (sanitizer sink) with water and Oasis 146 Multi-quat sanitizer solution. Use 200 ppm - 400 ppm.

The facility policy, "Food Preparation and Service" documented in part, "Food Service/Distribution...7. Food and nutrition services staff wear hair restrains (hair net, hat beard restraint, etc.) so that hair does not contact food."

According to 2017 Recommendations of the United States Public Health Service Food and Drug Administration
Drying 4-901.11 Equipment and Utensils, Air-Drying Required.
(B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored:
(1) In a self-draining position that allows air drying; and
(2) Covered or inverted.

The facility policy, "Cleaning and Disinfection of Environmental Surfaces" documented in part, "13. Mop heads and cleaning cloths will be decontaminated regularly (e.g, laundered and dried at least daily)."

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GLENBURNIE REHAB & NURSING CENTER	1901 LIBBIE AVE RICHMOND, VA 23226

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F 812	Continued From page 159 No further information was provided prior to exit.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842		10/27/19

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F 842	Continued From page 160 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review it was determined that the facility staff failed to maintain a complete and accurate medical record for two of 48 residents in the survey sample, Resident #60 and Resident #75. The facility staff documented administration of two tablets of Acetaminophen (650 milligrams) on Resident #60's MAR (medication	F 842	Corrective Action: On 9/10/19, resident #60, MD and RP were notified of the medication administration error regarding Tylenol.	

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F 842	Continued From page 161 administration record) on 09/10/2019, when the resident was only administered one tablet (325 milligram) and incorrectly discontinued an as-needed pain medication on Resident #75's MAR (medication administration record) without a provider's order to do so. As a result, the September 2019 POS (physician order sheet) and September 2019 MAR (medication administration record) were inaccurate. The findings include: 1. The facility staff failed to administer the prescribed dosage of the scheduled Acetaminophen (1) during medication administration observation for Resident #60 on 09/10/2019, however staff documented administration of the prescribed dosage on the MAR (medication administration record) on 09/10/2019. Resident #60 was admitted to the facility on 02/01/2019 with a readmission on 07/15/2019. Resident #60's diagnoses included but were not limited to Parkinson's disease (2) and hip fracture. Resident #60's most recent MDS (minimum data set), a thirty day assessment with an ARD (assessment reference date) of 08/12/19, coded Resident #60 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. On 9/10/19 at 5:10 p.m., an observation was made of the medication administration, to Resident #60 by RN (registered nurse) #1. RN #1 positioned the medication cart in the hallway opposite the doorway to Resident #60's room. RN #1 prepared the following medications for	F 842	A corrective action for resident #75 was not performed as the medical record is considered a closed record due to their discharge. Other Potential Residents Affected: Other residents that had orders for Tylenol the potential to be affected. Systematic Changes: On 9/30/19, licensed nurse staff were re-educated regarding the importance of completing the monthly medication change over process accurately and administering the pre-scribed dosage as scheduled during the medication administration pass. Monitoring System: Beginning 10/7/19, a weekly random audit of 10% of the current resident eMAR with orders for Tylenol will be conducted by the Director of Nursing and/or her designee for	

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F 842	Continued From page 162 Resident #60: -Acetaminophen 325mg (milligram) one tablet (used to treat pain or fever) -Benztropine 1mg one tablet (used to treat Parkinson's disease) -Calcium/Vitamin D 500mg/200 IU (international units) one tablet (mineral/vitamin supplement) -Metformin 1000mg one tablet (used to treat diabetes (3)) -Divalproex 500mg one tablet (used to treat seizures (4) or migraine headaches). RN #1 proceeded to administer the medications as prepared to Resident #60. The physicians order summary for Resident #60 dated "09/01/2019-09/30/2019" documented "Acetaminophe(n) Tab 325MG 2 (two) tablet(s) (650mg) by mouth every 6 (six) hours for chronic pain." Review of Resident #60's clinical record revealed an MAR (medication administration record) dated 09/01/2019 through 09/30/2019. The MAR documented, "Acetaminophe(n) tab 325mg 2 (two) tablet(s) (650 mg) by mouth every 6 (six) hours for chronic pain." Further review of the MAR revealed documentation of the Acetaminophen 650mg given on 9/10/19 for the 6 p.m. dose by RN #1. On 9/11/19 at 3:30 p.m., an interview was conducted with RN #1 regarding the medication administration observation on 9/10/19 at 5:10 p.m. When asked what is checked prior to medication administration RN #1 stated that the rights are checked, right person, right medication, right dose, right route, and right time. When asked what medications are checked with RN #1 stated the medications are checked with the	F 842	compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	

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MAR. When asked about the Acetaminophen administration for Resident #60 on 9/10/19 at 5:10 p.m. RN #1 stated that she was not sure about whether she gave one or two tablets. RN #1 stated that she normally does not work on that unit and is not familiar with the residents there. When asked to clarify the order by looking at the chart RN #1 stated that she was not on her usual unit and that she may have only given one tablet.

On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 4, regional clinical coordinator, ASM # 5, the director of nursing for another facility and ASM # 6, regional quality assurance director were made aware of the findings.

No further information was provided prior to exit.

References:
1. Acetaminophen
Nonnarcotic analgesics: Indications for
TYLENOL: Minor aches and pain. Fever. This information was obtained from the website:
https://www.empr.com/drug/tylenol/
2. Parkinson's disease
A type of movement disorder. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.
3. Diabetes
A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.
4. Seizures
Symptoms of a brain problem. They happen

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because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.
2. The facility staff incorrectly discontinued an as-needed pain medication on Resident #75's MAR (medication administration record) without a provider's order to do so. As a result, the September 2019 POS (physician order sheet) and September 2019 MAR (medication administration record) were inaccurate.

Resident #75 was admitted to the facility on 8/14/19; diagnoses included, but are not limited to, history of knee replacement and arthritis. On the most recent MDS (minimum data set), an admission assessment an ARD (assessment reference date) of 8/21/19, Resident #75 was coded as being moderately impaired for making daily decisions, having scored 10 out of 15 on the BIMS (brief interview for mental status). In section P, he was coded as having pain occasionally during the five days of the look back period.

A review of Resident #75's August 2019 POS (physician order sheet) revealed the following order, dated 8/14/19: "Oxycodone (1) IR (immediate release) 5 mg (milligrams), 1 or 2 tabs (tablets) po (by mouth) every 6 hours as needed for pain."

A review of Resident #75's August 2019 MAR (medication administration record) revealed the following entry: "Oxycodone (1) IR (immediate release) 5 mg (milligrams), 1 or 2 tabs (tablets) po (by mouth) every 6 hours as needed for pain."

A review of Resident #75's September 2019 POS

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(physician order sheet) failed to reveal an order for the prn Oxycodone as described above.

A review of Resident #75's September 2019 MAR revealed the following entry: "Oxycodone (1) IR (immediate release) 5 mg (milligrams), 1 or 2 tabs (tablets) po (by mouth) every 6 hours as needed for pain." This entry had a single line drawn through it. The space beside the entry contained the following: "D/C (discontinue) 8/23/19." No staff initials indicated that the medication had been given at all in September 2019.

On 9/12/19 at 10:19 a.m., LPN (licensed practical nurse) #8 was interviewed. She stated that she frequently takes care of Resident #75. After LPN #8 reviewed the August and September 2019 POS sheets and MARs as described above, she stated, "[The as-needed Oxycodone order] should never have been discontinued. I am the one who called the doctor and got him to order a scheduled Oxycodone for [Resident #75] so he could be sure to get something every day before he went to therapy. I specifically asked the doctor if he wanted me to discontinue the prn [order] and he said to leave it there in case of breakthrough pain. I don't know who stopped it. That is not my writing." When asked if the September 2019 POS and MAR were accurate, she stated, "No."

On 9/12/19 at 11:12 a.m., LPN #4, the assistant unit manager was interviewed. After LPN #4 reviewed the August and September 2019 POS sheets and MARs as described above, she stated, "I don't know what happened. It looks like we should not have stopped the prn (as needed) order." When asked who had done the recapitulation/changeover of the orders from

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F 842	Continued From page 166 August 2019 to September 2019, she stated the nurse's name. She stated, "She is not here anymore." When asked her process for the monthly recapitulation of orders, she stated, "I look at the previous month's POS and all the telephone orders. I would never just use a MAR. I verify order to order." She stated both the September 2019 POS and MAR for Resident #75 were inaccurate. On 9/12/19 at 12:43 p.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns. No further information was provided prior to exit. (1) "Oxycodone is used to relieve moderate to severe pain... Oxycodone is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682132.html.	F 842		
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document	F 909	Corrective Action:	10/27/19

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F 909	Continued From page 167 review, it was determined that the facility staff failed to obtain an annual inspection of the resident's bed rails for eight of 48 sampled residents (Resident's # 40, # 88, # 81, # 54, # 50, # 7, # 34, and # 68). The facility staff failed to evidence an annual inspection of bedrails for Resident's # 40, # 88, # 81, # 54, # 50, # 7, # 34, and # 68. The findings include: 1. The facility staff failed to evidence an annual inspection of bedrails for Resident # 40. Resident # 40 was admitted to the facility on 12/22/15 and a readmission of 04/05/18 with diagnoses that included but were not limited to repeated falls, lack of coordination and high blood pressure. Resident # 40's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 07/18/19, coded Resident # 40 as scoring a six on the brief interview for mental status (BIMS) of a score of 0 - 15, six - being severely impaired of cognition for making daily decisions. On 09/10/19 at 2:58 p.m., Resident # 40 was observed in bed, asleep. Observation of the bed revealed upper bilateral half side rails raised. On 09/11/19 at 3:05 p.m., Resident # 40 was observed in bed. Observation of the bed revealed upper bilateral half side rails raised. On 9/11/19 at approximately 4:00 p.m., a request was made to ASM (administrative staff member) # 1, the administrator for documentation of bed	F 909	On 9/23/19 annual inspections of the bedrails for residents #40, #88, #81, #54, #50, #7, #34 and #68 were completed. Other Potential Residents Affected: Other residents that did not have an annual bed-rail inspection had the potential to be affected. Systematic Changes: On 9/23/19, the Maintenance Director and other Maintenance staff were educated regarding the importance of conducting annual bedrail inspections of the beds in the facility. Monitoring System: Beginning 10/7/19, a weekly random audit of 10 beds for the annual bedrail inspections will be conducted by the Administrator and/or her designee for	

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F 909	Continued From page 168 rail inspections for Resident # 7. On 9/12/19 at approximately 8:30 a.m., a copy of the document titled "Bed System Measurement Device Test Results Worksheet" was received for Resident # 7. Review of the document revealed an assessment date of 12/04/2017. The document failed to evidence annual inspection of the bed rails for the bed in Resident # 7's room. On 09/12/19 at 9:45 AM, a review of the facility's "Bed System Measurement Device Test Results Worksheet" contained in a three-ring binder, and interview with OSM (other staff member) #5, the director of maintenance was conducted. Review of the "Bed System Measurement Device Test Results Worksheet" included inspections of bed rails. When asked how often the bed rails are inspected, OSM #5 stated, "At least annually." Review of the facility's "Bed System Measurement Device Test Results Worksheets" failed to evidence any dates on the worksheets for 2018 or 2019. Further review of the "Bed System Measurement Device Test Results Worksheet" revealed the most recent bed rail inspection was conducted on 12/04/2017 for the bed in Resident # 40's room. After reviewing the book containing the facility's "Bed System Measurement Device Test Results Worksheet" without the dates, OSM #5 stated that he was unable to determine when the inspections were completed after 2017. On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 4, regional clinical coordinator, ASM # 5, the director of nursing for another facility and ASM # 6, regional quality assurance director were made aware of the	F 909	compliance. Audits will be conducted for four weeks and then monthly thereafter for one month. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QAPI Committee for further review and/or possible revisions to facility protocol.	

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findings.

No further information was provided prior to exit.

2. The facility staff failed to evidence an annual inspection of bedrails for Resident # 88.

Resident # 88 was admitted to the facility on 03/26/2019 with a readmission to the facility on 06/30/2019. Diagnoses include but are not limited to swallowing difficulty, low iron, and high blood pressure.

Resident # 88's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 08/24/19, coded Resident # 88 as scoring a three on the staff assessment for mental status (BIMS) of a score of 0 - 15, three- being severely impaired of cognition for making daily decisions.

09/10/19, at 03:11 PM, Resident # 88 was observed in bed watching television. Observation of the bed revealed upper bilateral half side rails raised.

09/11/19 at 3:20 PM, Resident # 88 was observed in bed watching television. Observation of the bed revealed upper bilateral half side rails raised.

On 9/11/19 at approximately 4:00 p.m., a request was made to ASM (administrative staff member) # 1, the administrator for documentation of bed rail inspections for Resident # 7.

On 9/12/19 at approximately 8:30 a.m., a copy of the document titled "Bed System Measurement Device Test Results Worksheet" was received for Resident # 7. Review of the document revealed

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an assessment date of 12/04/2017. The document failed to evidence annual inspection of the bed rails for the bed in Resident # 7's room.

On 09/12/19 at 9:45 AM, a review of the facility's "Bed System Measurement Device Test Results Worksheet" contained in a three-ring binder, and interview with OSM (other staff member) #5, the director of maintenance was conducted. When asked how often the bed rails are inspected, OSM #5 stated, "At least annually." Review of the facility's "Bed System Measurement Device Test Results Worksheets" failed to evidence any dates on the worksheets for 2018 or 2019. Further review of the "Bed System Measurement Device Test Results Worksheet" revealed the most recent bed rail inspection was conducted on 12/04/2017 for the bed in Resident # 88's room. After reviewing the book containing the facility's "Bed System Measurement Device Test Results Worksheet" without the dates, OSM #5 stated that he was unable to determine when the inspections were completed after 2017.

On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 4, regional clinical coordinator, ASM # 5, the director of nursing for another facility and ASM # 6, regional quality assurance director were made aware of the findings.

No further information was provided prior to exit.

3. The facility staff failed to evidence an annual inspection of bedrails for Resident # 81.

Resident # 81 was admitted to the facility on 09/26/2011, with a readmission on 08/16/2019

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with diagnoses that included but were not limited to swallowing difficulty, low iron, and high blood pressure.

Resident # 81's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 08/23/19, coded Resident # 81 as scoring a three on the staff assessment for mental status (BIMS) of a score of 0 - 15, three- being severely impaired of cognition for making daily decisions.

On 09/10/19 at 3:10 p.m., Resident # 81 was observed in bed, asleep. The bed was observed with upper bilateral half side rails raised.

On 9/11/19 at approximately 4:00 p.m., a request was made to ASM (administrative staff member) # 1, the administrator for documentation of bed rail inspections for Resident # 7.

On 9/12/19 at approximately 8:30 a.m., a copy of the document titled "Bed System Measurement Device Test Results Worksheet" was received for Resident # 7. Review of the document revealed an assessment date of 12/04/2017. The document failed to evidence annual inspection of the bed rails for the bed in Resident # 7's room.

On 09/12/19 at 9:45 AM, a review of the facility's "Bed System Measurement Device Test Results Worksheet" contained in a three-ring binder, and interview with OSM (other staff member) #5, the director of maintenance was conducted. Review of the "Bed System Measurement Device Test Results Worksheet" revealed the most recent bed rail inspection was conducted on 12/04/2017 for the bed in Resident # 81's room. After reviewing the book, containing the facility's "Bed System

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Measurement Device Test Results Worksheet" without the dates OSM #5 stated that he was unable to determine when the inspections were completed after 2017.

On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 4, regional clinical coordinator, ASM # 5, the director of nursing for another facility and ASM # 6, regional quality assurance director were made aware of the findings.

No further information was provided prior to exit.
4. The facility staff failed to evidence an annual inspection of the bedrails/frames was conducted for Resident #54.

Resident #54 was admitted to the facility on 3/15/17 with diagnoses that include but were not limited to: diabetes, high blood pressure, absence of left great toe, asthma, and gastroparesis (a condition that reduces the ability of the stomach to empty its contents. It does not involve a blockage (obstruction) (1).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/5/19, coded the resident as having a BIMS (brief interview for mental status) score of "14" indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of two or more staff members for moving in the bed.

Resident #54 was observed in bed with both half rails in the upright position on 9/11/19 at 10:58 a.m. When asked if she uses the side rails,

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Resident #54 stated she uses them to help her turn in the bed.

The current physician orders documented "1/4 side rails for positioning & mobility."

The comprehensive care plan dated, 7/27/19, documented in part, "Focus: At risk for further alteration in skin integrity related to impaired mobility." The Interventions/Tasks" documented in part, "Side rails to bed as needed."

On 09/12/19 at 9:45 a.m., an interview with OSM [other staff member] #5, director of maintenance, and review of the facility's "Bed System Measurement Device Test Results Worksheet" contained in a three-ring binder was conducted. Review of the "Bed System Measurement Device Test Results Worksheet" revealed the most recent bed rail inspection was conducted on 12/06/2017 for the bed in Resident #54's room. After reviewing the book, containing the facility's "Bed System Measurement Device Test Results Worksheet" without the dates OSM # 5 stated that he was unable to determine when the inspections were completed after 2017. OSM # 5 further stated that forms without the dates were completed by the previous maintenance director and were completed prior to his start date of July 2018.

ASM (administrative staff member) #1, the administrator, ASM #3, the medical director, ASM #4, the regional clinical coordinator, and ASM #5, a director of nursing from another facility, were made aware of the above concerns on 9/12/19 at 9:45 a.m.

No further information was provided prior to exit.

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5. Resident #50 was admitted to the facility on 9/15/14 with diagnoses that included but are not limited to: congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) [1], diabetes, high blood pressure, and osteoarthritis (Characterized by degenerative changes in the joints, pain, stiffness and swelling can develop after exercise) [2].

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 7/25/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of two or more staff members for moving in the bed.

Resident #50 was observed in sitting on the side of her bed on 9/11/19 at 12:40 p.m. Both half side rails were up. When asked if she uses the side rails, Resident #50 stated they help her move around in the bed.

The physician orders documented, "Bilateral (2) x 1/4 side rails for positioning and safety, along with functional mobility and transfers.

The comprehensive care plan dated, 2/3/15 and revised on 8/9/19, documented in part, "Focus: ADL (activities of daily living) self care deficit related to physical limitations to shoulders and knees." The "Interventions/Tasks" documented in part, "Bilateral 1/4 side rails to aid in positioning and promote bed mobility."

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On 09/12/19 at 9:45 a.m., an interview with OSM [other staff member] #5, director of maintenance, and review of the facility's "Bed System Measurement Device Test Results Worksheet" contained in a three-ring binder was conducted. Review of the "Bed System Measurement Device Test Results Worksheet" revealed the most recent bed rail inspection was conducted on 12/04/2017 for the bed in Resident #50's room. After reviewing the book, containing the facility's "Bed System Measurement Device Test Results Worksheet" without the dates OSM # 5 stated that he was unable to determine when the inspections were completed after 2017. OSM # 5 further stated that forms without the dates were completed by the previous maintenance director and were completed prior to his start date of July 2018.

ASM (administrative staff member) #1, the administrator, ASM #3, the medical director, ASM #4, the regional clinical coordinator, and ASM #5, a director of nursing from another facility, were made aware of the above concerns on 9/12/19 at 9:45 a.m.

No further information was provided prior to exit.
6. The facility staff failed to evidence an annual inspection of bedrails for Resident # 7.

Resident # 7 was admitted to the facility 03/24/2018 with a readmission on 06/29/2019 with diagnoses that included but were not limited to fracture of femur (1) and rheumatoid arthritis (2).

Resident # 7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/10/19, coded

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Resident # 7 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 7 was coded as requiring extensive of two or more staff members for bed mobility.

An observation on 9/10/19 at 1:30 p.m. revealed Resident # 7 in the wheelchair beside his bed, which contained bilateral upper half side rails in the up position. When asked if he uses the side rails on his bed Resident # 7 stated that he tries but has rheumatoid arthritis, which makes it hard for him to grip the rails. When asked if staff have reviewed the risks and benefits of using side rails, Resident # 7 stated, "Yes, I signed a paper."

An additional observation on 09/11/19 at 9:30 a.m. revealed the same findings as stated above.

Additional observation on 9/12/19 at 1:30 p.m. revealed Resident # 7 in bed with bilateral upper side rails in the up position.

The comprehensive care plan documented, "Risk for further skin breakdown related to decrease mobility ... Date Initiated: 03/25/2018. Revision on 07/01/2019." Under "Interventions" it documented, "Side rails to bed as needed. Date Initiated: 04/10/2018."

The comprehensive care plan documented, "ADL (activities of daily living) Self care deficit related to physical limitations ... Date Initiated: 04/10/2018. Revision on 07/01/2019." Under "Interventions" it documented, "Bed Rail(s). Placement: upper 1/4 (one-quarter) bilat (bilateral). Bed Rail type: Date Initiated: 10/02/2018. Revision on: 07/08/2019."

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On 9/11/19 at approximately 4:00 p.m., a request was made to ASM (administrative staff member) # 1, the administrator for documentation of bed rail inspections for Resident # 7.

On 9/12/19 at approximately 8:30 a.m., a copy of the document titled "Bed System Measurement Device Test Results Worksheet" was received for Resident # 7. Review of the document revealed an assessment date of 12/04/2017. The document failed to evidence annual inspection of the bed rails for the bed in Resident # 7's room.

On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 4, regional clinical coordinator, ASM # 5, the director of nursing for another facility and ASM # 6, regional quality assurance director were made aware of the findings.

No further information was provided prior to exit.

References:

1. Femur fracture
You had a fracture (break) in the femur in your leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm.

2. Rheumatoid arthritis
A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also

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affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm.

7. The facility staff failed to evidence an annual inspection of bedrails for Resident # 34.

Resident # 34 was admitted to the facility 05/02/2016 with a readmission on 08/13/2019 with diagnoses, that included but were not limited to hemiplegia (1) and weakness.

Resident # 34's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/11/2019, coded Resident # 34 as scoring a 11 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 11- being moderately impaired for making daily decisions. Resident # 34 was coded as requiring extensive of one staff member for bed mobility.

An observation on 9/10/19 at 1:15 p.m. revealed Resident # 34 in the wheelchair beside his bed, which contained bilateral upper half side rails, which were in the up position. When asked if he uses the side rails on his bed Resident # 34 stated that he uses them to help himself turn over and to sit up.

An additional observation on 09/11/19 at 9:25 a.m. revealed Resident # 34 in the bed with bilateral upper side rails in the up position on the bed.

Additional observation on 9/12/19 at 1:35 p.m. revealed Resident # 34 in the wheelchair beside the bed with bilateral upper side rails in the up position on the bed.

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The comprehensive care plan documented, "Fall, at risk for further falls due to unsteady gait secondary to CVA (2) /right side weakness ... Date Initiated: 05/02/2016. Revision on 01/17/2019." Under "Interventions" it documented, "Side rail(s) - bilateral. Date Initiated 08/08/2017. Revision on 08/08/2017."

On 9/11/19 at approximately 4:00 p.m., a request was made to ASM (administrative staff member) # 1, the administrator for documentation of bed rail inspections for Resident # 34.

On 9/12/19 at approximately 8:30 a.m., a copy of the document titled "Bed System Measurement Device Test Results Worksheet" was received for Resident # 34. Review of the document revealed an assessment date of 12/04/2017. A second document titled the same was received documenting an assessment of the bed rails in Resident # 34's room but failed to document an assessment date.

On 09/12/19 at 9:45 AM, an interview with OSM (other staff member) #5, the director of maintenance, and review of the facility's "Bed System Measurement Device Test Results Worksheet" contained in a three-ring binder, was conducted. Review of the "Bed System Measurement Device Test Results Worksheet" revealed the most recent bed rail inspection was conducted on 12/04/2017 for the bed in Resident # 34's room. After reviewing the book containing the facility's "Bed System Measurement Device Test Results Worksheet" without the dates, OSM #5 stated that he was unable to determine when the inspections were completed after 2017. OSM #5 further stated that forms without the dates

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were completed by the previous maintenance director and were completed prior to his start date of July 2018.

On 09/12/19 at approximately 12:30 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 4, regional clinical coordinator, ASM # 5, the director of nursing for another facility and ASM # 6, regional quality assurance director were made aware of the findings.

No further information was provided prior to exit.

References:

1. Hemiplegia
Also called: Hemiplegia, Palsy, Paraplegia, and Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

2. CVA-cerebrovascular disease, infarction or accident
A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.

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8. The facility staff failed to evidence an annual inspection of bedrails/frames for Resident #68.

Resident #68 was admitted to the facility on 8/7/19. Resident #68's diagnoses included but were not limited to osteomyelitis of vertebra and sacral region (infection of bone and bone marrow of the spinal column) (1), paraplegia (paralysis of the lower limbs) (2), unstable angina (intermittent chest pain occurring with increasing frequency and intensity) (3).

Resident #68's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/16/19, coded that the resident's BIMS (brief interview for mental status) a score of "14" indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring substantial assistance of one or more staff members for moving in the bed.

Resident #68 was observed with upper one-half bed rails raised on 9/10/19 at 1:25 PM, 9/10/19 3:45 PM and 9/11/19 at 8:15 AM.

Resident #68's comprehensive care plan revised 8/12/19, documented the goal to minimize risk for injury for falls and included interventions of bilateral upper side rails.

On 09/12/19 at 9:45 a.m., an interview with OSM [other staff member] #5, director of maintenance, and review of the facility's "Bed System Measurement Device Test Results Worksheet" contained in a three-ring binder was conducted. Review of the "Bed System Measurement Device Test Results Worksheet" included inspections of bed rails. When asked how often the bed rails

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are inspected OSM # 5 stated, "At least annually." Review of the facility's "Bed System Measurement Device Test Results Worksheets" failed to evidence any dates on the worksheets for 2018 or 2019. Further review of the "Bed System Measurement Device Test Results Worksheet" revealed the most recent bed rail inspection was conducted on 12/06/2017 for the bed in Resident #68's room. After reviewing the book, containing the facility's "Bed System Measurement Device Test Results Worksheet" without the dates OSM # 5 stated that he was unable to determine when the inspections were completed after 2017. OSM # 5 further stated that forms without the dates were completed by the previous maintenance director and were completed prior to his start date of July 2018.

On 9/12/19 at 12:30 PM, ASM (administrative staff member) #1 (administrator), #2 (director of nursing), #3 (medical director), #4 (regional clinical coordinator), #5 (director of nursing for another facility) and #6 (regional quality assurance director) were made aware of the above concern.
No further information was presented prior to exit.

References:
1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 421.
2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 432.
3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 34.