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	495381	A. BUILDING _____ B. WING _____	10/24/2019

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/22/19 through 10/24/19. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/22/2019 through 10/24/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 91 at the time of the survey. The survey sample consisted of 19 current Resident reviews and (3) three closed record reviews.	F 000		
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, facility staff failed to obtain physician orders for the immediate care of a wound vac for one of 22 residents, Resident #89. Findings were: Resident #89 was admitted to the facility on	F 635	F 0635 1. Resident #89 has discharged from the facility. 2. A 100% audit of residents with Wound Vacs will be completed by the DON or designee to ensure physician□s orders are in place for the Wound Vac that includes Wound Vac settings and	12/5/19

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

Electronically Signed | 11/05/2019

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F 635	Continued From page 1 08/09/2019 with the following diagnoses including but not limited to: Left hip fracture, malignant neoplasm of the bone, COPD (chronic obstructive pulmonary disease), dysphagia, and pain. He died at the facility on 08/18/2019. A five day MDS (minimum data set) assessment was completed with an ARD (assessment reference date) of 08/16/2019. Resident #89 was assessed as cognitively intact with a cognitive summary score of "15". The clinical record was reviewed on 10/23/2019. On 08/09/2019 the following nursing note was written: "Pt [patient] arrived by [name of transport company] via stretcher at 1420 [2:20 p.m.] Pt moved to bed...on 4 L NC [liters nasal cannula]...skilled for left hip fracture. Wound vac on and running..." A physician's order dated 08/09/2019 contained the following information: "Wound vac". There were no orders for the wound vac settings, or for dressing changes to the wound vac. On 10/23/2019 at approximately 1:45 p.m. RN (registered nurse) #1, the unit manager for the unit where Resident #89 resided, and the ADON [assistant director of nursing] were interviewed regarding the wound vac. RN #1 stated, "It was discontinued on Monday so we didn't need to do any dressing changes, we do those on Monday, Wednesday, and Friday...the settings were in place from the hospital." RN #1 was asked how they knew the setting was correct or what to do if the seal on the dressing was lost and the wound vac stopped working. She stated, "We would need to contact the physician."	F 635	dressing changes to the Wound Vac. 3. Education will be provided to all Licensed Nurses by the DON or designee regarding obtaining orders for immediate care of Wound Vacs including Wound Vac settings and dressing changes to the Wound Vac. 4. A 10% audit of resident□s with Wound Vacs will be conducted monthly for 3 months by the DON or designee to ensure physician□s orders are in place for the wound vac that incudes Wound Vac settings and dressing changes to the wound vac. The results of these audits will be reported to the facility QAPI meeting to ensure on-going compliance. 5. Corrective action will be complete by 12/05/2019	

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The DON (director of nursing) presented progress notes from Resident #89's hospital record. The first dated 08/07/2019 contained the following: "...wound vac replaced over intact staples to outer left thigh...Periwound windowpaned with drape, covered all staples using one piece versatel, covered all with one piece black foam, drape to seal. Settings 125 mmhg/low/cont [continuous]..." The second dated 08/09/2019 contained the following: "Attempted to visit resident today to assess surgical wound with wound vac over a closed incision. Patient was discharged today to the [name of facility] and was discharged with the hospital wound vac in place. Inquired to the whereabouts of he vac with the charge nurse....who though the patient was sent home with a home vac but was unsure who switched it out...patient was indeed transferred to [name of facility] with [name of hospital] wound vac in place. Requested vac be removed and sent back to [hospital] via security or transport and a vac from the [facility] be applied."

The above information was discussed during an end of the day meeting on 10/23/2019 with the DON and the administrator. The DON was asked about the progress notes presented. She stated that they had been part of the hospital record not part of the facility record. She was asked if the wound vac had been changed out as documented in the progress note from the hospital. She stated, "No, the family didn't want us to change it since it was working so well." She was asked if that was documented in the clinical record. She stated, "I will need to look."

On 10/24/2019 a discharge summary from the hospital was presented by the DON. The hospital

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F 635	Continued From page 3 discharge summary contained no orders/parameters for the wound vac. The DON was asked how the nursing staff knew what to do with the wound vac if no orders were in place at the time of admission and were not obtained from the physician. She did not answer. No further information was obtained prior to the exit conference on 10/24/2019.	F 635		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F 655		12/5/19

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F 655	Continued From page 4 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to develop a baseline care plan for two of 21 residents. Resident #89 was admitted to the facility with a wound vac and a port-a-cath, and Resident #85 was admitted with a wound vac. A baseline care plan for the devices was not developed for either resident. Findings were: 1. Resident #89 was admitted to the facility on 08/09/2019 with the following diagnoses including but not limited to: Left hip fracture, malignant neoplasm of the bone, COPD (chronic obstructive pulmonary disease), dysphagia, and pain. He died at the facility on 08/18/2019. A five day MDS (minimum data set) assessment was completed with an ARD (assessment reference date) of 08/16/2019. Resident #89 was	F 655	F 0655 1. Resident # 89 has been discharged from the facility. The comprehensive care plan of resident # 85 was updated on 10/24/2019 to include specific problems, goals, and interventions related to the use of a Wound Vac to aid in the healing of his surgical incision. 2. A 100% audit of resident□s who have Wound Vacs or implanted ports will have their baseline care plans conducted by the DON or designee to ensure specific problems, goals, and interventions are in place related to Wound Vacs or implanted ports. 3. Education will be provided to Licensed Nurses by the DON or designee regarding developing base line care plans that include specific problems, goals, and interventions. A focus will be placed on Wound Vacs and implanted ports.	

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F 655	Continued From page 5 assessed as cognitively intact with a cognitive summary score of "15". The clinical record was reviewed on 10/23/2019. On 08/09/2019 the following nursing note was written: "Pt[patient] arrived by [name of transport company] via stretcher at 1420 [2:20 p.m.] Pt moved to bed...on 4 L NC [liters nasal cannula]...skilled for left hip fracture. Wound vac on and running..." Another note also dated 08/09/2019 contained the following: "...implanted port noted to right chest wall. Patient states this was decannulated and flushed today." The care plan was reviewed. There were no interventions listed on the care plan for the care of the wound vac or the implanted device. On 10/23/2019 at approximately 1:45 p.m. RN (registered nurse) #1, the unit manager for the unit where Resident #89 resided, and the ADON [assistant director of nursing] were interviewed regarding the care plan. RN #1 stated, "We mentioned the wound vac under falls because of the tubing." The area on the care plan RN#1 referred to was: "Problem: [Name] has a potential for falls and injury rt [related to] recent fall, hip fracture and multiple devices (wound vac). Goals: [Name] will not sustain serious injury rt fall thru next review. Interventions: Ensure call bell is within reach... PT [physical therapy] referral, Therapy interventions." There was no mention in the fall interventions regarding the wound vac tubing. RN#1 also stated, "We have an intervention for dressing changes as ordered beside the problem surgical incision/wound...that would include the	F 655	4. A 10% audit of residents with Wound Vacs or implanted ports will have their baseline care plans audited by the DON or designee monthly for 3 months to ensure specific problems, goals and interventions are in place. The results of these audits will be reported to the facility QAPI meeting to ensure on-going compliance. 5. Corrective action will be complete by 12/05/2019.	

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F 655	Continued From page 6	F 655		

wound vac even if it isn't mentioned...we don't care plan specifics about wound care because the orders change frequently...The wound vac was discontinued on Monday so we didn't really do anything with it." RN #1 was asked what the nurse's should be doing with a wound vac. She stated, "Monitoring the site, making sure the dressing is clean and dry, make sure the wound vac is running." She was asked if she thought that should be on the care plan. Neither she or the ADON answered. They were asked what the purpose of the care plan was. The ADON stated, "To direct the patient's care." She was asked if that meant the nursing interventions such as assessing the wound vac, the site, etc, should be on the care plan. She stated, "Yes."

The implanted port was also discussed. RN #1 stated, "We weren't doing anything with that so it wouldn't go on the care plan." She was asked if it should be added as a point of information for the nurses. She did not answer.

The above information was discussed during an end of the day meeting on 10/23/2019 with the DON (director of nursing) and the administrator.

No further information was obtained prior to the exit conference on 10/24/2019.

2. Resident # 85 was admitted to the facility on 9/25/19 with diagnoses that included arteriosclerotic heart disease, diabetes mellitus, chronic kidney disease, hyperlipidemia, difficulty walking, malignant neoplasm of the prostate, chronic systolic (congestive) heart failure, and MRSA (Methicillin Resistant Staphylococcus Aureus) of a surgical wound. According to a comprehensive Minimum Data Set, with an Assessment Reference Date of 9/30/19, the

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F 655	Continued From page 7	F 655		

resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

At entry on 9/25/19, Resident # 85 had the following physician's order: Clean sternum incision with saline. Place Versatel in wound bed with two pieces of black foam. Apply suction at 150 mmHg (millimeters of Mercury), low continuous. Three times (a week) on Monday, Wednesday, Friday.

During the orientation tour at 10:50 a.m. on 10/22/19, a small, clear plastic two drawer cabinet was observed outside the door to Resident # 85's room. A sign on the stand indicated the resident was on "Contact Precautions" and directed visitors to see a nurse before entering the room.

At approximately 11:00 a.m. on 10/22/19, RN # 2 (Registered Nurse), the Assistant Director of Nursing and the Unit Manager of the unit where Resident # 85's room was located, were asked about the cabinet and "Contact Precautions" sign. RN # 2 indicated the resident was on contact precautions for MRSA in a chest surgical wound, and that he had a Wound Vac. (NOTE: A wound vac is a type of therapy that reduces air pressure on a wound in order to help the wound heal more quickly. Ref. hopkinsmediciane.org.)

On at least two occasions, and during a resident interview, Resident # 85 was observed carrying the pump and canister portion of the wound vac, which was operating on battery power at the time.

Resident # 85's baseline care plan, dated 9/25/19, included the following problem, "(Name

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F 655	Continued From page 8 of resident) has the potential for pressure injury/skin care." The goal for the problem was, "Prevent pressure injury and skin breakdown." The interventions for the stated problem included, "Follow facility skin protocol; Preventative measures; and, Report to charge nurse any redness or skin breakdown immediately." A thorough review of Resident # 85's baseline care plan failed to reveal any problem, goal, or interventions related to the use of a Wound Vac to aid in the healing of his surgical incision. The findings were discussed at 4:00 p.m. on 10/23/19 during a meeting that included the Administrator, Director of Nursing, and the survey team.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		12/5/19

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F 656	Continued From page 9 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 section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for two of 22 residents in the survey sample. Resident #62 had no plan of care regarding use of a mitten and Resident #85 had no care plan regarding wound vacuum treatment. The findings include: 1. Resident #62 was admitted to the facility on 1/24/17 with a re-admission on 8/1/17. Diagnoses for Resident #62 included chronic kidney disease, cerebral infarction with right side hemiplegia, atrial fibrillation, high blood pressure,	F 656	F-0656 1. The comprehensive care plan for resident # 62 was updated on 10/23/2019 to include the use of a personal mitten on her right hand for dignity purposes. The comprehensive care plan for resident #85 was updated on 10/24/2019 to include a specific problem, goal, and interventions related to the care of the Wound Vac. 2. A 100% audit will be conducted by the DON or designee of Comprehensive Care Plans of resident□s who have Wound Vacs or mittens to ensure that the care plans are comprehensive and person centered.	

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F 656	Continued From page 10 hyperlipidemia, constipation, depression and vascular dementia with behavioral disturbance. The minimum data set (MDS) dated 9/19/19 assessed Resident #62 with severely impaired cognitive skills and as requiring the extensive assistance of one person for dressing. On 10/23/19 at 9:00 a.m., Resident #62 was observed seated in the day area in a Broda chair. The resident had a purple mitten on her right hand with her right hand and forearm positioned on a pillow. Resident #62's clinical record documented a hospice note dated 7/22/19 stating, "...A mitten is placed on her right hand to cover a very large cyst to her right wrist..." A nursing note dated 7/23/19 documented, "...skin assessment performed, raised area noted to right lower anterior arm dark in color, mitten on..." Resident #62's plan of care (effective 3/22/19) made no mention of the resident's use of the mitten or any reference to the mitten's purpose. On 10/23/19 at 9:09 a.m., the certified nurses' aide (CNA #1) caring for Resident #62 was interviewed about the mitten. CNA #1 stated the resident wore the mitten on her right hand to keep her hand warm. CNA #1 stated the resident was not able to use her right arm/hand and that was why the hand was positioned on the pillow. CNA #1 stated the resident had a cyst on the back of her right wrist that was covered by the mitten. On 10/23/19 at 11:20 a.m., the licensed practical nurse (LPN #1) caring for Resident #62 was interviewed. LPN #1 stated the family provided the mitten to cover the large cyst on the back of	F 656	3. Education will be provided to Licensed Nurses by the DON or designee regarding developing Comprehensive Care Plans that are person-centered and include problems, goals and interventions. 4. A 10% audit of residents who have Wound Vacs or mittens will be completed by the DON or designee monthly x 3 months to ensure Comprehensive Care Plans are person-centered and include problems, goals and interventions. The results of these audits will be reported to the facility QAPI meeting to ensure on-going compliance. 5. Corrective Action will be complete by 12/05/2019.	

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the resident's wrist. LPN #1 stated the mitten, "was a dignity thing" and a preference of the resident's family. LPN #1 stated the resident had little use of the right hand/arm and was on hospice care with no plans for aggressive treatment of the cyst. LPN #1 stated the unit managers were responsible for creating and/or updating care plans as needed. LPN #1 stated, "We could update it [care plan]."

This finding was reviewed with the administrator and director of nursing during a meeting on 10/23/19 at 4:15 p.m.

2. Resident # 85 was admitted to the facility on 9/25/19 with diagnoses that included arteriosclerotic heart disease, diabetes mellitus, chronic kidney disease, hyperlipidemia, difficulty walking, malignant neoplasm of the prostate, chronic systolic (congestive) heart failure, and MRSA (Methicillin Resistant Staphylococcus Aureus) of a surgical wound. According to a comprehensive Minimum Data Set, with an Assessment Reference Date of 9/30/19, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

At entry on 9/25/19, Resident # 85 had the following physician's order: Clean sternum incision with saline. Place Versatel in wound bed with two pieces of black foam. Apply suction at 150 mmHg (millimeters of Mercury), low continuous. Three times (a week) on Monday, Wednesday, Friday.

During the orientation tour at 10:50 a.m. on 10/22/19, a small, clear plastic two drawer cabinet was observed outside the door to Resident # 85's room. A sign on the stand

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F 656	Continued From page 12 indicated the resident was on "Contact Precautions" and directed visitors to see a nurse before entering the room. At approximately 11:00 a.m. on 10/22/19, RN # 2 (Registered Nurse), the Assistant Director of Nursing and the Unit Manager of the unit where Resident # 85's room was located, was asked about the cabinet and "Contact Precautions" sign. RN # 2 indicated the resident was on contact precautions for MRSA in a chest surgical wound, and that he had a Wound Vac. (NOTE: A wound vac is a type of therapy that reduces air pressure on a wound in order to help the wound heal more quickly. Ref. hopkinsmediciane.org.) Resident # 85's comprehensive care plan, developed after the baseline care plan, included the following problem, "(Name of resident) has the potential for pressure injury/skin care. Wound Vac." The goal for the problem was, "Prevent pressure injury and skin breakdown." Interventions to the stated problem were, "Follow facility skin care protocol; Preventative measures; and, Report to charge nurse any redness or skin breakdown immediately." A thorough review of the comprehensive care plan for Resident # 85 failed to identify any problem, goal, or interventions related to the care of the Wound Vac. The findings were discussed at 4:00 p.m. on 10/23/19 during a meeting that included the Administrator, Director of Nursing, and the survey team.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		12/5/19

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F 657	Continued From page 13 §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 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to review and revise a comprehensive care plan for one 22 residents, Resident #86. Interventions regarding the use of a PICC (Peripherally Inserted Central Catheter) line and the administration of IV (intravenous) antibiotics were not removed from the care plan when they were discontinued.	F 657	F 0657 1. Resident # 86□s care plan was updated on 10/23/2019 to reflect the removal of the PICC line and discontinuation of the IV Antibiotic. 2. A 100% audit of residents who have PICC lines or IV antibiotics will be completed by the DON or designee to ensure staff review and revise the Comprehensive Care Plan as indicated.	

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F 657	Continued From page 14 Findings were: Resident #86 was admitted to the facility on 09/11/2019 with the following diagnoses, including but not limited to: Bacteremia, cellulitis of left lower limb, atrial fibrillation, hypertension, chronic ulcer of left lower limb, and type II diabetes mellitus. The admission MDS (minimum data set) with an ARD (assessment reference date) of 09/18/2019, assessed Resident #86 as cognitively intact with a summary score of "13". On 10/22/2019 at approximately 2:00 p.m., Resident #86 was interviewed. She stated that she came to the facility due to sepsis and cellulitis. She stated, "I had it in my left leg and it was resolving when this area came up in my right leg...I went to the hospital and found out I had a staph infection and I got septic...I was on IV antibiotics and then oral antibiotics for a total of 36 days. I just finished the ones I was taking orally yesterday...I see a wound doctor and also infectious disease about it." She was asked is she had a special line when she was getting her IV antibiotics. She stated, "Yes, I had a PICC line in my left arm..it's out now." The clinical record was reviewed on 10/22/2019 and the following entry was observed in the progress notes section: "10/11/2019 Pt's [patient's] PICC line was removed by nurse. Nursing supervisor also present. Pt tolerated procedure well and had head turned away from site during removal. PICC line was inspected after removal and line was intact. Pressure held on site for 3 minutes. Gauze secured with tape. No pain, redness, or tenderness noted. Will	F 657	3. Education will be provided to Licensed Nurses by the DON or designee on reviewing and revising Comprehensive Care Plans. 4. A 10% audit of residents who have PICC lines or IV antibiotics will be completed by the DON or designee weekly x 1 month then monthly x 3 months to ensure Comprehensive Care plans are reviewed and revised. The results of these audits will be reported to the facility QAPI committee to ensure on going compliance. 5. All corrective action will be complete by 12/05/2019.	

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F 657	Continued From page 15 continue to monitor." The care plan was reviewed and contained the following: "Problems: [Name] is receiving IV antibiotic therapy for Bacteremia via left upper arm PICC line...Goals: [Name] will receive IV antibiotics as ordered without complications through the next review. Interventions: Medications as ordered; Maintain IV site per facility/IV therapy protocol; Change tubing every 72 hours; Observe site for signs of infection...; Observe for signs/symptoms of allergy to medication...; Contact physician with any changes as needed." The DON (director of nursing) was interviewed on 10/23/2019 at approximately 2:00 p.m. regarding Resident #86's care plan interventions for IV antibiotics and the use of a PICC Line. She was asked if the interventions should still be in place. She stated, "No, the care plan should have been updated when the PICC line and the IV antibiotics were discontinued." No further information was obtained prior to the exit conference on 10/24/2019.	F 657		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of	F 700		12/5/19

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F 700	Continued From page 16 entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to accurately assess, obtain informed consents and attempt alternatives prior to the use of bed rails for two of 22 residents in the survey sample. Residents #11 and #62 had bed rails in use with conflicting safety assessments, no prior attempted alternatives and without informed consent from their responsible parties. The findings include: 1. Resident #62 was admitted to the facility on 1/24/17 with a re-admission on 8/1/17. Diagnoses for Resident #62 included chronic kidney disease, cerebral infarction with right side hemiplegia, atrial fibrillation, high blood pressure, hyperlipidemia, constipation, depression and vascular dementia with behavioral disturbance. The minimum data set (MDS) dated 9/19/19 assessed Resident #62 with severely impaired cognitive skills and as requiring the extensive assistance of one person for bed mobility.	F 700	F 0700 1. A new side rail assessment was completed for residents #62 and #11 on 10/23/2019. Both assessments indicated side rails were appropriate. Informed consent was obtained from family members for both residents. 2. a 100% audit of in-house residents will be completed by the DON or designee to verify that alternatives are attempted prior to the use of side rails. The side rail assessment will include alternatives attempted prior to use of side rails. If side rails are indicated, informed consent will be obtained for their use. 3. Education will be provided by the DON or designee to Licensed Nurses on completing accurate Side Rail Assessments, utilizing alternatives prior to the use of side rails, and obtaining informed consent if side rails are utilized. 4. A 10% audit of resident□s on each neighborhood will have a review of their side rail assessment by the DON or	

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F 700	Continued From page 17 On 10/22/19 at 3:00 p.m., Resident #62 was observed in bed with two half-length bed rails in the raised position near the head of the bed. Resident #62's clinical record included conflicting documentation regarding the resident's need and safety with use of bed rails. The record documented a physician's order dated 8/1/17 for "1/2 rail both sides." The resident's plan of care (effective 3/22/19) listed the resident was at risk of falls due to fall history, right sided weakness, poor safety awareness and impaired awareness of functional limitations. Included in interventions for fall/injury prevention was "2-1/2 side rails to assist with bed mobility." Resident #62's most recent side rail assessment dated 10/15/19 documented the resident was not a candidate for side rail use. This assessment listed the resident was non-ambulatory, had poor balance and trunk control and did not use the rails for positioning or support. The record and assessment listed no prior attempts at alternatives to the rails. The clinical record documented no informed consent from the resident's family regarding risks/benefits of the side rails. On 10/23/19 at 11:20 a.m., the licensed practical nurse (LPN #1) caring for Resident #62 was interviewed about the bed rails. LPN #1 stated Resident #62 was totally dependent upon staff for all of her care needs. LPN #1 stated Resident #62 did not independently use the rails to move about in bed. LPN #1 stated the resident was able to hold the rail during care with her left hand but the resident had little use of her right arm/hand due to a stroke. LPN #1 stated	F 700	designee monthly x 3 months to validate accuracy of the assessment, that alternatives were attempted prior to use and that informed consent was obtained if side rails are used. The results of these audits will be reported to the facility QAPI meeting to ensure on-going compliance. 5. Corrective action will be complete by 12/05/2019.	

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Resident #62 was combative at times and had attempted to get out of the bed. LPN #1 was not aware of any attempted alternatives to the rails.

On 10/23/19 at 1:40 p.m., the director of nursing (DON) was interviewed about Resident #62's conflicting assessments and orders for bed rails. The DON stated the use of side rails listed on the care plan might have been about the resident holding the rails when staff provided care. The DON made no other comment regarding the bed rail assessment or any prior attempted alternatives to the rails.

On 10/23/19 at 3:10 p.m., the DON stated she looked and found no informed consent from Resident #62's responsible party and/or family regarding bed rails.

This finding was reviewed with the administrator and DON during a meeting on 10/23/19 at 4:15 p.m.

2. Resident #11 was admitted to the facility on 10/5/18 with diagnoses that included heart failure, atrial fibrillation, urinary retention, benign prostatic hyperplasia, neuralgia, depression, dysphagia and cervical spinal cord injury. The minimum data set (MDS) dated 7/24/19 assessed Resident #11 with severely impaired cognitive skills and as requiring the total assistance of two people for bed mobility.

On 10/23/19 at 9:14 a.m., Resident #11 was observed in bed with two half-length side rails in the raised position near the head of the bed. A blanket was hanging over each of the bed rails.

Resident #11's clinical record documented a

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nursing note dated 10/1/19 stating the resident rubbed his forehead against the bed rail during care and obtained a 1-centimeter skin tear.

Resident #11's clinical record included conflicting documentation regarding the resident's need and safety with use of bed rails. The record documented a physician's order dated 10/4/18 for, "Bedside rails for mobility/independence." The resident's plan of care (effective 6/13/19) listed the resident was at risk of falls due to fall history and non-ambulatory status. Included in interventions to prevent falls/injury were "2-1/2 side rails to assist with bed mobility."

Resident #11's most recent side rail assessment dated 8/14/19 documented the resident was not a candidate for side rail use. This assessment listed the resident was non-ambulatory, had poor mobility, difficulty moving and did not use the rails for positioning or support. The record and assessment listed no prior attempts at alternatives to bed rails. The clinical record documented no informed consent from the resident's family regarding risks/benefits of the side rails.

On 10/23/19 at 11:40 a.m., the licensed practical nurse (LPN #1) caring of Resident #11 was interviewed about the bed rails. LPN #1 stated Resident #11 was totally dependent upon staff for turning and moving about in bed. LPN #1 stated the resident had declined recently and was on hospice. LPN #1 was not sure why the blankets were draped over Resident #11's side rails. LPN #1 was not aware of any prior attempts at alternatives to the bed rails.

On 10/23/19 at 1:40 p.m., the director of nursing

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F 700	Continued From page 20 (DON) was interviewed about Resident #11's conflicting assessments and orders for bed rails. The DON made no other comment regarding the bed rail assessment or any prior attempts at alternatives to the rails. On 10/23/19 at 3:10 p.m., the DON stated she looked and found no informed consent from Resident #11's responsible party regarding bed rails. The facility's policy titled Bedside Rail Utilization (undated) documented, "This organization will take measures to develop and implement a strategy to minimize the possibility of resident entrapment while using side rails. This will include assessment of resident who have a need for or desire to use side rails and that may have characteristics that place them at special risk for entrapment...The side rail assessment is completed...Quarterly...At any time there is a significant change in resident condition...If the resident's assessment identifies him or her as appropriate for the use of side rails...Educate the resident/resident representative on the risks/benefits and obtain consent for use..." This finding was reviewed with the administrator and DON during a meeting on 10/23/19 at 4:15 p.m.	F 700		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		12/5/19

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categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

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

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

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

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

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be

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F 758	Continued From page 22 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure one of 22 residents was free from unnecessary medication. Resident #62 had a prn (as needed) physician's order for the anti-anxiety medication Lorazepam in place for over 14 days without a documented rationale and specified duration. The findings include: Resident #62 was admitted to the facility on 1/24/17 with a re-admission on 8/1/17. Diagnoses for Resident #62 included chronic kidney disease, cerebral infarction with right side hemiplegia, atrial fibrillation, high blood pressure, hyperlipidemia, constipation, depression and vascular dementia with behavioral disturbance. The minimum data set (MDS) dated 9/19/19 assessed Resident #62 with severely impaired cognitive skills. Resident #62's clinical record documented a physician's order dated 1/31/19 for Lorazepam 0.5 mg (milligrams) to be administered every four hours as needed for treatment of anxiety and restlessness. A pharmacy recommendation to the physician dated 2/25/19 documented, "Patient has an order for prn ativan [Lorazepam]...CMS [Center for Medicare & Medicaid Services] guidelines mandate prn psychoactive medications be limited to 2 week duration. Please consider a d/c [discontinue] of this medication." The nurse	F 758	F 0758 1. Resident # 62 was seen by the facility NP on 10/23/2019 and 10/25/2019. The PRN Ativan was discontinued on 10/25/2019. 2. A 100% audit of residents who have PRN orders for Psychotropic medications will be conducted by the DON or designee to ensure orders have a documented rationale and specified duration. 3. Education will be provided by the Administrator to providers on providing rationale and specific duration of PRN Psychotropic medications. 4. A 10% audit of residents who have PRN orders for Psychotropic medications will be conducted by the DON or designee weekly x 1 month; then monthly x 3 months to ensure there is documented rationale and specified duration. The results of these audits will be reported to the facility QAPI committee to ensure on-going compliance. 5. Corrective action will be complete by 12/05/2019.	

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practitioner responded on 2/8/19 documenting, "Patient is followed by hospice - she continues to need ativan prn. She currently has f/u [follow-up]."

There was no new order or specified duration written for Resident #62's Lorazepam.

On 10/23/19 at 11:40 a.m., the licensed practical nurse (LPN #1) caring for Resident #62 was interviewed. LPN #1 stated the resident's prn Lorazepam order had been in place since January 2019. LPN #1 stated the resident was administered the Lorazepam "occasionally" due to agitation. LPN #1 stated the resident's orders were now provided by hospice services.

On 10/23/19 at 1:40 p.m., the director of nursing (DON) was interviewed about the prn Lorazepam order in place since January 2019. The DON stated Resident #62 received hospice care and the hospice physician wrote orders for the prn medications.

This finding was reviewed with the administrator and director of nursing during a meeting on 10/23/19 at 4:15 p.m.