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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/15/19 through 7/18/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The census in this 120 certified bed facility was 106 at the time of the survey. The final survey sample consisted of 30 current Resident reviews and 4 closed record reviews.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard was conducted 07/15/19 through 07/16/19. An extended survey was conducted 07/16/19 through 07/18/19. One Complaint was investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Immediate Jeopardy was identified at a Scope and Severity Level IV in regards to failure to store medications safely and failure to ensure the environment (Alzheimers unit) was free of accident hazards. The Immediate Jeopardy process began on 07/16/19 at 9:02 a.m. The Immediate Jeopardy was removed at 07/16/19 at 7:02 p.m. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 106 at the time of the survey. The final survey sample consisted of 22 current Resident reviews and 4 closed record reviews The expanded survey sample consisted of 8 current Resident reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F 554		8/21/19

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

Electronically Signed | 08/15/2019

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F 554	Continued From page 1 §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to determine that medication self-administration for 2 out of 34 residents was appropriate (Resident #91 and Resident #95). The findings included: 1. The facility staff failed to assess Resident #91 for medication self-administration of eye drops (Systane Ultra). The clinical record of Resident #91 was reviewed 7/15/19 through 7/18/19. Resident #91 was admitted to the facility 6/13/19 with diagnoses, that included but not limited to sepsis, metastatic colon cancer, type 2 diabetes mellitus, morbid obesity, urogenital implants, chronic urinary retention, hypertension, chronic obstructive pulmonary disease, obstructive sleep apnea, systemic lupus erythematous, depression, and congestive heart failure. Resident #91's admission minimum data set (MDS) with an assessment reference date (ARD) of 6/20/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The surveyor interviewed Resident #91 on 7/15/19 at 6:31 p.m. During this interview, the surveyor observed a bottle of Systane Ultra eye	F 554	This plan of correction constitutes the written allegation of compliance for the deficiencies sited.¿ However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly.¿ This plan of correction is submitted to meet requirements established by State and Federal Law. F554 1. Self-Medication Assessments were completed for Residents #91 and #95, and medications were removed from bedside. 2. 100% audit of current residents with orders for meds at bedside to ensure completion of assessment and appropriateness of self-administration of medications. 3. Education of licensed nurses regarding self-administration of medication policy with appropriate orders and assessments. 4. Director of Nursing/designee shall audit new orders twice a week for twelve weeks to ensure no new orders for medications at bedside are written as well as new admission orders within 72 hours of admission for twelve weeks to monitor for medication at bedside orders. Audits shall be taken monthly to QAPI x3 months for review and revision as needed.	

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F 554	Continued From page 2	F 554	5. Date of Correction: August 21, 2019	

drops on the over the bed table. The bottle of eye drops did not have a label with directions for use. Resident #91 stated the eye drops were used for dry eyes.

The surveyor reviewed the clinical record for an order for Resident #91 to administer the Systane Ultra eye drops independently; reviewed the current comprehensive care plan for medication self-administration; and reviewed the clinical record for an assessment for medication self-administration.

The surveyor was unable to locate any of the above items in the clinical record.

The surveyor interviewed the director of nursing (DON) on 7/16/19 at 2:06 p.m. about the medication self-administration process. The DON stated an assessment of that resident would be done prior to the start of medication self-administration. The surveyor asked the DON to see if Resident #91 had a medication self-administration assessment for Systane Ultra eye drops.

The DON informed the surveyor on 7/16/19 at 2:30 p.m. that a medication self-administration assessment had not been completed on Resident #91. The DON stated someone from the resident's family probably brought the medicine in. The surveyor requested the facility policy on medication self-administration on 7/16/19.

The surveyor reviewed the facility policy titled "Self Administration of Medication Date Revised May 2016". The policy read in part "1. Verify physician's order in the resident's chart for self-administration of specific medications under

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consideration. 2. Complete Self-Administration of Medications Assessment form (AL 1008) with the resident. 5. In the event the Interdisciplinary team has determined the resident safe to administer medication (s), administration of medication (s) will be Care Planned for approved self-administered medication. 8. The MAR (medication administration record) must identify medications that are self-administered and the medication nurse will need to follow-up with the resident as to documentation and storage of medication during each medication pass. If medication (s) are kept at bedside, it must be kept in a locked box."

The surveyor informed the administrator, the director of nursing, the regional director of clinical services, the administrator-in-training, and the regional vice president of operations of the above concern on 7/17/19 at 11:35 a.m.

No further information was provided prior to the exit conference on 7/18/19.

2. The facility staff failed to assess Resident #95 for medication self-administration of nasal spray.

The clinical record of Resident #95 was reviewed 7/15/19 through 7/18/19. Resident #95 was admitted to the facility 11/10/15 and readmitted 6/17/19. Diagnoses included but were not limited to mycoplasma pneumonia, urinary tract infection, type 2 diabetes mellitus, chronic obstructive pulmonary disease, neuromuscular dysfunction of the bladder, hypokalemia, chronic kidney disease, obesity, hypertension, and anemia.

Resident #95's 5-day minimum data set (MDS) assessment with an assessment reference date

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(ARD) of 6/24/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

The surveyor interviewed Resident #95 on 7/16/19 at 11:40 a.m. and observed a bottle of Deep Sea moisturizing nasal spray on the over-the-bed table. The label read that resident may keep at bedside. Use in both nostrils. Resident #95 stated the oxygen tends to dry her nose and the spray helps with the dryness.

The surveyor reviewed the clinical record for an order for medication self-administration, an assessment for medication self-administration, and the care plan for medication self-administration.

The surveyor was unable to locate any of the above items in the clinical record.

The surveyor informed the director of nursing on 7/16/19 at 12:31 p.m. and requested if the DON could locate the order for the nasal spray and the medication self-administration assessment.

The DON informed the surveyor on 7/16/19 at 2:04 p.m. that a medication self-administration assessment had not been completed for the resident for the use of the nasal spray. The surveyor requested the facility policy on medication self-administration.

The surveyor reviewed the facility policy titled "Self Administration of Medication Date Revised May 2016". The policy read in part "1. Verify physician's order in the resident's chart for self-administration of specific medications under consideration. 2. Complete Self-Administration of Medications Assessment form (AL 1008) with the

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F 554	Continued From page 5 resident. 5. In the event the Interdisciplinary team has determined the resident safe to administer medication (s), administration of medication (s) will be Care Planned for approved self-administered medication. 8. The MAR (medication administration record) must identify medications that are self-administered and the medication nurse will need to follow-up with the resident as to documentation and storage of medication during each medication pass. If medication (s) are kept at bedside, it must be kept in a locked box." The surveyor informed the administrator, the director of nursing, the regional director of clinical services, the administrator-in-training, and the regional vice president of operations of the above concern on 7/17/19 at 11:35 a.m. No further information was provided prior to the exit conference on 7/18/19.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide a reasonable accommodation by maintaining the breath activated call cord/light within the resident's reach for 1 of 34 residents	F 558	F558 1. Resident #260 breath activated call cord was immediately placed in correct position. 2. Building sweep was conducted to ensure all call cord activators were in	8/21/19

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F 558	Continued From page 6 (Resident #260). The findings included: Resident #260's breath activated call cord was out of reach for twenty-five minutes. The clinical record of Resident #260 was reviewed 7/15/19 through 7/18/19. Resident #260 was admitted to the facility 6/24/19 and readmitted 7/2/19 with diagnoses that included but not limited to ventilator associated pneumonia, protein-calorie malnutrition, extradural and subdural abscess, quadriplegia, chronic respiratory failure, pressure ulcer sacral region, stage 2, osteomyelitis of vertebra, lumbosacral region, Hepatitis A, Hepatitis B, Hepatitis C, opioid abuse, hypertension, cocaine abuse, stimulant abuse, tracheostomy status, gastrostomy status, and dependence on ventilator. The admission MDS (minimum data set) assessment had not yet been completed but other clinical documentation indicated the resident was not cognitively impaired but did require total assistance with all aspects of care, was a quadriplegia, and was ventilator dependent. Resident #260's current care plan identified the focus area dated 6/25/19 that read the resident is ventilator dependent r/t (related to) respiratory failure. Interventions: Keep call bell within reach. The surveyor interviewed Resident #260 on 7/15/19 at 5:22 p.m. Resident #260 was in bed, ventilator in use. The surveyor observed the breath activated call cord was approximately 1	F 558	reach and any found not within reach were corrected. 3. Staff shall be educated on the importance of ensuring call light activating devices are within a resident reach. 4. Director of Nursing and/or designee shall round 10 rooms twice a week for twelve weeks to monitor for correct placement of call light indicators. Finding shall be reported to QAPI monthly x3 months for review and revisions as needed. 5.Date corrected: August 21, 2019	

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F 558	Continued From page 7 ½-2 inches from Resident #260's mouth. The surveyor sat in a chair at bedside and interviewed the resident. Resident #260 spoke in a very soft voice. The surveyor did not understand most of the words spoken by the resident. The surveyor had to have ear to Resident #260's mouth in order to hear the spoken words. During the interview, Resident #260 kept trying to blow into the breath activated call cord but was unable to activate it as indicated by his care plan. The call cord was approximately 1 ½ inches-2 inches from the resident's mouth. During the interview of approximately 25 minutes, the surveyor did not witness any staff attempt to check on Resident #260. Upon completion of the interview at 5:40 p.m., the surveyor informed Resident #260's nurse for the day-registered nurse #1 of the above concern. R.N. #1 followed the surveyor to Resident #260's room, adjusted the breath activated call cord and stated the call cord was within reach when checked earlier in the shift. The surveyor informed the administrator, the director of nursing, the regional director of clinical services, the vice president of regional operations, and the administrator-in-training of the above concern on 7/17/19 at 11:35 a.m. No further information was provided prior to the exit conference on 7/18/19.	F 558		
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		8/21/19

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F 641	Continued From page 8 resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to accurately assess 1 of 34 Residents in the survey sample, Resident # 409. The findings included: The facility staff documented assessments in the clinical record, and created a care plan that reflected that Resident # 409 had a urostomy when Resident # 409 did not have a urostomy. Resident #409 was an 87-year-old-female that was admitted to the facility on 7/11/19. Diagnoses included but were not limited to, urinary tract infection, hypertension, restlessness, and agitation. The clinical record for Resident # 409 was reviewed on 7/16/19 at 10:53 am. At the time of the survey, there were no completed MDS (minimum data set) assessments for Resident # 409. The baseline plan of care for Resident # 409 was initiated on 4/12/19. The facility staff documented a focus area for Resident # 409 as, "Resident requires urostomy." Interventions included but were not limited to, "Inspect stoma and peristomal skin area with each pouch change. Note: irritation, redness, rashes." Resident # 409 had current orders that included but were not limited to, "Suprapubic catheter care q (every) shift and prn (as needed)," which was initiated by the physician on 7/12/19. The	F 641	F641 1. Documentation for Resident #409 was corrected. Education provided to nurse who made error. 2. 100% Audit of resident's with Foley catheters to ensure correct documentation and terminology. 3. Education to all licensed nurses on accuracy of assessments and proper terminology. 4. Director of Nursing/designee shall audit all new admissions with Foley catheters within 72 hours of admission for twelve weeks to ensure accuracy of assessments and proper terminology. Director of Nursing/designee shall also audit five current residents with Foley catheters weekly to ensure accuracy of assessments and proper terminology. Audits will be taken to monthly QAPI x3 months for review and revisions as needed. 5. Date of Correction: August 21, 2019	

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surveyor reviewed the current physician's orders for Resident # 409 and did not observe any orders for urostomy care for Resident # 409.

On 7/16/19 at 3:38 pm, the surveyor observed Resident # 409 as CNA # 1 was providing ADL (activities of daily living) care. The surveyor observed that Resident # 409 had a suprapubic catheter size 20 Fr (French) with a 10 ml (milliliter) balloon. The suprapubic catheter and a leg drainage bag was secured to Resident # 409's left leg. The surveyor did not observe a urostomy site anywhere on Resident # 409's body.

On 7/17/19 at 8:04 am, the surveyor reviewed the facility "Admission/Readmission Evaluation" form for Resident # 409 that had been documented on 7/11/19 at 22:00 (10:00 pm). The admission/readmission evaluation form for Resident # 409 contained documentation that included but was not limited to,
..."13. Urinary Elimination
G. Urostomy (check mark observed in box beside urosotmy)." ...

A facility "72 Hour Post Admission Nursing Note" that was documented on 7/12/19 at 10:47 am, contained documentation that included but was not limited to:
..."5. Skin
4. Comments
(Typed in box below comments) Urostomy." ...

A facility "CHF (congestive heart failure) Pathway Daily Nursing Note" that was documented on 7/13/19 at 9:20 am, contained documentation that included but was not limited to,
..."2. Evaluation

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1. Reason for Resident being skilled?
PT, OT (physical therapy, occupational therapy) to treat ADLs, mobility and strengthening. Nursing to monitor vital signs, labs, nutrition, safety, s/p (status post) hospitalization for UTI (urinary tract infection) - Urostomy care." ...

A "CHF Pathway Daily Nursing Note" that was documented on 7/14/19 at 9:20 am, contained documentation that included but was not limited to,
..."Skilled Service Progression: Resident skilled for: PT, OT to treat ADLs, mobility and strengthening. Nursing to monitor vital signs, labs, nutrition, safety, s/p hospitalization for UTI - Urostomy care." ...

A "CHF Pathway Daily Nursing Note" that was documented on 7/15/19 at 9:20 am, contained documentation that included but was not limited to,
..."Overview: Resident skilled for: PT, OT to treat ADLs, mobility and strengthening. Nursing to monitor vital signs, labs, nutrition, safety, s/p hospitalization for UTI - Urostomy care. Therapies ordered PT OT" ...

A "CHF Pathway Daily Nursing Note" that was documented on 7/16/19 at 9:20 am, contained documentation that included but was not limited to,
..."Overview: Resident skilled for: PT, OT to treat ADLs, mobility and strengthening. Nursing to monitor vital signs, labs, nutrition, safety, s/p hospitalization for UTI - Urostomy care. Therapies ordered PT OT" ...

On 7/17/19 at 8:11 am, the surveyor interviewed LPN # 1 (licensed practical nurse). The surveyor

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F 641	Continued From page 11 asked LPN # 1 if Resident # 409 had a urostomy. LPN # 1 stated, "I don't think so but I will go check." On 7/17/19 at 8:15 am, LPN # 1 stated to the surveyor, "She does not have a urostomy." "She has a suprapubic catheter." On 7/17/19 at 8:21 am, the surveyor interviewed MDS coordinator # 1. The surveyor askes MDS coordinator # 1 to review Resident # 409 baseline care plan. The surveyor and MDS coordinator # 1 observed that Resident # 409 had a focus area for having a urostomy on her baseline care plan. The surveyor asked who generated the focus area for a urostomy for Resident # 409. MDS coordinator # 1 stated, "The nurse generated that on admission." On 7/17/19 at 6:42 pm, the regional vice president of operations, the regional director of clinical services, the administrator, the administrator in training, and the director of nursing was made aware of the findings as stated above. The regional director of clinical services agreed that the facility staff had documented that Resident # 409 had a urostomy when in fact Resident # 409 did not have a urostomy. No further information regarding this issue was presented to the survey team prior to the exit conference on 7/18/19.	F 641		
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	F 679		8/21/19

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F 679	Continued From page 12 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 observation, staff interview, and facility document review, the facility staff failed to provide activities to meet the needs of Residents on 1 of 3 units in the facility and for 3 of 34 Residents in the facility, Resident # 91, Resident # 260, and Resident # 108. The findings included: 1. The facility staff failed to provide group activities for Residents on the Carter Fold unit. On 7/15/19 at 4:32 pm, the surveyor was making observations on the Carter fold unit. The surveyor observed an activity calendar for July 2019 that was posted on the unit. The surveyor observed that the activity calendar had "Coffee Club" as an activity that was to be conducted at 4:30 pm. The surveyor did not observe any staff member conducting a group activity with the Residents on the unit. On 7/15/19 at 4:47 pm, the surveyor continued to conduct observations on the Carter Fold unit and did not observe any staff member conducting a group activity with the Residents on the unit. On 7/15/19 at 5:02 pm, the surveyor continued to conduct observations on the Carter Fold unit and	F 679	F679 1. Resident #91, and #260 activities preferences were reviewed and updated as needed. Resident #108 has been discharged from the facility. 2. Audit was conducted for current residents to ensure preferences were being offered. 3. Activities staff were in-serviced on importance to offer resident preferences and to offer activities on all units as scheduled. 4. Activities director/designee shall monitor activities 3X week for twelve weeks to ensure unit activities are occurring. Activities director and/or designee shall monitor at least three individual activity logs twice a week for twelve weeks Findings of audits shall be presented to QAPI monthly x3 months for review and revisions as needed. 5. Date corrected: August 21, 2019	

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did not observe any staff member conducting a group activity with the Residents on the unit.

On 7/16/19 at 9:35 am, the surveyor observed that the activity calendar posted on the Carter Fold unit had "Exercise" posted to be conducted at 9:30 am. The surveyor did not observe any staff member conducting group activities with the Residents on the unit at that time.

On 7/16/19 at 9:47 am, the surveyor continued to conduct observation on the Carter Fold unit and did not observe any staff member conducting group activities with the Residents on the unit.

On 7/16/19 at 10:08 am, the surveyor observed that "Noodle Ball" was posted to be conducted at 10:00 am on the activity calendar that was posted on the unit. The surveyor did not observe any staff member conducting group activities with the Residents on the unit.

On 7/16/19 at 10:35 am, the surveyor reviewed the activity calendar that was posted on the unit. The activity calendar had "Hand & Nails" as an activity that was to be conducted at 10:30 am. The surveyor did not observe any staff member conducting group activities with the Residents on the unit.

On 7/16/19 at 11:10 am, the surveyor reviewed the activity calendar that was posted on the unit. The calendar had "Rummy" as an activity that was to be conducted at 11:00 am. The surveyor did not observe any staff member conduct group activities with the Residents on the unit.

On 7/16/19 at 2:08 pm, the surveyor reviewed the activity calendar that was posted on the unit. The

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calendar has "About the Past" as an activity that was to be conducted at 2:00 pm. The surveyor did not observe any staff member conduct group activities with the Residents on the unit.

On 7/17/19 at 8:30 am, the surveyor met with the administrator in training and the director of nursing and reported the observations as stated above. The administrator in training informed the surveyor that the facility activity director was in Richmond testing during the week of the survey. The surveyor asked the administrator in training who assisted with activities when the activity director was not present in the facility. The administrator in training informed the surveyor that the CNAs (certified nursing assistants) and the activity assistant helped with activities when the activity director was absent. The surveyor informed the administrator in training that there were no observations of CNAs conducting group activities with the Residents on the unit, and the surveyor did not observe the activity assistant on the Carter Fold unit conducting group activities. The administrator in training stated, "She was busy with the rest of the building."

On 7/17/19 at 8:40 am, the surveyor interviewed the facility activity assistant. The surveyor made the activity assistant aware that she did not observe group activities being conducted with the Residents on Carter Fold on 7/15/19 and 7/16/19. The activity assistant informed the surveyor that she had been busy working on the other units and did not get to Carter Fold to conduct activities.

The facility "Activity Program/Calendar Policy" contained documentation that included but was not limited to,
..."Policy:

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The facility will provide activity programming to promote physical, cognitive, and/or emotional health, and that supports self-expression, exercise, socialization, lifestyle programs and leisure pursuits.
Procedure:
C) Activities will be offered every day for a minimum of six hours per day and including at least 2 evenings per week at hours offered at times convenient for the residents, and not to interfere during specific nursing care (i. e. medication administration) times." ...

On 7/17/19 at 6:42 pm, the regional vice president of operations, the regional director of clinical services, the administrator, the administrator in training, and the director of nursing was made aware of the findings as stated above.

No further information regarding this issue was presented to the survey team prior to the exit conference on 7/18/19.
2. The facility staff failed to provide an on-going program of activities designed to meet the needs, in accordance with the comprehensive assessment, the interests, and the physical, mental, and psychosocial well-being of Resident #260.

The clinical record of Resident #260 was reviewed 7/15/19 through 7/18/19. Resident #260 was admitted to the facility 6/24/19 and readmitted 7/2/19 with diagnoses that included but not limited to ventilator associated pneumonia, protein-calorie malnutrition, extradural and subdural abscess, quadriplegia, chronic respiratory failure, pressure ulcer sacral region, stage 2, osteomyelitis of vertebra,

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lumbosacral region, Hepatitis A, Hepatitis B, Hepatitis C, opioid abuse, hypertension, cocaine abuse, stimulant abuse, tracheostomy status, gastrostomy status, and dependence on ventilator.

The admission MDS (minimum data set) assessment had not yet been completed but other clinical documentation indicated the resident was not cognitively impaired, did require total assistance with all aspects of care, was a quadriplegia, and was ventilator dependent.

Resident #260's current care plan dated 7/8/19 read that the resident had made personal preferences known. She enjoys watching television, playing bingo, listening to music, socializing. Interventions: Have family involved with POC (plan of care), have snacks between meals, help keep personal belongings taken care of in the room and facility.

The surveyor interviewed Resident #260 on 7/15/19 at 5:22 p.m. Resident #260 was in bed, ventilator in use. The surveyor asked the resident about activities. Resident #260 stated in a very soft voice that she was ready to go to activities.

The surveyor reviewed Resident #260's Activities Evaluation Initial completed 7/8/19. Interests marked were bingo, small group, cards, one to one, movies, music, reading, current events, social/parties, family/friend visits, and television.

The surveyor interviewed the activity assistant on 7/17/19 at 9:37 a.m. The activity assistant stated Resident #260 attended social activities-sits in lounge area and talks with others. The activity

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assistant stated the resident had no active participation in an activity. The activity assistant stated the activity director (AD) was out of the facility this week and the activity director (AD) typically does 1-1 visits. The activity assistant was unable to locate documentation of any 1-1 visits.

The surveyor reviewed Resident #260's "Individual Resident Daily Participation Record" on 7/17/19. Group discussion was marked with an "A" from 7/2/19-7/16/19. "A"=active participation. Social/Parties was also marked with an "A" from 7/2/19 through 7/16/19.

During the survey from 7/15/19 through 7/18/19, the surveyor did not see Resident #260 participate in activities. The majority of the day Resident #260 sat in a small lounge across from the special care unit nurse's station. The surveyor did observe a male resident sitting with her during some of this time.

The surveyor requested a copy of the July 2019 calendar from the activity assistant on 7/17/19. Many of Resident #260's interests were scheduled on the calendar yet Resident #260 did not attend per the individual participation record:

Bingo scheduled on 7/4/19, 7/6/19, 7/8/19, 7/11/19, 7/13/19, and 7/15/19. Resident #260 did not attend any of these based on the individual record of participation.

Music time scheduled on 7/7/19, 7/8/19, 7/14/19 and 7/15/19- Resident #260 did not attend any of these based on the individual record of participation.

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Cards scheduled on 7/9/19 and 7/16/19. Resident #260 did not attend any of these based on the individual record of participation.

The surveyor informed the DON on 7/18/19 at 8:25 a.m. of the concern with activities. The DON stated she couldn't speak about activities but would try to get in touch with the AD for activities.

The surveyor informed the administrator, the director of nursing, the regional director of clinical services, the vice president of regional operations, and the administrator-in-training of the above concern on 7/17/19 at 11:35 a.m.

No further information was provided prior to the exit conference on 7/18/19.

3. The facility staff failed to provide an on-going program of activities designed to meet the needs, in accordance with the comprehensive assessment, the interests, and the physical, mental, and psychosocial well-being of Resident #91.

The clinical record of Resident #91 was reviewed 7/15/19 through 7/18/19. Resident #91 was admitted to the facility 6/13/19 with diagnoses, that included but not limited to sepsis, metastatic colon cancer, type 2 diabetes mellitus, morbid obesity, urogenital implants, chronic urinary retention, hypertension, chronic obstructive pulmonary disease, obstructive sleep apnea, systemic lupus erythematous, depression, and congestive heart failure.

Resident #91's admission minimum data set (MDS) with an assessment reference date (ARD) of 6/20/19 assessed the resident with a BIMS

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(brief interview for mental status) as 15/15.

Resident #91's current comprehensive care plan dated 6/25/19 and revised 7/8/19 read, "Alteration in supervised/organized recreation characterized by little or no involvement, lack of attendance related to isolation. The resident likes to watch tv and read. Interventions: Arrange 1-1 contracts, determine feasibility of offering activities of interest to resident that are not currently offered, offer activity program directed towards specific interests/needs of resident."

The surveyor interviewed Resident #91 on 7/15/19 at 6:25 p.m. The resident was asked about activities. Resident #91 stated, "The activity lady came in and talked to me but I've never seen the activity lady again." Resident #91 stated he/she had not attended any activities. Resident #91 stated that he/she watches tv (television) and reads the Bible while in the room.

The surveyor reviewed Resident #91's Activities Evaluation Initial completed 6/17/19. Activity pursuit patterns and preferences indicated the resident liked bingo, small groups, reading, television, and family/friend visits.

The surveyor interviewed the activity assistant on 7/17/19 at 9:40 a.m. and asked what activities Resident #91 attended. The activity assistant reviewed the "Individual Resident Daily Participation Record" and stated the only thing documented was tv (television) and current news/events. The surveyor stated both of those activities the resident can do without leaving the room. The activity assistant agreed. The activity assistant stated the activity director (AD) was out of the facility this week and the activity director

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(AD) typically does 1-1 visits. The activity assistant was unable to locate documentation of any 1-1 visits. The surveyor requested a copy of the July 2019 activity calendar.

The July 2019 Individual Resident Daily Participation Record was reviewed. Television was marked with an "A" from 7/1/19 through 7/16/19 for television and current events/news. "A"= active participation.

During the survey from 7/15/19 through 7/18/19, the surveyor observed Resident #91 in bed with the television on and with the Bible in it's case on the over-the-bed table.. Resident #91 was currently on reverse isolation.

The surveyor requested a copy of the July 2019 calendar from the activity assistant on 7/17/19. Many of Resident #91's interests were scheduled on the calendar yet Resident #91 did not attend per the individual participation record:

Bingo scheduled on 7/4/19, 7/6/19, 7/8/19, 7/11/19, 7/13/19, and 7/15/19. Resident #91 did not attend any of these based on the individual record of participation.

The surveyor informed the DON on 7/18/19 at 8:25 a.m. of the concern with activities. The DON stated he/she couldn't speak about activities but would try to get in touch with the AD for activities.

The surveyor informed the administrator, the director of nursing, the regional director of clinical services, the vice president of regional operations, and the administrator-in-training of the above concern on 7/17/19 at 11:35 a.m.

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No further information was provided prior to the exit conference on 7/18/19.
4. The facility staff failed to provide recreational activities for Resident #108.

Resident #108 was admitted to the facility on 6/24/19. Resident #108's diagnoses included, but were not limited to: heart failure, peripheral vascular disease, diabetes mellitus, arthritis, and non-Alzheimer's dementia. Resident #108's 7/1/19 minimum data set (MDS) assessment indicated the resident was able to express ideas and wants; the resident was oriented to year and month; and the "Activity Preferences" section documented it being 'very important' for the resident to listen to music, be around pets, and keep up with the news.

Observations of Resident #108 on 7/15/19, 7/16/19, and 7/17/19 failed to find the resident participating in recreational activities. Clinical documentation also failed to provide evidence Resident #108 had participated in recreational activities during her stay at the facility.

Resident #108's care plan included the following "Focus" information: "Alteration in supervised/organized recreation characterized by little or no involvement, lack of attendance related to: cognitive impairment, impaired mobility, impaired social interaction". The following interventions were listed related to this 'Focus' area:
-Arrange 1:1 contacts with resident
-assist with transport resident to activities [sic]
-Engage resident in group activities
-Familiarize resident with nursing home environment and activities programs on regular basis [sic]

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F 679	Continued From page 22 -Invite and encourage family to attend -Praise all efforts. The aforementioned care plan was provided to the surveyor by the facility's Administrator-In-Training (AIT) on 7/18/19 at 11:10 a.m.; the AIT reported no evidence was found to indicate this care plan had been implemented. The AIT reported to the surveyor that an activities staff member had unsuccessfully been attempting to contact Resident #108's family to identify activities the resident would enjoy. The failure of facility staff to have evidence of recreational activities being provided to Resident #108 was discussed during a survey team meeting with the facility's administrative staff on 7/18/19 at 11:55 a.m. The facility's Director of Nursing, Administrator, Administrator-In-Training, and Regional Director of Clinical Services were present at this meeting.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interviews and clinical record review, the facility staff failed to provided services	F 684	F684 1. Weights for Resident #19 discussed	8/21/19

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F 684	Continued From page 23 outline in the comprehensive care plan by following the physician's order in regards to notifying the physician when the resident's weight exceded 3 pounds for 1 of 34 residents, Resident #19. The findings included: The facility staff failed to notify the physician when Resident #19's weight gain exceeded 3 (three) pounds following dialysis. The order read to obtain weight upon return from dialysis and notify the physician of a weight gain greater than 3 (three) pounds (lbs). Resident #19's clinical record was reviewed on 07/16/19 through 07/18/19. The review reveal Resident #19 was initially admitted to the facility on 07/10/18 and was most recently re-admitted on 06/07/19. Diagnoses included but were not limited to, congestive heart failure, type 2 diabetes, and chronic kidney disease, stage 4 (severe). Section C (cognitive patterns) of the Residents' quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/22/19 and included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The Resident's electronic clinical record under the tab labeled "orders" contained an order with a start date of 06/08/19 at 7:00 p.m. that read to "obtain weight upon return from dialysis. Notify MD if 3+ lbs is noted, every night shift Tue, Thu, Sat." The Resident's care plan contained, but not	F 684	with Nurse practitioner and order was clarified. 2. 100% audit of all dialysis residents to clarify orders for weights. 3. Education of licensed nursing staff of dialysis policy and documentation of any notification of physicians and/or nurse Practitioner. 4. Director of Nursing/designee shall audit current dialysis residents and any new admissions on dialysis for appropriate order weekly for twelve weeks. Results of audits will be presented in monthly QAPI x3 months for review and revisions as needed. 5. Date of Correction: August 21, 2019	

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limited to, a focus area of CHF (congestive heart failure) which listed interventions to include monitoring weight. Another focus area read, "Resident is on hemodialysis. 3 days week. Tues., Thur., Saturday. (listed name and address of dialysis facility)" with one of the interventions to restrict fluids.

Resident #19's MAR (medication administration record) noted a weight gain greater than 3 (three) pounds on both Tuesday, 06/11/19 and Saturday, 06/15/19:
Weight: 243.2 lbs (pounds) on Saturday, 06/08/19 and 248.2 lbs on Tuesday, 06/11/19 reflecting a gain of 5 lbs.
Weight: 249.2 lbs on Thursday, 06/13/19 and 253.4 lbs on Saturday, 06/15/19 reflecting a gain of 4.2 lbs.

The facility's director of nursing (DON) and nurse practitioner (NP) were interviewed in the conference room on 07/17/19 at 4:10 p.m. The NP acknowledged the order read to notify the provider of a weight gain over 3 (three) pounds and stated she would expect to be notified of that weight gain especially if the weight gain was accompanied by other signs or symptoms of congestive heart failure (CHF) such as shortness of breath (SOB). The DON explained that since Resident #19 usually returned from dialysis later in the evening, sometimes as late as 7:00 p.m. or after, the staff weighed the Resident on night shift (night shift started at 7:00 p.m.) The NP stated her expectation would be the staff would write a note for the NP to see the next morning unless the Resident's condition (i.e. SOB) required sooner notification. The DON planned to look for any evidence the staff had notified the provider of the 2 (two) weights in June that were over 3 lbs.

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F 684	Continued From page 25 The DON was interviewed in the conference room on 07/18/19 at 9:25 a.m. She reiterated that if Resident #19 did not display any signs or symptoms of distress such as SOB, the facility staff would write the Resident's weight gain in the NP's "rounding book" for the NP to review the next day. The facility's process was that once the NP had reviewed the rounding book, the notes were shredded and therefore there was no evidence the staff had reported Resident #19's weight gains of over 3 lbs. The administrator, administrator in training, director of nursing, regional director of clinical services, and regional vice president of operations were notified of the above referenced concern on 07/17/19 at 11:35 a.m. The administrator, administrator in training, director of nursing, and regional director of clinical services were notified again on 07/18/19 at 11:56 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		8/21/19

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F 689	Continued From page 26 Based on observation, staff interview, and facility document review it was determined the facility staff failed to prevent an accident hazard by ensuring that a bag of medications had been properly secured on 1 of 3 units in the facility. The scope and severity was originally cited at Immediate Jeopardy, Level IV Isolated and was reduced to a Level II Isolated after the facility was cleared of Immediate Jeopardy. The administrator and regional vice president of operations were notified on 7/16/19 that the extended survey process had begun at 9:02 am, as the survey team had identified Immediate Jeopardy & Substandard Quality of Care in the area of Quality of Care. The findings included: The facility staff failed to ensure that a bag of medications had been properly secured on a dementia unit within the facility. The opened bag of medications was left on the floor in the nurse's station that was open and accessible to the wandering residents on the Carter's Fold secured dementia unit, which created an accident hazard with the potential for a serious adverse outcome. On 7/16/19 at 8:30 am, the surveyor entered the nurse's station on the Carter's Fold secured dementia unit. The surveyor observed that the nurse's station on the unit is open and accessible to anyone on the unit. The surveyor observed Resident # 86 wheel into the nurse's station with her wheelchair and then wheeled back out near the dining room table. The surveyor looked down onto the floor and observed a large plastic bag that was full of medications on the floor of the open and accessible nurse's station. The surveyor observed a total of five residents in the	F 689	F689 1. There were not any residents identified to be affected. On 7/16/2019, the unsecured medications were immediately removed from the Carters Fold nurse□s station. A door was installed at the nurses station with a slide lock to prevent wandering residents from entering the nurses station. The nurse□s station was immediately assessed for potential hazards for wandering residents. 2. Resident□s on the Carter□s Fold (secured unit) could be affected by this noncompliance practice of securing medications. All resident have the potential to be affected by this noncompliance practice. On 7/16/2019, the facility staff immediately conducted observation rounds in all resident rooms and nurse□s stations to ensure all medications are appropriately stored and secured so that residents remained free of accidents. No additional medications were found or identified to be unsecured in any areas. 3. To prevent this from recurring on 7/16/2019, the facility Director of Nursing and designee immediately began to provide education for staff regarding securing medications, and potential hazards for wandering residents. Current staff shall be educated prior to starting their next assignment when they return. These staff members shall not be permitted to work until education is received. This education will be included in all new hire training and on boarding. On 7/16/2019, the Regional Director of Clinical Services provided education to	

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F 689	Continued From page 27 area of the nurse's station at that time. The surveyor did not observe any staff supervision. The surveyor summoned another team member to report observations. On 7/16/19 at 8:38 am, three surveyors observed the large plastic bag full of medications on the floor of the open and accessible nurse's station on Carter's Fold secured dementia unit. The surveyor looked into the bag and observed that the following medications were in the bag: potassium, warfarin, vancomycin, Cymbalta, albuterol, levalbuterol, gas-x, hydrochlorothiazide, myrbetriq, singulair, zantac, protonix, midodrine, trimethoprim, anoro inhaler, insulin, and atropine eye drops. While the surveyors were observing the medications in the bag, one CNA entered the nurse's station to review the bath list that was posted on the wall at the nurse's station. The CNA looked at the list and exited the area without acknowledging the bag of medications. At that time, the surveyors observed five residents in the area of the open and accessible nurse's station without staff supervision. On 7/16/19 at 8:45 am, one surveyor remained on the unit with the medications to ensure that no resident handled the bag of medications, and the remaining surveyors conducted a team meeting to discuss the findings as stated above. While the team meeting was in progress a surveyor observed one resident in a wheelchair enter the open and accessible nurse's station where the bag of drugs were located. A surveyor also observed two staff members open the drawer directly above where the bag of medications was located to get the bathroom key and neither of the staff members acknowledged the bag of medications.	F 689	the Director of Nursing and Nursing Home Administrator on securing medication, medication storage, as well as potential accidents and hazards for secured unit. 4. Director of Nursing/designee will complete observation rounds daily to ensure medications remain secure for twelve weeks. Results of rounds will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meetings for review and revision as necessary. Person responsible: NHA, Anthony Brunicardi Action Complete Date July 16, 2019 5. Date of Correction: August 21, 2019	

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F 689	Continued From page 28 On 7/16/19 at 9:02 am, the administrator, administrator in training, director of nursing, and regional director of clinical services were made aware of the findings as stated above and that a Level IV Immediate Jeopardy deficiency had been cited. On 7/16/19 at 9:13 am, the administrator, administrator in training, director of nursing, and regional director of clinical services went onto the Carter's Fold secured dementia unit along with the surveyor and observed the bag of medications on the floor of the open and accessible nurse's station. The regional director of clinical services removed the bag of medications and searched the nurse's station to ensure that there were no other medications or hazards that had been left unsecured. On 7/16/19 at 1:30 pm, the facility staff presented the survey team with the facility "Immediate Jeopardy Removal Plan." The immediate jeopardy removal plan was documented as follows, "Identify those recipients who have suffered or likely to suffer as a result of the noncompliance: Residents on the Carter's Fold (secured unit) could be affected by this noncompliance practice of securing medications. There were not any residents identified to be affected. On 7/16/19, the unsecured medications were immediately removed from the Carter's Fold nurse's station. A door was installed at the nurse's station with a slide lock to prevent wandering residents from entering the nurse's station. The nurse's station was immediately assessed for potential hazards for wandering residents.	F 689		

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Residents likely to suffer a serious adverse outcome as a result of the noncompliance.

All residents have the potential to be affected by this noncompliance practice. On 7/16/19, the facility staff immediately conducted observation rounds in all resident rooms and nurse's stations to ensure all medications are appropriately stored and secured so that residents remained free of accidents. No additional medications were found or identified to be unsecured in any areas.

The action the entity will take to alter the process/system failure to prevent an adverse outcome from occurring or reoccurring:

To prevent this from reoccurring, the facility Director of Nursing and designee immediately began to provide education for all staff regarding securing medications, and potential hazards for wandering residents. All staff will be educated prior to starting their next assignment when they return. These staff members will not be permitted to work until education is received. This education will be included in all new hire training and on boarding.

On 7/16/19, the Regional Director of Clinical Services provided education to the Director of Nursing and Nursing Home Administrator on securing medication, medication storage, as well as potential accidents and hazards for secured unit.
DON (director of nursing) or designee will complete observation rounds daily to ensure medications remain secure for four weeks. Results of rounds will be brought to monthly Quality Assurance and Performance

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Improvement (QAPI) meetings for review and revision as necessary.

Person responsible: NHA (nursing home administrator) (Administrator's name withheld)
Action Complete Date
July 16, 2019"

On 7/16/19 at 6:34 pm, the surveyor interviewed LPN # 2 (licensed practical nurse). The surveyor asked LPN # 2 if she had worked the night shift on Carter's Fold on 7/15/19. LPN # 2 stated, "Yes." The surveyor asked LPN # 2 if she had seen the bag of medications that had been left unsecured in the nurse's station on Carter's Fold. LPN # 2 stated, "Me and another nurse bagged them up to send them back to the pharmacy." The surveyor asked LPN # 2 if she locked the bag of medications up before she left the facility. LPN # 2 stated, "No." The surveyor asked LPN # 2 if there was somewhere to lock the medications up until they are picked up from the pharmacy. LPN # 2 stated, "Yes there's an area to lock them up."

The facility policy on "Storage and Expiration of Medications, Biologicals, Syringes, and Needles" contained documentation that included but was not limited to,
..."Procedure
3.3 Facility staff should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.
17. Facility staff should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis." ...

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F 689	Continued From page 31 On 7/16/19 at 7:00 pm, the administrator in training presented the survey team with evidence that the corrective action as listed in the plan of correction had been completed. On 7/16/19 at 7:02 pm, the regional vice president of operations, the administrator, the administrator in training, the director of nursing, and the regional director of clinical services were made aware that the Level IV Isolated Immediate Jeopardy citation had been reduced to a Level II Isolated deficiency. On 7/17/19 at 6:00 pm, the director of nursing provided the surveyor with 2 statements that had been signed by the director of nursing. The first statement was documented as, "Statement for LPN # 3. LPN # 3 states that medications were bagged to be sent back to pharmacy. She states she intended to take medications and was called away, and failed to remove them." The second statement was documented as, "Statement obtained from LPN # 2. LPN # 2 states that medications had been secured in med room until she removed the bag with the intention of putting them in Clinch Hall med room to be picked up by pharmacy. LPN # 3 states she sat the medication down, and accidentally walked away, leaving the medication at the desk." No further information regarding this issue was presented to the survey team prior to the exit conference on 7/18/19.medications.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		8/21/19

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F 690	Continued From page 32 resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure that the resident received services and assistance to maintain continence by assuring that there was a physician	F 690	F690 1. Resident #79 had Physician's order added. 2. 100% Audit of resident's with Foley catheters to ensure accurate and	

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F 690	Continued From page 33 order for the size of the indwelling Foley catheter and balloon for 1 of 34 residents (Resident #79). The findings included: The clinical record of Resident #79 was reviewed 7/15/19 through 7/18/19. Resident #79 was admitted to the facility 5/2/19 and readmitted 6/5/19 with diagnoses that included but not limited to pneumonia, persistent vegetative state, adult failure to thrive, severe sepsis with septic shock, neuromuscular dysfunction of the bladder, dysphagia, hypothyroidism, acute respiratory failure, dependence on respirator, tracheostomy status, unspecified coma, and non-traumatic intracerebral hemorrhage. Resident #79's 30-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/3/19 assessed the resident to be in a persistent vegetative state in Section B0100. Section H Bladder and Bowel was coded for the presence of an indwelling catheter under appliance (H0100A) and urinary continence (H0300) was coded as a "9"-not rated, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days. Resident #79's current comprehensive care plan had the focus area that read "Indwelling catheter characterized by inability to control urination. At risk for infection/complications. Attempted d/c (discontinue) of catheter 5/6/19. Unable to void. Dx (diagnosis) neurogenic bladder. Date initiated 5/3/19. Revision on 5/15/19. Interventions: Indwelling cath per orders." The surveyor observed the resident on 7/15/19 at 3:01 PM. A Foley drainage bag was observed	F 690	current physician's order. 3. Education to licensed nurses that all residents with Foley catheters must have an accurate and to include current physician's order with the size included. 4.Director of Nursing/designee shall audit new admissions with Foley catheters weekly for twelve weeks to ensure they have accurate physician's order. Director of Nursing/designee shall audit five current residents with Foley catheters weekly for twelve weeks to ensure accuracy of physician's orders. Results of audits will be presented in monthly QAPI x3 months for review and revision as needed. 5. Date corrected: August 21, 2019	

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F 690	Continued From page 34	F 690		

from the doorway. A sign on the door indicated the resident was on contact precautions. Certified nursing assistant #1 was providing care during the observation. The surveyor asked C.N.A. #1 for the size of the indwelling Foley catheter. C.N.A. #1 stated the Foley size was 16 FR (French) with a 10 cc (cubic centimeter) balloon.

The surveyor reviewed the July 2019 physician's orders for the size of the indwelling Foley catheter and balloon on 7/18/19. The surveyor was unable to locate an order for the size of the catheter and balloon.

The surveyor informed the director of nursing on 7/18/19 at 8:51 a.m. and requested the facility policy on the care of indwelling Foley catheters.

The DON provided the facility policy on the care of Foleys on 7/18/19 at 10:34 a.m. and stated the July 2019 physician's orders were reviewed and he/she was unable to locate an order for the size of the catheter and balloon. The DON stated the size of the Foley catheter and the balloon size should be included in the order.

The surveyor reviewed the facility policy on 7/18/19 titled "Indwelling Catheter Use". The policy read "Indwelling catheters are used when ordered by a physician to treat a specific medical condition."

The surveyor informed the administrator, the director of nursing, the regional director of clinical services and the administrator-in-training of the above issue on 7/18/19 at 11:56 a.m.

No further information was provided prior to the e

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F 690	Continued From page 35 exit conference on 7/18/19.	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide pain management services through non-pharmacological interventions for pain management prior to the use of pain medication for 3 of 34 residents (Resident #67, Resident #81, and Resident #260). The findings included: nter 1. The facility staff failed to provide non-pharmacological pain interventions prior to the use of pain medication for Resident #67. The clinical record of Resident #67 was reviewed 7/15/19 through 7/18/19. Resident #67 was admitted to the facility 5/10/19 and readmitted 5/22/19, 6/17/19 and 7/3/19 with diagnoses that included but not limited to dependence on respirator, type 2 diabetes mellitus, chronic atrial fibrillation, hypertension, cardiac pacemaker, anemia, cirrhosis of the liver, gastrostomy tube, acute viral hepatitis, sedative, hypnotic, or anxiolytic dependence, opioid dependence, pyothorax without fistula, nicotine dependence, anxiety, and depressive episodes.	F 697	F697 1. Resident #260, #67 and #81 were unable to correct deficient actions as was related to past documentation. 2. 100% Audit of residents receiving PRN pain med have been reviewed to ensure non-pharmalogical interventions are in place. 3. Education to licensed nurses on implementing non-pharmacological interventions prior to administering medications. 4. Director of Nursing/ designee shall do weekly audit of five residents with orders for PRN pain medication for twelve weeks to ensure proper non-pharmacological interventions were implemented prior to administering medications. Findings of audits shall be presented in QAPI monthly x3 months for review and revisions as needed. 5. Date of Correction: August 21,2019	8/21/19

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Resident #67's admission minimum data set (MDS) with an assessment reference date (ARD) of 5/29/19 assessed the resident with a BIMS (brief interview for mental status) as 6/15. Section J Health Conditions indicated the resident, at the time of the interview, did not have pain.

Resident #67's current comprehensive care plan identified the focus area for pain initiated 5/10/19 and revised on 5/23/19. Interventions: assist with positioning for comfort, non-pharmacological interventions for pain, and therapy screens as needed.

Resident #67's July 2019 physician's orders read in part "Oxycodone hcl (hydrogen chloride) Tablet 5 mg (milligrams) Give 1 tablet by mouth q (every) 6 hours as needed for pain."

The surveyor reviewed the July 2019 electronic medication administration records (eMARs) on 7/18/19. Resident #67 was administered Oxycodone 5 mg twenty-three (23) times from 7/3/19 through 7/18/19 for pain ratings from 2 (lowest) to 9 (highest).

The surveyor reviewed the progress notes for 7/3/19. The 7/3/19 progress noted timed 18:36 (6:36 p.m.) read, "Oxycodone HCL Tablet 5 mg Give 1 tablet by mouth every 6 hours as needed for pain pulled from stat box." No non-pharmacological interventions documented.

The progress note dated 7/6/19 at 21:49 (9:49 p.m.) read in part "Oxycodone HCL Tablet 5 mg Give 1 tablet by mouth every 6 hours as needed for pain was requested by resident, resident could

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not express type of pain, location of pain and level of pain." No non-pharmacological interventions documented.

The 7/9/19 23:05 (11:05 p.m.) progress note read, "Oxycodone HCL Tablet 5 mg Give 1 tablet by mouth every 6 hours as needed for pain". No non-pharmacological interventions documented.

The 7/11/19 05:32 a.m. progress note read, "Oxycodone HCL Tablet 5 mg Give 1 tablet by mouth every 6 hours as needed for pain." There were not any non-pharmacological interventions documented.

The 7/13/19 07:42 a.m. progress note read, "Oxycodone HCL Tablet 5 mg Give 1 tablet by mouth every 6 hours as needed for pain." There were no non-pharmacological interventions documented.

The 7/14/19 12:23 p.m. progress note read, "Oxycodone HCL Tablet 5 mg Give 1 tablet by mouth every 6 hours as needed for pain." There were no non-pharmacological interventions documented.

The 7/15/19 14:57 (2:57 p.m.) progress note read, "Oxycodone HCL Tablet 5 mg Give 1 tablet by mouth every 6 hours as needed for pain." There were no non-pharmacological interventions documented.

The 7/15/19 22:54 (10:54 p.m.) progress note read, "Oxycodone HCL Tablet 5 mg Give 1 tablet by mouth every 6 hours as needed for pain." There were no non-pharmacological interventions documented.

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The 7/16/19 04:57 a.m. progress note read, "Oxycodone HCL Tablet 5 mg Give 1 tablet by mouth every 6 hours as needed for pain." There were no non-pharmacological interventions documented.

The 7/16/19 21:32 (9:32 p.m.) progress note read, "Oxycodone HCL Tablet 5 mg Give 1 tablet by mouth every 6 hours as needed for pain." There were no non-pharmacological interventions documented.

The 7/17/19 06:20 a.m. progress note read, "Oxycodone HCL Tablet 5 mg Give 1 tablet by mouth every 6 hours as needed for pain." There were no non-pharmacological interventions documented.

The 7/17/19 20:31 (8:31 p.m.) progress note read, "Oxycodone HCL Tablet 5 mg Give 1 tablet by mouth every 6 hours as needed for pain." There were no non-pharmacological interventions documented.

The surveyor informed the regional director of clinical services of the above concern with the lack of non-pharmacological interventions prior to the administration of Oxycodone twelve times during July 2019 on 7/18/19 at 10:24 a.m. Resident #67 received Oxycodone 23 times from 7/3/19 through 7/18/19. The regional director of clinical services stated he/she was unaware of the interventions on the care plan. The surveyor requested the current care plan from the regional director of clinical services and the facility policy on pain management.

The care plan for pain read as follows: Resident #67's current comprehensive care plan identified

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the focus area for pain initiated 5/10/19 and revised on 5/23/19. Interventions: assist with positioning for comfort, non-pharmacological interventions for pain, and therapy screens as needed.

There were not any non-pharmacological interventions offered or documented in the above progress notes prior to the administration of Resident #67's Oxycodone 5 mg tablet.

The surveyor informed the administrator, director of nursing, the regional director of clinical services and the administrator-in-training of the above issue on 7/18/19 at 11:56 a.m.

The surveyor reviewed the facility policy titled "Pain Management and Pain Protocol" on 7/18/19. The policy read in part "Procedure 3. Non-pharmacological intervention will be attempted prior to the administration of PRN (whenever needed) pain medications."

No further information was provided prior to the exit conference on 7/18/19.

2. The facility staff failed to provide non-pharmacological pain interventions prior to the use of pain medication for Resident #81.

The clinical record of Resident #81 was reviewed 7/15/19 through 7/18/19. Resident #81 was admitted to the facility 6/13/17 and readmitted 4/21/18 with diagnoses that included but not limited to cardiac arrest, ventilator dependence, hypertension, tracheostomy, atrioventricular block, complete, atherosclerotic heart disease, gastroesophageal reflux disease (GERD) with esophagitis, chronic obstructive pulmonary

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disease (COPD), depressive disorder, anxiety, scoliosis, visual loss, acute and chronic respiratory failure with hypercapnia, and muscular dystrophy.

Resident #81's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/7/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Section J Health Conditions assessed the resident to have received scheduled pain medication, received prn (as needed) pain medication, and received no non-medication interventions for pain.

Resident #81's current comprehensive care plan identified the focus area that read alteration in comfort related to pain from Muscular Dystrophy. Date initiated 6/14/17 and revised on 6/18/19. Interventions: Administer pain medications as ordered, monitor for pain, assess for pain every shift, eliminate or reduce causative factors, refer to pain flow sheet as needed, staff to attempt non-pharmacological interventions. Repositioning.

Resident #81's July 2019 physician's orders read in part "Hydrocodone-Acetaminophen Tablet 7.5-325 mg (milligrams) Give 1 tablet by mouth every 6 hours as needed for pain."

The surveyor reviewed the July 2019 electronic medication administration records. Resident #81 received pain medications thirty-one times from 7/1/19 through 7/16/19. Of the dates and times administered, fourteen (14) did not have non-medication interventions documented in the progress notes or on the electronic medication administration records (eMARs):

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F 697	Continued From page 41 7/3/19 at 1320 (1:20 p.m.) 7/3/19 at 2148 (9:48 p.m.) 7/4/19 at 0600 7/6/19 at 1219 7/6/19 at 1831 (6:31 p.m.) 7/7/19 at 0840 7/8/19 at 2003 (8:03 p.m.) 7/9/19 at 0653 7/11/19 at 0639 7/12/19 at 2050 (8:50 p.m.) 7/13/19 at 0734 7/13/19 at 1900 (7:00 p.m.) 7/14/19 at 1132 7/15/19 at 1651 (4:51 p.m.) The surveyor discussed the above lack of non-medication interventions with the director of nursing on 7/18/19 at 8:21 a.m. The DON stated the staff need to offer non-pharm interventions prior to use and document those interventions. The surveyor informed the DON that the record documents mainly nurses that work in the evenings and at nights. The DON stated some of those nurses were new. The surveyor requested the facility policy on pain management. The surveyor informed the administrator, director of nursing, the regional director of clinical services and the administrator-in-training of the above issue on 7/18/19 at 11:56 a.m. The surveyor reviewed the facility policy titled "Pain Management and Pain Protocol" on 7/18/19. The policy read in part "Procedure 3. Non-pharmacological intervention will be attempted prior to the administration of PRN (whenever needed) pain medications." No further information was provided prior to the	F 697		

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exit conference on 7/18/19.

3. The facility staff failed to provide non-medication interventions prior to pain medication administration for Resident #260.

The clinical record of Resident #260 was reviewed 7/15/19 through 7/18/19. Resident #260 was admitted to the facility 6/24/19 and readmitted 7/2/19 with diagnoses that included but not limited to ventilator associated pneumonia, protein-calorie malnutrition, extradural and subdural abscess, quadriplegia, chronic respiratory failure, pressure ulcer sacral region, stage 2, osteomyelitis of vertebra, lumbosacral region, Hepatitis A, Hepatitis B, Hepatitis C, opioid abuse, hypertension, cocaine abuse, stimulant abuse, tracheostomy status, gastrostomy status, and dependence on ventilator.
The admission MDS (minimum data set) assessment had not yet been completed but other clinical documentation indicated the resident was not cognitively impaired, did require total assistance with all aspects of care, was a quadriplegia, and was ventilator dependent.

Resident #260's current comprehensive care plan identified the focus area for pain r/t (related to) osteomyelitis initiated 6/25/19 and revised 6/25/19. Interventions included: assist with positioning for comfort, meds (medications) as ordered, and provide distractions prn (as needed) such as television, or activities. Interaction with others, reading material as able.

Resident #260's July 2019 physician's orders read in part "Hydrocodone-Acetaminophen (Hycet Solution) 7.5-325 mg (milligram)/15ml (milliliter)

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Give 15 ml by mouth every 4 hours as needed for pain-start date 7/2/19 and discontinued 7/16/19." Resident #260's July 2019 physician's orders read in part "Oxycodone Hcl Tablet 5 mg (milligrams) Give 1 tablet by mouth every 4 hours as needed for pain."

Resident #260 received Hycet 7.5-325mg thirty-two (32) times from 7/2/19 through 7/16/19. Fifteen (15) of those administered were administered prior to the use of a non-medication intervention. Those days and times were:
7/3/19 at 1409 (2:09 p.m.)
7/3/19 at 2045 (8:45 p.m.)
7/4/19 at 0458
7/6/19 at 1005
7/6/19 at 1545 (3:45 p.m.)
7/7/19 at 1313 (1:13 p.m.)
7/7/19 at 1758 (5:58 p.m.)
7/8/19 at 2301 (11:01 p.m.)
7/9/19 at 0714
7/10/19 at 0018
7/10/19 at 1100
7/13/19 at 0052
7/13/19 at1236
7/14/19 at 1117
7/15/19 at 1629 (4:29 p.m.)

Resident #260 received Oxycodone 5 mg twenty-one (21) times from 7/10/19 through 7/17/19. Of those administered, eight (8) were administered prior to the use on a non-medication intervention. Those days and times were:
7/10/19 at 1459 (2:59 p.m.)
7/11/19 at 0548
7/12/19 at 1152
7/13/19 at 0829
7/14/19 at 1022
7/15/19 at 1303 (1:03 p.m.)

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F 697	Continued From page 44 7/15/19 at 2013 (8:13 p.m.) 7/16/19 at 0109 The surveyor informed the director of nursing of the above concern on 7/18/19 at 8:30 a.m. that the staff had not offered/documented non-medication interventions prior to administration on the above days/times. The DON stated some of the residents don't want to try interventions. They know they can have the medications and they want them when they want them. The surveyor requested the facility policy on pain management on 7/18/19. The surveyor reviewed the facility policy titled "Pain Management and Pain Protocol" on 7/18/19. The policy read in part "Procedure 3. Non-pharmacological intervention will be attempted prior to the administration of PRN (whenever needed) pain medications." No further information was provided prior to the exit conference on 7/18/19.	F 697		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		8/21/19

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F 755	Continued From page 45 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and facility document review failed to determines that drug records are in order and that an account of all controlled drugs were maintained and periodically reconciled by completing the shift verification of controlled substances record on the special care unit for 15 opportunities. The findings included: During the survey from 7/15/19 through 7/18/19, the surveyor observed three medication carts on each of the three units. On 7/16/19 at 2:24 PM, the Special Care Unit medication cart was checked with licensed practical nurse #1. The surveyor and L.P.N. #1 checked the shift	F 755	F755 1. No specific residents identified. 2. 100% audit of narcotic books to ensure all signatures present. 3. Education to licensed nursing staff on signing the narcotic book at each narcotic count. 4. Director of Nursing/designee shall Audit narcotic books twice weekly for twelve weeks to ensure proper signatures. Results of audits shall be presented in QAPI monthly x3 months for review and revisions as needed. 5. Date of Correction: August 21, 2019	

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F 755	Continued From page 46 verification of controlled substances for June 2019 and July 2019. The surveyor identified the following areas where there was not a signature from the on-coming nurse or a signature from the off-going nurse: On 6/28/19 Day shift, there was not a signature by the off-going nurse. On 6/30/19 Day shift, there was not a signature by the off-going nurse. On 7/3/19 Day shift, there was not a signature by the on-coming nurse. On 7/3/19 Night shift, there is not a signature by the off-going nurse. On 7/6/19 Night shift, there was not a signature by the off-going nurse. On 7/7/19 Night shift, there was not a signature by the on-coming nurse. On 7/8/19 Day shift, there was not a signature by the on-coming nurse. On 7/13/19 Day shift, there was not a signature by the off-going nurse. On 7/13/19 Night shift, there was not a signature by the on-coming nurse. On 7/14/19 Night shift, there was not a signature by the off-going nurse. On 7/14/19 Day shift, there was not a signature by the on-coming nurse. On 7/15/19 Day shift-No signatures of on-going or off-going nurse. On 7/15/19 Night Shift, there was not a signature by the off-going nurse. On 7/16/19 Day shift, there was not a signature by the on-coming nurse. On 7/16/19 Night shift, there was not a signature by either the on-coming nurse or the off-going nurse.	F 755		

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The legend at the top of the form read:
"1. Two licensed nurses shall reconcile all doses of controlled substances stored in the assigned medication cart at the change of each shift.
2. The oncoming nurse shall inspect each package of controlled medication and read the remaining quantity in each package.
3. The off-going nurse shall read the remaining quantity documented on each resident Controlled Substance Declining Inventory record and record their findings.
4. Each nurse performing the reconciliation shall place his/her signature on the appropriate line for the date and shift.
5. If the quantities do not match, notify the Nursing Supervisor immediately to initiate an investigation."

The surveyor interviewed licensed practical nurse #1 on 7/16/19 at 2:24 p.m. if the completion of the shift verification of controlled substances should be done each shift. L.P.N. #1 stated yes and then stated, "I haven't signed off from this morning."

The surveyor informed the director of nursing (DON) of the above concern on 7/18/19 at 8:55 a.m. The DON stated the controlled sheets should be completed each shift. The surveyor requested the facility policy on storage of medication.

The facility policy titled "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles Revision Date 10/31/16" read in part "17. Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis."

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F 755	Continued From page 48 The surveyor informed the administrator, the director of nursing, the regional director of clinical services and the administrator-in-training of the above issue on 7/18/19 at 11:56 a.m. No further information was provided prior to the exit conference on 7/18/19.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		8/21/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 49 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure 1 of 34 residents was free of an unnecessary psychotropic medication (Resident #260). The findings included: The facility staff failed to identify and monitor resident specific target behaviors and identify non-pharmacological interventions associated with the use of Klonopin and Ativan for Resident #260. The clinical record of Resident #260 was reviewed 7/15/19 through 7/18/19. Resident #260 was admitted to the facility 6/24/19 and readmitted 7/2/19 with diagnoses that included but not limited to ventilator associated	F 758	F758 1. Behavior sheets were implemented for Resident #260 2. 100% Audit on Residents with orders for PRN psychotropic medications to ensure proper documentation of non-pharmacological interventions are in place. 3. Education to licensed nurses on behavior sheets and attempting non-pharmacological interventions prior to administering PRN psychotropic medications. 4. Director of Nursing/designee shall perform audit of current residents with orders for PRN psychotropic medications weekly for twelve weeks to ensure behavior sheets have been implemented. Results of audits shall be presented in	

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F 758	Continued From page 50 pneumonia, protein-calorie malnutrition, extradural and subdural abscess, quadriplegia, chronic respiratory failure, pressure ulcer sacral region, stage 2, osteomyelitis of vertebra, lumbosacral region, Hepatitis A, Hepatitis B, Hepatitis C, opioid abuse, hypertension, cocaine abuse, stimulant abuse, tracheostomy status, gastrostomy status, and dependence on ventilator. The admission MDS (minimum data set) assessment had not yet been completed but other clinical documentation indicated the resident was not cognitively impaired, did require total assistance with all aspects of care, was a quadriplegia, and was ventilator dependent. The current comprehensive care plan for Resident #260 had the focus area that read the resident uses anti-anxiety medications r/t (related to) anxiety disorder. Date initiated 7/9/19 and revision on 7/9/19. Interventions included to assess/record occurrence of targeted behaviors, educate the resident/family/and/or caregivers about risks, benefits and the side effects and or toxic symptoms of, and give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness. The July 2019 physician's orders were reviewed 7/15/19 through 7/18/19. Physician's orders included Ativan 0.5 mg (milligrams) every 6 hours as needed for 3 days-start date 7/3/19 and Klonopin 0.5 mg Give 0.25 mg by mouth every 12 hours as needed for anxiety for 14 days-start date 7/8/19. The surveyor was unable to locate specific behaviors for the use of Ativan and Klonopin.	F 758	QAPI monthly x3 months for review and revisions as needed. 5. Date of Correction: August 21, 2019	

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The surveyor was unable to locate non-pharmacological interventions prior to the use of Ativan and Klonopin.

The July electronic medication administration record (eMAR) documented that Resident #260 was administered Ativan 0.5 mg on 7/3/19 at 1643 (4:43 p.m.), 7/4/19 at 1359 (1:59 p.m.), 7/5/19 at 1027 and 7/6/19 at 1005. The surveyor reviewed the facility progress notes for 7/3/19 through 7/6/19. None of the progress notes documented that Resident #260 was offered non-medication interventions prior to use.

Resident #260 was administered Klonopin 0.25 mg twelve times from 7/9/19 through 7/17/19. Resident #260 was not offered non-medication interventions prior to medication administration nine times (9).

7/9/19 at 0707 Non-medication interventions were not documented in progress note prior to medication administration.
7/9/19 at 1925 (7:25 p.m.) No non-medication intervention documented in progress note prior to medication administration.
7/10/19 at 1743 (5:43 p.m.) No non-medication intervention documented in progress note prior to medication administration.
7/11/19 at 0548 No non-medication intervention documented in progress note prior to medication administration.
7/11/19 at 2308 (11:08 p.m.) No non-medication intervention documented in progress note prior to medication administration.
7/12/19 at 1107 No non-medication intervention documented in progress note prior to medication administration.
7/13/19 at 0829 No non-medication intervention

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documented in progress note prior to medication administration.
7/14/19 at 0751 No non-medication intervention documented in progress note prior to medication administration.
7/15/19 at 1514 (3:14 p.m.) No non-medication intervention documented in progress notes prior to medication administration.

The surveyor informed the regional director of clinical services of the above concern on 7/16/19 at 6:33 p.m. and requested the behavior monitoring sheets for Ativan and Klonopin for Resident #260.

The surveyor informed the director of nursing of the above concern on 7/18/19 at 8:26 a.m. The surveyor informed the director of nursing the care plan did not identify targeted behaviors or any non-medication interventions. The surveyor was unable to locate behavior monitoring sheets for Ativan and Klonopin. The DON stated the behavior monitoring had been corrected when brought to her/his attention. The surveyor requested the facility policy on psychotropic medication monitoring.

The surveyor reviewed the facility policy titled "Psychotropic Medication Documentation and Review Revised 2015" on 7/18/19. The policy read in part "Procedure: A. Residents receiving psychotropic medication will have a Behavior/Intervention Monthly Flow Record (BFR) (Form 4.11) initiated on admission or whenever psychotropic meds are ordered. a. Each psychotropic medication will be entered on BFR. b. Resident specific behaviors related to medication use will be entered on BFR. c. Diagnosis for the reason psychotropic medication

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F 758	Continued From page 53 is being given will be documented in medical record. B. Nurses will document on the following every shift: b. specific non-medication interventions used-entered code as indicated on BFR." The surveyor informed the administrator, the director of nursing, the regional director of clinical services and the administrator-in-training of the above concern on 7/18/19 at 11:56 a.m. No further information was provided prior to the exit conference on 7/18/19.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical document review, and during a medication pass and pour observation, it was determined the facility staff failed to ensure a medication error rate of less than 5%. There were three (3) errors in thirty-one (31) opportunities resulting in a medication error rate of 9.68%. The findings include: Medication errors were observed while completing the Medication Administration Task. There were three (3) errors in thirty-one (31) opportunities resulting in a medication error rate of 9.68%.	F 759	F759 1. Resident #20's medications that were unavailable were ordered and received from Pharmacy. Orders were received to hold one dose of one medication and to administer medication when available. Medication was administered upon arrival from pharmacy. 2. MAR to Cart audit was performed on medication carts to ensure availability of meds. 3. Licensed nursing staff educated on ordering medications in a timely manner, and the steps to take if a medication is determined to be unavailable. A	8/21/19

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F 759	Continued From page 54 On 7/12/19 at 8:48 a.m., LPN (licensed practical nurse) #11 was observed administering medications to Resident #20. LPN #11 reported that two (2) of Resident #20's medications, which were ordered for 9:00 a.m., were not found in the medication cart. These medications were Allopurinol and Lantus Insulin. LPN #11 looked in the unit's medication storage area and reported the two (2) medications were not available to be administered to Resident #20. After the medications were discovered to not be available, LPN #11 contacted the provider and obtained orders to hold the two (2) unavailable medications. On 7/12/19 at 8:48 a.m. LPN #11 was observed to administer Sodium Polystyrene Sulfonate Suspension to Resident #20. The bottle was noted to have the instructions for how to mix the medication covered by an adhesive label therefore unable to be read. LPN #11 consulted with LPN #12 about how much of the medication (which was a powder) should be mixed with water to obtain the ordered dose. It was decided that three (3) teaspoons of the medication should be mixed with water to get the ordered dose. The three (3) teaspoons were administered to Resident #20. Resident #20's clinical documentation included the following medication order: "Sodium Polystyrene Sulfonate Suspension 15GM/60ML. Give 60 ml by mouth one time a day for hyperkalemia." (Hyperkalemia is when the potassium level in one's blood is elevated.) The facility's pharmacy staff provided administration information about Sodium Polystyrene Sulfonate. This information included the following: "The average total daily adult dose of sodium polystyrene sulfonate is 15 g. to 60 g.	F 759	medication pass audit was performed on licensed nursing staff to ensure no medication errors were made during pass. 4. Director of nursing/designee shall audit 10% of residents weekly for twelve weeks to ensure all medications are available. Results of audits will be presented in monthly QAPI meeting x3 months for review and revision as needed. 5. Date of Correction: August 21. 2019	

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F 759	Continued From page 55 administered as a 15-g dose (four level teaspoons), one to four times daily." LPN #11 was observed to administer three (3) teaspoons not four (4) teaspoons of Sodium Polystyrene Sulfonate to Resident #20. The following information was found in a policy titled "6.0 General Dose Preparation and Medication Administration" (with an effective date of 12/1/07 and the most recent revision date of 01/01/13): "Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct time, for the correct resident ..." This policy was provided to the survey team by the Regional Director of Clinical Services (RDCS) on 7/18/19 at 12:50 p.m.; the RDCS reported this policy was obtained from the facility's pharmacy. On 7/17/19 at 10:45 a.m., the aforementioned three (3) medication errors were discussed during a survey team meeting with the facility's Director of Nursing, Administrator, Administrator-In-Training, Regional Director of Clinical Services, and Regional Vice-President of Operations.	F 759		
F 761 SS=J	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		8/21/19

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F 761	Continued From page 56 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and facility document review, the facility staff failed to appropriately store medications on 1 of 3 units and failed to label a medication for 1 of 34 residents, Resident # 20. The findings included: 1. The facility staff failed to ensure that a bag of medications had been properly stored on a dementia unit within the facility. The opened bag of medications was left on the floor in the nurse's station that was open and accessible to the wandering residents on the Carter's Fold secured dementia unit, which created the potential for a serious adverse outcome. The scope and severity was originally cited at Immediate Jeopardy, Level IV Isolated and was reduced to a Level II Isolated after the facility was cleared of Immediate Jeopardy. The administrator and regional vice president of operations were notified on 7/16/19	F 761	F761 1. Resident's on the Carter's Fold (secured unit) could be affected by this noncompliance practice of securing medications. There were not any residents identified to be affected. On 7/16/2019, the unsecured medications were immediately removed from the Carters Fold nurse's station. A door was installed at the nurses station with a slide lock to prevent wandering residents from entering the nurses station. The nurse's station was immediately assessed for potential hazards for wandering residents. 2. All resident have the potential to be affected by this noncompliance practice. On 7/16/2019, the facility staff immediately conducted observation rounds in all resident rooms and nurse's stations to ensure all medications are appropriately stored and secured so that	

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that the extended survey process had begun at 9:02 am, as the survey team had identified Immediate Jeopardy & Substandard Quality of Care in the area of Quality of Care.

On 7/16/19 at 8:30 am, the surveyor entered the nurse's station on the Carter's Fold secured dementia unit. The surveyor observed that the nurse's station on the unit is open and accessible to anyone on the unit. The surveyor observed Resident # 86 wheel into the nurse's station with her wheelchair and then wheeled back out near the dining room table. The surveyor looked down onto the floor and observed a large plastic bag that was full of medications on the floor of the open and accessible nurse's station. The surveyor observed a total of five residents in the area of the nurse's station at that time. The surveyor did not observe any staff supervision. The surveyor summoned another team member to report observations.

On 7/16/19 at 8:38 am, three surveyors observed the large plastic bag full of medications on the floor of the open and accessible nurse's station on Carter's Fold secured dementia unit. A total of five residents were observed in the area of the open and accessible nurse's station with no staff supervision. The surveyor looked into the bag and observed that the following medications were in the bag: potassium, warfarin, vancomycin, Cymbalta, albuterol, levalbuterol, gas-x, hydrochlorothiazide, myrbetriq, singulair, zantac, protonix, midodrine, trimethoprim, anoro inhaler, insulin, and atropine eye drops. While the surveyors were observing the medications in the bag, one CNA entered the nurse's station to review the bath list that was posted on the wall at the nurse's station. The CNA looked at the list

residents remained free of accidents. No additional medications were found or identified to be unsecured in any areas. Resident #20 medication was removed and new bottle was ordered and obtained from pharmacy.
3. To prevent this from recurring on 7/16/2019, the facility Director of Nursing and designee immediately began to provide education for all staff regarding securing medications, and potential hazards for wandering residents. All staff will be educated prior to starting their next assignment when they return. These staff members will not be permitted to work until education is received. This education will be included in all new hire training and on boarding. On 7/16/2019, the Regional Director of Clinical Services provided education to the Director of Nursing and Nursing Home Administrator on securing medication, medication storage, as well as potential accidents and hazards for secured unit. DON or designee will complete observation rounds daily to ensure medications remain secure for four weeks. Results of rounds will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meetings for review and revision as necessary. Person responsible: NHA, Anthony Brunicardi Action Complete Date July 16, 2019. 100% audit of all resident medications completed to ensure all instructions are visible and all medications present.
Staff were in-serviced on making sure no medications or other items that could injure a resident are not left unattended in

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and exited the area without acknowledging the bag of medications. At that time, the surveyors observed five residents in the area of the open and accessible nurse's station without staff supervision.

On 7/16/19 at 8:45 am, three surveyors observed two CNA staff members leave the unit. The surveyors observed five residents in the area of the open and accessible nurse's station without staff supervision. One surveyor remained on the unit with the medications to ensure that no resident handled the bag of medications, and the remaining surveyors conducted a team meeting to discuss the findings as stated above. While the team meeting was in progress a surveyor observed one resident in a wheelchair enter the open and accessible nurse's station where the bag of drugs were located. A surveyor also observed two staff members open the drawer directly above where the bag of medications was located to get the bathroom key and neither of the staff members acknowledged the bag of medications.

On 7/16/19 at 9:02 am, the administrator, administrator in training, director of nursing, and regional director of clinical services were made aware of the findings as stated above and that a Level IV Immediate Jeopardy deficiency had been cited.

On 7/16/19 at 9:13 am, the administrator, administrator in training, director of nursing, and regional director of clinical services went onto the Carter's Fold secured dementia unit along with the surveyor and observed the bag of medications on the floor of the open and accessible nurse's station. The regional director

resident rooms or care areas and to immediately remove if needed. License nurse were in-serviced not accepting medications with nonvisible labels.
4. Director of Nursing/designee shall monitor resident rooms and nurse stations five times a week for twelve weeks to ensure no medications or items that can injure a resident are left unattended. Director of nursing/designee shall audit 10% of medication labels to ensure labels are not covered weekly for twelve weeks. Results of audit shall be presented in QAPI monthly x3 for review and revisions as needed.
5. Date of Correction: August 21, 2019

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of clinical services removed the bag of medications and searched the nurse's station to ensure that there were no other medications or hazards that had been left unsecured.

On 7/16/19 at, the facility staff presented the survey team with the facility "Immediate Jeopardy Removal Plan." The immediate jeopardy removal plan was documented as follows,

"Identify those recipients who have suffered or likely to suffer as a result of the noncompliance:

Residents on the Carter's Fold (secured unit) could be affected by this noncompliance practice of securing medications. There were not any residents identified to be affected. On 7/16/19, the unsecured medications were immediately removed from the Carter's Fold nurse's station. A door was installed at the nurse's station with a slide lock to prevent wandering residents from entering the nurse's station. The nurse's station was immediately assessed for potential hazards for wandering residents.

Residents likely to suffer a serious adverse outcome as a result of the noncompliance

All residents have the potential to be affected by this noncompliance practice. On 7/16/19, the facility staff immediately conducted observation rounds in all resident rooms and nurse's stations to ensure all medications are appropriately stored and secured so that residents remained free of accidents. No additional medications were found or identified to be unsecured in any areas.

The action the entity will take to alter the process/system failure to prevent an adverse

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outcome from occurring or reoccurring:

To prevent this from reoccurring, the facility Director of Nursing and designee immediately began to provide education for all staff regarding securing medications, and potential hazards for wandering residents. All staff will be educated prior to starting their next assignment when they return. These staff members will not be permitted to work until education is received. This education will be included in all new hire training and on boarding.

On 7/16/19 at 1:30 pm, the Regional Director of Clinical Services provided education to the Director of Nursing and Nursing Home Administrator on securing medication, medication storage, as well as potential accidents and hazards for secured unit.
DON (director of nursing) or designee will complete observation rounds daily to ensure medications remain secure for four weeks. Results of rounds will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meetings for review and revision as necessary.

Person responsible: NHA (nursing home administrator) (Administrator's name withheld)

Action Complete Date
July 16, 2019"

On 7/16/19 at 6:34 am, the surveyor interviewed LPN # 2 (licensed practical nurse). The surveyor asked LPN # 2 if she had worked the night shift on Carter's Fold on 7/15/19. LPN # 2 stated, "Yes." The surveyor asked LPN # 2 if she had seen the bag of medications that had been left

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unsecured in the nurse's station on Carter's Fold. LPN # 2 stated, "Me and another nurse bagged them up to send them back to the pharmacy." The surveyor asked LPN # 2 if she locked the bag of medications up before she left the facility. LPN # 2 stated, "No." The surveyor asked LPN # 2 if there was somewhere to lock the medications up until they are picked up from the pharmacy. LPN # 2 stated, "Yes there's an area to lock them up."

The facility policy on "Storage and Expiration of Medications, Biologicals, Syringes, and Needles" contained documentation that included but was not limited to,
..."Procedure
3.3 Facility staff should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.
17. Facility staff should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis." ...

On 7/16/19 at 7:00 pm, the administrator in training presented the survey team with evidence that the corrective action as listed in the plan of correction had been completed.

On 7/16/19 at 7:02 pm, the regional vice president of operations, the administrator, the administrator in training, the director of nursing, and the regional director of clinical services were made aware that the Level IV Isolated Immediate Jeopardy citation had been reduced to a Level II Isolated deficiency.

On 7/17/19 at 6:00 pm, the director of nursing

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provided the surveyor with 2 statements that had been signed by the director of nursing. The first statement was documented as, "Statement for LPN # 3. LPN # 3 states that medications were bagged to be sent back to pharmacy. She states she intended to take medications and was called away, and failed to remove them." The second statement was documented as, "Statement obtained from LPN # 2. LPN # 2 states that medications had been secured in med room until she removed the bag with the intention of putting them in Clinch Hall med room to be picked up by pharmacy. LPN # 3 states she sat the medication down, and accidentally walked away, leaving the medication at the desk."

No further information regarding this issue was presented to the survey team prior to the exit conference on 7/18/19.

2. The facility staff failed to ensure a medication bottle was labeled in a manner that provided the needed instructions to correctly mix and administer the medication.

On 7/12/19 at 8:48 a.m., LPN (licensed practical nurse) #11 was observed administering medications to Resident #20. Resident #20 was admitted to the facility on 10/16/09. Resident #20's diagnoses included, but were not limited to: hypertension, diabetes mellitus, peripheral vascular disease/peripheral arterial disease, and hyperlipidemia. Resident #20's 4/22/19 quarterly minimum data set (MDS) assessment indicated the resident had adequate hearing and clear speech; the resident was also assessed as being oriented to year, month, and day.

Resident #20's clinical documentation included the following medication order: "Sodium

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Polystyrene Sulfonate Suspension 15GM/60ML. Give 60 ml by mouth one time a day for hyperkalemia." (Hyperkalemia is when the potassium level in one's blood is elevated.)

The facility's pharmacy staff provided administration information about Sodium Polystyrene Sulfonate. This information included the following: "The average total daily adult dose of sodium polystyrene sulfonate is 15 g. to 60 g. administered as a 15-g dose (four level teaspoons), one to four times daily."

The following information was found in a policy titled "6.0 General Dose Preparation and Medication Administration" (with an effective date of 12/1/07 and the most recent revision date of 01/01/13): "Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct time, for the correct resident ... Facility staff should not administer a medication if the medication or prescription label is missing or illegible." This policy was provided to the survey team by the Regional Director of Clinical Services (RDCS) on 7/18/19 at 12:50 p.m.; the RDCS reported this policy was obtained from the facility's pharmacy.

On 7/16/19 at 9:49 a.m., a unit manager (Registered Nurse (RN) #11) was interviewed about the labeling of Resident #20's Sodium Polystyrene Sulfonate Suspension bottle; RM #11 acknowledged a label was covering the mixing instructions

On 7/17/19 at 10:45 a.m., the mxing instructions on the aforementioned medication label being covered was discussed during a survey team

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F 761	Continued From page 64 meeting with the facility's Director of Nursing, Administrator, Administrator-In-Training, Regional Director of Clinical Services, and Regional Vice-President of Operations. On 7/18/19 at 12:57 p.m., the RDCS was interviewed about the aforementioned medication administration. The RDCS reported that if the label placed on the bottle was covering the administration directions then the pharmacy should be called for guidance.	F 761		
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 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 and staff interview the facility staff failed to prepare, distribute and serve food in a manner that would prevent foodborne	F 812	F812 1. There were no residents immediately identified by this action. The broccoli was	8/21/19

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F 812	Continued From page 65 illnesses. The facility staff did not complete any hand hygiene prior to obtaining food temperatures. The findings included: The facility staff when obtaining food temperatures allowed the top of the thermometer to touch the food. The top of this thermometer is what the facility staff held while obtaining food temperatures. The facility staff did not have gloves in place, were not observed to wash their hands prior to obtaining the temperatures, and were observed touching the top of the thermometer with their bare hands. On 07/16/19 at 11:41 a.m., the surveyor entered the kitchen to obtain tray line temperatures. Tray aide #1 was working in the kitchen area and stated she would obtain the tray line temperatures. Tray aide #1 did not wash their hands or apply any gloves prior to obtaining these temperatures. Tray aide #1 picked up the thermometer with their bare hands and placed the thermometer into a pan of broccoli. Tray aide #1 did not hold onto the thermometer and allowed the top of the thermometer to lay backwards onto the broccoli which resulted in the top of the thermometer touching the broccoli. On 07/16/19 at 12:00 p.m., the administrator in training who was in the kitchen stated he would discard the broccoli. The administrator, administrator in training, director of nursing, regional director of clinical services, and the regional vice president of	F 812	immediately discarded in the trash. Wet nesting dishes were rewashed and air dried properly prior to being used. 2. A sanitation audit was done to ensure there were no other issues found. 3. Dietary staff were educated on the policies for proper hand hygiene and temping of foods. Dietary staff was educated on wet nesting to ensure dishes are properly dried before storing. 4. Dietary Manager and/or designee shall do three different meal audits on wet nesting to ensure dishes are properly washed dried prior to storage for twelve weeks. Dietary Manager and/or designee shall conduct weekly audits on three different meals to ensure proper temperature taking and hand hygiene for twelve weeks. Audits shall be presented in QAPI monthly x3 months for review and revisions as needed. 5. Date Corrected: August 21,, 2019	

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F 812	Continued From page 66 operations were notified of the above issue during a meeting with the survey team on 07/17/19 at 11:35 a.m. No further information regarding these issues were provided to the survey team prior to the exit conference.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842		8/21/19

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F 842	Continued From page 67 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to ensure an	F 842	F842 1. Resident #86' Durable power of	

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F 842	Continued From page 68 accurate clinical record for 1 of 34 Residents in the survey sample, Resident # 86. The findings included: The facility staff failed to ensure that complete advanced directive documentation was in the clinical record for Resident # 86. Resident # 86 was a 90-year-old-female that was admitted to the facility on 3/6/19. Diagnoses included but were not limited to, cognitive communication deficit, hypertension, Alzheimer's disease, and Type 2 diabetes mellitus. The clinical record for Resident # 86 was reviewed on 7/16/19 at 9:44 am. The most recent MDS (minimum data set) assessment for Resident # 86 was a significant change assessment with an ARD (assessment reference date) of 6/12/19. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 86's cognitive status was moderately impaired. The current plan of care for Resident # 86 was reviewed and revised on 3/7/19. The facility staff documented a focus area for Resident # 86 as, "Resident has chosen DNR, DNI (do not recesutate, do not intubate)." The facility staff documented a goal for this focus area as, "Resident's code status will be honored daily through next review date." Resident # 86 had orders that included but were not limited to, "Code: No code/DNR," which was initiated by the physician on 5/28/19. On 7/16/19 at 10:35 am, the surveyor observed a "Durable Do Not Resuscitate Order" form in the clinical record for Resident # 86. The surveyor	F 842	attorney complete set of paperwork was obtained and place in file. 2. Audit was completed for current residents with durable power of attorney to ensure correct number of pages were present. 3. Social Service and admission team was in-serviced on need to ensure all pages are present before accepting durable power of attorney paper work. 4. Social Service Director/designee shall audit new admissions within 72 hours of admission to verify all pages related to durable power of attorney are present if applicable for twelve weeks. Social Service Director/designee shall audit 5% current resident's monthly to ensure all pages for durable power of attorney are still present for twelve months. Results of audits will be presented in monthly QAPI x3 months for review and revisions as needed. 5. Date of Correction: August 21, 2019	

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observed a handwritten "X" documented next to the following statement on the form: "While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "person Authorized to Consent on the Patient's behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)." The surveyor reviewed the entire clinical record for Resident # 86 and did not locate an advanced directive document for Resident # 86.

On 7/17/19 at 8:15 am, the surveyor spoke with the administrator in training and made him aware that the advanced directive documents were not located in Resident # 86's clinical record.

On 7/17/19 at 2:33 pm, the administrator in training provided the surveyor with a copy of a "Durable Power of Attorney" for Resident # 86. The surveyor observed a fax time stamp "07/07/2019 WED (Wednesday) 13:14 (1:14 pm)"at the top of the durable power of attorney form for Resident # 86 that had been provided by the administrator in training. The surveyor asked the administrator in training to explain the fax time stamp that had been observed at the top of the durable power of attorney document for Resident # 86.

On 7/17/19 at 2:47 pm, the administrator in training and the facility social service director informed the surveyor that document that had originally been submitted by Resident # 86's family only had the last two pages of the durable power of attorney, and when the surveyor asked for the document, the facility staff contacted the family and requested that the family fax the

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F 842	Continued From page 70 document to the facility. The administrator in training agreed that the durable power of attorney documentation was not complete in the clinical record for Resident # 86 at the time the surveyor reviewed and requested documentation. On 7/17/19 at 6:42 pm, the regional vice president of operations, the regional director of clinical services, the administrator, the administrator in training, and the director of nursing were made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/18/19.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		8/21/19

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arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 72 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure an infection control program during a medication pass and pour observation and for 4 of 34 residents (Resident 21, Resident #91, Resident #79, and Resident #20). The findings included: 1. The facility staff failed to perform hand hygiene during a medication pass and pour observation on 7/16/19 with licensed practical nurse #2. The surveyor observed a medication pass and pour observation on 7/16/19 beginning at 8:12 a.m. with licensed practical nurse #2. L.P.N. #2 used hand sanitizer before entering the medication cart to begin the medication pass. L.P.N. #2 prepared seven medications for Resident #21 and administered the medications. L.P.N. #2 returned to the medication cart. No hand washing was observed upon exiting Resident #21's room or prior to entering the medication cart. L.P.N. #2 left the medication cart, went to the medication room for two medications for Resident #21, poured the two medications, administered the two medications to Resident #21, exited the	F 880	F880 1. An isolation sign was immediately placed on the door of Resident #91. 2.An audit was performed of residents with orders for isolation to ensure proper sign placement. 3. Licensed nurses were educated on the facility's hand washing policy, proper cleaning of glucometers, proper disposal of used laboratory blood draw equipment, proper isolation sign placement, and proper donning and doffing of personal protective equipment. Non licensed staff were also educated to the facility's hand washing policy, proper isolation sign placement, and proper donning and doffing of personal protective equipment. 4. Director of Nursing/designee shall audit residents on isolation weekly to ensure proper isolation sign placement. Director of nursing/designee shall audit five employee's weekly to ensure proper hand hygiene. Director of nursing/designee shall audit five employee's weekly to ensure proper donning and doffing of personal protective equipment. Director of Nursing/designee shall audit five licensed nurses to ensure proper cleaning of glucometers after use. Director of Nursing/designee shall audit one licensed nurse weekly to ensure proper disposal of	

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F 880	Continued From page 73 resident room, and returned to the medication cart. No hand washing or hand hygiene was observed except the initial use of hand sanitizer. L.P.N. #2 entered the medication cart and began to prepare Resident #20's medication. L.P.N. #2 prepared three medications for the resident. L.P.N. #2 locked the medication cart, entered Resident #20's room and administered the medications. While administering the medications, Resident #20 dropped one of the medications on the floor [Aspirin 81 mg (milligrams)]. L.P.N. #2 picked the dropped medication from the floor with bare hands, returned to the medication cart, placed the dropped pill in the sharps container and headed to the medication room to retrieve a new Aspirin 81 mg from the floor stock. L.P.N. #2 did not perform hand hygiene after picking the pill up from the floor, going to the medication cart to discard the dropped pill, and entering and exiting the medication room. The surveyor requested the facility policy on handwashing from the director of nursing on 7/16/19 at 4:56 p.m. The facility policy titled "Hand Washing Date Revised: August 2015 read "3. Perform hand hygiene a. before and after having contact with residents. G. Wash hands with either plain or antimicrobial soap and water or rub hands with an alcohol based formulation before handling medication and preparing food." The surveyor informed the administrator, the director of nursing, the regional director of clinical services, and the administrator-in-training of the	F 880	laboratory blood draw equipment. Results of audits will be presented during monthly QAPI x3 months for review and revision as needed. 5. Date of Correction: August 21, 2019	

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above observation on 7/18/19 at 11:56 a.m.

The surveyor interviewed L.P.N. #2 on 7/18/19 12:19 p.m. L.P.N. #2 stated an in-service had been held that morning about the location of germicidal sprays and making sure medications were locked appropriately. L.P.N. #2 stated the spray wasn't available for use and L.P.N. #2 stated "I got nervous."

No further information was provided prior to the exit conference on 7/18/19.

2. The facility staff failed to follow physician's orders for reverse isolation for Resident #91.

The clinical record of Resident #91 was reviewed 7/15/19 through 7/18/19. Resident #91 was admitted to the facility 6/13/19 with diagnoses, that included but not limited to sepsis, metastatic colon cancer, type 2 diabetes mellitus, morbid obesity, urogenital implants, chronic urinary retention, hypertension, chronic obstructive pulmonary disease, obstructive sleep apnea, systemic lupus erythematous, depression, and congestive heart failure.

Resident #91's admission minimum data set (MDS) with an assessment reference date (ARD) of 6/20/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

Resident #91's current comprehensive care plan had the focus area that read "Resident is at risk of infection due to recent chemotherapy treatments secondary to cancer. Date initiated 6/18/19. Interventions: Reverse isolation precautions as ordered."

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The July 2019 physician's orders for Resident #91 read in part "Reverse Isolation."

The surveyor observed Resident #91 on 7/15/19 at 3:26 p.m. The surveyor observed a treatment cart between the resident's door and the entrance to the bedroom. The treatment cart contained PPE (personal protective equipment). There was no sign on the door describing the type of isolation. Resident #91 stated to the surveyor the type of isolation he/she was currently on. "I have cancer and you have to wear gloves and a mask when you come into my room."

The surveyor interviewed licensed practical nurse #7 on 7/15/19 at 3:27 p.m. L.P.N. #7 stated Resident #91 was on reverse isolation and a sign should be on the door. The surveyor and L.P.N. #7 checked the door for signage for isolation. There was none. L.P.N. #7 stated she would contact the physician to see if isolation should continue.

The surveyor interviewed the director of nursing on 7/15/19 at 4:14 p.m. regarding reverse isolation. The DON stated a sign should be on the door directing staff and visitors what precautions to take. The surveyor requested the facility policy on reverse isolation.

The director of nursing provided the surveyor with the "Reverse Isolation Precautions Guidelines for Immunocompromised Residents/Patients" on 7/16/19 at 11:30 a.m. The guidelines read in part "The purpose is to protect the resident/patient from any germs the staff or visitors are carrying. Residents/patients, who have a decreased immune system (neutropenic), usually from chemotherapy, may be placed in reverse

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isolation. For a resident/patient in reverse isolation, staff should wear gloves, a mask, and a gown. The use of Standard Precautions for all residents/patients and Transmission-Based Precautions for specified patients, as recommended in this guideline, should reduce the acquisition by these residents/patients of institutionally acquired bacteria from other patients and environments."

The surveyor reviewed the facility policy titled "Infection Control-Transmission Based Precautions Date Revised April 2016". The policy read in part "D. A sign will be placed on the door frame of the resident's room indicating that visitors should stop at Nurses Station before entering."

The surveyor informed the administrator, the director of nursing, the regional director of clinical services, the regional vice president of operations, and the administrator-in-training of the above issue on 7/17/19 at 11:35 a.m.

No further information was provided prior to the exit conference on 7/18/19.

3. The facility staff failed to follow infection control guidelines for Resident #79 who was on contact isolation. The surveyor was unable to locate the site of the infection for contact precautions.

The clinical record of Resident #79 was reviewed 7/15/19 through 7/18/19. Resident #79 was admitted to the facility 5/2/19 and readmitted 6/5/19 with diagnoses that included but not limited to pneumonia, persistent vegetative state, adult failure to thrive, severe sepsis with septic shock,

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neuromuscular dysfunction of the bladder, dysphagia, hypothyroidism, acute respiratory failure, dependence on respirator, tracheostomy status, unspecified coma, and non-traumatic intracerebral hemorrhage.

Resident #79's 30-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/3/19 assessed the resident to be in a persistent vegetative state in Section B0100.

The surveyor observed wound care on 7/17/19 at 8:33 a.m. with licensed practical nurse #3.
Resident #79's door had a sign that read "Contact Precautions".
L.P.N. #3 knocked and entered the room and hands washed.
L.P.N. #3 returned to the treatment cart and cleaned the over-the-bed table with a Sani-cloth wipe.
L.P.N. #3 left the treatment cart, went into Resident #79's room and washed hands. L.P.N. #3 returned to treatment cart and placed a barrier on the table.
L.P.N. #3 removed supplies from cart-poured hydrogel into graduated cup and placed on barrier. Cleaned scissors with Sani cloth and placed on barrier. Removed Maxorb Extra AG 2 packages and placed on table. Dated all dressings prior to entering the resident's room.
L.P.N. #3 placed a box of gloves, an opened package of telfa, 4x4's and a bottle of normal saline on the over-the-bed table.
L.P.N. #3 donned gown, masks and gloves, entered Resident #79's room with the over-the-bed table, and positioned the table on the left side of the bed.

Resident #79 was turned to the left side. Old

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dressing on left leg (hip region) removed and discarded. Gloves off and hands washed. Gloves applied and dressing on coccyx/sacrum removed. Gloves off and discarded. Hands washed. Gloves applied. Area on left leg cleaned with normal saline and discarded. Gloves removed and hands washed. Gloves applied. Maxorb extra AG applied. Covered with telfa (dated prior to applying). Gloves removed and hands washed.

L.P.N. #3 then left the resident's room, went to treatment cart for supplies, and then returned. L.P.N. #3 did not remove gown or masks when exiting Resident #79's room and re-entering. Upon return to room, L.P.N. #3 did wash hands and gloves applied. Area on coccyx cleaned with normal saline. Gloves removed and hands washed. Gloves applied. Area cleaned again with normal saline. Gloves off and hands washed. Gloves applied. Maxorb Extra AG applied then Telfa Island dressing applied (dated prior to applying).

L.P.N. #3 removed gloves and washed hands. Gloves on and cleaned scissors before leaving the room. L.P.N. #3 removed gloves and washed hands. Over-the-bed table and the box of gloves removed from the room. L.P.N. #3 cleaned the top of the over-the- bed table with Sani-wipe cloth. None of the metal frame of the over-the-bed table was cleaned with any type of disinfectant. The box of gloves was placed back on top of the treatment cart.

The surveyor interviewed L.P.N. #3 about the wound care observations. The surveyor questioned L.P.N. #3 if the gown and masks should have been removed and hands washed

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when the nurse exited the room to get supplies from the treatment cart. L.P.N. #3 stated he/she thought he/she should but then didn't. The surveyor also asked about taking gloves and the over-the-bed-table in and out of Resident #79's room. The surveyor asked if those items should be dedicated items and left in the resident's room. L.P.N. #3 stated he/she should have used the resident's over-the-bed table and left the box of gloves in the room when wound care was finished.

The surveyor interviewed the director of nursing (DON) on 7/17/19 at 10:00 a.m. and requested the facility policy on isolation, standard precautions, the July 2019 physician orders and Resident #79's current wound care orders and the site of the infection. The DON was informed of the surveyor's observations during wound care. The DON stated the gloves and table should have been left in the room and gown and masks should have been removed when L.P.N. #3 left the room.

The surveyor reviewed the facility policy titled "Infection Control-Transmission Based Precautions-Date Revised April 2016" on 7/17/19. The policy read in part "Procedure 1. Contact Precautions-d. Resident -Care equipment-use disposable non-critical equipment (thermometers, B/P (blood pressure) cuffs, stethoscope, etc.) or implement resident-dedicated equipment. If common use of equipment is unavoidable, clean and disinfect equipment before use on another resident." The surveyor did not receive the facility policy on Standard Precautions.

On 7/18/19 at 8:00 a.m., the director of nursing stated Resident #79's contact isolation had been

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removed. The director of nursing stated the resident had been on isolation prior to admission and the most recent progress note dated 7/16/19 did not address the reason for the isolation.

The surveyor informed the administrator, the director of nursing, the regional director of clinical services, and the administrator-in-training of the above concern on 7/18/19 at 11:56 a.m.

No further information was provided prior to the exit conference on 7/18/19.

4. Facility staff members failed to ensure point-of-care equipment (a glucometer) was cleaned prior to returning it to its storage area and facility staff members failed to ensure used laboratory blood draw equipment/supplies were not commingled with clean, unused laboratory blood draw equipment/supplies.

On 7/16/19 at 10:45 a.m., LPN (licensed practical nurse) #14 was observed to attempt to collect Resident #20's blood; LPN #14 made two (2) unsuccessful attempts to collect Resident #20's blood. Registered Nurse (RN) #11 was assisting LPN #14 with the attempt to collect the blood. It was noted after each of the two unsuccessful attempts that the protective device was put in place over the used butterfly needle but the used butterfly needle was placed in the laboratory caddy which also held clean blood collection supplies.

On 7/16/19 at 11:10 a.m., LPN #11 was observed to use a point-of-care device (a glucometer) to obtain a FSBS (finger stick blood sugar) test on Resident #20. LPN #11 was observed to return the glucometer to its storage area in the medication cart without cleaning and disinfecting

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the glucometer.

The following information, guiding the cleaning of the facility's glucometer, was found in a facility policy titled "Blood Glucose Monitoring via Finger Stick and Cleaning of Glucometers" (with the most recent revised date of 11/28/2018): "Wipe glucometer surface using a germicidal disposable wipe with bleach per manufacturer's directions and recommendation. The Surface must be visibly wet. a. Friction is the key to cleaning and disinfecting environmental surfaces. b. Take care not to get liquid in the test strip and key code ports of the meter." This policy indicated the aforementioned cleaning should occur prior to obtaining blood for testing and after the blood test is completed.

The following information was found in the facility's glucometer's User Instruction Manual: "Cleaning and Disinfecting: The cleaning procedure is needed to clean dirt as well as blood and other body fluids on the exterior of the meter and lancing device before performing the disinfection procedure. The disinfection procedure is needed to prevent transmission of blood-borne pathogens. -The meter should be cleaned and disinfected after use on each patient. This Blood Glucose Monitoring System may only be used for testing multiple patients when Standard Precautions and the manufacturer's disinfection procedures are followed ... Cleaning ... 1. Wear appropriate protective gears [sic] such as disposable gloves. 2. Open the cap of the disinfectant container and pull out 1 towelette and close the cap. 3. Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using one towelette to clean blood and other body fluids. 4. Dispose of the used

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towelette in a trash bin. The meter should be cleaned prior to each disinfection step. Disinfecting ... 5. Pull out 1 new towelette and wipe the entire surface of the meter 3 times horizontally and 3 times vertically using a new towelette to remove blood-borne pathogens. 6. Dispose of the used towelette in a trash bin. 7. Allow exteriors to remain wet for the corresponding contact time for each disinfectant. 8. After disinfection, the user's gloves should be removed to be thrown away and hands washed before proceeding to the next patient."

The following information was found in the facility policy titled "Infection Control" (with an effective date of May 2015): " ...Staff and residents shall maintain clean work areas ... All waste products shall be placed in appropriate containers ..."

On 7/17/19 at 10:45 a.m., the following infection control concerns were discussed during a survey team meeting with the facility's Director of Nursing, Administrator, Administrator-In-Training, Regional Director of Clinical Services, and Regional Vice-President of Operations: (a) observations of used butterfly needles being placed in the laboratory caddy which contained cleaned blood draw equipment and supplies and (b) the observation of a point-of-care device (glucometer) being returned to its storage area after use without first being cleaned and disinfected.