STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495233	A. BUILDING _____ B. WING _____	C 10/18/2019

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FAUQUIER HEALTH REHABILITATION & NURSING CENTER	360 HOSPITAL DRIVE WARRENTON, VA 20186

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/16/2019 through 10/18/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/16/2019 through 10/18/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. The census in this 113 certified bed facility was 79 at the time of the survey. The survey sample consisted of 40 resident reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		12/1/19

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

Electronically Signed | 11/08/2019

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to serve food and provide catheter care in a manner to promote resident dignity for one of 40 residents in the survey sample, Residents # 175. On 10/17/19, a nursing student was observed standing while feeding Resident #175 her breakfast in bed. The findings include: Resident # 175 was admitted to the facility on 10/11/2019 with diagnoses that included but were	F 550	Submission and implementation of this plan of correction does not constitute an admission of allegations of deficiency. Plan of Correction is prepared and/or executed because it is required by provision of federal and state regulations. After being observed standing while feeding resident #175 breakfast in the resident□s room, Nursing Student #1 was promptly instructed to sit while feeding resident. Nursing students and nursing instructor were gathered together by	

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F 550	Continued From page 2 not limited to: swallowing difficulties, low iron and high blood pressure. The most recent MDS (minimum data set) assessment for Resident # 175's was not due at the time of the survey. The facility's nursing admission assessment dated 10/11/2019, coded Resident # 175 as "Oriented to place" times one. Resident # 57 was coded as requiring the assistance of one staff member for eating. The facility's baseline care plan for Resident # 175 dated 10/11/2019 documented, "Cognitive status: Cognitively impaired." Under Communication" it documented, "1. Can the resident communicate easily with staff? No. Does the resident understand the staff? No." Under "Functional Abilities and Goals - Self Care" it documented, "1. Eating support provided: One person physical assist [assistance]." On 10/17/19 at approximately 8:45 a.m., an observation of Resident #175 from the hallway revealed she was in her bed, head of bed raised and eating breakfast with the assistance from a nursing student (NS [nursing student] #1). Further observation revealed the nursing student from [Name of Nursing School] standing next to the bed on Resident # 175's right side feeding her. On 10/17/19 at approximately 8:50 a.m., LPN [licensed practical nurse] # 4 was asked to observe the situation describe above from the hallway. LPN # 4 immediately went into Resident # 175's room, informed the nursing student that she should be seated when feeding a resident and drew the privacy curtain so the resident, could no longer be seen from the hallway.	F 550	nurse manager, on 10/17/19, to review incident and instructed to promote resident dignity at all times, to include sitting while assisting with feeding. All residents who require assistance with feeding have the potential to be affected by this deficient practice. Quality manager or designee will expand current Resident□s Rights education that is provided to new hires, contracted employees and to nursing students/instructors completing clinical rotations, beginning with Nov 11th orientation. Education will be revised to include sitting while assisting with feeding. Social Worker will conduct observations during mealtimes, of 10 meals weekly x 4 weeks, then 5 meals weekly thereafter. Results will be reviewed, trended, and reported monthly to QAPI for three months then quarterly thereafter to ensure continued compliance.	

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On 10/17/19 at 11:33 a.m., an interview was conducted with LPN # 4. When asked who was immediately responsible for the actions of nursing students on the floor providing care and services to residents', LPN # 4 stated, "I would say me because I'm responsible for the residents." When asked about Resident # 175's functional status, LPN # 4 stated, "She is nonverbal able to follow simple one-step directives with guidance and a lot of cueing." When asked about Resident's ability to feed herself, LPN # 4 stated, "She is unable to feed herself." When asked to describe the procedure that should be followed when assisting and feeding a resident with their meal, LPN # 4 stated, "Set up the resident's food, open containers, position the resident to 90 degrees, pull the curtain for privacy and sit next to the resident. You should be seated next to or in-front of resident when feeding them." When asked why someone should be in the position she described, LPN # 4 stated, "To not make them feel rushed because if someone was standing over the top of me, feeding me, I would feel rushed." When asked if it was dignified to stand and feed Resident # 175, LPN # 4 stated, "No. The student should have been sitting next to the bed and should have the curtain pulled for privacy."

The "[Name of Facility Resident Rights] documented in part, "A resident at "[Name of Facility] ...10. Is treated with consideration, respect, and in full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs."

The facility's policy "Conduct of Employees to Promote Patient/Resident Rights" documented in part, "Objective: It is the policy of this facility that

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F 550	Continued From page 4 all personnel conduct themselves in a manner that promotes dignity and respect to residents." Under "Procedure" it documented, "8. Treat all residents with kindness, respect and dignity." On 10/17/19 at 5:25 p.m., ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit.	F 550		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the	F 622		12/1/19

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F 622	Continued From page 5	F 622		

resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or

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F 622	Continued From page 6 discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide the necessary paperwork to the receiving facility for a facility initiated transfer for one of 40 residents, Resident #325. The facility staff failed to provide evidence that all required information was provided to the hospital staff when Resident #325 was transferred to the hospital on 9/5/19. The findings include: Resident #325 was admitted to the facility on 6/19/15 with diagnoses that include but are not limited to: congestive heart failure [circulatory congestion, retention of fluid in the lungs and edema of extremities. (1)], pleural effusion	F 622	Resident #325 transferred to the local hospital on 9/5/19 and returned to facility on 9/10/19, and was not negatively affected by this deficiency. On 10/17/19 a late entry was completed by nurse that transferred resident out on 9/5/19, to document that required documentation was sent with resident to hospital. All residents that transfer out of facility have the potential to be affected by this deficient practice. Admissions coordinator or designee will complete an audit for current residents that have transferred out since 10/18/19 to ensure required documentation was provided and documented in the clinical record, by	

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F 622	Continued From page 7 [accumulation of fluid in the space between the chest wall and the lungs. (2)] and atrial fibrillation [rapid and random contraction of the atria of the heart (3)]. The most recent MDS (minimum data set) assessment, a 14 day Medicare assessment, with an ARD (assessment reference date) of 9/24/19, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating he has moderately impaired cognition. Review of Resident #325's clinical record revealed the resident was transferred to the hospital on 9/5/19 for hypoxia and shortness of breath. The resident transfer form and discharge summary documented resident diagnosis, vital signs, code status and discharge diagnosis. The facility's Interact transfer form included a checklist including documents to be sent with resident upon transfer, this section was blank. Review of the clinical record failed to reveal a progress note documenting the information provided to the receiving hospital for Resident #325's hospital transfer on 9/5/19. On 10/17/19 at 5:30 PM, ASM (administrative staff member) #1, the administrator and #2, the director of nursing was informed of inability to find documentation of paperwork sent with Resident #325 upon transfer to the hospital on 9/5/19. On 10/18/19 at 8:00 AM, ASM #2, the director of nursing, provided a checklist for Resident #325's transfer to ER (emergency room) dated 9/5/19 and stated "I had the nurse write a late entry note	F 622	11/24/19. Quality manager or designee will re-educate Nurses on Facility Initiated Transfer and Discharge policy and required transfer documentation by 11/24/19. Transfer/discharge checklist will be completed by nurses and will scanned into clinical record when transferring residents from the facility. Copies of Transfer/discharge checklist forms will be submitted to the Quality Manager whom will monitor for compliance. Admissions Coordinator will audit clinical record when completing transfer out reviews for 100% of all transfers to hospital during the next 30 days, and then 50% monthly thereafter. Results will be reviewed, trended, and reported monthly to QAPI for three months and then quarterly thereafter to ensure continued compliance.	

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F 622	Continued From page 8 and complete the list of documentation that she sent." Review of the Checklist provided for Resident #325's transfer to ER revealed that the Checklist had been completed to reflect that all the required documentation was sent to the hospital and that the form was dated 9/5/19. ASM #2, the director of nursing, was asked when the Checklist was completed. ASM #2 stated, "Last evening." The late entry progress note dated 9/5/19 4:00 PM was created 10/17/19 at 6:41 PM by LPN (licensed practical nurse) #3. A phone interview to verify documentation was sent on 9/5/19, was attempted on 10/18/19 at 9:38 AM and message was left for LPN #3. The facility document titled, "Facility Initiated Transfer and Discharge" documented, "The medical record will identify information provided to the receiving provider which at a minimum will include: contact information of the practitioner, resident representative information, comprehensive care plan, advance directive information, special risks (falls and pressure ulcers) and all information necessary to meet the resident's needs." No further information was provided prior to exit. References: 1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 133. 2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 459. 3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 54.	F 622		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		12/1/19

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§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this

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section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed implement the comprehensive care plan for two of 40 residents in the survey sample, Residents # 63 and # 31. The facility staff failed to implement the comprehensive care plan for Resident # 63 and Resident #31 for the use of non-pharmacological interventions prior to the administration of as needed pain medications.

The findings include:

1. The facility staff failed to implement Resident # 63 comprehensive care plan for the use of non-pharmacological interventions prior to the administration of as needed Tylenol [1].

Resident # 63 was admitted to the facility on 04/20/2010 and was readmitted on 09/20/2019, with diagnoses that included but were not limited to: chronic pain osteoarthritis [2] and high blood pressure.

Resident # 63's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/26/19, coded Resident # 63 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition for making daily decisions. Section J "Health Conditions" coded Resident # 63 as having frequent pain at a level of six on a pain scale of zero to ten, with ten being the worse pain.

The comprehensive care plan for Resident # 63's

On 10/17/19, Resident #63 orders were obtained to document non-pharmacological interventions prior to administration of analgesics in regards to implementing care plan interventions for pain management. Pain assessment was completed on 11/6/19 to determine new person-centered interventions most effective for resident. On 10/17/19, Resident #31 orders were obtained to document non-pharmacological interventions prior to administration of analgesics in regards to implementing care plan interventions for pain management. Pain assessment to determine new person-centered interventions most effective for resident, was completed on 11/6/19.

All residents receiving as needed pain medications have the potential to be affected by this deficient practice. By 11/24/19, Nurse manager or designee will complete an audit of all residents with as needed pain medication orders and care plan interventions to ensure interventions are implemented to document non-pharmacological interventions prior to analgesic administration.

Quality manager or designee will re-educate nurses on Pain Management and Care Plan policies by 11/24/19. Nurse Managers will review 24 hour reports for documentation of non-pharmacological interventions to ensure compliance with

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F 656	Continued From page 11 pain documented, "[Name of Resident # 63] has chronic pain r/t [related to] Arthritis especially Right knee, back and hands. Date Initiated: 09/28/2018." Under "Interventions/Tasks" it documented, "Monitor/document for probable cause of ache pain episode. Remove/limit causes where possible. Date Initiated: 09/28/2018." The POS [physician order sheet] for Resident # 63 dated "OCT [October] 2019 documented, "Tylenol Tablet (Acetaminophen). Give 650 milligrams by mouth every 12 hours as needed for pain. Start Date: 05/21/20019." The eMAR [electronic medication administration record] for Resident # 63 dated "AUG [August] 2019" documented the physician order documented above on the October 2019 POS. Further review of the eMAR revealed Tylenol 650 milligrams was administered on the dates and times as follows: - 08/02/19 at 3:33 a.m. for pain level of eight, 08/06/19 at 2:54 a.m. with pain level of two, - 08/12/19 at 3:00 a.m. with pain level of eight, - 08/16/19 at 2:02 a.m. with pain level of six, - 08/23/19 at 3:48 a.m. with pain level of four and on 08/29/19 at 3:09 p.m. with pain level of eight. The eMAR for Resident # 63 dated "SEPT [September] 2019" documented the same physician order as documented above on the October 2019 POS [physician order sheet]. Further review of the eMAR revealed Tylenol 650 milligrams was administered on dates and times as follows: -09/01/19 at 3:06 p.m. with pain level of four, -09/02/19 at 5:42 p.m. with pain level of seven, - 09/06/19 at 4:21 p.m. with pain level of five and	F 656	implementation of care plan. The Director of Nursing or designee will audit 10 resident care plans weekly x 4 weeks then 10 resident care plans monthly to ensure residents with pain management care plans have documentation to support implementation of non-pharmacological interventions prior to administration of as needed pain medications. Results will be reviewed, trended, and reported monthly to QAPI for three months and then quarterly thereafter to ensure continued compliance.	

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on 09/23/19 at 2:50 a.m. with pain level of seven.

The eMAR for Resident # 63 dated "OCT [October] 2019" documented the same physician order for Tylenol as documented above on the October 2019, POS. Further review of the eMAR revealed Tylenol 650 milligrams was administered on 10/06/19 at 7:54 a.m. with pain level of five.

Review of the facility's nursing "Progress Notes' for the dates Tylenol was administered to Resident # 63 as stated above in August, September and October 2019, failed to evidence documentation non-pharmacological interventions were attempted prior to the administration of Tylenol.

On 10/16/19 at 4:10 p.m., an interview was conducted with Resident # 63. When asked about her pain medication, Resident # 63 stated, "I get scheduled and prn pain medication. They ask me the level of pain and where it is." When asked if the nursing staff attempt to alleviate her pain before giving her the as needed pain medication, Resident # 63 stated, "No. They just give me the medication."

On 10/18/19 at 10:37 a.m., LPN [licensed practical nurse] # 4 was interviewed. LPN #4 was asked to describe the process of administering prn [as needed] pain medication. LPN # 4 stated, "Determine where the pain is, get a pain level zero to ten, ten being the worse pain, will try a non-pharmacological interventions, if not effective then give the prescribed medication and recheck 30 minutes later to see if it was effective. When asked where non-pharmacological interventions are documented, LPN # 4 stated, "It's

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documented in the nurse's notes." When asked to describe the purpose of a resident's care plan, LPN # 4 stated, "To ensure we are providing the proper care." When asked if an intervention or approach should be implemented if it is documented on the resident's care plan, LPN # 4 stated, "Yes but if is not documented can't say it is being done." LPN #4 was asked to review Resident # 63's care plan statement "Monitor/document for probable cause of ache pain episode. Remove/limit causes where possible." When asked about this intervention, LPN # 4 stated, "I would interpret it as implementing non-pharmacological intervention." After reviewing the nurse's progress notes for the dates Tylenol was administered to Resident # 31 and eMARs dated August, September and October 2019, and the comprehensive care plan, LPN # 4 was asked if the care plan intervention for the use non-pharmacological interventions was being implemented. LPN # 4 stated, "no."

On 10/17/19 at 5:25 p.m., ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called

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analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html.

[2] The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html.

2. The facility staff failed to implement Resident # 31's comprehensive care plan for the use of non-pharmacological interventions prior to the administration of as needed Percocet [1] and Tylenol [2] for Resident # 31.

Resident # 31 was admitted to the facility on 05/31/17 and a re-admission on 01/18/19 with diagnoses that included but were not limited to: high blood pressure and chronic pain.

Resident # 31's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/23/19, coded Resident # 31 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section J "Health Conditions" coded Resident # 31 as having pain level of ten on a scale of zero to ten "Almost constantly."

The comprehensive care plan for Resident # 31's pain documented, "[Name of Resident # 30] has alteration in comfort r/t [related to] pain from h/o

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[history of] cellulitis of bilateral lower limbs, stage III pressure ulcer on coccyx, chronic right hip pain and gout, diabetic neuropathy. Date Initiated: 06/08/2017." Under "Interventions/Tasks" it documented, "Eliminate additional stressor or sources of discomfort when possible. Date Initiated: 06/08/2017."

The POS [physician order sheet] for Resident # 31 dated "OCT [October] 2019 documented, "Percocet Tablet 5-325MG [milligrams] (Oxycodone-Acetaminophen). Give 1 [one] tablet by mouth every 6 [six] hours as needed for pain. Order Date: 01/18/2019" and documented, "Tylenol Tablet (Acetaminophen). Give 1000 milligrams by mouth every 8 [eight] hours as needed for pain. Start Date: 03/01/20019."

The eMAR [electronic medication administration record] for Resident # 31 dated "AUG [August] 2019" documented the above physicians orders. Review of the eMAR revealed Percocet 5-325 mg was administered on the dates and times as follows:
-08/04/19 at 9:37 p.m. with pain level of eight,
-08/06/19 at 10:41 p.m. with pain level of nine,
-08/07/19 at 5:05 p.m. with pain level of five,
-08/08/19 at 4:56 p.m. with pain level of nine,
-08/15/19 at 8:54 a.m. with pain level of nine and at 8:20 p.m. with pain level of ten,
-08/18/19 at 4:40 p.m. with pain level of five,
08/22/19 at 2:01 a.m. with pain level of four, and on 08/31/19 at 12:11 p.m. with pain level of seven.

Further review of the AUG 2019 eMAR revealed Tylenol 1000 milligrams was administered on dates and times as follows:
-08/02/19 at 12:35 a.m. for pain level of nine,

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-08/03/19 at 2:22 a.m. with pain level of two and at 11:19 with pain level of five, 08/04/19 at 12:41 a.m. with pain level of three and at 4:38 p.m. with pain level of four,
-08/06/19 at 1:03 a.m. with pain level of two,
-08/10/19 at 1:24 p.m. with pain level of six, -08/11/19 at 10:42 a.m. with pain level of four,
-08/14/19 at 3:36 p.m. with pain level of ten,
-08/15/19 at 7:48 p.m. with pain level of ten,
-08/18/19 at 11:51 a.m. with pain level of five and at 11:53 p.m. with pain level of five and on 08/22/19 at 12:05 a.m. with pain level of two

The eMAR for Resident # 31 dated "SEPT [September] 2019" documented the above physicians orders for Percocet and Tylenol. Review of the eMAR revealed Percocet 5-325 mg was administered on dates and times as follows:
- 09/01/19 at 4:17 p.m. with pain level of seven,
- 09/07/19 at 11:30 a.m. with pain level of nine,
- 09/10/19 at 6:15 a.m. with pain level of three,
- 09/12/19 at 6:39 a.m. with pain level of two,
- 09/14/19 at 5:11 p.m. with pain level of four,
- 09/15/19 at 3:15 p.m. with pain level of six,
- 09/16/19 at 11:37 a.m. with pain level of nine,
- 09/17/19 at 11:44 a.m. with pain level of nine,
- 09/18/19 at 12:27 p.m. with pain level of eight,
- 09/19 at 11:24 a.m. with pain level of nine,
- 09/22/19 at 11:26 a.m. with pain level of seven,
- 09 /23/19 at 12:56 p.m. with pain level of nine,
- 09/24/19 at 5:58 a.m. with pain level of nine,
- 09/26/19 at 3:47 a.m. with pain level of two and at 12:01 p.m. with pain level of nine,
- 09/27/19 at12:17 p.m. with pain level of nine and on 09/29/19 12:34 p.m. with pain level of eight.

Further review of the SEPT 2019, eMAR revealed Tylenol 1000 milligrams was administered on the dates and times as follows:

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- 09/02/19 at 11:02 p.m. with pain level of nine,
- 09/10/19 at 9:33 p.m. with pain level of seven,
- 09/14/19 at 10:23 a11:44 a.m. with pain level of four,
- 09/15/19 at10:22 a.m. with pain level of four,
- 09/16 at 11:37 a.m. with pain level of nine,
- 09/17/19 at 2:52 a.m. with pain level of nine,
- 09/18/19 at 10:23 a.m. with pain level of nine,
- 09/19/19 at 11:23 a.m. with pain level of nine,
- 09/21/19 at 2:09 p.m. with pain level of three,
- 09/22/19 at 11:27 a.m. with pain level of seven,
- 09/24/19 at 12:44 p.m. with pain level of nine,
- 09/25/19 at 2:00 a.m. with pain level of two,
- 09/26 at 1:00 a.m. with pain level of two and at 12:01 p.m. with pain level of nine and on 09/28/19 at 3:56 a.m. with pain level of two.

The eMAR for Resident # 31 dated "OCT [October] 2019" documented the same physicians orders for Percocet and Tylenol as documented on the Oct 2019 POS. Review of the eMAR revealed Percocet 5-325 mg was administered on the dates and times as follows:
- 10/01/19 at 11:55 a.m. with pain level of four,
- 10/02/19 at 10:30 a.m. with pain level of eight,
- 10/03/19 at 1:15 p.m. with pain level of nine,
- 10/05/19 at 7:42 a.m. with pain level of five,
- 10/07/19 at 1:13 p.m. with pain level of nine,
- 10/08/19 at 11:48 a.m. with pain level of nine,
- 10/09/19 at 1:00 p.m. with pain level of nine,
- 10/10/19 at 1:00 p.m. with pain level of nine,
- 10/11/19 at 3:52 p.m. with pain level of eight,
- 10/14/19 at 4: 44 p.m. with pain level of eight and on 10/15/19 at 1:17 p.m. with pain level of nine.

Further review of the Oct 2019 eMAR revealed Tylenol 1000 milligrams was administered on dates and times as follows:

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- 10/02/19 at 12:19 a.m. with pain level of four,
- 10/03/19 at 7:38 a.m. with pain level of ten,
- 10/05/19 at12:07 p.m. with pain level of three,
- 10/06/19 at 12:52 p.m. with pain level of seven,
- 10/07/19 at 11:40 p.m. with pain level of two,
- 10/08/19 at 8:03 a.m. with pain level of nine,
- 10/12/19 at 12:32 p.m. with pain level of five and on 10/15/19 at 8:33 p.m. with pain level of three.

Review of the facility's nursing "Progress Notes' for the dates Percocet and Tylenol were administered to Resident # 30 as stated above in August, September and October 2019, failed to evidence documentation that non-pharmacological interventions were attempted prior to the administration of the pain medication.

On 10/16/19 at 11:07 a.m., an interview was conducted with Resident# 31 regarding his pain. Resident # 31 stated that he has chronic pain at a pain level of eight to nine out of ten. Resident # 31 stated, "When I'm in pain I tell the aide and they get the nurse and the nurse brings me my pain medication." When asked if the nurse tries to do anything to relieve the pain before giving the pain medication, Resident # 31 stated, "No."

On 10/18/19 at 10:37 a.m., LPN [licensed practical nurse] # 4 was interviewed. LPN #4 was asked to describe the process of administering prn [as needed] pain medication. LPN # 4 stated, "Determine where the pain is, get a pain level zero to ten, ten being the worse pain, will try a non-pharmacological interventions, if not effective then give the prescribed medication and recheck 30 minutes later to see if it was effective. When asked where non-pharmacological interventions are documented, LPN # 4 stated, "It's

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F 656	Continued From page 19	F 656		

documented in the nurse's notes." When asked to describe the purpose of a resident's care plan, LPN # 4 stated, "To ensure we are providing the proper care." When asked if an intervention or approach should be implemented if it is documented on the resident's care plan, LPN # 4 stated, "Yes but if is not documented can't say it is being done." LPN #4 was asked to review Resident # 31's care plan statement "Eliminate additional stressor or sources of discomfort when possible." After reviewing the statement, LPN #4 was asked about the intervention. LPN # 4 stated, "I would interpret it as implementing non-pharmacological intervention." After reviewing the nurse's progress notes for the dates Tylenol was administered to Resident # 31 and eMARs dated August, September and October 2019, and the comprehensive care plan, LPN # 4 was asked if the care plan was being implemented for the use non-pharmacological interventions. LPN # 4 stated, No."

On 10/17/19 at 5:25 p.m., ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Percocet- Oxycodone is used to relieve moderate to severe pain. Oxycodone extended-release tablets and extended-release capsules are used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. Oxycodone is also available in combination with acetaminophen (Oxycet, Percocet, Roxicet, Xartemis XR, others);

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F 656	Continued From page 20 aspirin (Percodan); and ibuprofen. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html [2] Acetaminophen is used to relieve mild to moderate pain.This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		12/1/19

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F 657	Continued From page 21 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to review or revise the comprehensive care plan for two of 40 residents in the survey sample, Resident # 41 and # 50. The facility staff failed to revise Resident # 41's comprehensive care plan to reflect the correct use of a seat cushion and not a back brace cushion for the resident, and failed to revise Resident # 50's comprehensive care plan to reflect the use of an indwelling catheter. The findings include: 1. Resident # 41 was admitted to the facility on 07/31/2018 with diagnoses that included but were not limited to: lower back pain, heart failure and chest pain. Resident # 41's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/04/2019, coded Resident # 41 as scoring an eight on the staff assessment for mental status (BIMS) of a score of 0 - 15, eight - being moderately impaired of cognition for making daily decisions. Resident # 41 was coded as requiring extensive assistance of one staff member for activities of daily living. The comprehensive care plan for Resident # 41 date 08/08/2019 documented, "Focus: [Name of Resident # 41] has an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] activity intolerance and impaired mobility. Date Initiated: 08/08/2019." Under "Interventions" it documented, "Provide back brace cushion to	F 657	Resident #41□s care plan was revised on 10/18/19 to remove use of back brace cushion to reflect accurate care plan. Resident #50□s care plan intervention was revised on 10/18/19 from change external catheter to change catheter. Initial care plan focus from 6/18/19 addressed indwelling catheter. All residents have the potential to be affected by this deficient practice. Resident care plans will be thoroughly reviewed by Interdisciplinary team, at next care plan review date to ensure accuracy, and corrections will be completed at time of discovery. Quality Manager or designee will re-educate Interdisciplinary team on care plan policy by 11/24/19 and requirement to ensure accuracy of individualized care plan with each care plan review. Nurse Managers will review 24 hour reports for changes and develop/revise care plan to ensure accuracy. Quality Manager or designee will audit 25% of care plan reviews with each required MDS assessment. Revisions will be made by Quality Manager or designee upon discovery of inaccuracy. Findings will be reviewed, trended and reported monthly to QAPI for three months and then quarterly thereafter to ensure continued compliance.	

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wheelchair. Date Initiated: 09/09/2019."

On 10/16/19 at 1:52 p.m., an observation of Resident # 41 revealed she was dressed sitting up in her wheelchair in her room. Observation of the wheelchair failed to evidence a back brace cushion.

On 10/17/19 at 11:17 a.m., an observation of Resident # 41 seated in her wheel chair failed to evidence a back brace cushion in the wheelchair.

On 10/18/19 8:20 a.m., an observation of Resident # 41 revealed she was sitting up in her wheelchair in her room. Observation of the wheelchair failed to evidence a back brace cushion.

The POS [physician's order sheet] for Resident # 41 dated OCT [October] 2019 for Resident # 41 failed to evidence the use of a back brace cushion.

On 10/18/19 at 8:25 a.m., an interview was conducted with LPN # 4 regarding Resident # 41's back brace cushion. After reviewing, the comprehensive care plan LPN # 4 was asked to examine Resident # 41's room and wheelchair for the cushion. LPN # 4 stated, "This was an intervention requested by the family." When asked about Resident # 41's comprehensive care plan, LPN # 4 stated, "I would say it needs to be revised to indicate it is provided by the family. I assume the family has it."

On 10/18/19 at 9:05 a.m., an interview was conducted with RN [registered nurse] #1, the MDS coordinator. RN # 1 was asked to review the comprehensive care plan for Resident # 41

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dated 08/08/2019 regarding the back brace cushion. RN # 1 stated, "It is documented on the care plan incorrectly. It should have a chair cushion not the back brace." When asked to describe the process to revise/update the care plan for a resident, RN # 1 stated, "I check the order recap report every day, its summary of all physician orders over past 24 hours and from Friday to Monday morning. I check for any changes that affect the resident, go through, and update the care plan. We also conduct quarterly reviews and it could have been pick up then."

The facility's policy "Baseline Care Assessment and Comprehensive Care Plan" documented in part, "12. The care plan is evaluated and changed in reference to the resident's response to treatment and whenever there is a change in the resident. All disciplines participate in maintaining the care plan so that it reflects the current status of the resident."

On 10/18/19 at approximately 11:25 a.m., ASM [administrative staff member] # 1, administrator, was made aware of the above findings.

No further information was provided prior to exit.

2. The facility staff failed to revise Resident # 50's comprehensive care plan to reflect the use of an indwelling catheter.

Resident # 50 was admitted to the facility on 06/10/2019, with a readmission to the facility on 07/18/2019, with diagnoses that included but were not limited to: stroke, other disorders of the autonomic nervous system [1] and low blood pressure.

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Resident # 50's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/13/19, coded Resident # 50 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition intact for making daily decisions. Resident # 50 was coded as requiring extensive assistance of one staff member for all activities of daily living. Section H "Bladder and Bowel" coded Resident # 50 as having an indwelling catheter [2].

On 10/16/19 at 2:15 p.m., an observation of Resident # 50 revealed he was lying in bed with a catheter bag connected to the side of the bed. When interviewed about this observation the resident confirmed he had an indwelling catheter in place.

On 10/17/19 at approximately 10:15 p.m., an observation of Resident # 50 revealed he was lying in bed and had an indwelling catheter.

On 10/18/19 at approximately 8:30 a.m., an observation of and interview with Resident # 50 revealed he was lying in bed and had an indwelling catheter.

The comprehensive care plan for Resident # 41 date 06/18/2019 documented, "Focus: [Name of Resident # 50] has an indwelling catheter. Date Initiated: 06/18/2019." Under "Interventions" it documented, "Change external catheter per facility protocol or MD [medical doctor] order. Date Initiated: 06/18/2019."

On 10/17/19 at 2:30 p.m., an interview was conducted with LPN # 4 regarding Resident #

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F 657	Continued From page 25 50's care plan for an external catheter. After reviewing the comprehensive care plan LPN # 4 was asked to describe an external catheter. LPN # 4 stated, "An external catheter for male patients sometimes called a 'Texas' catheter that fits over the penis. An indwelling catheter goes inside the urethra. When asked about Resident # 50's catheter LPN # 4 stated, "He has an indwelling catheter." After reviewing Resident # 50's catheter care plan, LPN # 4 stated that the care plan was not correct. On 10/18/19 at 10:17 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. ASM # 2 was asked to review Resident # 50's comprehensive care plan. When asked about Resident # 50's catheter, ASM # 2 stated, "He has an indwelling catheter." After reviewing Resident # 50's catheter, care plan ASM # 2 stated that the care plan was not correct. On 10/18/19 at 9:05 a.m., an interview was conducted with RN [registered nurse] #1 MDS coordinator. RN # 1 was asked to review the comprehensive care plan for Resident # 50 dated 06/18/2019 regarding the catheter. RN # 1 stated, "It is documented on the care plan incorrectly. It should be indwelling catheter." On 10/18/19 at approximately 11:25 a.m., ASM [administrative staff member] # 1, administrator, was made aware of the above findings. No further information was provided prior to exit.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		12/1/19

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F 695	Continued From page 26 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that facility staff failed to provide respiratory care consistent with professional standards of practice, the comprehensive person-centered care plan for two of 40 residents in the survey sample, Residents # 27 and 31. The facility staff failed to store Resident # 27's C-PAP [Continuous Positive Airway Pressure] [1] mask in a sanitary manner and failed to administer Resident # 31's oxygen according to the physician's orders. The findings include: 1. Resident # 27 was admitted to the facility on 03/04/16 and a re-admission on 08/22/16 with diagnoses that included but were not limited to: obstructive sleep apnea [1], anxiety [2], and muscle weakness. Resident # 27's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/21/19, coded Resident # 27 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Review of the annual MDS with an	F 695	Resident #27□s CPAP was observed by nurse manager to be bagged and stored properly on 10/18/19. Resident #31□s oxygen flow rate was observed by nurse manager to be set at ordered rate on 10/18/19. All residents with respiratory care services have the potential to be affected by this deficient practice. An audit of all respiratory masks/tubing not in use was observed to be bagged correctly and residents receiving oxygen was provided as ordered on 10/18/2019. Quality Manager or designee will educate nursing staff on correct storage of respiratory masks/tubing not in use and nurses will be educated on checking oxygen flow rate to ensure oxygen is administered as ordered, by 11/24/19. Nurse Managers will observe all residents with respiratory care services weekly x 4 weeks, then 50% weekly x 4 weeks, then 25% monthly to ensure appropriate storage of masks/tubing when not in use and oxygen flow rates are provided as	

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ARD of 02/26/19 coded Resident # 27 under Section O "Special Treatments, Procedures and Programs" as having a C-PAP.

The POS [physician order sheet] for Resident # 27 dated CT [October] 2019 documented, "C-PAP Machine at bedtime for sleep apnea. Order Date: 04/30/2016."

The comprehensive care plan for Resident # 27 dated 03/28/2016 documented, "[Name of Resident # 27] has Obstructive Sleep Apnea. Date Initiated: 07/14/2016." Under "Interventions" it documented, "C-PAP nightly per order. Date Initiated: 07/14/2016."

On 10/16/19 at 11:30 a.m., at 1:51 p.m., and at 4:50 p.m., observations of Resident # 27 room revealed the C-PAP mask lying on top of the over-the- bed table next to the bed uncovered.

On 10/17/19 at 8:40 a.m., an observation of Resident # 27 room revealed the C-PAP mask lying on top of the over-the- bed table next to the bed uncovered.

On 10/17/19 at 11:39 a.m., an interview was conducted with Resident # 27. When asked about the C-PAP mask Resident # 27 stated she wears the mask every night. When asked if staff ever told her to store the mask in a bag Resident # 27 stated no.

On 10/18/19 at 10:37 a.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked if a C-PAP was considered a piece of respiratory equipment, LPN # 4 stated yes. When asked how a C-PAP mask should be stored when not in use, LPN # 4 stated, "It should

ordered. Results will be reviewed, trended, and reported monthly to QAPI for three months and then quarterly thereafter to ensure continued compliance.

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be stored in a bag. Someone should have identified it and bagged it." When informed of the above observations of Resident # 27's C-PAP mask uncovered and not stored in a bag, LPN # 4 stated, "It should be bagged."

On 10/18/19 at approximately 11:25 a.m., ASM [administrative staff member] # 1, administrator, was made aware of the above findings and the policy for storing respiratory equipment was requested.

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment."

No further information was provided prior to exit.

References:
[1] Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm.

2. The facility staff failed to administer Resident # 31's oxygen according to the physician's orders. Resident #31 was observed receiving oxygen at a flow rate of between two and a half liters and three liters per minute when the physician order

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was for three liters of oxygen a minute.

Resident # 31 was admitted to the facility on 05/31/17 and a re-admission on 01/18/19 with diagnoses that included but were not limited to: hypertension [1], gastroesophageal reflux disease [2], hypotension [3] and chronic pain.

Resident # 31's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/23/19, coded Resident # 31 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Under Section O "Special Treatments, Procedures and Programs" Resident # 31 was coded as receiving oxygen while a resident.

On 10/16/19 at 11:07 a.m., an observation of Resident # 31 revealed he was lying in bed receiving oxygen [O2] by nasal cannula connected to an oxygen concentrator. Observation of the O2 flow meter on the oxygen concentrator revealed the O2 flow rate was between two and a half liters and three liters per minute. Resident # 31 stated, "I get oxygen when I need it. It should be at three [three liters per minute."

On 10/17/19 at 8:48 a.m., an observation of Resident # 31 revealed he was lying in bed watching television receiving oxygen [O2] by nasal cannula connected to an oxygen concentrator. Observation of the O2 flow meter on the oxygen concentrator revealed the O2 flow rate was set between two and a half liters and three liters per minute.

On 10/17/19 at 8:51 a.m., an observation of

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Resident # 31's oxygen flow rate was conducted. Observation of the O2 flow meter on the oxygen concentrator revealed the O2 flow rate was between two and a half liters and three liters per minute.

The POS [physician order sheet] for Resident # 31 dated "OCT [October] 2019" documented, "Oxygen at 3L/Min [three liters per minute] via [by] nasal cannula every shift. Order Date: 01/18/2019."

The comprehensive care plan for Resident # 31 dated 12/03/2018 documented, "[Name of Resident # 27] has oxygen therapy r/t [related to] acute respiratory failure. Date Initiated: 12/03/2018." Under "Interventions" it documented, "Oxygen as ordered. Date Initiated: 12/03/2018."

On 10/18/19 at 10:37 a.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked how often a resident's oxygen flow rate is checked, LPN # 4 stated, "At the beginning of every shift." When asked to describe how to read the oxygen flow rate on the flow meter of the oxygen concentrator, LPN # 4 stated, "The liter line should go through the middle of the ball." When informed of the observations of Resident # 31's oxygen flow rate, LPN # 4 stated it was not set correctly.

According to Fundamentals of Nursing, 6th edition, Potter and Perry, 2005, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity (Thomson, 2002). As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse

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F 695	Continued From page 31 should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." On 10/18/19 at approximately 11:25 a.m., ASM [administrative staff member] # 1, administrator, was made aware of the above findings. No further information was provided prior to exit. References: [1] High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. [2] Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. [3] Low blood pressure. This information was taken from the website: https://medlineplus.gov/lowbloodpressure.html.	F 695		
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.	F 755		12/1/19

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F 755	Continued From page 32 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure physician prescribed medication was obtained and provided for administration as ordered for one of 40 residents in the survey sample, Resident #8. The facility staff failed to ensure Resident #8's newly prescribed antibiotic medication was provided for administration on 1/2/19 at 9:00 PM as ordered by the physician. The antibiotic was not obtained and administered until 1/3/19 at 9:00 AM. The findings include:	F 755	Resident #8 has all prescribed medications available for administration as of 10/18/19. All residents have the potential to be affected by this deficient practice. Nurse Managers completed audit on 10/18/19 to ensure all medications pending confirmation had been confirmed to ensure communication of new orders to pharmacy for fill. By 11/24/19, Quality Manager or designee will educate nurses on requirement to check for orders pending confirmation on	

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F 755	Continued From page 33 Resident #8 was admitted to the facility on 7/19/18 with the diagnoses of but not limited to Parkinson's disease, dementia, high blood pressure, psychosis, glaucoma, and left arm fracture. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/24/19 coded the resident as being severely impaired in ability to make daily life decisions. A review of the clinical record revealed a social worker note dated 1/2/19 regarding an interdisciplinary meeting that documented, "....Wound culture results will be looked at more thoroughly by NP (Nurse Practitioner) before making any recommendations...." Further, review revealed results of a wound culture, collected 12/31/19 and results of the culture dated 1/2/19, that documented a positive result for Escherichia Coli (1) in a wound. A physician, staff member on 1/2/19, initialed the culture results. An order entered into the electronic medical record system on 1/2/19 at 3:43 PM by the Physician's Assistant, documented, "Cefprozil (2) tablet, 500 mg (milligrams), Give 1 tablet every 12 hours for infection, skin, until 1/12/19." A review of the January 2019 MAR (Medication Administration Record) revealed that this order was to begin at 9:00 PM on 1/2/19. The first dose was not administered until 9:00 AM on 1/3/19. Further review of the above order revealed the nurse confirmed it electronically, on 1/3/19 at 4:02 AM.	F 755	day and evening shifts, preferably at beginning and midway through shift. Education will include requesting contracted pharmacy to retrieve newly prescribed antibiotics from back up pharmacy when medication is unavailable in Cubex. Night shift nurses will check all residents clinical records for orders pending confirmation at beginning of shift. Any unnecessary missed doses due to delay in confirming orders will be documented as medication error. Nurse Managers or designee will audit orders pending confirmation twice weekly x 4 weeks and then weekly x 4 weeks to ensure all orders are confirmed timely and all unnecessary missed doses are reported as medication errors. Results will be reviewed, trended and reported monthly to QAPI for three months and quarterly thereafter to ensure continued compliance.	

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On 10/18/19 at 9:50 AM, when providing this surveyor a copy of the order details, ASM #2 (Administrative Staff Member) the Director of Nursing, stated that the order was not confirmed until the night shift. ASM #2 stated she was not employed at the facility at the time. She states she could not speak to why the antibiotic order was not confirmed until the night shift.

On 10/18/19 at approximately 10:20 AM in an interview was conducted with LPN #1 (Licensed Practical Nurse). LPN #1 stated that nurses should check the electronic system every hour for any new orders that need to be confirmed. LPN #1 stated that the orders are not complete and sent electronically to the pharmacy for filling until the nurse confirms an order. She stated the confirmation process involves the nurse clicking on "confirm." LPN #1 stated not confirming an order entered at 3:43 PM until 4:02 AM caused a delay in treatment for Resident #8.

On 10/18/19 at 11:37 AM, in an interview with LPN #6, she stated that she was not sure how the electronic system worked regarding when the orders are sent to the pharmacy but that nurses should check at least twice a shift.

On 10/18/19 at 12:05 PM, in a follow up interview with ASM #2, she stated that nurses should check at the beginning and midway through their shifts for any new orders that need to be confirmed. ASM #2 stated that the order is not sent electronically to the pharmacy to be filled until the nurse clicks on confirm. She stated this only applies to orders entered by physician staff. ASM #2 stated that when a nurse enters an order, it is confirmed immediately. When a physician staff member enters an order, they enter the

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medication, dose, route, and frequency, but the nurses enter the scheduled times for the medication, which is why the nurse has to confirm the order, so that the order to be completed and then sent to the pharmacy. ASM #2 stated the orders are not sent electronically until the order is complete, which happens in the confirmation step. ASM #2 stated in this case, even if the nurse had checked at the beginning of the shift and if the order was not in yet at that time, that the nurse should have caught it on a mid-shift check around 7:00 PM so the medication could have been sent, or obtained from the back up pharmacy. ASM #2 stated the medication was not one that is available in the on-site medication supply.

A review of the facility policy, "Telephone Orders" did not address the above concern.

On 10/18/19 at 12:18 AM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.

(1) Escherichia Coli - E. coli is the name of a type of bacteria that lives in your intestines. Most types of E. coli are harmless. However, some types can make you sick and cause diarrhea....You can get E. coli infections by eating foods containing the bacteria.
Information obtained from https://medlineplus.gov/ecoliinfections.html

(2) Cefprozil - an antibiotic used to treat certain infections caused by bacteria, such as bronchitis; and infections of the skin, ears, sinuses, throat, and tonsils.

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F 755	Continued From page 36 Information obtained from https://medlineplus.gov/druginfo/meds/a698022.html	F 755		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed ensure the drug regimen for three of 40 residents in the survey sample, Residents # 63, # 30 and # 31, were free from unnecessary pain medications. The facility staff failed to implement non-pharmacological interventions prior to the	F 757	Resident #63 had orders added to document non-pharmacological interventions prior to administration of analgesics on 10/17/19. Pain assessment was completed on 11/6/19 to determine new person-centered interventions most effective for resident. Resident #30 had orders added to document	12/1/19

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F 757	Continued From page 37 administration of as needed pain medication, for Resident # 63 and #31 on multiple occasions in August, September and October 2019, and for Resident # 30 on multiple occasions in September 2019. The findings include: 1. The facility staff failed to implement non-pharmacological interventions prior to the administration of as needed pain medication, Tylenol [1] for Resident # 63 on multiple occasions in August, September and October 2019. Resident # 63 was admitted to the facility on 04/20/2010 and was readmitted on 09/20/2019, with diagnoses that included but were not limited to: chronic pain osteoarthritis [2] and high blood pressure. Resident # 63's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/26/19, coded Resident # 63 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition for making daily decisions. Section J "Health Conditions" coded Resident # 63 as having frequent pain at a level of six on a pain scale of zero to ten, with ten being the worse pain. The POS [physician order sheet] for Resident # 63 dated "OCT [October] 2019 documented, "Tylenol Tablet (Acetaminophen). Give 650 milligrams by mouth every 12 hours as needed for pain. Start Date: 05/21/20019." The eMAR [electronic medication administration	F 757	non-pharmacological interventions prior to administration of analgesics on 10/17/19. Pain assessment was completed on 11/6/19 to determine new person-centered interventions most effective for resident. Resident #31 had orders added to document non-pharmacological interventions prior to administration of analgesics on 10/17/19. Pain assessment to determine new person-centered interventions most effective for resident, was completed on 11/6/19. All residents receiving as needed pain medications have the potential to be affected by this deficient practice. Nurse Manager or designee will complete a 100% audit of all residents with as needed pain medication orders by 11/24/19 to ensure orders are obtained and documentation presence of non-pharmacological interventions prior to analgesic administration. Quality Manager or designee will re-educate nurses on Pain Management policy by 11/24/19. Nurse Managers will review 24 hour reports for documentation of non-pharmacological interventions to ensure compliance. The Director of Nursing or designee will audit 10 resident clinical records weekly x 4 weeks then 10 resident clinical records monthly to ensure residents with as needed pain medications have documentation to support implementation of non-pharmacological interventions prior	

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F 757	Continued From page 38 record] for Resident # 63 dated "AUG [August] 2019" documented the physician order documented above on the October 2019 POS. Further review of the eMAR revealed Tylenol 650 milligrams was administered on the dates and times as follows: - 08/02/19 at 3:33 a.m. for pain level of eight, 08/06/19 at 2:54 a.m. with pain level of two, - 08/12/19 at 3:00 a.m. with pain level of eight, - 08/16/19 at 2:02 a.m. with pain level of six, - 08/23/19 at 3:48 a.m. with pain level of four and on 08/29/19 at 3:09 p.m. with pain level of eight. The eMAR for Resident # 63 dated "SEPT [September] 2019" documented the same physician order as documented above on the October 2019 POS [physician order sheet]. Further review of the eMAR revealed Tylenol 650 milligrams was administered on dates and times as follows: -09/01/19 at 3:06 p.m. with pain level of four, -09/02/19 at 5:42 p.m. with pain level of seven, - 09/06/19 at 4:21 p.m. with pain level of five and on 09/23/19 at 2:50 a.m. with pain level of seven. The eMAR for Resident # 63 dated "OCT [October] 2019" documented the same physician order for Tylenol as documented above on the October 2019, POS. Further review of the eMAR revealed Tylenol 650 milligrams was administered on 10/06/19 at 7:54 a.m. with pain level of five. Review of the facility's nursing "Progress Notes' for the dates Tylenol was administered to Resident # 63 as stated above in August, September and October 2019, failed to evidence documentation non-pharmacological interventions were attempted prior to the administration of Tylenol.	F 757	to administration of as needed pain medications. Results will be reviewed, trended, and reported monthly to QAPI for three months then quarterly thereafter to ensure continued compliance.	

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The comprehensive care plan for Resident # 63's pain documented, "[Name of Resident # 63] has chronic pain r/t [related to] Arthritis especially Right knee, back and hands. Date Initiated: 09/28/2018." Under "Interventions/Tasks" it documented, "Monitor/document for probable cause of ach pain episode. Remove/limit causes where possible. Date Initiated: 09/28/2018."

On 10/16/19 at 4:10 p.m., an interview was conducted with Resident # 63. When asked about her pain medication, Resident # 63 stated, "I get scheduled and prn pain medication. They ask me the level of pain and where it is." When asked if the nursing staff attempt to alleviate her pain before giving her the as needed pain medication, Resident # 63 stated, "No. They just give me the medication."

On 10/18/19 at 10:37 a.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked to describe the process of administering prn [as needed] pain medication, LPN # 4 stated, "Determine where the pain is, get a pain level zero to ten, ten being the worse pain, try non-pharmacological interventions, if not effective then give the prescribed medication and recheck 30 minutes later to see if it was effective. When asked where staff document non-pharmacological interventions attempted, LPN # 4 stated, "It's documented in the nurse's notes." When asked to describe the purpose of using non-pharmacological interventions LPN # 4 stated, "To see if we can do without pain medication to relieve the pain." After reviewing the nurse's progress notes for the dates Tylenol was administered to Resident # 63 and eMARs dated August, September and October 2019, LPN

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4 was asked if non-pharmacological interventions were documented. LPN # 4 stated, no. If it wasn't documented it wasn't done."

The facility's policy "Pain Management" documented in part, "3B. Alternative treatments such as positioning, heat, and cold applications, music, aroma therapy, message, acupuncture, etc ... Non-pharmacological interventions should be attempted before or in addition to medication."

On 10/17/19 at 5:25 p.m., ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html.

[2] The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information

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was obtained from the website: https://medlineplus.gov/osteoarthritis.html.

2. The facility staff failed to implement non-pharmacological interventions prior to administering as needed pain medications, Butalbital-APAP-Caffeine Tablet [1], and Tylenol extra strength [2] to Resident # 30 on multiple occasions in September 2019.

Resident # 30 was admitted to the facility on 12/15/2017, with a readmission on 03/18/2019 with diagnoses that included but were not limited to: muscle spasms, lumbago [4] with sciatica [5] and high blood pressure.

Resident # 30's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 08/19/19, coded Resident # 30 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section J "Health Conditions" coded Resident # 30 as having severe pain "Almost constantly."

The POS [physician order sheet] for Resident # 30 dated "OCT [October] 2019 documented,
- "Butalbital-APAP-Caffeine Tablet 50-325-40 MG [milligrams]. Give 1 [one] tablet by mouth every 4 [four] hours as needed for Pain." Order Date: 04/01/2019."
- "Tylenol Extra Strength Tablet 500 MG. (Acetaminophen). Give 2 [two] tablet by mouth every 8 [eight] hours as needed for Moderate Pain. Order Date: 08/30/2019."

The eMAR [electronic medication administration record] for Resident # 30 dated "SEPT

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[September] 2019" documented the above physicians orders documented on the October 2019 POS. Review of the eMAR revealed Butalbital-APAP-Caffeine Tablet 50-325-40 milligrams was administered on the dates and times as follows: 09/15/19 at 2:00 a.m. with pain level of two and on 09/18/19 at 8:20 p.m. with pain level of eight.
Further review of the September 2019 eMAR revealed Tylenol Extra Strength Tablet 500 milligrams was administered on the dates and times as follows:
-09/03/19 at 12:42 a.m. with pain level of four,
- 09/06/19 at 9:24 a.m. with pain level of six,
- 09/14/19 at 10:19 a.m. with pain level of six,
- 09/15/19 at 9:46 a.m. with pain level of four,
- 09/17/19 at 5:30 p.m. with pain level of eight and on 09/29/19 at 9:38 a.m. with pain level of six and at 10:54 p.m. with pain level of five.

Review of the facility's nursing "Progress Notes' for Resident # 30 for the dates Butalbital-APAP-Caffeine Tablet and Tylenol Extra Strength was administered to Resident # 30 as stated above in September 2019, failed to evidence documentation non-pharmacological interventions were attempted prior to the administration of the pain medications.

The comprehensive care plan for Resident # 30's pain dated 12/27/2017 documented, "[Name of Resident # 30] has alteration in comfort related to depression, Hx [history] of breast CA [cancer], and low back pain secondary to stenosis 08/10/2018; new c/o [complaint of] rib pain when coughing and L [left] shoulder pain. Revision on: 11/14/2018."

On 10/17/19 at 9:01 a.m., an interview was

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conducted with Resident # 30. When asked about her pain medication, Resident # 30 stated, "I get scheduled and prn pain medication. They ask me the level of pain and where it is." When asked if the nursing staff attempts to alleviate her pain before giving her the as needed pain medication, Resident # 30 stated, "No. They just give me the medication."

On 10/18/19 at 10:37 a.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked to describe the process of administering prn [as needed] pain medication, LPN # 4 stated, "Determine where the pain is, get a pain level zero to ten, ten being the worse pain, try non-pharmacological interventions, if not effective then give the prescribed medication and recheck 30 minutes later to see if it was effective. When asked where staff document non-pharmacological interventions attempted, LPN # 4 stated, "It's documented in the nurse's notes." When asked to describe the purpose of using non-pharmacological interventions, LPN # 4 stated, "To see if we can do without pain medication to relieve the pain." After reviewing the nurse's progress notes for the dates Butalbital-APAP-Caffeine and Tylenol Extra Strength was administered to Resident # 30 and eMARs dated September 2019, LPN # 4 was asked if non-pharmacological interventions were documented. LPN # 4 stated, no. If it wasn't documented it wasn't done."

On 10/17/19 at 5:25 p.m., ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

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References:
[1] This combination of drugs is used to relieve tension headaches. The combination of aspirin, butalbital, and caffeine comes as a capsule and tablet to take by mouth. It usually is taken every 4 hours as needed. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601023.html.

[2] Acetaminophen is used to relieve mild to moderate pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html.

[4] Back pain. This information was obtained from the website: https://medlineplus.gov/backpain.html.

[5] Refers to pain, weakness, numbness, or tingling in the leg. It is caused by injury to or pressure on the sciatic nerve. Sciatica is a symptom of a medical problem. It is not a medical condition on its own. This information was obtained from the website: https://medlineplus.gov/ency/article/000686.htm.

3. The facility staff failed to implement non-pharmacological interventions prior to administering as needed pain medications Percocet [1] and Tylenol [2] to Resident # 31 on multiple occasions in August, September, and October 2019.

Resident # 31 was admitted to the facility on 05/31/17 and a re-admission on 01/18/19 with

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diagnoses that included but were not limited to: high blood pressure and chronic pain.

Resident # 31's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/23/19, coded Resident # 31 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section J "Health Conditions" coded Resident # 31 as having pain level of ten on a scale of zero to ten "Almost constantly."

The POS [physician order sheet] for Resident # 31 dated "OCT [October] 2019 documented, "Percocet Tablet 5-325MG [milligrams] (Oxycodone-Acetaminophen). Give 1 [one] tablet by mouth every 6 [six] hours as needed for pain. Order Date: 01/18/2019" and documented, "Tylenol Tablet (Acetaminophen). Give 1000 milligrams by mouth every 8 [eight] hours as needed for pain. Start Date: 03/01/20019."

The eMAR [electronic medication administration record] for Resident # 31 dated "AUG [August] 2019" documented the above physicians orders. Review of the eMAR revealed Percocet 5-325 mg was administered on the dates and times as follows:
-08/04/19 at 9:37 p.m. with pain level of eight,
-08/06/19 at 10:41 p.m. with pain level of nine,
-08/07/19 at 5:05 p.m. with pain level of five,
-08/08/19 at 4:56 p.m. with pain level of nine,
-08/15/19 at 8:54 a.m. with pain level of nine and at 8:20 p.m. with pain level of ten,
-08/18/19 at 4:40 p.m. with pain level of five,
08/22/19 at 2:01 a.m. with pain level of four, and on 08/31/19 at 12:11 p.m. with pain level of seven.

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Further review of the AUG 2019 eMAR revealed Tylenol 1000 milligrams was administered on dates and times as follows:
-08/02/19 at 12:35 a.m. for pain level of nine,
-08/03/19 at 2:22 a.m. with pain level of two and at 11:19 with pain level of five, 08/04/19 at 12:41 a.m. with pain level of three and at 4:38 p.m. with pain level of four,
-08/06/19 at 1:03 a.m. with pain level of two,
-08/10/19 at 1:24 p.m. with pain level of six, -08/11/19 at 10:42 a.m. with pain level of four,
-08/14/19 at 3:36 p.m. with pain level of ten,
-08/15/19 at 7:48 p.m. with pain level of ten,
-08/18/19 at 11:51 a.m. with pain level of five and at 11:53 p.m. with pain level of five and on 08/22/19 at 12:05 a.m. with pain level of two

The eMAR for Resident # 31 dated "SEPT [September] 2019" documented the above physicians orders for Percocet and Tylenol.
Review of the eMAR revealed Percocet 5-325 mg was administered on dates and times as follows:
- 09/01/19 at 4:17 p.m. with pain level of seven,
- 09/07/19 at 11:30 a.m. with pain level of nine,
- 09/10/19 at 6:15 a.m. with pain level of three,
- 09/12/19 at 6:39 a.m. with pain level of two,
- 09/14/19 at 5:11 p.m. with pain level of four,
- 09/15/19 at 3:15 p.m. with pain level of six,
- 09/16/19 at 11:37 a.m. with pain level of nine,
- 09/17/19 at 11:44 a.m. with pain level of nine,
- 09/18/19 at 12:27 p.m. with pain level of eight,
- 09/19 at 11:24 a.m. with pain level of nine,
- 09/22/19 at 11:26 a.m. with pain level of seven,
- 09 /23/19 at 12:56 p.m. with pain level of nine,
- 09/24/19 at 5:58 a.m. with pain level of nine,
- 09/26/19 at 3:47 a.m. with pain level of two and at 12:01 p.m. with pain level of nine,
- 09/27/19 at12:17 p.m. with pain level of nine and

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on 09/29/19 12:34 p.m. with pain level of eight.

Further review of the SEPT 2019, eMAR revealed Tylenol 1000 milligrams was administered on the dates and times as follows:
- 09/02/19 at 11:02 p.m. with pain level of nine,
- 09/10/19 at 9:33 p.m. with pain level of seven,
- 09/14/19 at 10:23 a11:44 a.m. with pain level of four,
- 09/15/19 at10:22 a.m. with pain level of four,
- 09/16 at 11:37 a.m. with pain level of nine,
- 09/17/19 at 2:52 a.m. with pain level of nine,
- 09/18/19 at 10:23 a.m. with pain level of nine,
- 09/19/19 at 11:23 a.m. with pain level of nine,
- 09/21/19 at 2:09 p.m. with pain level of three,
- 09/22/19 at 11:27 a.m. with pain level of seven,
- 09/24/19 at 12:44 p.m. with pain level of nine,
- 09/25/19 at 2:00 a.m. with pain level of two,
- 09/26 at 1:00 a.m. with pain level of two and at 12:01 p.m. with pain level of nine and on 09/28/19 at 3:56 a.m. with pain level of two.

The eMAR for Resident # 31 dated "OCT [October] 2019" documented the same physicians orders for Percocet and Tylenol as documented on the Oct 2019 POS. Review of the eMAR revealed Percocet 5-325 mg was administered on the dates and times as follows:
- 10/01/19 at 11:55 a.m. with pain level of four,
- 10/02/19 at 10:30 a.m. with pain level of eight,
- 10/03/19 at 1:15 p.m. with pain level of nine,
- 10/05/19 at 7:42 a.m. with pain level of five,
- 10/07/19 at 1:13 p.m. with pain level of nine,
- 10/08/19 at 11:48 a.m. with pain level of nine,
- 10/09/19 at 1:00 p.m. with pain level of nine,
- 10/10/19 at 1:00 p.m. with pain level of nine,
- 10/11/19 at 3:52 p.m. with pain level of eight,
- 10/14/19 at 4: 44 p.m. with pain level of eight and on 10/15/19 at 1:17 p.m. with pain level of

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nine.

Further review of the Oct 2019 eMAR revealed Tylenol 1000 milligrams was administered on dates and times as follows:
- 10/02/19 at 12:19 a.m. with pain level of four,
- 10/03/19 at 7:38 a.m. with pain level of ten,
- 10/05/19 at12:07 p.m. with pain level of three,
- 10/06/19 at 12:52 p.m. with pain level of seven,
- 10/07/19 at 11:40 p.m. with pain level of two,
- 10/08/19 at 8:03 a.m. with pain level of nine,
- 10/12/19 at 12:32 p.m. with pain level of five and on 10/15/19 at 8:33 p.m. with pain level of three.

Review of the facility's nursing "Progress Notes' for the dates Percocet and Tylenol were administered to Resident # 30 as stated above in August, September and October 2019, failed to evidence documentation that non-pharmacological interventions were attempted prior to the administration of the pain medication.

The comprehensive care plan for Resident # 31's pain documented, "[Name of Resident # 30] has alteration in comfort r/t [related to] pain from h/o [history of] cellulitis of bilateral lower limbs, stage III pressure ulcer on coccyx, chronic right hip pain and gout, diabetic neuropathy. Date Initiated: 06/08/2017." Under "Interventions/Tasks" it documented, "Eliminate additional stressor or sources of discomfort when possible. Date Initiated: 06/08/2017."

On 10/16/19 at 11:07 a.m., an interview was conducted with Resident# 31 regarding his pain. Resident # 31 stated that he has chronic pain at a pain level of eight to nine out of ten. Resident # 31 stated, "When I'm in pain I tell the aide and

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they get the nurse and the nurse brings me my pain medication." When asked if the nurse tries to do anything to relieve the pain before giving the pain medication, Resident # 31 stated, "No."

On 10/18/19 at 10:37 a.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked to describe the process of administering prn [as needed] pain medication LPN # 4 stated, "Determine where the pain is, get a pain level zero to ten, ten being the worse pain, try non-pharmacological interventions, if not effective then give the prescribed medication and recheck 30 minutes later to see if it was effective. When asked where non-pharmacological interventions are documented, LPN # 4 stated, "It's documented in the nurse's notes." When asked to describe the purpose of using non-pharmacological interventions, LPN # 4 stated, "To see if we can do without pain medication to relieve the pain." After reviewing the nurse's progress notes for the dates Tylenol was administered to Resident # 31 and eMARs dated August, September and October 2019, LPN # 4 was asked if non-pharmacological interventions were documented. LPN # 4 stated, "No. If it wasn't documented it wasn't done."

On 10/17/19 at 5:25 p.m., ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:

[1] Percocet- Oxycodone is used to relieve moderate to severe pain. Oxycodone

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F 757	Continued From page 50 extended-release tablets and extended-release capsules are used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. Oxycodone is also available in combination with acetaminophen (Oxycet, Percocet, Roxicet, Xartemis XR, others); aspirin (Percodan); and ibuprofen. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html [2] Acetaminophen is used to relieve mild to moderate pain.This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		12/1/19

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F 761	Continued From page 51 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 staff interview and clinical record review, it was determined that the facility staff failed to dispose of biologicals upon expiration date in one of two nourishment rooms. The facility staff failed to dispose of biologicals upon expiration date. Three bottles of expired tube feeding formula were observed available for resident use in the Dogwood/Willow nourishment room. The findings include: On 10/17/19 at 8:00 AM an inspection of nourishment rooms was conducted. Three bottles of expired tube feeding formula were found in one nourishment room, 1000 milliliter bottle of Osmolite expired 3/1/19, 1000 milliliter bottle of Jevity expired 7/1/19 and 500 milliliter bottle of Vital expired 9/1/19. An interview was conducted with LPN (licensed practical nurse) #2, on 10/17/19 at 8:00 AM. LPN #2 stated, "I was checking the tube feedings this morning and found they were expired, but I couldn't reach them to throw them out." All three bottles of expired tube feedings were located on the third shelf. When asked about the process for checking expiration dates of tube feeding, LPN #2 stated, "The supply manager stocks the	F 761	The three expired enteral feeding bottles found in nourishment room were discarded by charge nurse on 10/17/19. There were no other enteral feeding bottles observed in nourishment room. All residents with enteral feeding orders have the potential to be affected by this deficient practice. Enteral feeding bottles stored in central supply area were checked and confirmed to not be expired, on 10/17/19. Policy and Procedure on Medication storage will be revised to include storage of biologicals by 11/14/19. Quality Manager or designee will educate nursing staff by 11/24/19, on revised policy and process that enteral feeding bottles brought to unit need to be returned to centralized storage room upon discontinuation of enteral feeding orders or resident discharge, and requirement to check expiration dates on enteral feedings. Central supply coordinator will audit nourishment rooms weekly for storage of enteral feeding, and audit central supply area monthly. Expired enteral feeding will	

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F 761	Continued From page 52 tube feeding and checks expiration dates." An interview was conducted on 10/17/19 at 11:30 AM with ASM (administrative staff member) #1, the administrator. When asked about the process for stocking tube feedings and removing expired biological's, ASM #1 stated, "The supply manager stocks tube feedings and rotates stock so older stock is out front." When asked who takes the tube feedings to the nourishment room, ASM #1 stated, "I believe the nursing staff, maybe the nursing assistants, take it from central supply to nourishment room." An interview was conducted on 10/17/19 at 4:00 PM with CNA (certified nursing assistant) #2. When asked who stocks the nourishment room, CNA #2 stated, "The supply manager stocks it." When asked about the process staff follows for checking for expired tube feedings, CNA #2 stated, "I don't know her process." ASM #1, the administrator and ASM #2, the director of nursing were informed of the expired tube feedings on 10/17/19 at 5:30 PM. ASM #2 stated, "The CNA's don't stock the tube feeding in the nourishment room. The nurse's usually take it to the nourishment room." ASM #2 was informed the LPN's and CNA's stated the supply manager stocked the nourishment room. ASM #1 and ASM #2 were asked to provide a copy of the facility policy regarding checking for expired biologicals including tube feedings. On 10/18/19 8:00 AM, ASM #1 stated they did not have a policy on expired biologicals or tube feedings. On 10/18/19 at 11:20 AM during exit with ASM #2, she stated, "I can't find any policy on expired biologicals or tube feedings, but I will	F 761	be immediately discarded. Results will be reviewed, trended and reported monthly to QAPI for three months and quarterly thereafter to ensure continued compliance.	

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F 761	Continued From page 53 keep on looking." No further information was provided prior to exit.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or 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	F 880		12/1/19

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F 880	Continued From page 54 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that facility staff failed to implement infection control practices to prevent the development and transmission of infections for one of 40 residents in the survey sample, Residents # 27. The facility staff failed to	F 880	Resident #27□s CPAP was observed by Nurse Manager to be bagged and stored properly on 10/18/19. All residents with respiratory care services have the potential to be affected by this	

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F 880	Continued From page 55 implement infection control practices for the storage of Resident # 27's C-PAP mask [Continuous Positive Airway Pressure] [1] when it was not in use. The findings include: Resident # 27 was admitted to the facility on 03/04/16 and a re-admission on 08/22/16 with diagnoses that included but were not limited to: obstructive sleep apnea [1], anxiety [2], and muscle weakness. Resident # 27's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/21/19, coded Resident # 27 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Review of the annual MDS with an ARD of 02/26/19 coded Resident # 27 under Section O "Special Treatments, Procedures and Programs" as having a C-PAP. On 10/16/19 at 11:30 a.m., at1:51 p.m., and at 4:50 p.m., an observations of Resident # 27 room revealed the C-PAP mask lying on top of the over-the- bed table next to the bed uncovered. On 10/17/19 at 8:40 a.m., an observation of Resident # 27 room revealed the C-PAP mask lying on top of the over-the- bed table next to the bed uncovered. The POS [physician order sheet] for Resident # 27 dated CT [October] 2019 documented, "C-PAP Machine at bedtime for sleep apnea. Order Date: 04/30/2016."	F 880	deficient practice. On 10/18/19, Nurse Managers completed an audit for all residents receiving respiratory care to ensure all respiratory masks/tubing not in use was bagged correctly. Quality manager or designee will educate nursing staff on correct storage of respiratory masks/tubing not in use, by 11/24/19. Nurse Managers will observe all residents with respiratory care services weekly x 4 weeks, then 50% weekly x 4 weeks, then 25% monthly to ensure appropriate storage of masks/tubing when not in use. Results will be reviewed, trended, and reported monthly to QAPI for three months then quarterly thereafter to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495233	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAUQUIER HEALTH REHABILITATION & NURSING CENTER	360 HOSPITAL DRIVE WARRENTON, VA 20186

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F 880	Continued From page 56	F 880		

The comprehensive care plan for Resident # 27 dated 03/28/2016 documented, "[Name of Resident # 27] has Obstructive Sleep Apnea. Date Initiated: 07/14/2016." Under "Interventions" it documented, "C-PAP nightly per order. Date Initiated: 07/14/2016."

On 10/17/19 at 11:39 a.m., an interview was conducted with Resident # 27. When asked about the C-PAP mask Resident # 27 stated she wears the mask every night. When asked if staff ever told her to store the mask in a bag Resident # 27 stated no.

On 10/18/19 at 10:37 a.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked if a C-PAP was considered a piece of respiratory equipment, LPN # 4 stated yes. When asked how a C-PAP mask should be stored when not in use, LPN # 4 stated, "It should be stored in a bag." When asked why the C-PAP mask should be stored in a bag, LPN # 4 stated, "For infection control." When informed of the above observations of Resident # 27's C-PAP mask, LPN # 4 stated, "It should be bagged."

On 10/18/19 at approximately 11:25 a.m., ASM [administrative staff member] # 1, administrator, was made aware of the above findings.

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment."

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 57 References: [1] Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm.	F 880		