STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. BUILDING _____ B. WING _____	C 08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/30/19 through 08/02/19 and 08/05/19 through 08/07/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E000		
E015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at 418.113(b)(6)(iii):]	E015	The Laurels of University Park wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is September 20, 2019. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements E015 No negative outcomes occurred as a result of this practice. The sewage policy has been expanded and incorporated into the emergency preparedness plan. Residents currently at the facility have the potential to be affected. NHA or designee will educate department	9/20/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	09/12/2019

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

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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E015	Continued From page 1 Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documentation that the emergency plan included policies and procedures for waste disposal. The findings include: On 08/07/19 at 9:15 a.m., a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator and OSM (other staff member) # 6, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence	E015	managers on the updated sewage policy and the location in the emergency preparedness books. Staff will be educated on the location of emergency preparedness books. NHA or designee will audit emergency preparedness books for the updated sewage policy. The policy has been updated and reviewed with the QA committee. It will be reviewed on an annual basis and changes will be made as needed. Any variances will be corrected and additional education or counseling will be provided as needed Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facilitys quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: September 20, 2019	

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E015	Continued From page 2 documentation that the emergency plan included policies and procedures for waste disposal. ASM # 1 stated, "We discussed it at VHASS(Virginia Hospital Alerting and Status System) but did not develop a policy." No further information was provided prior to exit.	E015		
E026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at 403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff	E026	E026 The 1135 policy has been updated to reflect the facility's role in providing care and treatment at altered care sites. No negative outcome occurred as a result of this process. Residents currently in the facility have the potential to be affected NHA or designee will educate department managers on the updated 1135 waiver policy. NHA or designee will audit emergency preparedness books to ensure that the updated 1135 policy is in place. The policy has been updated and will be reviewed with the QA committee. It will be reviewed on an annual basis and changes will be made as needed. Any variances will be corrected and additional education or counseling will be provided as needed Any concerns will be reported to the quality assurance committee monthly until resolved.	9/20/19

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E026	Continued From page 3 failed to have a complete emergency preparedness plan. The Facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. The findings include: On 08/07/19 at approximately 9:15 a.m., a review of the facility's emergency preparedness plan and interview was conducted with ASM (administrative staff member) # 1, administrator and OSM (other staff member) # 6, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. ASM # 1 stated that the facility did not have it. No further information was provided prior to exit.	E026	Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: September 20, 2019	
F000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/30/19 through 8/2/19 and continued 8/5/19 through 8/7/19. Complaints were investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 145 certified bed facility was 132 at the time of survey. The survey sample consisted of 60 current Resident reviews and 12 closed record reviews. The expanded survey sample consisted of eight current Resident	F000		

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F000	Continued From page 4 reviews. On 08/01/2019 at approximately 3:15 PM, Immediate Jeopardy was identified in the area of Pharmacy Services at a Scope and Severity Level four-pattern, which constituted Substandard Quality of Care. On 08/01/2019 at 3:45 PM, the facility administration was informed. On 08/05/2019 at 2:26 PM, the Immediate Jeopardy was abated and was lowered to a level III isolated. The Life Safety Code survey/report will follow.	F000		
F578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) 483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. 483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F578	F Tag 578: Resident #51: No negative outcome occurred as a result of this practice. Additional information regarding advance directives has been given. Resident # 54: No negative outcome occurred as a result of this practice. Additional information regarding advance directives has been given. Advance directive information has been obtained from the resident. Resident # 44 No negative outcome occurred as a result of this practice. A copy of the advance directive was requested and obtained from the residents family and has been place in the clinical record. Residents currently in the facility have the potential to be affected. The NHA or designee will educate the	9/20/19

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F578	Continued From page 5 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to implement the facility policies to meet the requirements for advanced directives for three of 72 residents in the survey sample, Residents #51, #54, and #44. Staff failed to provide Resident #51 additional information about advanced directives as requested by the resident upon admission, staff failed to provided Resident #54 advanced directive information as requested by the resident and failed to obtain an Advanced Directive Notification/Acknowledgement upon admission, and staff failed to obtain and place a copy of Resident # 44's advance directives on the clinical record. The findings include: 1. The facility staff failed to provide further	F578	admissions department on review and completion of advance directive documentation upon admissions and providing additional information as requested upon admission. The NHA or designee will provide education to the social services department on reviewing advance directives and documenting in the medical record with the residents upon admission, quarterly, and as requested thereafter. In addition to this, social services will maintain resources about advance directives that can be available upon request. The Director of Social Services or designee will audit advance directive documentation on current residents in the facility. The Social Services department or designee will monitor new admissions and residents due for quarterly care plan review and assessment. The admissions director or designee will initiate a tracking log for monitoring of new admissions and Advance Directive information given and/or requested. Advance directive documentation and additional education and/or counseling will be provided or obtained as indicated. Monitoring will occur 5 times a week for 1 week, weekly for 4 weeks, and monthly for 3 months and will be reviewed in the clinical operations meeting. Any variances will be corrected and additional education or counseling will be provided as needed Concerns will be	

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F578	Continued From page 6 information regarding advance directives upon Resident #51's admission to the facility as requested by the resident. Resident #51 was admitted to the facility on 2/9/19 with diagnoses that included but were not limited to: dementia, high blood pressure, and fractures of the ribs. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/26/19, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The "Advanced Directive Notification/Acknowledgement" form dated, 2/9/19, documented, a check mark next to, "2. I HAVE NOT executed Advanced Medical Directive(s)." A second check mark was documented next to, "I DO WANT MORE INFORMATION regarding advance directives." This form was signed by the resident on 2/9/19 and the admissions representative. Review of the clinical record failed reveal any there documentation by the social worker regarding advanced directives for the resident. The face sheet documented the resident was a full code. The admissions representative that signed the form was no longer employed at the facility and unavailable for interview. An interview was conducted with other staff member (OSM) #8, the director of marketing and OSM #10, the admissions coordinator, on 8/1/19 at 4:44 p.m. When asked the process for	F578	reported by the DSS or designee to the quality assurance committee. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: September 20, 2019	

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F578	Continued From page 7 admissions related to the advanced directive, OSM #10 stated, "Upon admission the 'Advanced Directive Notification/Acknowledgement' form is reviewed with the resident and/or resident representative." When asked if the box marked 'I DO WANT MORE INFORMATION regarding advance directives' is check, what is the process for providing the resident the information requested, OSM #10 stated, "The policy is that we let social services know that they want more information regarding the advanced directive." An interview was conducted with other staff member (OSM) #11, social worker on 8/1/19 at 5:18 p.m. When asked if there is documentation that Resident #51 received the information on advanced directives, OSM #11 stated the other social worker had her before she did. I found out about this yesterday. She has a scheduled care plan meeting coming up and will do it at that time." When asked if this should have already been done, OSM #11 stated, "Yes, Ma'am." The facility's policy "Advance Directives" documented, "Policy: It is the policy of this facility to inform guest's family members and/or representatives of their right to execute and Advance Directive. Procedure: 1. Upon admission, Social Services or facility representative will inquire as to whether the guest has executed an advance directive for care decisions and/or established a power of attorney in the event they cannot make decisions for their care. 2. If the guest has not executed an advance directive, Social Services will inform the guest family/legal representative that the guest may execute an advance directive, and provide information on how to execute an advance directive. The facility will honor the advance directive developed in	F578		

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F578	Continued From page 8 accordance with state law. Notification will include information that neither admission to the facility not continued residence in the facility is conditioned upon the existence of an advanced directive. 3. The guest/family/legal representative will receive a copy of the facility policy regarding advance directives. 4. Social services will acknowledge that advance directive information was given to and discussed with the guest/family/legal representative in the social service progress notes. 5. All executed advance directives will be requested by Social Service, so that a copy can be made of the original and placed in the guest's current medical record. 6. NO FACILITY STAFF, INCLUDING SOCIAL SERVICE, CAN BE INVOLVED IN ASSISTING THE GUEST IN EXECUTING AN ADVANCE DIRECTIVE. Administrative staff member (ASM) #1, the administrator, ASM #2, the regional clinical coordinator and ASM #3, the director of nursing, were made aware of the above concern on 8/2/19 at 2:00 p.m. No further information was provided prior to exit. 2. The facility staff failed to evidence Resident #54 was provided information regarding advanced directives and failed to obtain an "Advanced Directive Notification/Acknowledgement" on admission. Resident #54 was admitted to the facility on 8/13/17 with diagnoses that included but were not limited to: quadriplegia (Paralysis affecting all four limbs and the trunk of the body below the level of spinal cord injury. Trauma is the usual cause) (1), chronic pain, and muscle weakness. The most recent MDS (minimum data set)	F578		

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F578	Continued From page 9 assessment, a quarterly assessment, with an assessment reference date of 6/3/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating we was capable of making daily cognitive decisions. Review of the clinical record failed to evidence documentation related to the "Advanced Directive Notification/Acknowledgement" form. Review of the clinical record failed reveal any there documentation by the social worker regarding advanced directives for the resident. The face sheet documented the resident was a full code. A request was made on 7/31/19 at 12:55 p.m. to administrative staff member (ASM) #1, the administrator, for evidence that Resident #54 had documentation of the "Advanced Directive Notification/Acknowledgement" form sign upon admission. No documentation was presented for Resident #54. An interview was conducted with other staff member (OSM) # 11, the social worker, on 8/1/19 at 5:18 p.m. When asked if the facility had discussed with the resident upon admission his wishes regarding an advanced directive, OSM #11 stated, "Admissions would have gotten that. I review it with him at his care plan meetings." An interview was conducted on 8/1/19 at 5:35 p.m. with OSM # 10, the admissions coordinator. When asked for Resident #54's the paperwork signed upon admission regarding the advanced directive, OSM #10 stated, "We have no admission paperwork signed for him. He's a quadriplegic. He isn't able to sign." When asked for the documentation that his admission	F578		

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F578	Continued From page 10 paperwork was reviewed verbally with him upon admission, OSM #10 stated, "No, he's a quadriplegic." An interview was conducted with Resident #54 on 8/1/19 at approximately 5:45 p.m. When asked if the facility went over a stack of papers upon admission with him, Resident #54 stated, "I would have remembered a stack of papers as I would have probably gotten bored." When asked if he can sign or document his name, Resident #54 demonstrated on the surveyor's paper a "D" drawn with a pen in his mouth. The resident has a computer in his room, that he was observed during the survey, to use. ASM #1, ASM #2, the regional clinical consultant, and ASM #3, the director of nursing, were made aware of the above concern on 8/6/19 at 5:19 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 489. 3. The facility staff failed to ensure the obtain and place a copy of Resident # 44's advance directives on the clinical record. Resident # 44 was admitted to the facility on 11/18/2018 with diagnoses that included but were not limited to: high blood pressure, and pneumonia. Resident # 44's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/21/19, coded Resident # 44 as scoring an 11 on the brief	F578		

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F578	Continued From page 11 interview for mental status (BIMS) of a score of 0 - 15, 11 - being moderately impaired of cognition for making daily decisions. Review of the EHR (electronic health record) for Resident # 44 revealed an "Advance Directive Notification/Acknowledgment" signed by (Name of Responsible Party) on "1/10/19 and by the facility's admissions representative on 1/10/19. Under "Advance Directive Acknowledgment" it documented, "1. I HAVE executed Advance Directive(s); I HAVE provided the Healthcare Center with a copy verified by the Healthcare Center." Further review of the EHR for Resident # 44 failed to evidence a copy of the advance directive. On 08/01/19 at 5:15 p.m., an interview was conducted with OSM (other staff member) # 11, social worker. When asked to locate Resident # 44's advance directive OSM # 11 reviewed the EHR (electronic health record) for Resident # 44 and stated she was unable to locate the advance directive. When asked to describe the process for obtaining a resident's advance directive OSM # 11 stated, "The admissions department will ask for the advance directive at the time the resident is admitted. If the advance directive is not here at the time of the care plan I will ask for it from the responsible party." On 08/01/19 at 5:20 p.m., an interview was conducted with OSM (other staff member) # 8, director of admissions. When asked about the process of obtaining the advance directive OSM # 8 stated, "It is apart of the admission agreement. If the family or the resident has an advance directive we ask them to provide a copy as soon as possible. If they don't provide it we call and remind them." When informed of the documentation on the "Advance Directive	F578		

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F578	Continued From page 12 Notification/Acknowledgment" for Resident #44 that documented a copy of the advance directive was provided to the facility, and that an advanced directive was not located in the clinical record. OSM # 8 stated, "If they don't bring it we can't force them to bring it in. We tried to follow up with (Resident # 44's) family." On 8/6/19 at 10:18 a.m. administrative staff member (ASM) #2, the regional clinical coordinator, was asked what standard of practice the facility follows. ASM #2 stated, "We follow our policies and Lippincott." The facility's policy "Advance Directives" documented in part, "5. All executed advance directives will be requested by Social Service, so that a copy can be made of the original and placed in the guest's current medical record." On 08/05/19 at 5:10 p.m., ASM (administrative staff member) #1, administrator, ASM # 2, regional clinical coordinator and ASM #3 (director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F578		
F580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) 483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's	F580	Ftag 580 Resident #338: The resident no longer resides in the facility. Resident #93: No negative outcome occurred as a result of this practice. The physician was notified of the missed medication. Resident # 8: No negative outcome	9/20/19

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F580	Continued From page 13 physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in 483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in 483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in 483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). 483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in 483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under 483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F580	occurred as a result of this practice. A stat PT/INR was ordered for the resident and the physician was notified. Resident #189: No negative outcome occurred as a result of this practice. A stat PT/INR was ordered for the resident and the physician was notified. All residents currently in the facility have the potential to be affected. DON or designee will educate licensed nursing staff on physician notification for when a change in condition has occurred. DON or designee will educate licensed nursing staff on obtaining medications when not available. Education will also be provided on the revised process of completing the Coumadin log, transcribing and following orders in the EMR from the log and physician notification. The DON or designee will audit the last 30 days of MARs for current residents for any medications not administered and/or on hold pending pharmacy delivery. The DON or designee will audit Coumadin logs and orders for any discrepancies with transcription and physician notification. The DON or designee will audit the last 7 days of the 24-hour report for physician notification of changes in condition. In the clinical operations meeting, DON or designee will monitor MARs 5 times a	

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F580	Continued From page 14 Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed immediately notify/consult with the physician/nurse practitioner for a change in condition and/or the possible need to alter treatment for four of 72 residents in the survey sample, Residents #338, #93, #8, and #189). The physician was not notified/consulted regarding Resident #338's bleeding on 7/22/18. The physician was not notified/consulted when Resident #93's medications were not administered for three days; when, a double dose of Coumadin was administered to Resident #8, and when the 11/10/18, ordered PT/INR was not completed; and when, Resident #189's Coumadin was held on multiple dates without orders; and PT/INR tests were not obtained as ordered. The findings include: 1. The facility staff failed to immediately notify Resident #338's physician (and/or nurse practitioner) of a significant change in condition when the resident (who was receiving Coumadin a high risk blood thinning medication) presented with an episode of bleeding on 7/22/18. Resident #338 a 77-year-old female was admitted to the facility on 6/29/18. Resident #338's diagnoses included but were not limited to revision of left total knee removal, asthma and high blood pressure. Resident #338's most recent MDS (minimum data set) (prior to discharge), a 14 day Medicare assessment with an ARD (assessment reference date) of 7/13/18, coded the resident as being cognitively intact with a BIMS (brief interview for mental status) score of 15. Section N coded Resident #338 as	F580	week for 1 week, 3 times a week for 2 weeks, weekly for 4 weeks and monthly for 3 months for any medications not given and MD notification. DON or designee will monitor Anticoagulant logs 5 times a week for 1 week, 3 times a week for 2 weeks, weekly for 4 weeks and monthly for 3 months. Documentation within the 24 hour reports will monitored for change in condition 5 days a week for 1 week, 3 days a week for 2 weeks, weekly for 4 weeks and monthly for 3 months. Variances will be corrected. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: September 20, 2019	

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F580	Continued From page 15 having received an anticoagulant (blood thinning) medication seven out of the last seven days. Review of Resident #338's clinical record revealed a physician's order dated 6/29/18 that documented an order for Coumadin [an anticoagulant medication] 2 mg (milligrams) by mouth in the evening for DVT (deep vein thrombosis) [2] prophylaxis. Warfarin (Coumadin) is in a class of medications called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood. [1] Black Box Warning [A boxed warning is the strongest warning that the FDA (Food and Drug Administration) requires, and signifies that medical studies indicate that the drug carries significant serious or even life-threatening adverse effects]: BLEEDING RISK: COUMADIN can cause major or fatal bleeding. Perform regular monitoring of INR [international normalized ratio - a laboratory blood test that measures how long it takes for blood to clot (4)] in all treated patients. [3] Review of Resident #338's June 2018 and July 2018 MARs (medication administration records) revealed the resident was administered 2 mg of Coumadin as prescribed by the physician from 7/1/18 through 7/22/18. Resident #338's comprehensive care plan dated 7/11/18 documented, "BLEED101: At risk for abnormal bleeding R/T (related to) anticoagulant use...Interventions: Administer medications as ordered...Observe for abnormal s/sx (signs/symptoms) of bleeding. i.e. Bruising, bleeding gums, petechiae (tiny red spots caused by bleeding into the skin), nosebleeds, hematuria (bloody urine), headaches, back of	F580		

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F580	Continued From page 16 abdominal pain, decrease blood pressure or pulse, occult blood in the stool, etc. Report all abnormal findings to physician..." A nurse's note dated 7/22/18 at 11:46 p.m. documented, "It was reported that guest has blood stain on bed linen. Bright red blood observed on linen unable to determine if vaginal bleed. Trace bright red blood on washcloth after pericare. Guest has + (positive) bowel sounds which are hyperactive in all 4 quadrants." The note failed to evidence the physician and/or nurse practitioner was immediately notified of the bleeding. A NP (nurse practitioner) note dated 7/23/18 at 8:30 a.m. documented, "CC (Chief Complaint): blood in stool. HPI (History of Present Illness): ATSP (Asked to See Patient) for blood in stool. Patient reports bright red blood per rectum on several occasions over the weekend. States that she has had blood on her pad and bed. Endorses abdominal pain and burning, diarrhea, and nausea. Unsure if there was blood in the toilet with BM (bowel movement) this morning, was unable to see. Has tried Zofran (4) and pain medication over the weekend with no relief...A/P (Assessment/Plan) GI (gastrointestinal) bleeding: referred to ER (emergency room)..." Review of hospital records revealed Resident #338's INR [5] was 11.8 on 7/23/18. The resident was administered Vitamin K [3] and underwent a blood transfusion on 7/24/18. "Prothrombin time (PT) is a blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot." "PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized	F580		

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F580	Continued From page 17 ratio)." "The most common reason to perform this test is to monitor your levels when you are taking a blood-thinning medicine called warfarin. You are likely taking this medicine to prevent blood clots. Normal Results: PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio). If you are taking warfarin to prevent blood clots, your provider will most likely, choose to keep your INR between 2.0 and 3.0." [5] The nurse who wrote the 7/22/18 note that documented bright red blood was observed on Resident #338's linen was no longer employed at the facility. On 8/6/19 at 10:01 a.m., an interview was conducted with RN (registered nurse) #8. RN #8 was asked to review the nurse's note dated 7/22/18 that documented a bloodstain was observed on Resident #338's sheet. After reviewing the note, RN #8 stated, "Contact the physician. Immediately." When asked why, RN #8 stated, "She's bleeding bright red blood, she could be bleeding out, have a GI (gastrointestinal) bleed. She probably needs to be sent for an evaluation or if a physician is here they could evaluate her." On 8/6/19 at 12:04 p.m., an interview was conducted with ASM (administrative staff member) #9 (the facility medical director). ASM #9 was asked to review the nurse's note dated 7/22/18 that documented a bloodstain was observed on Resident #338's sheet. ASM #9 reviewed the note. ASM #9 stated the nurse should have immediately called the supervisor and doctor." When asked why, ASM #9 stated, "its a significant change in condition." On 8/7/19 at 9:29 a.m., an interview was	F580		

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F580	Continued From page 18 conducted with ASM #5 (Resident #338's facility physician). ASM #5 was asked to review the nurse's note dated 7/22/18 that documented a bloodstain was observed on Resident #338's sheet. ASM #5 reviewed the note. When asked if she was aware of the bleeding event on 7/22/18, ASM #5 stated she would not have known unless she was on call. ASM #5 was asked if the nurse should have notified the on-call doctor. ASM #5 stated, "No." ASM #5 stated that event, even though the resident was receiving Coumadin, would not have prompted an emergency phone call because there was a trace amount of blood. ASM #5 stated that event could have been documented in the doctor's book for the resident to be seen the next day and the nurse practitioner did see Resident #338 the next day. On 8/6/19 at 11:25 a.m., ASM #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. The facility policy titled, "PHYSICIAN NOTIFICATION" documented, "Policy: The licensed nurse will report changes in the guest's condition due to illness, exacerbation of existing condition, or accidents and incidents to the physician, nurse practitioner, or physician assistant, following the established Interact protocols for immediate, no-immediate, or routine notification. Definitions: -Immediate: Notify the attending or on-call MD (medical doctor), NP (nurse practitioner), or PA (physician) as soon as possible. -Non-Immediate: Notify the attending or on-call MD, NO (sic) or PA no later than the next work day (Sic.). -Routine: Notify the attending or on-call MD, NP,	F580		

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F580	Continued From page 19 or PA no later than the next regular visit or phone/fax communication. Procedure: 1. Notify the physician of a change in the guest's condition. 2. Document the time and date that the physician was notified, the physician's response, and any treatment ordered in the Progress Notes..." No further information was presented prior to exit. [1] This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682277.html (2) "Deep vein thrombosis, or DVT, is a blood clot that forms in a vein deep in the body. Most deep vein clots occur in the lower leg or thigh. If the vein swells, the condition is called thrombophlebitis. A deep vein thrombosis can break loose and cause a serious problem in the lung, called a pulmonary embolism." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dvt&_ga=2.137988019.2081124811.1565615930-1667741437.1550160688 [3] Reversal of COUMADIN anticoagulation may be obtained by discontinuing COUMADIN therapy and, if necessary, by administration of oral or parenteral vitamin K. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d91934a0-902e-c26c-23ca-d5accc4151b6#	F580		

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F580	Continued From page 20 information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601209.html [5] This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3aproject=medlineplus&v%3asources=medlineplus-bundle&query=laboratory%20tests%20for%20PT%20calculation%20of%20INR& 2. The facility staff failed to notify Resident #93's physician (and/or nurse practitioner) when medications were not available for administration on 4/2/19, 4/3/19 and 4/4/19. Resident #93 was admitted to the facility on 7/30/15. Resident #93's diagnoses included but were not limited to heart disease, high blood pressure and major depressive disorder. Resident #93's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/28/19, coded the resident's cognition as severely impaired. Review of Resident #93's clinical record revealed the following physician's orders: -9/21/17- Flovent (1) 110 micrograms- two puffs, inhale orally two times a day. -3/23/19- Miacalcin (2) Solution 200 units- one spray alternating nostrils one time a day. Review of Resident #93's April 2019 MAR (medication administration record) revealed the above medications were held on the following dates: -Flovent was held on 4/2/19 at 9:00 a.m., 4/3/19 at 9:00 a.m. and 4/4/19 at 9:00 a.m. (nurses notes for all three dates documented the medication was pending and the nurse would	F580		

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F580	Continued From page 21 -Miacalcin was held on 4/2/19 at 9:00 a.m. and 4/3/19 at 9:00 a.m. (nurses notes for both dates documented the medication was pending and the nurse would administer when available). Further review of Resident #93's clinical record (including the April 2019 MAR and April 2019 nurses' notes) failed to reveal Resident #93's physician (and/or nurse practitioner) was made aware the above medications were not available or administered on 4/2/19, 4/3/19 and 4/4/19. Resident #93's comprehensive care plan dated 2/27/19 documented, "(Name of Resident #93) is at risk for respiratory complications R/T (related to): having allergies Rhinitis (3)...Medications as ordered by the Physician..." The nurse responsible for administering Flovent and Miacalcin when the medications were held on 4/2/19, 4/3/19 and/or 4/4/19 was no longer employed at the facility. On 8/2/19 at 12:24 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was asked how nurses ensure medications are available for administration. LPN #7 stated, "We should call the pharmacy to see how long it's going to be and if past the allotted time for them to have it, we would notify the doctor." LPN #7 stated this should be documented in a nurse's note. Review of the Omni cell list revealed Flovent and Miacalcin were not available in the Omni cell. On 8/6/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the	F580		

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F580	Continued From page 22 above concern. The facility/pharmacy policy titled, "7.0 Medication Shortages/Unavailable Medications" documented, "Procedure: 1. Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. If the medication shortage is discovered at the time of medication administration, Facility staff should immediately take the action specified in Sections 2 or 3 of this Policy 7.0, as applicable. 2. If a medication shortage is discovered during normal Pharmacy hours: 2.1 Facility nurse should call Pharmacy to determine the status of the order. If the medication has not been ordered, the licensed Facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an emergency delivery...4. If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions..." No further information was presented prior to exit. (1) Flovent is used to prevent difficulty breathing and wheezing. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601056.html	F580		

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F580	Continued From page 23 bone disease). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601031.html (3) "Allergic rhinitis is a diagnosis associated with a group of symptoms affecting the nose. These symptoms occur when you breathe in something you are allergic to, such as dust, animal dander, or pollen. Symptoms can also occur when you eat a food that you are allergic to." This information was obtained from the website: https://medlineplus.gov/ency/article/000813.htm 3. The facility staff failed to notify the physician/nurse practitioner when the laboratory test (PT/INR) for the monitoring and safe administration of Coumadin to Resident #8 was not completed as ordered on 11/10/18. The staff also failed to notify the physician/nurse practitioner of a significant medication error on 8/21/18 when the staff administered a double dose of Coumadin (15.5 mg instead of 8 mg ordered) to Resident #8 and on 5/2/19 when the staff failed to hold 6 mg (milligram) Coumadin as ordered on 5/2/19. Resident # 8 was admitted to the facility on 08/14/2015 and a readmission on 01/08/2019 with diagnoses that included but were not limited to: deep vein thrombosis (4), ~~other~~ specified disorders of veins and high cholesterol. Resident # 8's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/19/19, coded Resident # 8 as scoring a seven on the brief interview for mental status (BIMS) of a score of 0 - 15, seven - being severely impaired of	F580		

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F580	Continued From page 24 "Medications" coded Resident # 8 as receiving an anticoagulant in the past seven days. The comprehensive care plan for Resident # 8 dated 02/05/2019 documented, "Need. (Resident # 8) is at risk for abnormal bleeding/bruising R/T (related to): medication use. Anticoagulant. Hx (history) of GI (gastrointestinal) bleeding." Under "Interventions", it documented in part, "Administer medications as ordered." "Date initiated: 02/05/2019, Obtain labs (laboratory tests) and diagnostics as ordered and report abnormal findings to the physician. Date initiated 02/05/2019." A nurse practitioner's note dated 06/28/1018 documented in part: "HPI (history of present illness): Male patient on Coumadin (1) for DVT. INR (international normalized ratio) 2.2 ...." "..INR 2.2. Goal: 2-3 (two to three)." The facility's "Anticoagulant Record" for Resident # 8 documented, "Current Anticoagulant Drug and Dose: Coumadin 7.5mg." "PT: 16.7. INR: 1.4 [blow the resident goal placing the resident at risk for blood clots]" "08/20/18 Action Taken by Physician: an arrow point up (indicating increase Coumadin) 8mg qd (every day)." The eMAR (electronic medication administration record) dated August 2018 documented the physician's telephone order dated 08/20/18 as stated above with a start date of 07/11/2018. Further review of the eMAR revealed a check mark and the nurse's initials under the date of 08/21/18 indicating Resident # 8 received 8 mg and 7.5 mg of Coumadin on 08/21/18. Review of the nurse's progress notes, physician	F580		

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F580	Continued From page 25 notes and nurse practitioner notes dated 08/01/18 through 08/31/18 failed to evidence any documented recommendations or orders for the resident to receive both 8 mg and 7.5 mg for a total of 15.5mg of Coumadin on 08/21/18. There was no documentation evidencing the nurse practitioner or physician were notified the significant medication error. The facility's "Nurse Practitioner's Note" for Resident # 8 dated 11/09/18 and signed by ASM (administrative staff member) # 7, nurse practitioner, at 12:45 p.m., documented in part, "HPI (History of Present Illness): ATSP (Asked To See Patient) for lab (laboratory) review. Male patient on Coumadin for DVT. INR: 3.5. Goal 2-3 (two to three). On 6 (six) mg daily. No s/sx of bleeding." Under "A/P (Assessment/Plan)" it documented, "Leg DVT - Stable. INR elevated. Hold Coumadin x1 (times one day) and recheck tomorrow [11/10/18]." The Physician's telephone order documented, "Created Date: 11/9/18 at 17:14 (5:14 p.m.) Communication method: Phone." Documented "Order Summary: Coumadin Tablet 6 MG [milligram] (Warfarin Sodium) Give 6 MG by mouth in the evening for anticoagulant therapy Discontinue 11/9/18 17:14 (5:14 p.m.) Discontinue Date/Reason: on hold Confirmed By: name of (Licensed Practical Nurse)." A second physicians order date 11/9/2018 at 17:15 (5:15 p.m.) documented, "Order Summary: check pt/inr on sat [Saturday] 11/10/18 one time only for coumadin (Sic.) use 1 day." The facility's "Anticoagulant Record" for Resident # 8 dated 11/09/18 documented, Current Anticoagulant Drug and Dose: "Coumadin 6 mg (milligrams)" "PT 3.5 INR: 41.6	F580		

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F580	Continued From page 26 and the PT level under the INR. The INR was elevated above the resident goal of 2-3 placing the resident at risk for bleeding]." Under "Action Taken by Physician" it documented, "Hold x 1 (times one day) re-check 11/10/18." Further review of the "Anticoagulant Record" failed to evidence results of a PT/INR for 11/10/18. Review of the eMAR (electronic medication administration Record) for November 2018 revealed, Coumadin Tablet 6 MG [milligram] (Warfarin Sodium) Give 6 MG by mouth in the evening for anticoagulant therapy Start Date 9/12/18 D/C Date 11/9/18. On 11/9/18 a "5 (five)" was documented with staff initials for the dose of Coumadin scheduled at 1700 (5:00 p.m.). The code for 5 on the MAR documented, "Hold/See Nurse Notes." A Nurse's Note" dated 11/09/18 for Resident # 8 at 7:25 p.m. documented, "Hold Coumadin 6MG (milligrams) today 11/09/18 recheck PT/INR on SAT (Saturday) 11/10/18 will cont (continue) to monitor guest." Further review failed to evidence nurses notes documenting why the PT INR was not obtained on 11/10/18 as ordered by the physician. There was no documentation evidencing the physician was notified the PT/INR was not obtained as ordered on 11/10/18. On 5/2/19 the "Anticoagulant Record" for Resident # 8 documented, "Current Anticoagulant Drug Dose: Held on 5/1/19, PT 39.0 INR 3.2" Under "Action Taken by Physician" it documented, "Hold x 1 (times one day) re-check 5/3/19." The nurse's progress note for Resident # 8 dated 05/02/2019 at 4:44 p.m. documented in part, "PT/INR 39.0/3.2. Per MD (medical	F580		

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F580	Continued From page 27 doctor), hold Coumadin today [5/2/19] and recheck tomorrow [5/3/19]." A "Nurse Practitioner's Note" for Resident # 8 dated 5/03/19, signed by ASM (administrative staff member) # 7, nurse practitioner, at 5:10 p.m. documented in part, "A/P: Leg DVT - Stable. 5MG coumadin (Sic.) QD (every day) and check INR 5/10/19. Monitor closely." On 5/3/19 Resident #8's "Anticoagulant Record" documented, "Current Anticoagulant Drug Dose: Coumadin 6 mg held on 5/2/19, PT 24.9 INR 2.1" Under "Action Taken by Physician" it documented, " 5 mg [Coumadin] QD [every day] re-check 5/10/19." Further review of the "Anticoagulant Record" failed to evidence results of a PT/INR for 05/10/19. The Date 5/10/19 was crossed out with a line on the Anticoagulant Record. A hand written notation was written beside the crossed out date 5/10/10, and documented, "MD (medical doctor) aware NNO (no new order)." Review of the May 2019 MAR revealed, "Coumadin Tablet 6 MG (Warfarin Sodium) Give 6 mg by mouth one time a day for anti-coagulant. Start Date- 01/11/2019 1700 (5:00 p.m.), -Hold Date- from 05/01/2019 1445 (4:45 p.m.) -05/02/2019 1444 (2:44 p.m.). This order was documented as discontinued on 5/15/19. Review of the MAR for 5/2/19 evidenced staff initials with a check mark on 5/2/19 indicating the staff administered 6 mg of Coumadin to Resident #8, instead of holding the medication as ordered by the nurse practitioner. Review of the electronic health record failed to evidence documentation that the physician/nurse practitioner was notified that Resident # 8 received 6 mg of Coumadin on	F580		

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F580	Continued From page 28 5/2/19 when it was ordered to be held. On 7/31/19 at 2:36 p.m., an interview was conducted with ASM (administrative staff member) #5, Resident # 8's physician at the facility. ASM #5 was asked why Coumadin must be monitored. ASM #5 stated Coumadin (levels) could quickly become out of control because the medication can variably react with food and other medications. ASM #5 stated this is why the medication has to be monitored. ASM #5 was asked how often PT/INRs should be obtained to monitor Coumadin and stated that depends on the patient and other variables. ASM #5 was asked where the monitoring of Coumadin and PT/INRs are documented. ASM #5 stated they are documented in the Coumadin book (anticoagulant record). When asked how orders for Coumadin changes and PT/INRs are communicated, ASM #5 stated those are written in the anticoagulant record and she does not write actual orders for those. When asked who is responsible for overseeing the anticoagulant record, ASM #5 stated she was not sure but she assumed the unit managers. ASM #5 was made aware there was missing evidence of Coumadin monitoring in Resident # 8's clinical record, and that Resident # 8 received incorrect doses of Coumadin and the Coumadin was not held on 05/02/19. ASM #5 reviewed her notes and stated she had no documentation in her notes. On 08/06/19 at 11:15 a.m., during an interview conducted with RN (registered nurse) # 8, assistant director of nursing/unit manager regarding the incorrect doses and the double dose of Coumadin Resident # 8 received on 8/21/18 and 05/03/19 through 05/14/19. After reviewing the anticoagulant record, eMAR dated August 2018 and May 2019 and the progress notes RN # 8 stated, "He should have only	F580		

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F580	Continued From page 29 received 8mg" referring to 08/21/18 and confirmed that Resident # 8 was not receiving the correct dose from 05/03/19 through 05/14/19. When asked what would happen if a resident received too much Coumadin, RN # 8 stated the resident's blood could become too thin and they could bleed. RN #8 was asked about Resident #8's Coumadin not being held as ordered on 05/02/10. RN # 8 stated the order should have been followed to hold it. On 8/7/19 9:53 a.m., an interview was conducted by another surveyor with LPN (licensed practical nurse) #1, a nurse working at the facility. When asked about the process for notifying the physician of an error in Coumadin administration, LPN #1 stated "I write myself notes from the Coumadin log and take that with me so no mistake in giving Coumadin. I check the log and make sure it is not given. If there is a mistake, we call the physician." On 08/05/19 at 5:10 p.m., ASM (administrative staff member) #1, administrator, ASM # 2, regional clinical coordinator and ASM #3 (director of nursing) were made aware of the above concern. No further information was presented prior to exit. References: (1) A blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot. This information was obtained from the website: https://medlineplus.gov/ency/article/003652.htm. (2) International normalized ratio (INR) is the preferred test of choice for patients taking vitamin K antagonists (VKA). It can also be used	F580		

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F580	Continued From page 30 to assess the risk of bleeding or the coagulation status of the patients. Patients taking oral anticoagulants are required to monitor INR to adjust the VKA doses because these vary between patients. The INR is derived from prothrombin time (PT) which is calculated as a ratio of the patient's PT to a control PT standardized for the potency of the thromboplastin reagent developed by the World Health Organization (WHO) using the following formula: This information was obtained from the website: https://www.ncbi.nlm.nih.gov/books/NBK507707/ . (3) A medicine that makes your blood less likely to form clots. It is important that you take warfarin exactly as you have been told. Changing how you take your warfarin, taking other medicines, and eating certain foods all can change the way warfarin works in your body. If this happens, you may be more likely to form a clot or have bleeding problems. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000292.htm. (4) A condition that occurs when a blood clot forms in a vein deep inside a part of the body. It mainly affects the large veins in the lower leg and thigh, but can occur in other deep veins such as in the arms and pelvis. This information was obtained from the website: https://medlineplus.gov/ency/article/000156.htm. 4. The facility staff failed to notify and consult the physician when Coumadin was held without a physicians order on: 8/15/18, 9/27/18, 11/15/18, 1/10/19, 4/25/19, 5/12/19, and 5/20/19. In	F580		

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F580	Continued From page 31 ordered PT/INR laboratory tests were not obtained as ordered on 4/12/19, 6/27/19 and 7/26/19. when the residents INR (international normalized ratio) was below the documented goal placing the resident at risk for blood clots. Resident #189 was admitted to the facility on 9/16/17, with a most recent readmission on 7/16/19, with diagnoses that included but were not limited to: mechanical heart valve, stroke, high blood pressure and atrial fibrillation. (Atrial fibrillation is a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria). [1] The most recent MDS (minimum data set) assessment, a Medicare five day admission, with an assessment reference date of 7/23/19, coded the resident as scoring a "11" on the BIMS (brief interview for mental status score) indicating the resident was moderately impaired to make daily decisions. In Section N - Medications, the resident was coded as receiving an anticoagulant for the seven days of the look back period. Warfarin (also known by the brand names Coumadin....) is a blood thinner prescribed to prevent and treat blood clots. Warfarin therapy may be prescribed for patients with certain types of irregular heartbeat, blood clots in the legs or lungs, and patients who have certain medical device implants such as artificial heart valves. Warfarin must be monitored to ensure it is working effectively and being used safely. Achieving the correct warfarin dosage can be difficult but is extremely important. If the dose of	F580		

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F580	Continued From page 32 warfarin is too low, the patient is at risk of developing harmful blood clots. If the dose of warfarin is too high, the patient may be at risk of serious bleeding. An INR [International normal ratio] target range is set by a health care provider. It is typically between 2.0 and 3.0 for basic blood-thinning needs, though the range may vary based on a patient's specific conditions. An INR above the patient-specific target range may increase the risk of bleeding, while an INR below the target range may increase the risk of developing a blood clot. [2] The comprehensive care plan dated, 12/19/18 and revised on 3/7/19, documented in part, "Focus: (Resident #189) is at risk for abnormal bleeding/bruising R/T (related to) medication use, anticoagulant diagnosis of A-Fib (atrial fibrillation), stroke." The "Interventions" documented in part, "Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician.... ." The nurse practitioner note dated, 8/10/18, documented, "INR goal 2.5 - 3.5." "Prothrombin time (PT) is a blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot." "PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio)." "The most common reason to perform this test is to monitor your levels when you are taking a blood-thinning medicine called warfarin [Coumadin]. You are likely taking this medicine to prevent blood clots. Normal Results: PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio). If you are taking warfarin to prevent blood clots, your provider will most	F580		

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F580	Continued From page 33 likely, choose to keep your INR between 2.0 and 3.0." [3] The "Anticoagulant Record," which was not part of the electronic medical record and stored on a shelf at the nurse's station, revealed On 8/15/18, Resident #189's documented INR on the Anticoagulant record was 1.8, [below the documented INR goal of 2.5 - 3.5 placing the resident at risk for blood clots]. The current Coumadin dose was documented as "5 mg [milligrams]" the physician directive documented, "Increase to 5.5 mg recheck 8/18/18. Review of the EMR (electronic medical record) revealed a documented physicians order to increase Coumadin to 5.5 mg dated 8/15/18. Review of the August 2018 MAR revealed the documented order for "Coumadin 5.5 mg by mouth in the evening, effective 8/15/18." Further review of the MAR revealed a "5" documented for the dose of Coumadin due on 8/15/18. A "5" per the MAR indicated to "Hold/see nurse's notes." A review of the EMR [electronic medical record] failed to evidence a nurse's note for 8/15/18. The resident did not receive any Coumadin on 8/15/18, as per the physician order. There was no order in the EMR to hold Resident #189's Coumadin on 8/15/18 and no documented notification to the physician that the medication was not administered as ordered. Resident #189's INR on the "Anticoagulant Record" dated; 8/15/8 was 1.8 and on 8/17/18, the INR was documented as 1.6, below the documented INR goal of 2.5 - 3.5 placing the resident at risks for blood clots. Review of the physician orders revealed a documented order for Coumadin 5 mg qd (every day) on 9/27/18.	F580		

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	495109	A. BUILDING _____ B. WING _____	C 08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F580	Continued From page 34 Review of the September MAR documented the above 9/27/18 physician order for Coumadin 5 mg qd. The start date documented, 9/28/18. Further review of the MAR failed to evidence the resident received any Coumadin on 9/27/18 per the physician's orders. There was no order to hold Resident #189's Coumadin on 9/27/18. Staff failed to administer the medication as ordered when the residents INR was below the identified goal of 2.5-3.5 placing the resident at risk for blood clots. Review of the EMR failed to evidence any documentation the physician was notified the Coumadin was not administered as ordered on 9/27/18. The "Anticoagulant Record" revealed the 11/15/18 date was crossed off and the date of 11/14/18 was documented the PT/INR as 2.2 below the identified goal of 2.5-3.5 placing the resident at risk for blood clots]. The physician directive documented, to increase Coumadin to 5 mg and recheck on 11/19/18. A nurse practitioner note dated, 11/15/18, documented in part, "CC: lab (laboratory) review. INR today 2.2. On Coumadin 4.5 mg for MVR (mechanical valve replacement) and A. fib. Goal 2.5 - 3.5...On Coumadin. Increase to 5 mg qd and recheck on 11/19/18. Review of the EMR revealed a physician order dated 11/15/18 to increase the Coumadin to 5 mg. Review of the November MAR documented the above directive on 11/9/18 for Coumadin 4.5 mg qd. The medication was administered from 11/9/18 through 11/14/18. On 11/15/18, a "5" was documented under the Coumadin 4.5 mg dose. A "5" indicated, "Hold/See nurse's note."	F580		

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F580	Continued From page 35 There was no nurse's note for 11/15/18. Review of the electronic medical record failed to evidence a physician order to hold Resident #189's Coumadin on 11/15/18. Review of the EMR failed to evidence any documentation the physician was notified the ordered dose of Coumadin was not administered on 11/15/8. The "Anticoagulant Record" dated, 1/9/19, documented the current Coumadin dose as 5 mg, INR level 4.0" [above therapeutic goal], the physician was notified on 1/9/19. The physician directive documented, "Hold Coumadin, recheck 1/10/19." There was a physician order in the EMR to hold the Coumadin and to recheck the Coumadin on 1/10/19. On 1/10/19, the "Anticoagulant Record" documented the current Coumadin dose as "HOLD" "INR 2.8." The physician directive documented, "(Coumadin) 4.5 mg qd (every day), recheck 1/15/19. Physician orders were in place in the EMR for the above Coumadin directives. The January 2019 MAR documented the following order, "Coumadin 2.5 mg; give 1 tablet by mouth in the evening for A fib to give with 2 mg to make 4.5 mg." Further review of the January 2019 MAR failed to evidence the resident received any Coumadin on 1/10/19. The order was transcribed to start on 1/11/19. There was no physician order in the clinical record to hold Resident #189'2 Coumadin on 1/10/19 and no documentation evidencing the physician was notified the medication was not administered as ordered. On Resident #189's "Anticoagulant Record" dated, 4/11/19, the current Coumadin dose was documented as 2.5 mg, INR 2.3, [below therapeutic goal placing the resident at risk for blood clots for a level too low and bleeding for a	F580		

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F580	Continued From page 36 level to high]. The physician directive documented, "No change recheck in one day." A physician order dated, 4/11/18 in the EMR documented, "Recheck PT/INR level on 4/12/19. The "Anticoagulant Record" dated, 4/12/19, failed to evidence the PT/INR test was performed on 4/12/19. The form was dated 4/12/19 with the current Coumadin dose documented as 2.5 mg but the rest of the line was empty. Review of the nurse's note failed to evidence a nurse's note for 4/12/19. The test was not completed per the physician order dated 4/11/19 in the EMR and the physician directive documented on the "Anticoagulant Record." There was no documentation evidencing the physician was notified the ordered PT/INR was not obtained on 4/12/19. Review of the physician's orders revealed an order dated 4/24/19 that documented 6 mg of Coumadin every day. The April 2019 MAR documented that the resident received the Coumadin 6 mg on 4/24/19. The "Anticoagulant Record" dated, 4/25/19, documented the current Coumadin dose as 6 mg. the PT/INR was documented as 2.2 [below the identified goal of 2.5-3.5 placing the resident at risk for clots]. The physician directive on the record documented, no change recheck on 4/27/19. Review of the April MAR failed to evidence the resident received the prescribed dose of Coumadin, 6 mg on 4/25/19. There was no physician order in the clinical record to hold Resident #189's Coumadin on 4/25/19 and no documentation evidencing the physician was notified the Coumadin was not administered to Resident #189 as ordered. The "Anticoagulant Record" dated, 5/12/19,	F580		

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F580	Continued From page 37 documented the current Coumadin dose as 5.5 mg. The INR was documented as 2.8. The physician directive documented, "Decrease (Coumadin) to 3 mg, recheck 1 wk." A physician order in the EMR dated, 5/12/19, documented, "Coumadin 3 mg by mouth in the evening for anticoagulation." The order was transcribed to the May 2019 MAR. The MAR documented the order to start on 5/13/19. The resident did not receive any Coumadin on 5/12/19. There was no physician order in the EMR to hold Resident #189's Coumadin on 5/12/19 and no documentation evidencing the physician was notified the medication was not administered as ordered. The "Anticoagulant Record" dated, 5/20/19, documented the current Coumadin dose as 3 mg INR 1.6 [below the therapeutic goal]. The physician directive documented, "Increase to 4 mg, recheck 1 wk [week]." The physician order in the EMR dated, 5/20/19 documented, "Coumadin 4 mg; give 1 tablet by mouth in the evening for prevent dvt (deep vein thrombosis)." The May MAR documented the order above for the Coumadin 4 mg. The order was documented to start on 5/21/19. Further review of the MAR failed to evidence the resident received any Coumadin on 5/20/19. There was no physician order in the EMR to hold Resident #189's Coumadin and no documentation evidencing the physician was notified the medication was not administered as ordered. On 6/26/19, the "Anticoagulant Record" documented in part under: "Action Taken By The Physician": "Hold x1, recheck 6/27/19." A nurse practitioner note dated, 6/26/19, documented in part, "INR today 4.6. On	F580		

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F580	Continued From page 38 Coumadin 5.5.mg (milligram) qd. (every day), goal 2.5 - 3.5, hold x 1 and recheck 6/27/19." The EMR documented in part a physician order dated to recheck on 6/27/19. Review of Resident #189's "Anticoagulant Record" failed to evidence documentation that Resident #189's INR was obtained on 6/27/19, as ordered by the physician. There was no documentation evidencing the physician was notified the PT/INR was not obtained as ordered on 6/27/19. A physician order in the EMR dated, 7/25/19, documented, "PT/INR on 7/26/19, notify MD of results." On 7/26/19, the "Anticoagulant Record" documented the current Coumadin dose of 5 mg. The rest of the line was blank and there was no PT/INR documented. The PT/INR for Resident #189 was not obtained as ordered by the physician. There were no nurse's notes for 7/26/19, and no documentation the physician was notified the PT/INR was not obtained as ordered. On 7/31/19 at 2:36 p.m., an interview was conducted with ASM (administrative staff member) #5 (Resident #189's physician at the facility). ASM #5 was asked why Coumadin must be monitored. ASM #5 stated Coumadin (levels) could quickly become out of control because the medication can variably react with food and other medications. ASM #5 stated this is why the medication has to be monitored. An interview was conducted with administrative staff member (ASM) #7, the nurse practitioner for Resident #189, on 8/6/19 at 7:53 a.m. When	F580		

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F580	Continued From page 39 asked if an order for Coumadin is written on the same day the PT/INR test is obtained, when does that order take effect, ASM #7 stated it should be initiated that same day. An interview was conducted with RN #8 on 8/6/19 at 3:12 p.m. When asked if the physician's order documents to administer a dose of Coumadin, should the medication be given as ordered, RN #8 stated, "Yes, we should always follow the physician order." RN #8 was asked if the physician gives an order to change the dose of Coumadin, after the PT/INR is obtained in the morning, when is the change dose effective. RN #8 stated, "It goes in effect before the evening dose [of Coumadin] that same day." When asked if the physician ordered dose change should be documented to start the next day, RN #8 stated, "No, it has to start the same day. That's why we do PT/INRs in the morning so we can have the correct dose for the evening dose of Coumadin." The "Anticoagulant Record" for Resident #189, nurse's notes, MARs, physician and NP notes and orders from 7/18/18 through 7/29/19, was reviewed with RN #8 and the above documented concerns reviewed. When RN #8 was asked if staff hold a dose of Coumadin, should there be a physicians order in the electronic record. RN #8 sated, "Yes, there should be an order anytime the Coumadin is held." When asked about the PT/INRs that were not completed as ordered on 4/12/19, 5/1/19, 6/27/19 and 7/26/19, RN #8 stated, they should be done as ordered and if not done the physician should be notified and then we follow any order that they may give. When asked if the nurses should follow the documented physician directive or a physician order, RN #8 stated, "Yes, we should always follow the physician	F580		

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F580	Continued From page 40 order." On 8/7/19 9:53 a.m., an interview was conducted by another surveyor with LPN (licensed practical nurse) #1, a nurse working at the facility. When asked about the process for notifying the physician of an error in Coumadin administration, LPN #1 stated "I write myself notes from the Coumadin log and take that with me so no mistake in giving Coumadin. I check the log and make sure it is not given. If there is a mistake, we call the physician." ASM (administrative staff member) #1, the administrator, ASM #2, the regional clinical coordinator, and ASM #3, the director of nursing were made aware of all of the above concerns on 8/6/19 at 5:19 p.m. No further information was provided prior to exit. [1] Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F580		
F584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) 483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- 483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F584	Ftag 584 Resident # 54: No negative outcome occurred from this practice. The residents room was deep cleaned, and the mattress was inspected and replaced. Residents currently in the facility have the potential to be affected. The DON or designee will educate nursing staff on incontinence care and resolving odors. The housekeeping director will	9/20/19

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F584	Continued From page 41 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. 483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; 483.10(i)(3) Clean bed and bath linens that are in good condition; 483.10(i)(4) Private closet space in each resident room, as specified in 483.90 (e)(2)(iv); 483.10(i)(5) Adequate and comfortable lighting levels in all areas; 483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81F; and 483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a clean, comfortable, homelike environment for one of 72 residents in the survey sample, Resident #54. The facility staff failed to maintain Resident #54's room in a homelike manner. A strong, persistent urine odor was noted in the resident's room on 7/30/19, 7/31/19 and 8/1/19.	F584	educate the housekeeping department on the daily room cleaning process. The NHA or designee will educate department managers on room rounding and identifying odors for correction. Department managers or designee will conduct room rounds on their assigned rooms to identify any odors. The housekeeping director or designee will inspect mattresses and floors in resident rooms to identify further cleaning needs. The housekeeping director or designee will monitor rooms 5 days a week for 1 week and then weekly for 4 weeks. Any variances will be corrected and additional education or counseling will be provided as needed. Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: September 20, 2019	

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F584	Continued From page 42 The findings include: Resident #54 was admitted to the facility on 8/13/17. Resident #54's diagnoses included but were not limited to quadriplegia (paralysis of all four limbs), chronic pain syndrome and abnormal posture. Resident #54's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/3/19, coded the resident as being cognitively intact. Under section H (Bladder and Bowel) the resident was coded as having an external (condom) catheter and as always incontinent of bowel. On 7/30/19 at 3:46 p.m., 7/31/19 at 7:58 a.m. and 7/31/19 at 3:28 p.m., observations of Resident #54 lying in bed were conducted. During each observation, a strong, persistent urine odor was noted. On 7/31/19 at 3:28 p.m., an interview was conducted with Resident #54. Resident #54 confirmed he could smell the urine odor. On 8/1/19 at 8:04 a.m., an interview was conducted with CNA (certified nursing assistant) #8. CNA #8 was asked what is done to prevent urine odors in resident rooms. CNA #8 stated, "Take the diaper off and clean them for one. Change the beds, then tell housekeeping or clean the beds ourselves or if (the odor is) real strong, we tell the nurse cause there may be something else going on." On 8/1/19 at 8:20 a.m., observation of Resident #54's room was conducted with CNA #8. CNA #8 confirmed the strong urine odor and stated maybe urine had gotten into the mattress. On 8/6/19 at 11:25 a.m., ASM (administrative	F584		

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F584	Continued From page 43 staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. The facility policy titled, "PHYSICAL ENVIRONMENT" documented, "The facility will provide a safe, functional, sanitary, and comfortable environment for our guests, staff, and the public..." No further information was presented prior to exit.	F584		
F600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) 483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. 483.12(a) The facility must- 483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure three of 72 residents in the survey sample, (Resident #338, #93 and	F600	Ftag 600 Resident #338: The resident no longer resides in the facility. Resident # 93: The resident did not incur any injuries as a result of this event. The facility completed an FRI when the event occurred. The employee no longer works at the facility Resident #61: The resident did not incur any injuries as a result of this event. No further incidents have occurred. Residents with aggressive behaviors or receiving Coumadin have the potential to be affected. The DON or designee will educate staff on abuse and neglect, identifying and managing aggressive behaviors, and the process of Coumadin logs, following orders and ensuring Anticoagulant services are	9/20/19

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F600	Continued From page 44 #61) were free from neglect and abuse. Staff neglected to provide Resident #338, adequate monitoring for safe administration of anticoagulant medication, (Coumadin), she subsequently presented with bleeding, was transferred to the hospital where she received blood clotting medication, and a blood transfusion, resulting in harm; Resident #93 was hit by, OSM (other staff member) #12 (a former housekeeping employee), and Resident #61 was slapped by Resident #93. The findings include: 1. Resident #338 received no laboratory monitoring for the use of the high-risk anticoagulant (blood thinning medication) medication Coumadin [1] from 6/29/18 (admission) through 7/23/18, and presented with bleeding on 7/22/18, at 11: 46 p.m., which was not immediately addressed with the physician. On the morning of 7/23/18, the nurse practitioner evaluated Resident #338, and transferred her to the hospital, where she received blood clotting medication and a blood transfusion for gastrointestinal bleeding, resulting in harm. Resident #338 was admitted to the facility on 6/29/18. Resident #338's diagnoses included but were not limited to revision of left total knee removal, asthma and high blood pressure. Resident #338's most recent MDS (minimum data set) (prior to discharge), a 14 day Medicare assessment with an ARD (assessment reference date) of 7/13/18, coded the resident as being cognitively intact. Section N coded Resident #338 as having received an anticoagulant medication seven out of the last seven days.	F600	being delivered as ordered. The DON or designee will conduct an audit of Coumadin logs and physicians orders for accuracy and completion. The behavior management team or designee will audit residents who are being monitored for aggressive behaviors and review current interventions and care plans for residents with aggressive behaviors. Nursing administration will monitor Coumadin logs and orders 5 days a week for 1 week, 3 days a week for 2 weeks, weekly for 4 weeks, and monthly for 3 months. Residents being monitored for aggressive behaviors will be reviewed 5 days a week for 1 week, 3 days a week for 2 weeks, weekly for 4 weeks, and monthly for 3 months. Any variances will be corrected and additional education or counseling will be provided as needed Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: September 20, 2019	

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F600	Continued From page 45 Review of Resident #338's hospital record prior to discharge to the facility revealed Coumadin was initiated during the resident's hospitalization for dvt (deep vein thrombosis) [2] prophylaxis. Further review of the hospital record revealed a PT/INR (prothrombin time/international normalized ratio) [3] of 24.1/2.4 on 6/29/18. A hospital pharmacist note dated 6/29/18 documented, "Warfarin (Coumadin) dosing- Day #5 Consult provided for this 77 y.o. (year old) female to manage warfarin for VTE (sic) prophylaxis s/p (status post) orthopedic surgery. INR Goal: 1.7-2.2. Drugs that may increase INR: Ceftriaxone [4]. Drugs that may decrease INR: None. Other current anticoagulants/drugs that may increase bleeding risk: NSAIDs (nonsteroidal anti-inflammatory drugs) [5]. Risk factors: > (greater than) 65. Daily INR ordered: Yes... Date INR Dose 6/15 1.0 6/25 4mg (milligrams) 6/26 1.0 mg 6/27 2.8 HOLD 6/28 2.1 2 mg 6/29 2.4 Hold Assessment/Plan: Will hold warfarin today for INR above goal. Pharmacy will continue to monitor daily and adjust therapy as indicated." Review of Resident #338's facility clinical record revealed discharge orders from the hospital, documented as being verified by a facility nurse with the on-call physician for ASM (administrative staff member) #5 (Resident #338's facility physician) on 6/29/18, documented an order for warfarin (Coumadin) 2 mg- one tablet by mouth daily for dvt (deep vein thrombosis) prevention. Further review of the discharge orders verified by the facility on-call physician failed to reveal any orders for a	F600		

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F600	Continued From page 46 PT/INR or any orders for the monitoring of adverse outcomes. Warfarin (also known by the brand names Coumadin....) is a blood thinner prescribed to prevent and treat blood clots. Warfarin therapy may be prescribed for patients with certain types of irregular heartbeat, blood clots in the legs or lungs, and patients who have certain medical device implants such as artificial heart valves. Warfarin must be monitored to ensure it is working effectively and being used safely. Achieving the correct warfarin dosage can be difficult but is extremely important. If the dose of warfarin is too low, the patient is at risk of developing harmful blood clots. If the dose of warfarin is too high, the patient may be at risk of serious bleeding. A health care provider sets an INR [International normal ratio] target range. It is typically between 2.0 and 3.0 for basic blood-thinning needs, though the range may vary based on a patient's specific conditions. An INR above the patient-specific target range may increase the risk of bleeding, while an INR below the target range may increase the risk of developing a blood clot. [2] Black Box Warning [A boxed warning is the strongest warning that the FDA (Food and Drug Administration) requires, and signifies that medical studies indicate that the drug carries significant serious or even life-threatening adverse effects]: BLEEDING RISK: COUMADIN can cause major or fatal bleeding. Perform regular monitoring of INR [international normalized ratio - a laboratory blood test that measures how long it takes for blood to clot [3]] in all treated patients. [8] A physician's order in the clinical record dated 6/29/18 documented an order for Coumadin- 2	F600		

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F600	Continued From page 47 mg by mouth in the evening for DVT prophylaxis. Review of Resident #338's June 2018 and July 2018 MARs (medication administration records) revealed the resident was administered 2 mg of Coumadin as prescribed by the physician from 7/1/18 through 7/22/18. Resident #338's baseline care plan (no date) documented "Anticoagulant- (a check mark beside) Observe S/S (signs or symptoms) of bleeding, report as indicated..." Resident #338's comprehensive care plan dated 7/11/18 documented, " BLEED101: At risk for abnormal bleeding R/T (related to) anticoagulant use...Interventions: Administer medications as ordered...Observe for abnormal s/sx (signs/symptoms) of bleeding. i.e. Bruising, bleeding gums, petechiae (tiny red spots caused by bleeding into the skin), nosebleeds, hematuria (bloody urine), headaches, back of abdominal pain, decrease blood pressure or pulse, occult blood in the stool, etc. Obtain labs as ordered. Report abnormal findings to physician. Report all abnormal findings to physician..." Further review of Resident #338's clinical record (including nurses' notes, NP (nurse practitioner) notes and physician notes from date of admission to date of discharge) revealed no documentation of monitoring for the prescribed use of Coumadin. The physician note dated 7/2/18 failed to document information regarding Coumadin or monitoring for the medication. The NP notes dated 7/3/18, 7/10/18, 7/11/18, 7/12/18, 7/16/18, 7/17/18, 7/18/18, 7/19/18 and 7/20/18 documented information regarding, "Pertinent lab results" but failed to document any information regarding PT/INRs and Coumadin monitoring. The notes further documented, "On	F600		

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F600	Continued From page 48 Coumadin therapy for DVT prophylaxis..." but failed to document any information regarding the monitoring of Coumadin. There was no anticoagulant record for Resident #338. (The "Anticoagulant Record" a tracking flowsheet that was being utilized by facility staff for Coumadin monitoring separate from the clinical record. It includes the date, current anticoagulant drug and dose, PT/INR, name of the nurse who completed the PT/INR, the test strip lot number, quality control test for the machine used to test for the PT/INR, the date the physician was notified and action taken by the physician. Directives for testing and Coumadin dose changes were documented on the sheet by nurses and physicians but were not signed and the facility did not have a policy regarding the process and use of the flowsheet). Review of notes documented by the pharmacist on 7/2/18 and 7/21/18 revealed the pharmacist reviewed Resident #338's clinical record on those dates. The notes failed to document any information regarding the use of Coumadin or monitoring for the medication. Review of Resident #338's June 2018 and July 2018 MARs (medication administration records) revealed the resident was administered 2 mg of Coumadin as prescribed by the physician from 7/1/18 through 7/22/18 (including on 7/22/18 at 5:00 p.m.) A nurse's note dated 7/22/18 at 11:46 p.m. documented, "It was reported that guest has blood stain on bed linen. Bright red blood observed on linen unable to determine if vaginal bleed. Trace bright red blood on washcloth after pericare. Guest has + (positive) bowel sounds which are hyperactive in all 4 quadrants."	F600		

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F600	Continued From page 49 A NP (nurse practitioner) note dated 7/23/18 at 8:30 a.m. documented, "CC (Chief Complaint): blood in stool. HPI (History of Present Illness): ATSP (Asked to See Patient) for blood in stool. Patient reports bright red blood per rectum on several occasions over the weekend. States that she has had blood on her pad and bed. Endorses abdominal pain and burning, diarrhea, and nausea. Unsure if there was blood in the toilet with BM (bowel movement) this morning, was unable to see. Has tried Zofran [6] and pain medication over the weekend with no relief...A/P (Assessment/Plan) GI (gastrointestinal) bleeding: referred to ER (emergency room)..." Review of hospital records revealed Resident #338's INR was 11.8 on 7/23/18. The resident was administered Vitamin K (7) and underwent a blood transfusion on 7/24/18. *"Prothrombin time (PT) is a blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot." "PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio)." "The most common reason to perform this test is to monitor your levels when you are taking a blood-thinning medicine called warfarin [Coumadin]. You are likely taking this medicine to prevent blood clots. Normal Results: PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio). If you are taking warfarin to prevent blood clots, your provider will most likely, choose to keep your INR between 2.0 and 3.0." [3] On 7/31/19 at 2:36 p.m., an interview was conducted with ASM (administrative staff member) #5 (Resident #338's physician at the facility). ASM #5 was asked the process for Coumadin monitoring for a resident newly	F600		

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F600	Continued From page 50 admitted to the facility. ASM #5 stated the process depends on the orders provided by the hospital. ASM #5 stated the hospital usually specifies the next date a PT/INR should be obtained and that order should be followed. ASM #5 was asked what should be done if the hospital does not provide an order for a PT/INR. ASM #5 stated usually she would review the resident's chart, find out the last date a PT/INR was checked and order for a PT/INR to be checked within the next few days. ASM #5 stated she likes to have a baseline PT/INR and the value of that PT/INR will determine when the next one should be done. ASM #5 stated the facility staff obtains PT/INRs and documents them in the "Coumadin book" (anticoagulant record). ASM #5 stated the clinician can be proactive and check the anticoagulant record or often, the nurses will flag the anticoagulant record for a recently obtained PT/INR or the nurses will verbally tell her that they checked a resident's PT/INR and ask for her review. ASM #5 was asked why Coumadin must be monitored. ASM #5 stated Coumadin (levels) could quickly become out of control because the medication can variably react with food and other medications. ASM #5 stated this is why the medication has to be monitored. ASM #5 was asked how often PT/INRs should be obtained to monitor Coumadin and stated that depends on the patient and other variables. When asked where staff document the monitoring of Coumadin and PT/INRs, ASM #5 stated in the Coumadin book (anticoagulant record). When asked how orders for Coumadin changes and PT/INRs are communicated, ASM #5 stated those are written in the anticoagulant record and she does not write actual orders for those. When asked who is responsible for overseeing the anticoagulant record, ASM #5 stated she was not sure but she assumed the	F600		

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F600	Continued From page 51 unit managers. ASM #5 was made aware there was no evidence of Coumadin monitoring in Resident #338's clinical record and no evidence of an anticoagulant record for the resident. ASM #5 reviewed her notes and stated she had no documentation in her notes. On 7/31/19 at 2:45 p.m. and 4:57 p.m., ASM #1 (the administrator) was asked to provide Resident #338's anticoagulant record. On 8/1/19 at 7:57 a.m., ASM #1 stated she could not find Resident #338's anticoagulant record. On 8/1/19 at 8:46 a.m., an interview was conducted with RN (registered nurse) #1, regarding the facility process for Coumadin monitoring. RN #1 stated when a resident is admitted, she tells the doctor the resident is receiving Coumadin and asks the doctor if she should obtain a PT/INR so there is a baseline before the first dose of Coumadin is given. RN #1 stated she enters the Coumadin order into the computer system, obtains a PT/INR and immediately notifies the doctor. RN #1 stated she makes the doctor aware of the PT/INR results and asks if he/she wants to continue the prescribed dose of Coumadin, make changes, and when the next PT/INR should be done. RN #1 stated she obtains this information then documents the current Coumadin dose, the PT/INR results and action taken by the physician, including the due date for the next PT/INR on the anticoagulant record. On 8/1/19 at approximately 10:45 a.m., ASM #1 was asked to provide the anticoagulant policies. On 8/1/19 at 1:36 p.m., a telephone interview was conducted with ASM #8 (the consulting pharmacist), regarding the pharmacy process for Coumadin monitoring. ASM #8 stated he	F600		

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F600	Continued From page 52 typically reviews the medications prescribed for a newly admitted resident within three days of admission and then monthly. ASM #8 was asked if he identifies whether a PT/INR has been obtained for residents receiving Coumadin. ASM #8 stated usually residents are admitted from the hospital with a PT/INR order and sometimes he completes his medication review before the facility physician evaluates the resident. ASM #8 was asked if he noticed that a PT/INR had not been obtained for Resident #338 during her stay at the facility. ASM #8 stated the resident's INR was stable at the hospital on 6/28/18, so he would have reviewed for the need for a PT/INR during his monthly review. ASM #8 stated a PT/INR would not have been due until 7/24/18. When asked why, ASM #8 stated monthly monitoring of PT/INRs was a common clinical practice. ASM #8 was asked to provide/fax the reference referred to for the common clinical practice to this surveyor for review. On 8/1/19 at approximately at approximately 2 p.m. ASM #1, the administrator provide the policy titled Anticoagulant Therapy. Review of the facility policy titled, "ANTICOAGULANT THERAPY" (revised 10/10), failed to reveal any documentation regarding the use of the "Anticoagulant Record." On 8/1/19 at 2:25 p.m., ASM #1 (the administrator) provided a fax from ASM #8. The fax documented, "Comments: See below verbiage for warfarin/anticoagulant monitoring references: Please ensure that the INR was obtained, communicating the result to the prescriber and documenting in the medical record as soon as it becomes available. Rationale for Recommendation; Continuous appropriate INR and clinical monitoring of	F600		

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F600	Continued From page 53 warfarin therapy is required to avoid preventable events (e.g. embolism [blood clot], bruising, bleeding). References: 1) Coumadin prescribing information. Princeton, NJ: Bristol-Myers Squibb Company. 2017 Aug. 2) Gurwitz JH et al. The safety of warfarin therapy in the nursing home setting. The Am J Med. 2007; 120:539-544." On 8/2/19 at 12:55 p.m., another telephone interview was conducted with ASM #8. ASM #8 was made aware a medication review for Resident #338 was completed on 7/21/18 and was asked why he did not complete a review of the resident's Coumadin monitoring. ASM #8 stated the computer software notifies him regarding a needed review one month after the last INR entered into the software. ASM #8 stated if the last INR was obtained in the hospital and he entered that INR into the software, then the software would not flag for him to complete a review for an INR need until one month after the resident is admitted to the facility. ASM #8 stated he completes the review after the computer software flags for him to do so. Review of notes documented by ASM #8 on 7/2/18 and 7/21/18 revealed ASM #8 reviewed Resident #338's clinical record on those dates. The notes failed to document any information regarding the use of Coumadin or monitoring for the medication. On 8/5/19 at 5:10 p.m., an interview was conducted with RN (registered nurse) #8. RN #8 was asked to define neglect. RN #8 stated, "It can be physical, as far as not changing a resident, bathing a resident. It could be mental, neglect, abuse, not providing their basic care needs, and doing anything that would potentially cause harm to the patient." When asked if not	F600		

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F600	Continued From page 54 providing monitoring and care for medical needs is neglect, RN #8 stated, "Yes." On 8/6/19 at 7:53 a.m., an interview was conducted with ASM #7 (the nurse practitioner). ASM #7 was asked to describe her role and responsibility regarding Coumadin monitoring. ASM #7 stated residents typically are admitted from the hospital with an order that determines when the PT/INR should be re-checked. ASM #7 stated if she is reviewing a resident's orders then she usually asks the nurses to check the resident's PT/INR on the day of admission then determines if any changes to the Coumadin needs to be made and when to check the next PT/INR based on the PT/INR obtained that day. ASM #7 stated sometimes when a resident is admitted from the hospital, the clinicians are trying to establish a therapeutic Coumadin range. ASM #7 stated the therapeutic range is based on the resident's diagnosis and sometimes residents are admitted from the hospital with a documented therapeutic range but if not, she determines the desired therapeutic range based on the resident's diagnoses. ASM #7 was asked if she could provide any information regarding Resident #338's Coumadin monitoring. ASM #7 stated she began employment at the facility on 6/24/18. ASM #7 stated initially, the only place she documented monitoring information (such as Coumadin dose and PT/INRs) was on the anticoagulant records. ASM #7 stated that over time, she notices that the monitoring information was more clear to her and helped her follow her plan of care when she documented the information in her notes and she now does that. ASM #7 was asked if Resident #338 or facility staff reported any bleeding episodes during the	F600		

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F600	Continued From page 55 weekend prior to her examination of the resident on Monday 7/23/18. ASM #7 stated that information was not in her notes and she could not recall. On 8/6/19 at 9:39 a.m., a telephone interview was conducted with ASM #9 (the facility medical director), regarding the facility Coumadin monitoring process and his role as the medical director. ASM #9 stated in general, he attends the monthly facility QAPI (quality assurance and performance improvement) meetings and ad hoc meetings that are held for issues that need to be addressed. ASM #9 stated he also participates in the facility policy and procedure reviews. ASM #9 stated he does not currently have any patients who reside at the facility but providers from the company, he is employed at, do. ASM #9 stated Coumadin monitoring is a partnership between the nursing staff, the pharmacist, the doctors and the nurse practitioners. When asked if he was aware of any concerns regarding Coumadin monitoring (prior to the survey), ASM #9 stated he was not. ASM #9 was asked what monitoring is expected for a resident admitted to the facility and is receiving Coumadin. ASM #9 stated in general, the facility physicians are getting orders from the hospital and this is about transition of care. ASM #9 stated if a resident is admitted from an acute care environment then the resident should have medication and PT/INR check orders, that are submitted to the facility staff and the interdisciplinary team reviews, follows and implements the orders and discharges the patient when appropriate. ASM #9 stated appropriate recommendations and order clarifications should be obtained for any medication that requires supervision. ASM #9 was asked if there were any special items (recommendations) for Coumadin. ASM #9	F600		

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	495109	A. BUILDING _____ B. WING _____	C 08/07/2019

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F600	Continued From page 56 stated that it goes back to all medications, including the right drug and the right dose. When ASM #9 was asked if the use of Coumadin requires any laboratory monitoring, he stated INRs and the therapeutic index should be checked. When asked who is responsible for Coumadin monitoring, ASM #9 stated that while residents are admitted under the care of the attending physicians, residents often have outside providers such as a cardiologist. ASM #9 stated the attending physicians review the medications that residents were on in the hospital and decide what needs to be done at the facility. ASM #9 stated there is a shared responsibility between the attending physicians and the outside providers, because the physicians want optimal transition of care. The nurse who wrote the 7/22/18 note that documented a bright red bloodstain was observed on Resident #338's sheet was no longer employed at the facility. On 8/6/19 at 11:25 a.m., ASM #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. ASM #1 was asked to define neglect. ASM #1 stated neglect was a failure to provide care and services. ASM #1 was informed of the concern regarding Resident #338 being admitted to the facility, and receiving Coumadin while at the facility, without any monitoring. Resident #338 was then transferred to the hospital for bleeding, diagnosed with a gastrointestinal bleed, and presented with an elevated INR. ASM #1 was asked if the lack of monitoring for Coumadin was neglect. ASM #1 stated, "Yes." At this time, ASM #1, ASM #2 and ASM #3 were made aware of the concern for harm related to Resident #338's neglect.	F600		

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F600	Continued From page 57 The facility policy titled, "ABUSE PROHIBITION, INVESTIGATION, AND REPORTING" documented, "It is the policy of this facility to prohibit mistreatment, neglect, and abuse of guests/residents and/or misappropriation of guest/resident property or resources..." "Neglect: failure by a caregiver or other responsible person to protect an elder from harm, or the failure to meet needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living or shelter, which results in a serious risk of compromised health and safety. Examples include not providing adequate nutrition, hygiene, clothing, shelter, or access to necessary health care; or failure to prevent exposure to unsafe activities and environments." This information is taken from the Centers for Disease Control website https://www.cdc.gov/violenceprevention/elderabuse/definitions.html No further information was presented prior to exit. References: [1]This information was obtained from the webiste: https://www.fda.gov/medical-devices/vitro-diagnostics/warfarin-inr-test-meters [2] "Deep vein thrombosis, or DVT, is a blood clot that forms in a vein deep in the body. Most deep vein clots occur in the lower leg or thigh. If the vein swells, the condition is called thrombophlebitis. A deep vein thrombosis can break loose and cause a serious problem in the lung, called a pulmonary embolism." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-	F600		

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F600	Continued From page 58 bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dvt&_ga=2.137988019.2081124811.1565615930-1667741437.1550160688 [3] This information was obtained from the website: This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3aproject=medlineplus&v%3asources=medlineplus-bundle&query=laboratory%20tests%20for%20PT%20calculation%20of%20INR& [4] Ceftriaxone is used to treat infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a685032.html [5] "NSAIDs (nonsteroidal anti-inflammatory drugs) are some of the most commonly used pain medicines in adults." This information was obtained from the website: https://www.rheumatology.org/I-Am-A/Patient-Caregiver/Treatments/NSAIDs [6] Zofran is used to prevent nausea. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601209.html [7] " Vitamin K: Reversal of COUMADIN anticoagulation may be obtained by discontinuing COUMADIN therapy and, if necessary, by administration of oral or parenteral vitamin K. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d91934a0-902e-c26c-23ca-d5accc4151b6# and from the website:	F600		

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F600	Continued From page 59 3Asources=medlineplus-bundle&query=vitamin+k&_ga=2.117115013.2081124811.1565615930-1667741437.1550160688 [8] This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d91934a0-902e-c26c-23ca-d5accc4151b6 2. The facility staff failed to ensure Resident #93 was free from physical abuse. On 2/13/19, OSM (other staff member) #12 (a former housekeeping employee) hit Resident #93. Resident #93 was admitted to the facility on 7/30/15. Resident #93's diagnoses included but were not limited to heart disease, high blood pressure and major depressive disorder. Resident #93's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/28/19, coded the resident's cognition as severely impaired. A FRI (facility reported incident) submitted from the facility to the SA (state agency) on 2/13/19 documented, "Report date: 2/13/19. Incident date: 2/13/19. Residents involved: (name of Resident #93). Injuries: No. Incident type: Allegation of abuse/mistreatment. Describe incident, including location, and action taken: Resident observed by nurse (LPN [licensed practical nurse]) sliding to floor. Nurse asked for assistance. Housekeeper quickly came into room & said, 'I can do this, no problem.' Nurse told her she needed appropriately trained staff & that she (housekeeper) could not assist. Housekeeper picked resident up off the floor and placed in chair as CNA (certified nursing	F600		

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F600	Continued From page 60 struck the housekeeper & per resident & LPN, Housekeeper struck the resident back." The housekeeper was suspended, pending outcome of the investigation. Review of Resident #93's clinical record (including nurses' notes dated 2/13/19) failed to document information regarding the above incident. Review of documented investigative information obtained by ASM (administrative staff member) #1 (the administrator) from witnesses of the above incident (no dates) revealed the following: Information obtained from CNA #9: "(LPN #19) asked for help, (OSM #12) went in to pick her up. Saw (Resident #93) hit her, heard what sounded like another hit. Heard (LPN #19) say 'you can't do that' as she was leaving the room." Information obtained from LPN #19: "Witnessed her fall, was in the hallway. Stood up from chair and fell. Sitting on floor, asked CNA's for help. Housekeeper went to room to help. Picked her up by herself. (Resident #93) hit (OSM #12) and (OSM #12) hit her in the back. Older CNA was in the room. Said she wanted an investigation." Information obtained from CNA #8: "CNA in the room- (CNA #8). Hskpg (Housekeeping) picked her up. (Resident #93) hit her in the back. She swung back. Happened so quick, she said it was reflex. Nurse 'don't ever do that no more.'" Information obtained from OSM #12: "Was in the hallway, OSM #12 went to help and picked her up. Swung and hit me in the back. Swung again, trying to block her hand (with) my hand. Didn't ball my fist up. Was blocking her. Swinging back at (OSM #12), hand on back of w/c (wheelchair) behind guest. Trying to block hand." A final report submitted from the facility to the	F600		

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F600	Continued From page 61 SA on 2/18/19 documented, "To Whom It May Concern: Please accept this final report in response to our initial facility report filed on February 13, 2019 and an allegation of abuse regarding resident (Resident #93). (Resident #93) is an 84-year-old Caucasian female who resides at the facility. Her diagnoses include: dementia with behaviors, HTN (hypertension [high blood pressure]), CAD (coronary artery disease), Ataxia (trouble coordinating movements), Hx (History) of MI (myocardial infarction [heart attack]), and Major Depressive Disorder. She has episodes of physically and verbally aggressive behavior, hitting staff, throwing objects, making paranoid statements, and placing herself on the floor. (Resident #93) has short and long term memory loss, her BIMS (Brief Interview for Mental Status) score is 6/15 (indicating severe cognitive impairment). On February 13, 2018 (sic), (LPN #19), reported that she witnessed (OSM #12), housekeeper, hit the resident. (OSM #12) was suspended pending investigation, the resident was assessed, and no injuries were observed. The LPN reported that the resident was being assisted to her chair from sitting on the floor. The resident allegedly hit the housekeeper and then witnessed the housekeeper hit her back. She was then removed from the situation. An interview was conducted with (CNA #8) who was present during the situation. She reports that the resident hit the housekeeper in the back and that she witnessed the employee 'swinging back' stating 'it happened so quick, it could have been a reflex.' An interview was conducted with (CNA #9); she reports not witnessing the resident being hit but hearing the sound of a 'second hit' as she was walking out of the room. An interview was conducted with (OSM #12), she reports that the resident hit her in the back and that a second attempt was made by the resident	F600		

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F600	Continued From page 62 to hit her. She reports that during this time she put her arm up to block the resident from hitting her again. Interviews were conducted with the resident and the roommate, but neither could not recall the incident. Based on interviews and witnesses to the incident, the facility can substantiate that the employee hit back at the resident. Despite the resident's extensive aggressive behavior history, the facility feels that the housekeeper could have responded differently to behaviors displayed, therefore employment has been terminated. The resident remains in the facility at this time, and has no recollection of the event..." OSM #12 was no longer employed at the facility. LPN #19 was no longer employed at the facility. On 8/1/19 at 8:04 a.m., an interview was conducted with CNA #8. CNA #8 was asked to describe what she witnessed in regards to the incident between Resident #93 and OSM #12 on 2/13/19. CNA #8 stated she was charting and completing an in-service at a kiosk, and Resident #93 must have fell because OSM #12 said Resident #93 was on the floor. CNA #8 stated she told OSM #12 they needed two people to get Resident #93 off the floor and they could not do anything until a nurse saw the resident. CNA #8 stated she got the nurse and the nurse was going to help assist Resident #93 off the floor but then OSM #12 stated she would get the resident off the floor and picked the resident up. CNA #8 stated as OSM #12 stood Resident #93 up, the resident hit OSM #12 and OSM #12 had a reflex and swung back at the resident, and hit her. CNA #8 stated the nurse told OSM #12 she could not do that. On 8/5/19 at 3:12 p.m., an interview was	F600		

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F600	Continued From page 63 conducted with CNA #9. CNA #9 was asked to describe what she witnessed in regards to the incident between Resident #93 and OSM #12 on 2/13/19. CNA #9 stated Resident #93 fell and the staff went into the room to assist the resident off the floor. CNA #9 stated OSM #12 got Resident #93 up off the floor and the resident hit OSM #12. CNA #9 stated she heard a noise described as someone slapping someone and then the nurse said, "You can't do that." CNA #9 stated she did not actually see OSM #12 hit Resident #93 but it looked like the nurse said "You can't do that" to OSM #12. On 8/5/19 at 3:44 p.m., an interview was conducted with RN (registered nurse) #8. RN #8 was asked what would be an appropriate employee action if a resident hits an employee. RN #8 stated, "Stop. Let the resident calm down. Try to re-direct them and if not yourself, another staff member needs to assist that resident." RN #8 was asked if it was appropriate for an employee to hit a resident even if it was a reaction to being hit by that resident. RN #8 stated, "No. Never." On 8/6/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 3. The facility staff failed to ensure Resident #61 was fee from physical abuse. Resident #93 slapped Resident #61 on 7/8/19. Resident #93 was admitted to the facility on	F600		

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F600	Continued From page 64 7/30/15. Resident #93's diagnoses included but were not limited to heart disease, high blood pressure and major depressive disorder. Resident #93's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/28/19, coded the resident's cognition as severely impaired. Resident #61 was admitted to the facility on 5/7/11. Resident #61's diagnoses included but were not limited to muscle weakness, abnormal posture and Alzheimer's disease. Resident #61's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/5/19, coded the resident's cognition as severely impaired. A FRI (facility reported incident) submitted from the facility to the SA (state agency) on 7/10/19 documented, "Report date: 7/10/19. Incident date: 7/8/19. Residents involved: (Resident #93) (Resident #61). Describe incident, including action, and action taken: (Resident #93) slapped (Resident #61), unable to state why. No injuries noted..." Review of documented investigative information obtained by ASM (administrative staff member) #1 (the administrator) from witnesses of the above incident on 7/8/19 revealed the following: Information obtained from RN (registered nurse) #3: "Witnessed (Resident #93) slapping (Resident #61) in the face. No incident observed to precipitate the event. Both guests interviewed, unable to state why it happened." Information obtained from ASM #6 (nurse practitioner): "Witnessed the event. Denies seeing anything that precipitated the event. Witnessed (Resident #93) slap (Resident #61)." A final report submitted from the facility to the	F600		

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F600	Continued From page 65 SA on 7/12/19 documented, "To Whom It May Concern: Please accept this final report in response to our initial facility report filed on July 10, 2019 regarding residents (Resident #93) and (Resident #61) and a resident to resident altercation. (Resident #93) is an 84-year-old Caucasian female. Her diagnoses include: Dementia with behaviors, CAD (coronary artery disease), HTN (hypertension [high blood pressure]), Ataxia (trouble coordinating movements). She has periods of confusion. She is care planned for aggressive behaviors towards others, paranoia, and making false accusations. (Resident #61) is a 77-year-old Caucasian female. Her diagnoses include: Bipolar disorder (a mental illness), schizophrenia (a mental illness), Rheumatoid arthritis, Picks disease (1), hypothyroidism. She has periods of confusion. She is care planned for aggressive behaviors towards others. (RN #3) witnessed both residents at the nurse's station when (Resident #93) slapped (Resident #61) in the face. There was not witnessed events leading up to the incident and neither resident (sic) are able to state what happened and why it occurred. They were separated and put on q (every) 15 (minute) checks for the day with no further incident. (Resident #61) was assessed for injuries, there are no injuries and she is not in any psychosocial distress. (Resident #93) is currently on 1:1 in the facility..." On 8/5/19 at 2:49 p.m., an interview was conducted with RN #3 regarding the above incident. RN #3 stated Resident #93, and Resident #61 were sitting beside each other and Resident #93 slapped Resident #61 with an open hand. When asked if either of the residents verbalized anything, RN #3 stated they did not. RN #3 stated she separated the	F600		

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F600	Continued From page 66 residents and reported the incident to the unit manager after the incident occurred. Resident #93 was observed multiple times during the survey on each day, throughout the day from 7/30/19 through 8/2/19 and 8/5/19 through 8/7/19. During each observation, the resident remained on 1:1 with staff supervision. Resident #93 was not observed displaying not any aggressive behaviors during these observations. On 8/6/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. (1) "Niemann-Pick disease (NP) refers to a group of inherited metabolic disorders known as lipid storage diseases. Lipids (fatty materials such as waxes, fatty acids, oils, and cholesterol) and proteins are usually broken down into smaller components to provide energy for the body. In Niemann-Pick disease, harmful quantities of lipids accumulate in the brain, spleen, liver, lungs, and bone marrow. Neurological symptoms may include ataxia (lack of muscle control during voluntary movements such as walking), loss of muscle tone, brain degeneration, increased sensitivity to touch, spasticity (stiff muscles and awkward movement), and slurred speech." This information was obtained from the website: https://www.ninds.nih.gov/Disorders/All-Disorders/Niemann-Pick-Disease-Information-Page	F600		

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THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F608 F608 SS=C	Continued From page 67 Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) 483.12(b) The facility must develop and implement written policies and procedures that: 483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to implemented policies and	F608 F608	Ftag 608 The Federal Elder Justice Act notification was posted during the survey by the time clock and additionally in the employee break room. Residents currently in the facility have the potential to be affected. The DON or designee will educate staff on the contents of the Federal Elder Justice Act notification and the locations of the posting. Both locations have been observed to have the notifications posted for employees. NHA or designee will monitor the posting locations weekly for 4 weeks to ensure they are posted. Any variances will be corrected immediately. Any additional education or counseling will be provided. Continued compliance will be monitored through the facilitys quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: September 20, 2019	9/20/19

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F608	Continued From page 68 procedures related to ensuring the reporting reasonable suspicion of crimes. The facility failed post notice of employee rights regarding the reporting of suspicious crimes. The findings include: The facility policy regarding the Federal Elder Justice Act documented, "The facility will post conspicuously in an appropriate location a sign specifying the rights of employees under the EJA (Elder Justice Act). Such sign shall include a statement that an employee may file a complaint with the Secretary against a long-term care facility that violates the provisions of this subsection and information with respect to the manner of filing such a complaint and that the facility will not prohibit reporting and will prevent retaliation of such reporting..." On 7/31/19 at approximately 3:45 p.m., observation of the main time clock, employee breakroom and additional clock-in computers in the main dining room and on the regency unit was conducted with RN (registered nurse) #5. No posted notice of employee rights regarding the reporting of suspicious crimes was observed. On 8/6/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. On 8/6/19 at 5:21 p.m., ASM #1 stated the posted notice of employee rights regarding the reporting of suspicious crimes previously had been posted by the time clock but she checked and it was not posted. ASM #1 stated she did not know why it [notice of employee rights] was	F608		

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F608	Continued From page 69 not posted, but it was posted now. No further information was presented prior to exit.	F608		
F609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) 483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: 483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. 483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F609	Past noncompliance: no plan of correction required	

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F609	Continued From page 70 Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure the reporting of abuse to the SA (State Agency) within the required time frame (immediately, but not later than 2 hours) for one of 72 residents in the survey sample, Resident #61. On 7/8/19, Resident #93 slapped Resident #61. The facility staff failed to report this occurrence of abuse to the SA until 7/10/19. The findings include: Resident #93 was admitted to the facility on 7/30/15. Resident #93's diagnoses included but were not limited to heart disease, high blood pressure and major depressive disorder. Resident #93's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/28/19, coded the resident's cognition as severely impaired. Resident #61 was admitted to the facility on 5/7/11. Resident #61's diagnoses included but were not limited to muscle weakness, abnormal posture and Alzheimer's disease. Resident #61's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/5/19, coded the resident's cognition as severely impaired. A FRI (facility reported incident) submitted from the facility to the SA (state agency) on 7/10/19 documented, "Report date: 7/10/19. Incident date: 7/8/19. Residents involved (Resident #93) (Resident #61). Describe incident, including action, and action taken: (Resident #93) slapped (Resident #61), unable to state why. No injuries noted..." A final report submitted from the facility to the	F609		

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F609	Continued From page 71 SA on 7/12/19 documented, "To Whom It May Concern: Please accept this final report in response to our initial facility report filed on July 10, 2019 regarding residents (Resident #93) and (Resident #61) and a resident-to-resident altercation. (Resident #93) is an 84-year-old Caucasian female. Her diagnoses include: Dementia with behaviors, CAD (coronary artery disease), HTN (hypertension [high blood pressure]), Ataxia (trouble coordinating movements). She has periods of confusion. She is care planned for aggressive behaviors towards others, paranoia, and making false accusations. (Resident #61) is a 77-year-old Caucasian female. Her diagnoses include: Bipolar disorder (a mental illness), schizophrenia (a mental illness), Rheumatoid arthritis, Picks disease (1), hypothyroidism. She has periods of confusion. She is care planned for aggressive behaviors towards others. (RN #3) witnessed both residents at the nurse's station when (Resident #93) slapped (Resident #61) in the face. There was not witnessed events leading up to the incident and neither resident (sic) are able to state what happened and why it occurred. They were separated and put on q (every) 15 (minute) checks for the day with no further incident. (Resident #61) was assessed for injuries, there are no injuries and she is not in any psychosocial distress. (Resident #93) is currently on 1:1 in the facility..." On 8/2/19 at 12:24 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was asked what nurses are supposed to do if a resident hits another resident. LPN #7 stated the staff has to immediately separate the residents, complete two incident reports, notify the doctor, notify the family, and depending on how bad the situation	F609		

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F609	Continued From page 72 is the nurses will possibly separate the residents' rooms on different wings. LPN #7 stated the nurses are supposed to notify administrator or director of nursing, both at the time of the incident. On 8/5/19 at 2:49 p.m., an interview was conducted with RN #3 regarding the above incident. RN #3 stated Resident #93, Resident #61 were sitting beside each other, and Resident #93 slapped Resident #61 with an open hand. When asked if either of the residents verbalized anything, RN #3 stated they did not. RN #3 stated she separated the residents and reported the incident to the unit manager after the incident occurred. On 8/6/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. ASM #1 was asked the facility process for reporting resident-to-resident incidents to the SA. ASM #1 stated staff should report the incidents to her as soon as the incidents occur then she should report the incidents to the SA within two hours. The facility policy titled, "ABUSE PROHIBITION, INVESTIGATION, AND REPORTING" documented, "IV. Initial Reporting: A. All allegations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property must be reported immediately to the Administrator...i. Allegations of abuse or serious bodily injury; If the event that caused the allegation involves an allegation of abuse or serious bodily injury, it should be reported to the state immediately, but no later than two (2) hours after the allegation is made. ii. All Other Allegations: The	F609		

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F609	Continued From page 73 Administrator or his/her designee will notify the state of all alleged violations involving abuse, neglect, exploitation, mistreatment of a guest, or misappropriation of guest property and injuries of unknown source as soon as possible, but no later than twenty-four (24) hours from the time the incident/allegation was made known to the staff member..." On 8/7/19 at 8:20 a.m., ASM #1 presented an action plan regarding timely abuse reporting. The action plan documented, "Final goal date: 7/11/19 ACTION TO BE COMPLETED: 1. ISSUE IDENTIFICATION: Facility has self-identified an issue with timely abuse reporting. 2. PROCESS CHANGE TO ENSURE THAT OTHERS ARE NOT AFFECTED BY POTENTIALLY DEFICIENT PRACTICE: All guests (or the guest's RP [responsible party] in the cases of non-verbal guests) will be interviewed to ensure they have not seen abuse or felt abused in the facility. 3. EDUCATION: All staff and residents will be educated on the process of reporting abuse. 4. MONITORING: 30 guest abuse interviews will be conducted quarterly. Education and corrective actions will be provided as needed. 5. QA (Quality Assurance): All progress and variances will be reported in the monthly QA meeting for 3 months and will include any new occurrences thereafter." No further incidents of not timely reporting for abuse were identified during the survey. The action plan and all credible evidence was verified by the survey team through observation, staff interviews and review of current residents, review of facility reported incidents addressing allegations of abuse and all documentation of monitoring prior to exit.	F609		

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F609	Continued From page 74 PAST NON-COMPLIANCE (1) "Niemann-Pick disease (NP) refers to a group of inherited metabolic disorders known as lipid storage diseases. Lipids (fatty materials such as waxes, fatty acids, oils, and cholesterol) and proteins are usually broken down into smaller components to provide energy for the body. In Niemann-Pick disease, harmful quantities of lipids accumulate in the brain, spleen, liver, lungs, and bone marrow. Neurological symptoms may include ataxia (lack of muscle control during voluntary movements such as walking), loss of muscle tone, brain degeneration, increased sensitivity to touch, spasticity (stiff muscles and awkward movement), and slurred speech." This information was obtained from the website: https://www.ninds.nih.gov/Disorders/All-Disorders/Niemann-Pick-Disease-Information-Page	F609		
F622 SS=E	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;	F622	Ftag 622 Resident #96: Has since returned from the hospital, no negative outcome has occurred as a result of this practice. Resident #106: Has since returned from the hospital, no negative outcome has occurred as a result of this practice. Resident #79: Has since returned from the hospital, no negative outcome has occurred as a result of this practice. Resident #70: Has since returned from the hospital, no negative outcome has occurred as a result of this practice.	9/20/19

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F622	Continued From page 75 (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. 483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is 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	F622	Resident #62: Has since returned from the hospital, no negative outcome has occurred as a result of this practice. Residents who are currently in the hospital have the potential to be affected. Care plan goals have been sent for current residents in the hospital. The DON or designee will educate license nursing staff on sending Care Plan goals when a resident is transferred to the hospital. Education will also include hospital transfer folders that are to be sent with the resident upon hospital transfer to ensure appropriate documentation is sent. Review of hospital transfers will occur during the clinical operations meeting. The DON or designee will audit current residents in the hospital for care plan goals being sent. Any identified areas will be corrected. Nursing administration or designee will monitor documentation sent with hospital transfers 5 days a week for 1 week, 3 days a week for 2 weeks, weekly for 4 weeks, and monthly for 3 months. Any variances will be corrected and additional education or counseling will be provided as needed Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored	

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F622	Continued From page 76 section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with 483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide the comprehensive care plan goals to the receiving facility at the time of facility transfers to the hospital for five of 72 residents in the survey sample, Residents #96, #106, #79, #70 and #62. The findings include:	F622	through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: September 20, 2019	

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F622	Continued From page 77 1. The facility staff failed to evidence that Resident # 96's comprehensive care plan goals were provided to the receiving provider for a transfer to the hospital on 05/23/2019. Resident # 96 was admitted to the facility on 04/22/2009 and a readmission on 05/29/2019 with diagnoses that included but were not limited to bipolar disorder (1), borderline personality disorder and depressive disorder (2). Resident # 96's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/10/19, coded Resident # 96 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. The facility's "Nurse Practitioner's Note" dated 05/23/2019 at 2:14 p.m. for Resident # 96 documented in part, "Upon entering patient's room she is tearful and withdrawn. Initially patient refuse to discuss her mood. Then states, 'I am in a crisis' patient feels 'out of control' and is having thoughts of feeling 'worthless.' Patient denies SI (suicidal ideation) and denies plan. States she misses her mother, who often helped her talk through her feelings when she felt this way. She requests admission to in patient phych (psychiatric) for stabilization. A/P (assessment and plan): Patient states she is in crisis. Will transfer to (Name of Hospital) ED (emergency department) for acute psych eval (evaluation). Patient is agreeable to plan." Review of the clinical record and the EHR (electronic health record) for Resident # 96 failed to evidence that Resident # 96's comprehensive care plan goals were provided to the receiving provider upon transfer to the	F622		

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F622	Continued From page 78 hospital on 05/23/2019. On 07 31/19 at 12:55 p.m. a list of residents who were transferred to the hospital that included a request for evidence that the required information (including the comprehensive care plan goals) was provided to the receiving facility was provided to ASM (administrative staff member) # 2, regional clinical coordinator. On 08/01/19 at approximately 10:14 a.m., ASM # 2 provided the list of residents transferred to the hospital and stated there is no documentation that the care plan goals were sent at the time of transfer for Resident # 96. On 08/05/19 at 5:10 p.m., ASM (administrative staff member) #1, administrator, ASM # 2, regional clinical coordinator and ASM #3 (director of nursing) were made aware of the above concern. On 8/6/19 at 10:18 a.m. administrative staff member (ASM) #2, the regional clinical coordinator, was asked what standard of practice the facility follows. ASM #2 stated, "We follow our policies and Lippincott The facility's policy "Physician Transfer / Discharge Documentation" failed to evidence documentation regarding comprehensive care plans being provided to the receiving facility. No further information was presented prior to exit. References: (1) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-	F622		

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F622	Continued From page 79 (2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. 2. The facility staff failed to evidence Resident # 106's comprehensive care plan goals were provided to the receiving provider for a facility-initiated transfer to the hospital on 05/28/2019. Resident # 106 was admitted to the facility on 05/09/2016 and a readmission on 06/06/2019 with diagnoses that included but were not limited to heart failure, bipolar disorder (1), and dysphagia (2). Resident # 106's most recent MDS (minimum data set), a 30-Day assessment with an ARD (assessment reference date) of 07/03/19, coded Resident # 106 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 - being moderately impaired of cognition for making daily decisions. A "Nurse Practitioner Note" 05/28/2019 at 2:14 p.m. for Resident # 106 documented in part, "Call from patient's nurse. Patient reported to have been found lying in bed blue and gurgling." Oxygen sat (saturation) low on non-rebreather. Patient not responding verbally. Sent to ED (emergency department) for acute eval (evaluation) requiring higher level of care." Review of the clinical record and the EHR (electronic health record) for Resident # 106 failed to evidence that the comprehensive care	F622		

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F622	Continued From page 80 plan goals or a care plan summary was provided to the receiving provider for Resident #106's transfer to the hospital on 05/28/2019. On 07 31/19 at 12:55 p.m. a list of residents who were transferred to the hospital that included a request for evidence that the required information (including comprehensive care plan goals), was provided to the receiving facility was provided to ASM (administrative staff member) # 2, regional clinical coordinator. On 08/01/19 at approximately 10:14 a.m., ASM # 2 provided the list of residents transferred to the hospital and stated there is no documentation that the care plan goals were sent at the time of transfer for Resident # 106. On 08/05/19 at 5:10 p.m., ASM (administrative staff member) #1, administrator, ASM # 2, regional clinical coordinator and ASM #3 (director of nursing) were made aware of the above concern. No further information was presented prior to exit. References: (1) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. 3. The facility staff failed to evidence that	F622		

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F622	Continued From page 81 facility initiated transfer of the resident on 6/7/19. Resident #79 was admitted to the facility on 5/20/19. Resident #79's diagnoses included but were not limited to gastroenteritis (1), ulcerative colitis (2), muscle weakness and failure to thrive. Resident #79's most recent MDS (minimal data set), a 14-day scheduled assessment with an ARD (assessment reference date) of 6/24/19, coded the resident as cognitively intact. Review of Resident #79's clinical record revealed an "eINTERACT SBAR Summary" dated 6/7/19, which documented in part, the resident was sent to the hospital for evaluation after staff found the resident unresponsive and unable to follow commands, with a low blood pressure and HR (heart rate) and a large amount of dark red blood in toilet. The Nurse Practitioner was called and directed staff to send the resident to hospital. Further review of Resident #79's clinical record (including an eINTERACT SBAR Summary and nurses' notes) failed to evidence that Resident #79's comprehensive care plan goals were provided to the hospital for the facility-initiated hospital transfer of the resident on 6/7/19. On 7 31/19 at approximately 12:55 p.m., a list of residents who were transferred to the hospital that included a request for evidence that the required information (including the comprehensive care plan goals) was provided to the receiving facility was provided to ASM (administrative staff member) #2 (regional clinical coordinator). On 8/1/19 at approximately 10:14 a.m., ASM #2 provided the list of residents, transferred to the hospital, and stated there is no documentation	F622		

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F622	Continued From page 82 that the care plan goals were sent at the time of transfer for Resident #79. On 8/5/19 at approximately 6:15 p.m., ASM #1 (administrator), ASM #2 (regional clinical coordinator) and ASM #3 (director of nursing) were made of the above concern. No further information was provided prior to the end of the survey. (1) Gastroenteritis is an inflammation of the lining of the intestines caused by a virus, bacteria, or parasites. This information was obtained from the following website: https://medlineplus.gov/gastroenteritis.html (2) Ulcerative colitis (UC) is a disease that causes inflammation and sores, called ulcers, in the lining of the rectum and colon. It is one of a group of diseases called inflammatory bowel disease. This information was obtained from the following website: https://medlineplus.gov/ulcerativecolitis.html UC can happen at any age, but it usually starts between the ages of 15 and 30. It tends to run in families. The most common symptoms are pain in the abdomen and blood or pus in diarrhea. Other symptoms may include: - Anemia - Severe tiredness - Weight loss - Loss of appetite - Bleeding from the rectum 4. The facility staff failed to evidence that Resident # 70's comprehensive care plan goals were provided to the receiving provider for a	F622		

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F622	Continued From page 83 facility-initiated transfer of the resident to the hospital on 7/11/2019. Resident # 70 was admitted to the facility 12/06/2018 with diagnoses, that included but were not limited to cerebral infarction, unspecified (1), and muscle weakness (generalized). Resident # 70's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/15/19, coded Resident # 70 as scoring a 0 (zero) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 0- being severely impaired for making daily decisions. The nurse's "Progress Notes," dated 07/11/2019 for Resident # 70 documented in part that Resident #70 was sent to the hospital for evaluation after the resident was found on the floor face down in her room. The nurse's "Progress Notes," dated 07/11/2019 for Resident # 70 documented, "23:00 (11:00 p.m.) guest returned to facility at 10pm on a stretcher accompanied by emt's (emergency medical technicians) ... discharge summary from the hospital faxedto [sic] md's (medical doctor's) office." Review of the EHR (electronic health record) for Resident # 70 failed to evidence that the resident's comprehensive care plan goals were provided to the receiving provider for a facility-initiated transfer of the resident to the hospital on 07/11/2019. On 07/31/19 at 12:55 p.m., a list of residents who were transferred to the hospital, which included a request for evidence that the required information (including the comprehensive care plan goals) was provided to the receiving facility,	F622		

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F622	Continued From page 84 was provided to ASM (administrative staff member) #2, regional clinical coordinator. On 08/01/19 at approximately 10:14 a.m., ASM # 2 provided the list of residents transferred, to the hospital, and stated there is no documentation that the care plan goals were sent at the time of transfer for Resident #70. On 08/02/19 at approximately 2:00 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 2, regional clinical coordinator and ASM # 3, director of nursing were made aware of the findings. No further information was provided prior to exit. References: 1. Cerebral infarction A stroke occurs when blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm. 5. The facility staff failed to evidence that Resident #62's comprehensive care plan goals were provided to hospital staff when the resident was transferred to the hospital on 7/19/19. Resident #62 was admitted to the facility on 2/17/17. Resident #62's diagnoses included but were not limited to difficulty swallowing, fractured left arm and repeated falls. Resident #62's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment	F622		

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F622	Continued From page 85 reference date) of 6/6/19, coded the resident's cognition as severely impaired. Review of Resident #62's clinical record revealed the resident was transferred to the hospital on 7/19/19 due to an injury sustained from the resident biting his finger. Further review of Resident #62's clinical record (including an acute care transfer checklist, a hospital transfer form and nurses' notes) failed to reveal evidence that the resident's comprehensive care plan goals were provided to the hospital staff. On 7 31/19 at 12:55 p.m. a list of residents who were transferred to the hospital that included a request for evidence that the required information (including the comprehensive care plan goals) was provided to the receiving facility was provided to ASM (administrative staff member) #2 (the regional clinical coordinator). On 8/1/19 at approximately 10:14 a.m., ASM #2 provided the list of residents transferred to the hospital, and stated there was no documentation that the care plan goals were sent at the time of transfer for Resident #62. On 8/6/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F622		
F641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) 483.20(g) Accuracy of Assessments.	F641	Ftag 641 Resident #96: The MDS has been updated	9/20/19

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F641	Continued From page 86 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete MDS (minimum data set) assessments to accurately reflect the status of five out of 72 sampled residents (Residents #96, #140, #239, #238 and #100). Resident # 96's use of oxygen was not coded on the MDS assessment, Resident # 140 discharged to the community and was coded as discharging to an "Acute hospital", and for Resident #239, Resident #238 and Resident #100, Sections C - Cognitive Patterns and Section D - Mood of the MDS assessment was not completed. The findings include: 1. The facility staff failed to code Resident # 96's use of oxygen on the quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/10/19. Resident # 96 was admitted to the facility on 07/04/2019 with diagnoses that included but were not limited to: respiratory failure (1), obstructive sleep apnea (2). Resident # 96's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/10/19, coded Resident # 96 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section O "Special Treatments, Procedures and Programs" failed to code Resident # 96 for the use of oxygen.	F641	to reflect oxygen and Bipap use. No negative outcomes have occurred as a result of this practice. Resident #140: The resident no longer resides in the facility. The MDS was corrected and submitted. Resident #239: The resident no longer resides in the facility. The MDS was corrected and submitted. Resident #238: The resident no longer resides in the facility. Resident #100: A MDS was completed on 8/16/19 and submitted. No negative outcomes occurred as a result of this practice. Residents currently in the facility have the potential to be affected. The Regional Clinical Resource Specialist or designee will educate the MDS department on accuracy of MDS assessments, including respiratory equipment and discharge disposition. The regional clinical resource specialist or designee will educate the Social services department on the completion of sections C and D on the MDS. The MDS coordinator or designee will audit the last 90 days of MDS assessments for accurate discharge disposition, respiratory equipment and completion of sections C	

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F641	Continued From page 87 The POS (physician's order sheet) for Resident # 96 dated August 2019 documented, "BIPAP [Bi-level Positive Airway Pressure] on QHS (every hour of sleep) off in the AM (a.m.) BIPAP 21/9 with 4 (four) liters of oxygen DX (diagnosis): sleep apnea. Every evening and night shift for SLEEP APNEA. Date Ordered: 08/02/2019. Start Date: 08/02/2019." The comprehensive care plan for Resident # 96 with a revision on 08/01/2019 documented, "Need. (Resident # 96) has potential for difficulty breathing and risk for respiratory complications R/T (related to): dx (diagnosis) of Obstructive Sleep Apnea. Requires Bi-PAP (3) machine. Guest removes Bi-PAP mask at times. Revision on: 08/01/2019." On 08/01/19 at 4:36 p.m., an interview was conducted with RN (registered nurse) # 4, MDS coordinator. After reviewing Resident # 96's MDS assessment with an ARD of 07/10/19 and the comprehensive care plan with a revision on 08/01/2019, RN # 4 stated, stated, "Oxygen should have been coded for the use of the BiPAP." When asked what she uses as guidance for completing the MDS assessments, RN # 4 stated she uses the RAI (Resident Assessment Instrument) manual. CMS's (Centers for Medicare/Medicaid Services) Long-Term Care RAI (Resident Assessment Instrument) Version 3.0 Manual documented, "O0100: Special Treatments, Procedures, and Programs (cont.) O0100C, Oxygen therapy. Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric	F641	and D. Corrected MDS will be completed as needed. The MDS coordinator or designee will monitor completed MDS 5 days a week for 1 week, 3 days a week for 2 weeks, weekly for 4 weeks and monthly for 3 months. Any variances will be corrected and additional education or counseling will be provided as needed Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: September 20, 2019	

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F641	Continued From page 88 oxygen for wound therapy in this item. This item may be coded if the resident places or removes his/her own oxygen mask, cannula." On 08/051/19 at approximately 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, and ASM # 3, were made aware of the above findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (2) Obstructive sleep apnea (OSA) is a problem in which your breathing pauses during sleep. This occurs because of narrowed or blocked airways. This information was obtained from the website: https://medlineplus.gov/ency/article/000811.htm. (3) Stands for Bi-level Positive Airway Pressure, and is very similar in function and design to a CPAP machine (continuous positive airway pressure). Similar to a CPAP machine, A BiPAP machine is a non-invasive form of therapy for patients suffering from sleep apnea. Both machine types deliver pressurized air through a mask to the patient's airways. The air pressure keeps the throat muscles from collapsing and reducing obstructions by acting as a splint. Both CPAP and BiPAP machines allow patients to breathe easily and regularly throughout the night. This information was obtained from the website: https://www.alaskasleep.com/blog/what-is-	F641		

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F641	Continued From page 89 2. The facility staff failed to accurately code Resident # 140's discharge status to community on the discharge assessment MDS (minimum data set) with an ARD (assessment reference date) of 06/12/19. Instead, the resident's discharge was coded as "Acute hospital." Resident # 140 was admitted to the facility on 05/24/19 with diagnoses that included but were not limited to muscle weakness, depression disorder (1) and bipolar disorder (2). Resident # 140's MDS (minimum data set), a discharge assessment with an ARD (assessment reference date) of 06/12/19, coded Resident # 140 as "03 (three) - Acute hospital" under "Section "A2100 Discharge Status." The facility's "Social Service Note" for Resident # 140 dated 06/12/2019 documented in part, "Guest discharged home today." The facility's "Progress Notes" for Resident # 140 dated 06/12/2019 documented in part, "Guest discharged at this time with friend to transport." On 08/01/19 at 4:19 p.m., an interview was conducted with RN (registered nurse) # 4, MDS coordinator. RN #4 was asked if Resident # 140's "Discharge Return Not Anticipated" MDS dated 04/29/2019 was correctly coded. After reviewing Resident # 140's progress notes and the social services notes, RN # 4 stated, "No." When asked to describe the process for coding the discharge MDS for the correct discharge location, RN # 4 stated, "We get the information from discharge planning meetings, care plan meetings and daily meetings. When asked what she uses as guidance for completing the MDS	F641		

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F641	Continued From page 90 assessments, RN # 4 stated she uses the RAI (Resident Assessment Instrument) manual. CMS's (Centers for Medicare/Medicaid Services) Long-Term Care RAI (Resident Assessment Instrument) Version 3.0 Manual documented, "A2100: OBRA [Omnibus Budget Reconciliation Act] Discharge Status. Steps for Assessment 1. Review the medical record including the discharge plan and discharge orders for documentation of discharge location." On 08/051/19 at approximately 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, and ASM # 3, were made aware of the above findings. No further information was provided prior to exit. References: (1) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (2) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.	F641		

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F641	Continued From page 91 - Cognitive Patterns and Section D - Mood, on Resident #239's Admission/5-day MDS assessment with an ARD (assessment reference date) of 7/26/19. Resident #239 was admitted to the facility on 7/19/19. Diagnoses include but are not limited to, left lower leg fracture, peripheral neuropathy, and alcohol abuse. The admission/5-day MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 7/26/19 was completed, but review of the cognitive section (Section C, Cognitive Patterns) revealed it was incomplete. The admission "Nursing Comprehensive Evaluation" dated 7/19/19 documented the resident as being alert and oriented to person, place, and time. The above MDS assessment coded the resident as requiring extensive assistance for bathing, hygiene, toileting, and transfers; limited assistance with dressing; and supervision for eating. Review of the above MDS assessment revealed that the questions in the above-identified Section C were coded with dashes in each space, indicating that it was not done. The staff interview portion of Section C (for a resident that could not be interviewed) was not completed either and was marked with dashes in each space. In Section D, Mood was not completed for the resident interview or staff interview sections each area was marked with dashes. On 8/06/19 at 11:07 AM, in an interview with RN #4 (Registered Nurse, the MDS Coordinator) she stated that the social worker completes these sections. (The social worker was out of town during survey.) When asked if she knew why these sections were not completed, she stated she did not. When asked if, as the MDS	F641		

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F641	Continued From page 92 Coordinator, was it her responsibility to ensure that all departments complete their sections, RN #4 stated it was. When asked if there is any follow up communication between her and the departments who are responsible for completing sections of the MDS assessment, RN #4 stated that it is communicated through emails to the departments what assignments need to be completed and when, and any follow up communication about those assignments. When asked if she follows up to find out why something wasn't completed, RN #4 stated, "Yes." When asked if she knew why these sections of this MDS were not completed, RN #4 stated, "No." On 8/06/19 at 1:40 PM, in a follow up interview with RN #4, she stated that she had no further information as to why Sections C and D of this MDS were not completed. She stated the facility uses the RAI manual (Resident Assessment Instrument) for completing MDS assessments. On 8/06/19 at 1:44 PM, ASM #1 (Administrative Staff Member) the Administrator was made aware of the findings. No further information was provided. According to the RAI Manual 3.0, October 2017; Section C: Cognitive Patterns: Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions. Item Rationale: Health-related Quality of Life oThis information identifies if the interview will	F641		

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F641	Continued From page 93 be attempted. o Most residents are able to attempt the Brief Interview for Mental Status (BIMS). o A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance. - Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis. - Structured interviews will efficiently provide insight into the resident's current condition that will enhance good care. Planning for Care o Structured cognitive interviews assist in identifying needed supports. o The structured cognitive interview is helpful for identifying possible delirium behaviors. Section D: Mood Intent: The items in this section address mood distress, a serious condition that is under diagnosed and under treated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable. It is important to note that coding the presence of indicators in Section D does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis in Section D; they simply record the presence or absence of specific clinical mood indicators. Facility staff should recognize these indicators and consider them when developing the resident ' s individualized care plan. - Depression can be associated with: - psychological and physical distress (e.g., poor adjustment to the nursing home, loss of independence, chronic illness, increased	F641		

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F641	Continued From page 94 sensitivity to pain), - decreased participation in therapy and activities (e.g., caused by isolation), - decreased functional status (e.g., resistance to daily care, decreased desire to participate in activities of daily living [ADLs]), and - poorer outcomes (e.g., decreased appetite, decreased cognitive status). - Findings suggesting mood distress should lead to: - identifying causes and contributing factors for symptoms, - identifying interventions (treatment, personal support, or environmental modifications) that could address symptoms, and - ensuring resident safety. Item Rationale: This item helps to determine whether or not a resident or staff mood interview should be conducted. Health-related Quality of Life - Most residents who are capable of communicating can answer questions about how they feel. - Obtaining information about mood directly from the resident, sometimes called "hearing the resident's voice," is more reliable and accurate than observation alone for identifying a mood disorder. 4. The facility staff failed to complete Sections C - Cognitive Patterns and Section D - Mood, on Resident #238's Admission MDS assessment with an ARD of 7/18/19. Resident #238 was admitted to the facility on 7/11/19, with diagnoses that included, but are not limited to, cardiomyopathy, tachycardia, diabetes, high blood pressure, systemic inflammatory response syndrome, toxic	F641		

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F641	Continued From page 95 encephalopathy, dementia, dysphagia, prostatic hyperplasia, and urinary retention. The admission MDS (Minimum Data Set) assessment was completed; however, the cognitive section (Section C, Cognitive Patterns) was incomplete. The admission "Nursing Comprehensive Evaluation" dated 7/11/19 documented the resident as being alert and oriented to person, place, and time. The above MDS assessment coded the resident as requiring total care for dressing; and extensive care for transfers, eating, toileting and hygiene. Review of the above MDS assessment revealed that the questions in the above identified Section C were coded with dashes in each space, indicating that it was not done, and the staff interview portion of Section C (for a resident that could not be interviewed) was not completed either and was also marked with dashes in each space. In addition, Section D, Mood, was not completed for the resident interview or staff interview sections each area was marked with dashes. On 8/06/19 at 11:07 AM, in an interview with RN #4 (Registered Nurse, the MDS Coordinator) she stated that the social worker completes these sections. (The social worker was out of town during survey.) When asked if she knew why these sections were not completed, she stated she did not. When asked if, as the MDS Coordinator, was it her responsibility to ensure that all departments complete their sections, RN #4 stated it was. When asked if there is any follow up communication between her and the departments who are responsible for completing sections of the MDS, RN #4 stated that it is communicated through emails to the departments what assignments need to be completed and when, and any follow up	F641		

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F641	Continued From page 96 communication about those assignments. When asked if she follows up to find out why something wasn't completed, RN #4 stated, "Yes." When asked if she knew why these sections of Resident #238's Admission MDS assessment with an ARD of 7/18/19, were not completed, RN #4 stated, "No." On 8/06/19 at 1:40 PM, in a follow up interview with RN #4, she stated that she had no further information as to why Sections C and D of this MDS were not completed. RN #4 stated the facility uses the RAI manual (Resident Assessment Instrument) for completing MDS assessments. On 8/06/19 at 1:44 PM, ASM #1 (Administrative Staff Member) the Administrator was made aware of the findings. No further information was provided. 5. The facility staff failed to complete Sections C - Cognitive Patterns and Section D - Mood, on the 30-day MDS assessment with an ARD (assessment reference date) of 7/19/19, for Resident #100. Resident #100 was admitted to the facility on 6/21/19; diagnoses included but are not limited to, spinal stenosis, sepsis, dysphagia, gastrostomy, quadriplegia, pneumonia, high blood pressure, chronic obstructive pulmonary disease, peripheral neuropathy, and neurogenic bladder. The most recent MDS (Minimum Data Set) assessment, which was a 30-day assessment with an ARD of 7/19/19, was completed; however, the cognitive section (Section C, Cognitive Patterns) was incomplete. The previous MDS, an admission/5-day assessment with an ARD of 6/28/19, coded the	F641		

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F641	Continued From page 97 resident as being cognitively intact in ability to make daily life decisions. Review of the above 30-day MDS revealed that the questions in the above identified Section C were coded with dashes in each space, indicating that it was not done, and the staff interview portion of Section C (for a resident that could not be interviewed) was not completed either and was also marked with dashes in each space. In addition, Section D, Mood, was not, completed for either, the resident interview or staff interview sections each area was marked with dashes. On 8/06/19 at 11:07 AM, in an interview with RN #4 (Registered Nurse, the MDS Coordinator) she stated that the social worker completes these sections. (The social worker was out of town during survey.) When asked if she knew why these sections were not completed, she stated she did not. When asked if, as the MDS Coordinator, was it her responsibility to ensure that all departments complete their sections, RN #4 stated it was. When asked if there is any follow up communication between her and the departments who are responsible for completing sections of the MDS, RN #4 stated that it is communicated through emails to the departments what assignments need to be completed and when, and any follow up communication about those assignments. When asked if she follows up to find out why something wasn't completed, RN #4 stated, "Yes." When asked if she knew why these sections of the 30-day MDS assessment for Resident #100 with an ARD (assessment reference date) of 7/19/19 were not completed, RN #4 stated, "No." On 8/06/19 at 1:40 PM, in a follow up interview	F641		

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F641	Continued From page 98 with RN #4, she stated that she had no further information as to why Sections C and D of this MDS were not completed. She stated the facility uses the RAI manual (Resident Assessment Instrument) for completing MDS assessments. On 8/06/19 at 1:44 PM, ASM #1 (Administrative Staff Member) the Administrator was made aware of the findings. No further information was provided.	F641		
F655 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	F655	F655 Resident #527: No longer resides at the facility Residents newly admitted to the facility have the potential to be affected. DON or designee will educate nursing administration and licensed nursing staff on the completion of Baseline care plans to include Anticoagulant therapy. New admissions will be reviewed during morning clinical meeting to ensure that the baseline care plan is completed and accurate MDS coordinator or designee will audit baseline care plans for the last 30 days of new admissions. Nursing administration will monitor completion of the Baseline care plan for new admissions 5 days a week for 1 week, 3 days a week for 2 weeks, weekly for 4	9/20/19

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F655	Continued From page 99 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). 483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to develop a baseline care plan for the administration of the medication Coumadin (anticoagulant medication) for one of 72 residents in the survey sample, Resident #527. The facility staff failed to develop a baseline care plan or comprehensive care plan within 48 hours, to address the prescribed anticoagulant medication Coumadin and monitoring for Resident #527. A comprehensive care plan addressing the medication was not developed or implemented for Resident #527 until 8/1/19, (approximately 20 days after admission). The findings include:	F655	weeks, and monthly for 3 months. Any variances will be corrected and additional education or counseling will be provided as needed Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facilitys quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: September 20, 2019	

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F655	Continued From page 100 Resident #527 was admitted to the facility on 7/12/19 with diagnoses including, but not limited to: broken rib, broken arm, broken hip which had been repaired by recent surgery, and a history of a DVT (deep vein thrombosis) (2) and PE (pulmonary embolism) (3). On the most recent MDS (Minimum Data Set), an admission assessment with an ARD (assessment reference date) of 7/19/19, Resident #527 was coded as severely cognitively impaired for daily decision making, having scored 3 out of 15 on the BIMS (brief interview for mental status). In Section N of this assessment, she was coded as receiving an anticoagulant (4) on all seven days of the look back period. A review of Resident #527's clinical record revealed the following order dated 7/12/19: "Warfarin [Coumadin] Sodium Tablet 2 MG (milligrams). Give 2 mg by mouth one time a day every Tue (Tuesday), Thu (Thursday), Fri (Friday), Sat (Saturday), Sun (Sunday) for h/o (history of) DVT and PE (pulmonary embolism)." Give 3 mg by mouth one time a day every Mon (Monday), Wed (Wednesday) for h/o (history of) PE and DVT." A review of Resident #527's July 2019 MAR (medication administration record) revealed that the Warfarin Sodium [Coumadin] was administered as ordered. A review of Resident #527's comprehensive care plan initiated on 7/12/19 revealed, in part, the following: "[Resident #527] is at risk for abnormal bleeding/bruising R/T (related to): medication use. Anticoagulant...Date Initiated 8/1/19. Created on 8/1/19...Will have no signs of active bleeding through next review...Administer medications as ordered...Obtain labs [laboratory] and diagnostics as ordered and report abnormal	F655		

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F655	Continued From page 101 findings to the physician." The nurse who created this care plan was not available for interview at the time of the survey. On 8/6/19 at 10:25 a.m., an interview was conducted with LPN (licensed practical nurse) #1, who works both the floor and functions as a unit manager. When asked about the process for developing a baseline care plan for a newly admitted resident, LPN #1 stated, "We used to have a paper initial care plan. We would check off boxes that applied to a resident." LPN #1 stated the facility had transitioned in the past month (July 2019) from using the paper care plans to creating an electronic version using the facility's EMR (electronic medical record) software. LPN #1 stated the admitting nurse usually completes the initial care plan. When asked to locate the paper version of an initial care plan for Resident #527, LPN #1 searched the EMR (electronic medical record). She stated, "I don't see it. If there were one, we would have scanned it in, but I can't find it. She must have come in right about the time we were moving over to the electronic care plans." When asked if a resident on Coumadin should have an initial care plan for its use, LPN #1 stated, "Absolutely. She should have a care plan and a flow sheet ["Anticoagulant Record"] started for the Coumadin." When asked why a baseline care plan would be important for Coumadin for Resident #527, LPN #1 stated, "The dosage can change, and it has to be right. The resident's blood can get too thick, or it can be too thin. We have to watch for that." When shown Resident #527's care plan for the usage of Coumadin was not initiated until 8/1/19, LPN #527 stated, "It shouldn't be. That should have been started when she was first admitted."	F655		

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F655	Continued From page 102 On 8/6/19 at 11:15 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional clinical coordinator, and ASM #3, the director of nursing, were informed of these concerns. A review of the facility policy "Interdisciplinary Care Plan" revealed, in part, the following: "A preliminary care plan is developed upon the guest's admission. The preliminary care plan is used only until the comprehensive care plan has been developed." No further information was provided prior to exit. (1) Coumadin (generic name Warfarin) - "Warfarin is used to prevent blood clots from forming or growing larger in your blood and blood vessels. It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. Warfarin is also used to treat or prevent venous thrombosis (swelling and blood clot in a vein) and pulmonary embolism (a blood clot in the lung). Warfarin is in a class of medications called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood." This information was taken from the National Institutes of Health website https://medlineplus.gov/druginfo/meds/a682277.html. (2) DVT - "Thrombosis is the medical term for the formation of a blood clot in a blood vessel. In deep vein, thrombosis (DVT), the blood clot forms in one of the larger, deeper veins that run through the muscles. Deep vein thrombosis usually occurs in the lower leg. It often goes unnoticed and dissolves on its own. But it may cause symptoms like pain and swelling. If	F655		

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F655	Continued From page 103 treatment to avoid serious complications such as pulmonary embolism. This can occur if the blood clot breaks away from its original site and is carried to the lungs in the bloodstream. The risk of deep vein thrombosis increases after more major operations such as knee or hip replacement surgery. Because of this, people who have had this kind of surgery are usually given medication to prevent blood clots from forming. This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/books/NBK425364/ . (3) PE - "A pulmonary embolism (PE) is a sudden blockage in a lung artery. It usually happens when a when a blood clot breaks loose and travels through the bloodstream to the lungs." This information is taken from the National Institutes of Health website https://medlineplus.gov/pulmonaryembolism.html. (4) Anticoagulant - "Anticoagulant...which means that it thins the blood, preventing blood clots from forming." This information is taken from the National Institutes of Health website	F655		
F656 SS=E	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 -	F656	Ftag 656 Resident # 338: No longer resides at the facility Resident #526: No longer resides at the facility Resident #488: The care plan has been updated to reflect side rails. No negative outcome occurred as a result of this practice.	9/20/19

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F656	Continued From page 104 (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 section. 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 the facility staff failed to develop and/or implement the comprehensive care plan for eight of 72 sampled residents, (Residents # 338, #526, #488, #8, #27, #189, #91, #71).	F656	Resident #8: A stat PT/INR was obtained and the Coumadin log was updated and the care plan was updated. Corresponding physician orders were transcribed into the EMR. No negative outcome occurred as a result of this practice. Resident # 27: Non pharmacological intervention are being attempted and documented prior to PRN pain medication administration and the care plan was updated. No negative outcome occurred as a result of this practice. Resident# 189: A stat PT/INR was obtained and the Coumadin log was updated and the care plan was updated. Corresponding physician orders were transcribed into the EMR. No negative outcome occurred as a result of this practice. Resident #91: The resident no longer resides at the facility. Resident # 71: Non pharmacological intervention are being attempted and documented prior to PRN pain medication administration. No negative outcome occurred as a result of this practice. Residents receiving Coumadin therapy, PRN pain medication, oxygen and have side rails and food allergies have the potential to be affected. The DON or designee will educate licensed nursing staff and nursing administration on	

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F656	Continued From page 105 The findings include: 1. The facility staff failed to implement Resident #338's anticoagulant (blood thinning medication) use comprehensive care plan. The care plan documented to observe for abnormal signs and symptoms of bleeding and report abnormal findings to the physician. On 7/22/18, Resident #338 presented with bleeding and the nurse failed to immediately, report the bleeding to the physician and/or nurse practitioner. Resident #338 was not evaluated by the nurse practitioner until 7/23/18 and was then transferred to the hospital. Resident #338 was admitted to the facility on 6/29/18. Resident #338's diagnoses included but were not limited to revision of left total knee removal, asthma and high blood pressure. Resident #338's most recent MDS (minimum data set) (prior to discharge), a 14 day Medicare assessment with an ARD (assessment reference date) of 7/13/18, coded the resident as being cognitively intact. Section N coded Resident #338 as having received an anticoagulant medication seven out of the last seven days. A physician's order dated 6/29/18 documented an order for Coumadin (anticoagulant medication) - 2 mg by mouth in the evening for DVT (deep vein thrombosis) [3] prophylaxis. Review of Resident #338's June 2018 and July 2018 MARs (medication administration records) revealed the resident was administered 2 mg of Coumadin as prescribed by the physician from 7/1/19 through 7/22/19. Warfarin (Coumadin) is in a class of medications	F656	care planning the use of side rails and allergies. Education will be provided on following the plan of care for Coumadin management, oxygen settings per physician orders, and non pharmacological approaches for pain management. New interventions identified in the clinical meeting will be communicated to the staff. The DON or designee will audit care plans for residents who have side rails and allergies. An audit of residents on oxygen will be conducted to ensure accurate settings. Residents receiving PRN pain medication will be audited for non pharmacological approaches. An audit of Coumadin logs, and orders will be conducted for residents receiving Coumadin therapy. Corrections will be made as needed. The DON or designee will monitor new orders for side rails 5 days for 1 week, 3 days for 2 weeks, weekly for 4 weeks, and monthly for 3 months ensure the care plan has been revised. The DON or designee will monitor new food allergies through review of new admissions and the 24-hour report in clinical operations meeting. DON or or designee will round on oxygen settings 5 days for 1 week, 3 days for 2 weeks, weekly for 4 weeks, and monthly for 3 months Documentation of non pharmacological approaches for PRN pain medication will be monitored 5 days for 1 week, 3 days for 2 weeks, weekly for 4 weeks, and monthly for 3 months	

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F656	Continued From page 106 called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood. [1] Resident #338's comprehensive care plan dated 7/11/18 documented, "BLEED101: At risk for abnormal bleeding R/T (related to) anticoagulant use...Interventions: Administer medications as ordered...Observe for abnormal s/sx (signs/symptoms) of bleeding. i.e. Bruising, bleeding gums, petechiae (tiny red spots caused by bleeding into the skin), nosebleeds, hematuria (bloody urine), headaches, back of abdominal pain, decrease blood pressure or pulse, occult blood in the stool, etc. Report abnormal findings to physician. Report all abnormal findings to physician..." A nurse's note dated 7/22/18 at 11:46 p.m. documented, "It was reported that guest has blood stain on bed linen. Bright red blood observed on linen unable to determine if vaginal bleed. Trace bright red blood on washcloth after pericare. Guest has + (positive) bowel sounds which are hyperactive in all 4 quadrants." The note failed to evidence the physician and/or nurse practitioner was immediately notified of the bleeding. A NP (nurse practitioner) note dated 7/23/18 at 8:30 a.m. documented, "CC (Chief Complaint): blood in stool. HPI (History of Present Illness): ATSP (Asked to See Patient) for blood in stool. Patient reports bright red blood per rectum on several occasions over the weekend. States that she has had blood on her pad and bed. Endorses abdominal pain and burning, diarrhea, and nausea. Unsure if there was blood in the toilet with BM (bowel movement) this morning, was unable to see. Has tried Zofran [3] and pain medication over the weekend with no relief...A/P (Assessment/Plan) GI (gastrointestinal)	F656	Coumadin log and orders will be monitored 5 days a week for 1 week, 3 days for 2 weeks, weekly for 4 weeks and monthly for 3 months. Any variances will be corrected and additional education or counseling will be provided as needed Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: September 20, 2019	

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F656	Continued From page 107 bleeding: referred to ER (emergency room)..." Review of hospital records revealed Resident #338's INR [5] was 11.8 on 7/23/18. The resident was administered Vitamin K [4] and underwent a blood transfusion on 7/24/18. "Prothrombin time (PT) is a blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot." "PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio)." "The most common reason to perform this test is to monitor your levels when you are taking a blood-thinning medicine called warfarin. You are likely taking this medicine to prevent blood clots. Normal Results: PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio). If you are taking warfarin to prevent blood clots, your provider will most likely, choose to keep your INR between 2.0 and 3.0." [5] The nurse who documented the 7/22/18 note was no longer employed at the facility. On 8/6/19 at 9:22 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked the purpose of a care plan. LPN #3 stated, "Pretty much just to evaluate, set goals, see where they are at and set goals (for) what they are trying to achieve." LPN #3 was asked how nurses ensure they are implementing residents' care plans for Coumadin administration. LPN #3 stated, "We have a care plan log. Update it in the computer." When asked if nurses reference residents' care plans to ensure they are providing the necessary care, LPN #3 stated, "Yes."	F656		

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F656	Continued From page 108 On 8/6/19 at 10:01 a.m., an interview was conducted with RN (registered nurse) #8. RN #8 was asked to review the nurse's note dated 7/22/18 that documented a bright red bloodstain was observed on Resident #338's sheet. After reviewing the note, RN #8 was informed the resident was on Coumadin and was asked what the nurse who documented the note should have done. RN #8 stated, "Contact the physician. Immediately." When asked why, RN #8 stated, "She's bleeding bright red blood, she could be bleeding out, have a GI (gastrointestinal) bleed. She probably needs to be sent for an evaluation or if a physician is here they could evaluate her." On 8/6/19 at 12:04 p.m., an interview was conducted with ASM (administrative staff member) #9 (the facility medical director). ASM #9 was asked to review the nurse's note dated 7/22/18 that documented a bright red bloodstain was observed on Resident #338's sheet. After ASM #9 reviewed the note, ASM #9 was made aware the resident was receiving Coumadin. ASM #9 was asked what the nurse who documented the note should have done. ASM #9 stated the nurse should have immediately called the supervisor and doctor. When asked why, ASM #9 stated, "It's a significant change in condition." On 8/7/19 at 9:29 a.m., an interview was conducted with ASM #5 (Resident #338's facility physician). ASM #5 was asked to review the nurse's note dated 7/22/18 that documented a bright red bloodstain was observed on Resident #338's sheet. ASM #5 reviewed the note. When asked if she was aware of the bleeding event on 7/22/18, ASM #5 stated she would not have known unless she was on call. ASM #5 was asked if the nurse should have notified the	F656		

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F656	Continued From page 109 on-call doctor. ASM #5 stated, "No." ASM #5 stated that event, even though the resident was receiving Coumadin, would not have prompted an emergency phone call because there was a trace amount of blood. ASM #5 stated that event could have been documented in the doctor's book for the resident to be seen the next day and the nurse practitioner did see Resident #338 the next day. On 8/6/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. The facility policy titled, "Interdisciplinary Care Plan" documented, "Policy: It is the policy of this facility to develop an interdisciplinary care plan for each guest that includes measurable goals and time frames directed toward achieving and maintaining each guest's optimal medical, physical, mental and psychosocial needs...2. The interdisciplinary care plan will: a. Incorporate identified problem areas b. Incorporate risk factors associated with identified problems c. Build on the guest's strengths d. Reflect treatment goals and objectives in measurable outcomes e. Identify the professional services that are responsible for each element of care and frequency of services provided f. Prevent declines in the guest's functional status and/or functional levels..." No further information was presented prior to exit. [1] "Warfarin (Coumadin) is used to prevent blood clots from forming or growing larger in	F656		

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F656	Continued From page 110 your blood and blood vessels. It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. Warfarin is also used to treat or prevent venous thrombosis (swelling and blood clot in a vein) and pulmonary embolism (a blood clot in the lung). Warfarin is in a class of medications called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682277.html *"Warfarin (Coumadin) can cause major or fatal bleeding. Regularly monitor INR in all patients." This information was obtained from the reference: Nursing 2016 Drug Handbook (Wolters Kluwer, 2016, p.1495) Black Box Warning [2] "Deep vein thrombosis, or DVT, is a blood clot that forms in a vein deep in the body. Most deep vein clots occur in the lower leg or thigh. If the vein swells, the condition is called thrombophlebitis. A deep vein thrombosis can break loose and cause a serious problem in the lung, called a pulmonary embolism." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dvt&_ga=2.137988019.2081124811.1565615930-1667741437.1550160688 [3] Zofran is used to prevent nausea. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601209.html	F656		

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F656	Continued From page 111 [4] This information was obtained from the website: Reversal of COUMADIN anticoagulation may be obtained by discontinuing COUMADIN therapy and, if necessary, by administration of oral or parenteral vitamin K. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d91934a0-902e-c26c-23ca-d5accc4151b6# [5] This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3aproject=medlineplus&v%3asources=medlineplus-bundle&query=laboratory%20tests%20for%20PT%20calculation%20of%20INR&2. 2. a. The facility staff failed to develop and/or implement the comprehensive care plan for the administration of oxygen for Resident #526. Resident #526 was admitted to the facility on 7/26/19; diagnoses included but are not limited to left hip fracture, lung cancer, high blood pressure and pacemaker. Due to the recent admission, the MDS (Minimum Data Set) had not yet been completed. According the "Nursing Admission" note dated 7/26/19, Resident #526 was alert and oriented to time, place, and person; requires extensive assistance for toileting; total care for transfers and bed mobility; and continent of bladder and bowel. On 7/30/19 at 12:08 PM, 7/31/19 at 9:29 AM, and 5:28 PM, observations of Resident #526's oxygen, concentrator's flow rate were conducted. Resident #526's oxygen, concentrator flow rate was observed at 2 1/2	F656		

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F656	Continued From page 112 resident. A physician's order dated 7/26/19, documented in part the following, "Oxygen 3L/min (liter/minute) via nasal cannula SOB (shortness of breath), every shift for SOB/Wheezing." A review of the clinical record failed to reveal a comprehensive care plan for oxygen administration for Resident #526. Resident #526's TAR (Treatment Administration Record) for July 2019, documented in part the following with a start date of 7/26/19, "Oxygen 3L/min via nasal cannula SOB (shortness of breath), every shift for SOB/Wheezing." On 8/1/19 at 10:55 AM, an interview was conducted with LPN (Licensed Practical Nurse) #3. LPN #3 was asked if a resident with a physician's order for oxygen, should have a care plan for the administration of the oxygen, LPN #3 stated, "Yes." A review of the facility policy "Interdisciplinary Care Plan" documented in part the following, "It is the policy of this facility to develop an interdisciplinary care plan for each guest ...directed toward achieving and maintaining each guest's optimal medical, physical, mental, and psychosocial needs ... The interdisciplinary care plan will ...Incorporate identified problem areas ...Prevent declines in the guest's functional status and/or functional levels ..." According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of	F656		

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F656	Continued From page 113 information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." On 8/2/19 at 1:48 PM, ASM (Administrative Staff Member) #1, the Administrator, ASM #3, the Director of Nursing, and ASM #2, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey. 2. b. The facility staff failed to develop a comprehensive care plan to address Resident #526's allergy to citrus products. On 7/30/19 at 1:56 PM, an observation of two packets of lemon glycerin, mouth swabs were on Resident #526's bedside table. One packet was open and had two mouth swabs in the packet. A visitor (sister-in-law) of Resident #526 stated, "(Name of) Resident #526 is allergic to citrus and was given lemon glycerin mouth swabs." When Resident #526 and his visitor were asked if the facility knew of the allergy, RV (resident visitor) #1, the visitor stated, "I told them about it." A review of the lemon glycerin, mouth swab's ingredients revealed the following: water, glycerin, citric acid, lemon flavor, and sodium benzoate. A follow up interview with Resident #526 was conducted on 7/31/19 at 3:44 PM. When Resident #526 was asked if he used the lemon glycerin, mouth swabs, he stated, "One." When	F656		

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F656	Continued From page 114 Resident #526 was asked if there were any adverse reactions to the use of the lemon glycerin mouth swab, Resident #526 stated, "Thankfully, no." A review of the clinical record revealed Resident #526's allergy to citrus products was documented and listed on the following: Admission Record, Physician's order Summary, Physician Progress note dated 7/26/19, Nursing Comprehensive Evaluation dated 7/26/19, Nursing Progress note 7/26/19, Comprehensive Care Plan, Medication Administration Record (MAR), Treatment Administration Record (TAR), Dietary History / Food Preferences note dated 7/29/19, and Meal Tickets for each meal. Further review of the clinical record failed to reveal a comprehensive care plan developed specifically for Resident #526's allergy to citrus products. However, each page of the comprehensive care plan documented at the bottom of the page, along with the resident's name, admission date, room number, and physician name, what all his allergies were. A review of the facility policy "Interdisciplinary Care Plan" documented in part the following: "It is the policy of this facility to develop an interdisciplinary care plan for each guest .... directed toward achieving and maintaining each guest's optimal medical, physical, mental, and psychosocial needs ...The interdisciplinary care plan will ...Incorporate identified problem areas ...Prevent declines in the guest's functional status and/or functional levels ..." On 7/31/19 at 3:51 PM, an interview with CNA #1 was conducted. CNA #1 was asked how staff would know what a resident is allergic to, CNA #1 stated, "I usually read the chart once	F656		

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F656	Continued From page 115 the resident arrives for the things I need to know to take care of them. Usually, there is an armband with the allergies listed. Usually, on the meal ticket there will be something about allergies." When asked if there were, mouth swabs available for Resident #526 to use that do not contain ingredients he is allergic to, CNA #1 stated, "Yes. There is a green type that you can dip in water or mouthwash to refresh a resident's mouth." CNA #1 was asked what would be a considered a concern with Resident #526's citrus products allergy. CNA #1 stated, "It should be flagged to alert us." On 7/31/19 at 5:22 PM, an interview with CNA #2 was conducted. CNA #2 was asked where in a resident's chart a CNA would locate the resident's allergy information. CNA #2 stated, "From the care plan." CNA #2 then located the allergy information on the care plan in the electronic documentation tool the CNAs use. CNA #2 stated, "We go to the care plan first, then we ask the family. As the CNA, you go by the care plan." On 7/31/19 at 4:12 PM, an interview with LPN (Licensed Practical Nurse) #1 was conducted. When asked how staff would know what a resident is allergic to, LPN #1 stated, "On the MAR; listed at the top is all their allergies." LPN #1 stated, "If it is a food allergy, it would be on the meal ticket along with their dislikes, and in the dietary notes." When asked about staff using mouth swabs that a resident could be allergic to, LPN #1 stated, "Me, personally, before they (staff member) give it to them, they should ask the nurse or look in the chart. I prefer they ask me first so I can verify." When asked if a resident with allergies should have an identifying bracelet on, LPN #1 stated, "We don't use arm bracelets here. We don't use name	F656		

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F656	Continued From page 116 bracelets either. That is why it is important for the CNA's to ask the nurse." According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." On 7/31/19 at 5:40 PM, ASM (Administrative Staff Member) #1, the Administrator, and ASM #3, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. 3. The facility failed to develop and/or implement the comprehensive care plan for the use of bed rails for Resident #488. Resident #488 was admitted to the facility on 7/17/19, diagnoses included but are not limited to multiple sclerosis (1), high blood pressure, and immobility syndrome (paraplegic) (2). Due to the recent admission, the MDS (Minimum Data Set) had not yet been completed. According to the "Nursing Admission" note dated 7/22/19, Resident #488 was alert and oriented to time, place, and person; requires total care and is incontinent of bladder and bowel.	F656		

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F656	Continued From page 117 On 7/30/19 at 12:27 PM, 4:51 PM, and 7/31/19 at 9:19 AM, it was observed Resident #488 had two upper side rails (one on each side) and the bed rails were up at each observation. Resident #488 was observed in bed during the 7/31/19 at 9:19 AM observation, with the bed rails in the up position. A physician's order dated 7/17/19, documented in part, "...Two half side rails up as an enabler when in bed ..." A review of the clinical record revealed a care plan dated 7/17/19, which documented in part requiring assistance with bed mobility. However, the care plan did not address the use of side rails. On 8/1/19 at 10:55, an interview with LPN (Licensed Practical Nurse) #3 was conducted. When LPN #3 was asked if a resident has an order for bed rails, should the use of side rails be care planned, LPN #3 stated, "Yes." A follow up interview with LPN #3 was conducted on 8/6/19 at 8:36 AM. When LPN #3 was asked if Resident #488 uses the bed rails, LPN #3 stated, "I have seen her use the bed rails." On 8/2/19 at 1:48 PM, ASM (Administrative Staff Member) #1 the Administrator, ASM #3, the Director of Nursing, and ASM #2, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey. References: (1) Multiple sclerosis: A nervous system disease	F656		

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F656	Continued From page 118 that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from the following website: https://medlineplus.gov/multiplesclerosis.html (2) Paraplegic: Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia. Most paralysis is due to strokes or injuries such as spinal cord injury or a broken neck. This information was obtained from the following website: https://medlineplus.gov/paralysis.html 4. The facility staff failed to implement Resident # 8's comprehensive care plan for the use and monitoring of an anticoagulant medication. Resident # 8 was admitted to the facility on 08/14/2015 and a readmission on 01/08/2019 with diagnoses that included but were not limited to: deep vein thrombosis (1), other specified disorders of veins and high cholesterol. Resident # 8's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/19/19, coded Resident # 8 as scoring a seven on the brief interview for mental status (BIMS) of a score of 0 - 15, seven - being severely impaired of	F656		

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F656	Continued From page 119 cognition for making daily decisions. Section N "Medications" coded Resident # 8 as receiving an anticoagulant in the past seven days. The comprehensive care plan for Resident # 8 dated 02/05/2019 documented, "Need. (Resident # 8) is at risk for abnormal bleeding/bruising R/T (related to): medication use. Anticoagulant. Hx (history) of GI (gastrointestinal) bleeding." Under "Interventions", it documented in part, "Administer medications as ordered. Observe for effectiveness and side effects, report abnormal findings to the physician. Date initiated: 02/05/2019, Obtain labs (laboratory tests) and diagnostics as ordered and report abnormal findings to the physician. Date initiated 02/05/2019." A nurse practitioner's note dated 06/28/1018 documented in part: "Stable. INR 2.2. Goal: 2-3 (two to three)." The facility's "Anticoagulant Record" for Resident # 8 dated 8/20/19 documented, "Current Anticoagulant Drug and Dose: Coumadin 7.5mg." "PT: 16.7. INR: 1.4" "08/20/18 Action Taken by Physician: arrow pointing up (indicating to increase Coumadin) 8mg qd (every day) recheck in 1 wk (week)." A physician's telephone order dated 08/20/18 at 11:58 a.m. for Resident # 8 documented, "Order Summary: Warfarin Sodium Tablet Give 8mg by mouth every evening shift for treating/preventing blood clots." The eMAR (electronic medication administration record) dated August 2018 documented the physician's telephone order dated 08/20/18 as stated above with a start date of 07/11/2018.	F656		

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F656	Continued From page 120 Further review of the eMAR revealed a check mark and the nurse's initials under the date of 08/21/18 indicating Resident # 8 received 8 mg and 7.5 mg of Coumadin on 08/21/18. Review of the nurse's progress notes, physician notes and nurse practitioner notes dated 08/01/18 through 08/31/18 failed to evidence any documented recommendations or orders for the resident to receive both 8 mg and 7.5 mg for a total of 15.5mg of Coumadin on 08/21/18. On 8/23/19, a physicians order to discontinue Coumadin 7.5 mg was obtained from the physician and documented: "Order Summary: Coumadin Tablet 7.5 MG (Warfarin Sodium) Give 1 (one) tablet by mouth in the evening for anticoagulant therapy. Discontinue Date / Reason: increase in dosage." The facility's "Nurse Practitioner's Note" for Resident # 8 dated 11/09/18 and signed by ASM (administrative staff member) # 7, nurse practitioner, at 12:45 p.m. documented in part, "HPI (History of Present Illness): ATSP (Asked To See Patient) for lab (laboratory) review. Male patient on Coumadin for DVT. INR: 3.5. Goal 2-3 (two to three). On 6 (six) mg daily. No s/sx of bleeding." Under "A/P (Assessment/Plan)" it documented, "Leg DVT - Stable. INR elevated. Hold Coumadin x1 (times one day) and recheck tomorrow." The Physician's telephone order documented, "Created Date: 11/9/18 at 17:14 (5:14 p.m.) Communication method: Phone." Documented "Order Summary: Coumadin Tablet 6 MG [milligram] (Warfarin Sodium) Give 6 MG by mouth in the evening for anticoagulant therapy Discontinue 11/9/18 17:14 (5:14 p.m.) Discontinue Date/Reason: on hold Confirmed By: name of (Licensed Practical Nurse)." A	F656		

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F656	Continued From page 121 second physicians order date 11/9/2018 at 17:15 (5:15 p.m.) documented, "Order Summary: check pt/inr on sat [Saturday] 11/10/18 one time only for coumadin use 1 day." The facility's "Anticoagulant Record" for Resident # 8 dated 11/09/18 documented, Current Anticoagulant Drug and Dose: "Coumadin 6 mg (milligrams)" "PT 3.5 INR: 41.6 [Note the staff entered the INR level under PT and the PT level under the INR. The INR was elevated above the resident goal placing the resident at risk for bleeding]." Under "Action Taken by Physician" it documented, "Hold x 1 (times one day) re-check 11/10/18." Further review of the "Anticoagulant Record" failed to evidence results of a PT/INR for 11/10/18. A Nurse's Note" dated 11/09/18 for Resident # 8 at 7:25 p.m. documented, "Hold Coumadin 6MG (milligrams) today 11/09/18 recheck PT/INR on SAT (Saturday) 11/10/18 will cont (continue) to monitor guest." Further review failed to evidence nurses notes documenting why the PT INR was not obtained on 11/10/19 as ordered by the physician and no documentation evidencing the physician was notified the laboratory testing was not obtained. Review of the eMAR (electronic medication administration Record) for November 2018 revealed, Coumadin Tablet 6 MG [milligram] (Warfarin Sodium) Give 6 MG by mouth in the evening for anticoagulant therapy Start Date 9/12/18 D/C Date 11/9/18. On 11/9/19 a "5 (five)" was documented with staff initials for the dose of Coumadin scheduled at 1700 (5:00 p.m.). The code for 5 on the MAR documented, "Hold/See Nurse Notes." Further review of the November 2018 MAR revealed that no Coumadin was administered to Resident #8 as	F656		

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F656	Continued From page 122 evidenced by an "X" documented for 11/10/2018 and 11/11/2018. Review of the electronic health record failed to evidence any orders or clarification for holding or administering Coumadin to Resident #8 on 11/10/18 and 11/11/18. A "Nurse Practitioner's Note" for Resident # 8 dated 05/01/19 and signed by ASM (administrative staff member) # 7, nurse practitioner, at 12:26 p.m. documented in part, "HPI (history of present illness) INR: 5.1. Under "A/P" it documented, "Leg DVT - Stable. INR elevated. Hold Coumadin x1 (times one day) and recheck on 5/2/19. Monitor closely." A physicians order dated 5/1/19 documented, "Order Summary: PT/INR 5/01/19 one time only for anticoagulation therapy for 1 day. A physician's telephone order dated 05/01/19 for Resident # 8 documented, "Coumadin Tablet 6MG (Warfarin Sodium). Give 6MG by mouth one time a day for anti-coagulant. Hold 05/01/2019 14:45 (2:45 p.m.) - 05/02/2019 14:44 (2:44 p.m.)." The facility's "Anticoagulant Record" for Resident # 8 dated 05/01/19 documented, "Current Anticoagulant Drug Dose Coumadin 6 mg PT 61.5 INR: 5.1 [higher than the goal of 2-3 placing the resident at risk for bleeding]." Under "Action Taken by Physician" it documented, "Hold x 1 (times one day) re-check 5/2/19." On 5/2/19 the "Anticoagulant Record" for Resident # 8 dated 05/01/19 documented, "Current Anticoagulant Drug Dose: Held on 5/1/19, PT 36.9 INR 3.1" Under "Action Taken by Physician" it documented, "Hold x 1 (times	F656		

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F656	Continued From page 123 one day) re-check 5/3/19." The nurse's progress note for Resident # 8 dated 05/02/2019 at 4:44 p.m. documented in part, "PT/INR 39.0/3.2. Per MD (medical doctor), hold Coumadin today and recheck tomorrow." A "Nurse Practitioner's Note" for Resident # 8 dated 5/03/19, signed by ASM (administrative staff member) # 7, nurse practitioner, at 5:10 p.m. documented in part, "A/P: Leg DVT - Stable. 5MG coumadin QD (every day) and check INR 5/10/19. Monitor closely." On 5/3/19 Resident #8's "Anticoagulant Record" documented, "Current Anticoagulant Drug Dose: Coumadin 6 mg held on 5/2/19, PT 24.9 INR 2.1" Under "Action Taken by Physician" it documented, " 5 mg QD [every day] re-check 5/10/19." Further review of the "Anticoagulant Record" failed to evidence results of a PT/INR for 05/10/19. The Date 5/10/19 was crossed out with a line on the Anticoagulant Record. A hand written notation was written beside the crossed out date 5/10/10, documented, "MD (medical doctor) aware NNO (no new order)." Review of the May 2019 eMAR revealed, "Coumadin Tablet 6 MG (Warfarin Sodium) Give 6 mg by mouth one time a day for anti-coagulant. Start Date- 01/11/2019 1700 (5:00 p.m.), -Hold Date- from 05/01/2019 1445 (4:45 p.m.) -05/02/2019 1444 (2:44 p.m.). This order was documented as discontinued on 5/15/19. Review of the eMAR for 5/2/19 evidenced staff initials with a check mark on 5/2/19 indicating Resident #8 was administered 6 mg of Coumadin instead of holding the medication as ordered.	F656		

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F656	Continued From page 124 On 8/1/19 at approximately 2:59 p.m., an interview was conducted with LPN # 3 (licensed practical nurse), regarding the lack of PT/INR results on Resident #8's anticoagulant log on 5/10/19. LPN # 3 was asked what it meant if the laboratory [lab] results weren't written on the log. LPN # 3 stated, "It means that the lab wasn't drawn." LPN # 3 also stated that the physician was aware the PT/INR had not been drawn. LPN # 3 was asked if she knew why the PT/INR had not been drawn for Resident #8. LPN # 3 stated, "I'm unsure." Further review of Resident #8's clinical record revealed no additional documentation as to why the PT/INR was not drawn. On 07/31/19 at 3:12 p.m., an interview was conducted with RN (registered nurse) # 2, unit manager. When asked to describe the purpose of the resident's care plan RN # 2 stated, "They are goals for the patient and it lets us know their orders specific to them and the different devises they may use. When it is documented on the care plan it should be followed and if it isn't the care plan is not being followed." On 08/051/19 at approximately 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, and ASM # 3, were made aware of the above findings. No further information was provided prior to exit. References: (1) A condition that occurs when a blood clot forms in a vein deep inside a part of the body. It mainly affects the large veins in the lower leg and thigh, but can occur in other deep veins such as in the arms and pelvis. This information was obtained from the website: https:	F656		

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F656	Continued From page 125 //medlineplus.gov/ency/article/000156.htm. (2) International normalized ratio (INR) is the preferred test of choice for patients taking vitamin K antagonists (VKA). It can also be used to assess the risk of bleeding or the coagulation status of the patients. Patients taking oral anticoagulants are required to monitor INR to adjust the VKA doses because these vary between patients. The INR is derived from prothrombin time (PT) which is calculated as a ratio of the patient's PT to a control PT standardized for the potency of the thromboplastin reagent developed by the World Health Organization (WHO) using the following formula: This information was obtained from the website: https://www.ncbi.nlm.nih.gov/books/NBK507707/ . (3) A blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot. This information was obtained from the website: https://medlineplus.gov/ency/article/003652.htm. 5. The facility staff failed to implement Resident # 27's comprehensive care plan for the use of non-pharmacological interventions prior to the administration of as needed pain medication. Resident # 27 was admitted to the facility on 10/26/2017 with diagnoses that included but were not limited to: osteoarthritis (2) and breast cancer. Resident # 27's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/09/19, coded Resident # 27 as scoring a one on the brief	F656		

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F656	Continued From page 126 0 - 15, one - being severely impaired of cognition for making daily decisions. Section J coded Resident # 27 as being unable to answer the pain assessment interview. The staff assessment for pain documented vocal complaints of pain from Resident # 27 and showing indicators of pain or possible pain observed 3 to 4 days in the five days prior to the ARD. The POS (physician's order sheet) dated August 2019 for Resident # 27 documented, "Acetaminophen Tablet 325 (five) MG (milligrams. Give two tablets by mouth every 4 (four) hours as needed for pain/ fever greater than 100 nte (not to exceed) 3g/24hrs (grams in 24 hours). Order Date: 11/01/2017. Start Date: 11/01/2017." The eMAR (electronic medication administration record) for Resident # 27 dated "May 2019" documented the same orders as stated in the POS above. Review of the eMAR revealed Acetaminophen 470mg was administered on "05/03/19 at 1447 (2:47 p.m.), 05/07/19 at 1141 (11:41 a.m.), 05/08/19 at 1401 (2:41 p.m.), 05/16/19 at 1817 (5:17 p.m.) and on 05/20/19 at 0315 (3:15 a.m.)." Further review failed to evidence documentation of non-pharmacological interventions on the dates listed above. The eMAR (electronic medication administration record) for Resident # 27 dated "June 2019" documented the same orders as stated in the POS above. Review of the eMAR revealed Acetaminophen 470mg was administered on "06/01/19 at 2100 (9:00 p.m.), 06/10/19 at 0242 (2:42 a.m.), 06/13/19 at1840 (6:40 p.m.), 06/20/19 at 0027 (12:27 a.m.), 06/22/19 at 0400 (4:00 a.m.), 06/24/19 at 1549 (3:49 p.m.), 06/26/19 at 2000 (8:00 p.m.) and on 06/30/19 at	F656		

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F656	Continued From page 127 1835 (6:35 p.m.)." Further review failed to evidence documentation of non-pharmacological interventions on the dates listed above. The eMAR (electronic medication administration record) for Resident # 27 dated "Jul (July) 2019" documented the same orders as stated in the POS above. Review of the eMAR revealed Acetaminophen 470mg was administered on "07/03/19 at 1826 (6:26 p.m.), 07/27/19 at 1231 (12:31 p.m.), 07/29/19 at 1800 (6:00 p.m.) and on 07/31/19 at 1600 (4:00 p.m.)." Further review failed to evidence documentation of non-pharmacological interventions on the dates listed above. Review of the nurse's progress notes and eMAR notes for Resident # 27 dated 05/03/19 through 07/31/19 failed to evidence documentation of non-pharmacological interventions prior to the administration of Roxicodone 5mg on the dates listed on the eMARs listed above. The comprehensive care plan for Resident # 27 dated 11/07/2017 documented, "Need. Potential for pain r/t (related to) Arthritis. Date Initiated: 11/07/2017." Under "Interventions" it documented, "Assist to position for comfort with physical support as necessary. Date Initiated: 11/07/2017." On 08/01/19 at 11:36 a.m., an interview was conducted with LPN (licensed practical nurse) # 2 regarding the procedure for administering prn (as needed) pain medication. LPN # 2 stated, "I ask the resident where the pain is, what the level is based a scale of zero to ten with ten being the worst pain, administer the medication and recheck the resident after about an hour for effectiveness." When asked if she would attempt non-pharmacological interventions prior	F656		

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F656	Continued From page 128 to the administration of the pain medication to try to alleviate the pain LPN # 2 stated, "Generally yes." When asked where they document non-pharmacological interventions are tried and/or attempted LPN # 2 stated, "In the nurse's notes." After reviewing Resident # 27's eMARs, nurse's notes and eMAR notes dated 05/03/19 through 07/31/19 LPN # 2 stated, "It's not being done because it's not documented." On 08/05/19 at 5:10 p.m., ASM (administrative staff member) #1, administrator, ASM # 2, regional clinical coordinator and ASM #3 (director of nursing) were made aware of the above concern. No further information was presented prior to exit. References: (1) 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: 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:	F656		

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F656	Continued From page 129 6. The facility staff failed to implement the comprehensive care plan in regards to the administration of medication per the physician's order, monitoring laboratory results and notifying the physician of any abnormal findings for Resident #189. On multiple occasions, the staff failed to administer Coumadin and failed to obtain laboratory tests or notify the physician of test results per orders and the comprehensive care plan. Resident #189 was admitted to the facility on 9/16/17 with a most recent readmission on 7/16/19 diagnoses included but were not limited to: mechanical heart valve, stroke, high blood pressure and atrial fibrillation. (Atrial fibrillation is a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (1). The most recent MDS (minimum data set) assessment, a Medicare five day admission, with an assessment reference date of 7/23/19, coded the resident as scoring an "11" on the BIMS (brief interview for mental status score) indicating the resident was moderately impaired to make daily decisions. In Section N - Medications, the resident was coded as receiving an anticoagulant for the seven days of the look back period. The comprehensive care plan dated, 12/19/18 and revised on 3/7/19, documented in part: "Focus: (Resident #189) is at risk for abnormal bleeding/bruising R/T (related to) medication use, anticoagulant diagnosis of A-Fib (atrial fibrillation), stroke." The "Interventions"	F656		

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F656	Continued From page 130 documented in part, "Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician. Obtain labs (laboratory) and diagnostics as ordered and report abnormal findings to the physician. Observe and report to physician PRN (as needed) s/sx (signs and symptoms) of complications: blood tinges/frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain , lethargy, bruising, blurred vision, SOB (shortness of breath), loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs - blood pressure, heart rate, respirations), bleeding gums, petechiae (tiny reddish or purple flat spot appearing on the skin as the results of tiny hemorrhages within the skin or subcutaneous layers) (2), back or abdominal pain and nosebleeds." Review of the "Anticoagulant Record" and the clinical record including physician order, physician and nurse practitioner progress notes, nursing notes, and the MAR (medication administration record) was conducted. A nurse practitioner note dated, 7/31/18, documented in part, "Patient is on anticoagulant (substance that delays blood clotting coagulation. Anticoagulants are used to prevent clotting in blood for transfusion and in blood vessels.) (3) Anticoagulated with Coumadin (Coumadin is an anticoagulant/blood thinner that keeps your body from forming blood clots.) (4). INR goal 2.5 to 3.5." "Prothrombin time (PT) is a blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot." "PT is measured	F656		

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F656	Continued From page 131 in seconds. Most of the time, results are given as what is called INR (international normalized ratio)." "The most common reason to perform this test is to monitor your levels when you are taking a blood-thinning medicine called warfarin. You are likely taking this medicine to prevent blood clots. Normal Results: PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio). If you are taking warfarin to prevent blood clots, your provider will most likely, choose to keep your INR between 2.0 and 3.0." (5) On 8/15/19, the Anticoagulant record [a record maintained separately from the clinical record and not signed by the physician] documented INR on was 1.8, [below the documented INR goal of 2.5 - 3.5 [placing Resident #189 at risk for blood clots due to the low INR level]. The current Coumadin dose was documented as "5 mg [milligrams]" the action taken by the physician directive documented, "Increase to 5.5 mg recheck 8/18/18. Review of the EMR (electronic medical record) revealed a physician order for the increase in the Coumadin dated 8/15/18. The August 2018 MAR revealed the above physicians order for "Coumadin 5.5 mg by mouth in the evening, effective 8/15/18." Further review revealed a "5" documented for the dose of Coumadin due on 8/15/18. A "5" per the MAR indicated to "Hold/see nurse's notes." A review of the EMR [electronic medical record] failed to evidence a nurse's note for 8/15/18. Thus, the resident did not receive any Coumadin on 8/15/18, as per the physician order. The "Anticoagulant Record" dated 9/27/19 documented the "Current Anticoagulant Drug	F656		

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F656	Continued From page 132 and Dose" as "On Hold." The PT/INR 9/27/18 was documented as 1.8. The physician directive documented, "5 mg qd (every day) recheck 10/1/18. Review of the physician orders revealed a documented order for Coumadin 5 mg qd (every day) on 9/27/18. Review of the September MAR documented the above 9/27/19 physician order for Coumadin 5 mg qd. The start date documented, 9/28/18. Further review of the MAR failed to evidence the resident received any Coumadin on 9/27/18 per the physician's orders. There was no order to hold Resident #189's Coumadin on 9/27/18 and staff failed to administer the medication as ordered when the residents INR was below the identified goal of 2.5-3.5 placing the resident at risk for blood clots. Resident #189's "Anticoagulant Record" dated, 11/9/18 documented, "Current Anticoagulant Drug and Dose: 5 mg Coumadin." The PT/INR was documented as 3.3. The physician directive documented, "4.5 mg (Coumadin) qd recheck 11/15/18." The "Anticoagulant Record" revealed the 11/15/18 date was crossed off and the date of 11/14/18 was documented the PT/INR as 2.2 below the identified goal of 2.5-3.5 placing the resident at risk for blood clots]. The physician directive documented, to increase Coumadin to 5 mg and recheck on 11/19/18. A nurse practitioner note dated, 11/15/18, documented in part, "CC: lab (laboratory) review. INR today 2.2. On Coumadin 4.5 mg for MVR (mechanical valve replacement) and A. fib. Goal 2.5 - 3.5...On Coumadin. Increase to 5 mg	F656		

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F656	Continued From page 133 qd and recheck on 11/19/18. Review of the EMR revealed a physician order dated 11/15/18 to increase the Coumadin to 5 mg. Review of the November MAR documented the above directive on 11/9/19 for Coumadin 4.5 mg qd. The medication was administered from 11/9/18 through 11/14/18. On 11/15/18, a "5" was documented under the Coumadin 4.5 mg dose. A "5" indicated, "Hold/See nurse's note." There was no nurse's note for 11/15/18. Review of the electronic medical record failed to evidence a physician order to hold Resident #189's Coumadin on 11/15/19. Staff held the medication without a physician's order and failed to administer Coumadin 5 mg as ordered by the physician on 11/15/19. The "Anticoagulant Record" dated, 1/9/19, documented the current Coumadin dose as 5 mg, INR level 4.0" [above therapeutic goal], the physician was notified on 1/9/19. The physician directive documented, "Hold Coumadin, recheck 1/10/19." There was a physician order in the EMR to hold the Coumadin and to recheck the Coumadin on 1/10/19. On 1/10/19, the "Anticoagulant Record" documented the current Coumadin dose as "HOLD" "INR 2.8." The physician directive documented, "(Coumadin) 4.5 mg qd (every day), recheck 1/15/19. Physician orders were in place in the EMR for the above Coumadin directives. The January 2019 MAR documented the following order, "Coumadin 2.5 mg; give 1 tablet by mouth in the evening for A fib to give with 2 mg to make 4.5 mg." Further review of the January 2019 MAR failed to evidence the resident received any Coumadin on 1/10/19.	F656		

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F656	Continued From page 134 The order was transcribed to start on 1/11/19. There was no physician order in the clinical record to hold Resident #189'2 Coumadin on 1/10/19. The "Anticoagulant Record" dated, 4/11/19, documented the current Coumadin dose as 2.5 mg, INR 2.3, [below therapeutic goal placing the resident at risk for blood clots for a level too low and bleeding for a level to high]. There were no test -strip lot numbers, documented and no documentation under the "Quality Control Test," if it was successful for QC or error noted. The physician directive documented, "No change recheck in one day." The physician order dated, 4/11/18 in the EMR documented, "Recheck PT/INR level on 4/12/19. The "Anticoagulant Record" dated, 4/12/19, failed to evidence the PT/INR test was performed on 4/12/19. The form was dated 4/12/19 with the current Coumadin dose documented as 2.5 mg but the rest of the line was empty. Review of the nurse's note failed to evidence a nurse's note for 4/12/19. The test was not completed per the physician order dated 4/11/19 in the EMR and the physician directive documented on the "Anticoagulant Record." Review of the physician's orders revealed an order dated 4/24/19 that documented 6 mg of Coumadin every day. The April 2019 MAR documented that the resident received the Coumadin 6 mg on 4/24/19. The "Anticoagulant Record" dated, 4/25/19, documented the current Coumadin dose as 6 mg. the PT/INR was documented as 2.2 [below the identified goal of 2.5-3.5 placing the resident at risk for clots]. The physician directive on the record documented, no change recheck on 4/27/19.	F656		

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F656	Continued From page 135 Review of the April MAR failed to evidence the resident received the prescribed dose of Coumadin, 6 mg on 4/25/19. There was no physician order in the clinical record to hold Resident #189's Coumadin on 4/25/19. The "Anticoagulant Record" dated, 5/12/19, documented the current Coumadin dose as 5.5 mg. The INR was documented as 2.8. The physician directive documented, "Decrease (Coumadin) to 3 mg, recheck 1 wk." A physician order in the EMR dated, 5/12/19, documented, "Coumadin 3 mg by mouth in the evening for anticoagulation." The order was transcribed to the May 2019 MAR. The MAR documented the order to start on 5/13/19. The resident did not receive any Coumadin on 5/12/19. There was no physician order in the EMR to hold Resident #189's Coumadin on 5/12/19. The "Anticoagulant Record" dated, 5/20/19, documented the current Coumadin dose as 3 mg INR 1.6 [below the therapeutic goal]. The physician directive documented, "Increase to 4 mg, recheck 1 wk [week]." The physician order in the EMR dated, 5/20/19 documented, "Coumadin 4 mg; give 1 tablet by mouth in the evening for prevent dvt (deep vein thrombosis)." The May MAR documented the order above for the Coumadin 4 mg. The order was documented to start on 5/21/19. Further review of the MAR failed to evidence the resident received any Coumadin on 5/20/19 and there was no physician order in the EMR to hold Resident #189's Coumadin. The "Anticoagulant Record" dated, 6/26/19, documented the current Coumadin dose as 5.5 mg. The INR was documented as 4.3 [higher	F656		

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	495109	A. BUILDING _____ B. WING _____	C 08/07/2019

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F656	Continued From page 136 than the identified goal]. The physician directive documented, "Hold x1, recheck 6/27/19." The EMR documented physician orders dated 6/27/19 to hold the Coumadin and recheck on 6/27/19. The nurse practitioner note dated, 6/26/19, documented in part, "INR today 4.6. On Coumadin 5.5.mg qd., goal 2.5 - 3.5, hold x 1 and recheck 6/27/19." The "Anticoagulant Record" failed to evidence documentation of the repeat INR on 6/27/19, per the physician order evidencing a delay in monitoring. An interview was conducted with RN (registered nurse) #5, the unit manager, on7/31/19 at 1:29 p.m., regarding the purpose of the care plan, RN #5 stated, "It lays out the plan of care while they (the residents) are here." When asked if staff should implement and follow the comprehensive care plan, RN #5 stated, "Yes." An interview was conducted with administrative staff member (ASM) #7, the nurse practitioner for Resident #189, on 8/6/19 at 7:53 a.m. When asked if an order for Coumadin is written on the same day the PT/INR test is obtained, when does that order take effect, ASM #7 stated it should be initiated that same day. An interview was conducted with RN #8 on 8/6/19 at 3:12 p.m. When asked if the physician's order documents to administer a dose of Coumadin, should the medication be given as ordered, RN #8 stated, "Yes, we should always follow the physician order." RN #8 was asked if the physician gives an order to change the dose of Coumadin, after the PT/INR is obtained in the morning, when is the change dose effective. RN #8 stated, "It goes in effect before the evening dose [of Coumadin] that	F656		

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F656	Continued From page 137 same day." When asked if the physician ordered dose change should be documented to start the next day, RN #8 stated, "No, it has to start the same day. That's why we do PT/INRs in the morning so we can have the correct dose for the evening dose of Coumadin." The "Anticoagulant Record" for Resident #189, nurse's notes, MARs, physician and NP notes and orders from 7/18/18 through 7/29/19, was reviewed with RN #8 and the above documented concerns reviewed. When RN #8 was asked if staff hold a dose of Coumadin, should there be a physicians order in the electronic record. RN #8 sated, "Yes, there should be an order anytime the Coumadin is held." An interview was conducted with RN #8, the assistant director of nursing, on 8/6/19 at 3:12 p.m. When asked if staff were implementing the care plan if they failed to implement the documented interventions to give medication as ordered and to obtain laboratory tests as ordered, on the multiple occasions as documented above, RN #8 stated, "No, Ma'am." ASM #1, the administrator, ASM #2, the regional clinical coordinator, and ASM #3, the director of nursing were made aware of all of the above concerns on 8/6/19 at 5:19 p.m. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55 (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 450. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg	F656		

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F656	Continued From page 138 and Chapman, page 41. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682277.html (5) This information was obtained from the following website: This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3aproject=medlineplus&v%3asources=medlineplus-bundle&query=laboratory%20tests%20for%20PT%20calculation%20of%20INR&2. 7. The facility staff failed to implement the comprehensive care plan regarding the administration of oxygen to Resident #91 as ordered. Resident #91 was admitted to the facility on 6/20/19 with diagnoses that included but were not limited to: cancer and COPD (chronic obstructive pulmonary disease - a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1). The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 6/27/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating he was cognitively intact to make daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen while a resident in the facility.	F656		

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F656	Continued From page 139 a potential for difficulty breathing and risk for respiratory complications R/T (related to) dx (diagnosis) of COPD, requires O2." The "Interventions" documented in part, "Administer mediations & treatments per physician orders. Monitor for ineffectiveness, side effects and adverse reactions, report abnormal findings to the physician." Observation was made on 7/30/19 at 12:26 p.m. of Resident #91 in his bed, asleep with his oxygen on via a nasal cannula (a two-pronged tubing that inserts into the nose) connected to an oxygen concentrator. The oxygen concentrator was set at 3 LPM (liter per minute). A second observation was made of Resident #91 on 7/30/19 at 4:15 p.m. The oxygen was in use by the resident and the oxygen concentrator was set at 3 LPM. Observation was made on 7/31/19 at 8:38 a.m. and 1:25 p.m. of Resident #91 in his bed with his oxygen on via the nasal cannula. The oxygen concentrator was set at 3 LPM. Another surveyor verified this. The physician order dated, 7/26/19, documented, "O2 (oxygen) 2L/min (liters per minute) via NC (nasal cannula) every shift for shortness of breath. On 7/31/19 at 1:29 p.m., an interview and observation of Resident #91's flow rate was conducted with RN (registered nurse) #5, the unit manager. RN #5 was asked to view Resident #91's oxygen concentrator and state the flow rate of oxygen the resident was currently receiving. RN #5 observed the oxygen flow rate and stated, "It's [oxygen flow rate] set at 3 LPM [liters per minute]. I checked it this morning." RN #5 was asked to verify the	F656		

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F656	Continued From page 140 physician order for Resident #91's oxygen. RN #5 reviewed the Resident #91's physician orders for oxygen and stated, "He should be on 2 LPM." When asked the purpose of the care plan, RN #5 stated, "It lays out the plan of care while they (the residents) are here." When asked if the staff should follow and implement care plan interventions, RN #5 stated, "Yes." Administrative staff member (ASM) #1, the administrator, ASM #2, the regional clinical coordinator and ASM #3, the director of nursing, were made aware of the above concern on 8/2/19 at 2:00 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. 8. The facility staff failed to implement Resident # 71's care plan for the use of non-pharmacological interventions prior to the administration of as needed Tramadol (1). Resident # 71 was admitted to the facility on 06/21/2012 with a readmission on 01/02/2016, with diagnoses that included but were not limited to contracture (2), and paraplegia (3). Resident # 71's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/13/19, coded Resident # 71 as scoring a 13 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 13-being cognitively intact for making daily decisions. Section J coded Resident # 71 as having pain frequently. On 07/31/19 at 8:45 a.m., an interview was	F656		

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F656	Continued From page 141 conducted with Resident # 71. When asked if the staff assess her pain before giving her an as needed pain medication Resident # 71 stated, "Yes, they ask where it is and how bad it is." When asked if the staff try other methods to alleviate the pain before administering the pain medication Resident # 71 stated, "No, they give me my medicine when I need it." The comprehensive care plan for Resident # 71 dated 10/20/2017 documented, "Actual pain related to: muscle spastisity [sic] (4), bilateral foot drop (5) ankle contractures, paraplegia, gas/constipation. Date Initiated 10/20/2017. Revision on: 06/25/2019." Under "Interventions", it documented, "Instruct in relaxation techniques as needed and offer comfort measure such as: distraction, back rubs, slow breathing, change of position, etc. Date Initiated: 10/20/2017." The POS (physicians order sheet) dated "07/31/2019" for Resident # 71 documented, "Tramadol HCL (hydrochloride) F/C (film coated) 50MG (milligram) tablet Give 1 (one) tablet by mouth every 8 (eight) hours as needed for pain. Order date 02/27/2017, Start date 09/21/2017." The POS also documented, "Document non-pharmacological interventions prior to administering PRN (as needed) medication for pain. 1) Re-positioning, 2) Cold compress or ice pack 3) Warm compress 4) Massage 5) elevation 6) deep breathing or guided imagery as needed for pain document intervention number attempted. Order Date 07/24/2018 Start date 07/24/2018." The eMAR (electronic medication administration record) dated "Jun (June) 2019" documented the same physician orders as above in the POS. Review of the eMAR revealed administration of	F656		

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F656	Continued From page 142 Tramadol HCL (hydrochloride) F/C (film coated) 50MG on the following dates: On 06/03/19 at "19:00 (7:00 p.m.), 06/09/19 at 23:54 (11:54 p.m.), and on 06/30/19 at 14:08 (2:08 p.m.)." Further review failed to evidence documentation of non-pharmacological interventions for the dates listed above on the eMAR. Review of the nurse's progress notes and the eMAR notes dated 06/01/2019 through 06/30/2019 failed to evidence documentation of non-pharmacological interventions. The eMAR (electronic medication administration record) dated "Jul (July) 2019" documented the same physician orders as above. Review of the eMAR revealed administration of Tramadol HCL F/C 50MG on 07/23/19 at "23:49 (11:59 p.m.)." Further review failed to evidence documentation of non-pharmacological interventions for the date listed above on the eMAR. Review of the nurse's progress notes and the eMAR notes dated 07/01/19 through 07/31/19 failed to evidence documentation of non-pharmacological interventions. On 07/31/19 at 4:30 p.m., an interview was conducted with LPN (licensed practical nurse) # 17. LPN # 17 was asked to describe the procedure for the administration of prn (as needed) pain medication. LPN # 17 stated, "If the patient is in pain, first I try to use interventions, if they don't work then I give medication. I check back after intervention to see if it worked before giving the medication." When asked what she means by interventions LPN # 17 stated, "Interventions like positioning, creating a calm environment." When LPN #17 was asked if care plan	F656		

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F656	Continued From page 143 interventions state to instruct on non-pharmacological interventions should this instruction be documented, LPN # 17 stated, "Yes." When asked if staff is implementing the care plan if there is no documentation of the attempts for non-pharmacological interventions, LPN # 17 stated, "I guess not." After reviewing the POS (physician order summary) and eMAR (electronic medication administration record) for Resident # 71 dated June and July 2019 LPN # 17 stated that non-pharmacological interventions were not documented for the dates that prn Tramadol was administered. LPN # 17 stated that staff should documented if the resident refuses or if non-pharmacological interventions were attempted and refusals should be documented on the eMAR. On 8/01/19 at 12:30 p.m., an interview was conducted with ASM (administrative staff member) # 3, director of nursing, regarding the purpose of a care plan. ASM # 3 stated, "To let the nurse know how to care for the resident and let the resident communicate how they want to be cared for." When asked if a pain care plan contains an intervention to instruct on non-pharmacological interventions when would the staff be implement the intervention, ASM # 3 stated prior to giving prn (as needed) pain medications. When asked if staff are implementing the care plan if there are interventions on the care plan that are not being documented as completed, ASM # 3 stated "No." ASM # 3 reviewed the eMAR and POS dated June 2019 and July 2019 for Resident # 71 and stated that non-pharmacological interventions should have been documented as done or refused on the dates listed above when the prn pain medication was administered. On 08/02/19 at approximately 2:00 p.m., ASM	F656		

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F656	Continued From page 144 (administrative staff member) # 1, the administrator, ASM # 2, regional clinical coordinator and ASM # 3, director of nursing were made aware of the findings. No further information was provided prior to exit. References: 1. Tramadol- is in a class of medications called opiate (narcotic) analgesics is used to relieve moderate to moderately severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html 2. Contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This information was obtained from the website: https://medlineplus.gov/ency/article/003185.htm. 3. Paraplegia is the loss of muscle function in part of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html 4. Spasticity is a condition in which there is an abnormal increase in muscle tone or stiffness of muscle, which might interfere with movement, speech, or be associated with discomfort or pain. This information was obtained from the website: https://www.ninds.nih.gov/Disorders/All-Disorders/Spasticity-Information-Page 5. Foot drop is when you have difficulty lifting the front part of your foot. This information was obtained from the website: https://medlineplus.gov/ency/article/007761.htm	F656		

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F657 F657 SS=E	Continued From page 145 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 comprehensive and quarterly review assessments. 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 review and/or revise the comprehensive care plan for four of 72 residents in the survey sample, (Residents #93, #61, #70 and #59).	F657 F657	Ftag 657 Resident #93: Care plan has been updated and revised to reflect the incidents that occurred on 2/13/19 and 7/8/19. No negative outcome occurred as a result of this practice. Resident #61: Care plan has been updated and revised to reflect the incident that occurred on 7/8/19. No negative outcome occurred as a result of this practice. Resident #70: The fall intervention for 7/11 has been added to the care plan. No negative outcome occurred as a result of this practice. Resident # 59: The incentive spirometer has been discontinued and the care plan has been updated to reflect this change. No negative outcome occurred as a result of this practice. Residents currently residing in the facility have the potential to be affected. The DON or designee will educate licensed nursing staff on care plan revisions for fall interventions and incentive spirometer use and aggressive behaviors. The social services department will be educated on care planning abuse incidents/ allegations. The DON or designee will audit the care plans for resident FRIs that have occurred	9/20/19

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F657	Continued From page 146 The findings include: 1. a. The facility staff failed to review and/or revise Resident #93's comprehensive care plan, after an employee hit the resident was on 2/13/19. Resident #93 was admitted to the facility on 7/30/15. Resident #93's diagnoses included but were not limited to heart disease, high blood pressure and major depressive disorder. Resident #93's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/28/19, coded the resident's cognition as severely impaired. A FRI (facility reported incident) submitted from the facility to the SA (state agency) on 2/13/19 documented, "Report date: 2/13/19. Incident date: 2/13/19. Residents involved: (name of Resident #93). Injuries: No. Incident type: Allegation of abuse/mistreatment. Describe incident, including location, and action taken: Resident observed by nurse (LPN [licensed practical nurse]) sliding to floor. Nurse asked for assistance. Housekeeper quickly came into room & said, 'I can do this, no problem.' Nurse told her she needed appropriately trained staff & that she (housekeeper) could not assist. Housekeeper picked resident up off the floor and placed in chair as CNA (certified nursing assistant) arrived. (Name of Resident #93) struck the housekeeper & per resident & LPN, Housekeeper struck the resident back." The housekeeper was suspended, pending outcome of the investigation. A final report submitted from the facility to the SA on 2/18/19 documented, "To Whom It May Concern: Please accept this	F657	since survey exit. Care plans for residents who have fallen in the last 30 days will be audited for interventions. Care plans for residents who receive incentive spirometer treatment will be audited for accuracy. Corrections will be made as appropriate. DON or designee will monitor for any allegations of abuse, resident to resident behaviors, and care planning. DON or designee will review care plans for any new falls 5 days a week and ongoing. Nursing administration will monitor care plans for new incentive spirometer orders. Monitoring will occur 5 days a week for 1 week, 3 days a week for 2 weeks, weekly for 4 weeks, and monthly for 3 months. Any variances will be corrected and additional education or counseling will be provided as needed Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: September 20, 2019	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. BUILDING _____ B. WING _____	C 08/07/2019

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F657	Continued From page 147 final report in response to our initial facility report filed on February 13, 2019 and an allegation of abuse regarding resident (Resident #93). (Resident #93) is an 84-year-old Caucasian female who resides at the facility. Her diagnoses include: dementia with behaviors, HTN (hypertension [high blood pressure]), CAD (coronary artery disease), Ataxia (trouble coordinating movements), Hx (History) of MI (myocardial infarction [heart attack]), and Major Depressive Disorder. She has episodes of physically and verbally aggressive behavior, hitting staff, throwing objects, making paranoid statements, and placing herself on the floor. (Resident #93) has short and long term memory loss, her BIMS (Brief Interview for Mental Status) score is 6/15 (indicating severe cognitive impairment). On February 13, 2018 (sic), (LPN #19), reported that she witnessed (OSM #12), housekeeper, hit the resident. (OSM #12) was suspended pending investigation, the resident was assessed, and no injuries were observed. The LPN reported that the resident was being assisted to her chair from sitting on the floor. The resident allegedly hit the housekeeper and then witnessed the housekeeper hit her back. She was then removed from the situation. An interview was conducted with (CNA #8) who was present during the situation. She reports that the resident hit the housekeeper in the back and that she witnessed the employee 'swinging back' stating 'it happened so quick, it could have been a reflex.' An interview was conducted with (CNA #9); she reports not witnessing the resident being hit but hearing the sound of a 'second hit' as she was walking out of the room. An interview was conducted with (OSM #12), she reports that the resident hit her in the back and that a second attempt was made by the resident to hit her. She reports that during this time she put her arm up to block the resident from hitting	F657		

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F657	Continued From page 148 her again. Interviews were conducted with the resident and the roommate, but neither could not recall the incident. Based on interviews and witnesses to the incident, the facility can substantiate that the employee hit back at the resident. Despite the resident's extensive aggressive behavior history, the facility feels that the housekeeper could have responded differently to behaviors displayed, therefore employment has been terminated. The resident remains in the facility at this time, and has no recollection of the event..." Review of Resident #93's clinical record (including nurses' notes dated 2/13/19) failed to document information regarding the above incident. Review of Resident #93's comprehensive care plan dated 2/27/19 failed to reveal evidence that care plan was reviewed and/or revised after the 2/13/19 incident. On 8/5/19 at 3:44 p.m., an interview was conducted with RN (registered nurse) #8. RN #8 was asked if a resident's care plan should be reviewed and/or revised, after the resident is hit by an employee. RN #8 stated, "Yes." When asked why, RN #8 stated reviewing and revising the care plan may affect changes to the resident's care, to help the resident in the future. On 8/6/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. The facility policy titled, "Interdisciplinary Care Plan" documented, "4. Care plans are revised as dictated by change(s) in the guest's condition. Reviews are done at least quarterly..."	F657		

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F657	Continued From page 149 No further information was presented prior to exit. 1. b. The facility staff failed to review and/or revise Resident #93's comprehensive care plan after the resident slapped another resident on 7/8/19. Resident #93 was admitted to the facility on 7/30/15. Resident #93's diagnoses included but were not limited to heart disease, high blood pressure and major depressive disorder. Resident #93's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/28/19, coded the resident's cognition as severely impaired. A FRI (facility reported incident) submitted from the facility to the SA (state agency) on 7/10/19 documented, "Report date: 7/10/19. Incident date: 7/8/19. Residents involved: (Resident #93) (name of another resident). Describe incident, including action, and action taken: (Resident #93) slapped (name of another resident), unable to state why. No injuries noted..." Resident #93's comprehensive care plan dated 12/4/18 documented, "(Resident #93) has a (sic) actual behavior problem...She exhibits physical aggressive behaviors such as hitting out at others..." Further review of Resident #93's comprehensive care plan failed to reveal the care plan was reviewed and/or revised after the resident slapped the other resident on 7/8/19. On 8/5/19 at 3:44 p.m., an interview was conducted with RN (registered nurse) #8. RN #8 was asked if a resident's care plan should be reviewed and/or revised if the resident hits another resident. RN #8 stated, "Yes." When	F657		

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F657	Continued From page 150 asked why, RN #8 stated there could be a reason why a resident is aggressive and having behaviors at certain times. RN #8 stated the staff needs to document and review/revise the care plan because it helps staff plan care for the resident. On 8/6/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 2. The facility staff failed to review and/or revise Resident #61's comprehensive care plan after the resident was slapped by another resident on 7/8/19. Resident #61 was admitted to the facility on 5/7/11. Resident #61's diagnoses included but were not limited to muscle weakness, abnormal posture and Alzheimer's disease. Resident #61's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/5/19, coded the resident's cognition as severely impaired. A FRI (facility reported incident) submitted from the facility to the SA (state agency) on 7/10/19 documented, "Report date: 7/10/19. Incident date: 7/8/19. Residents involved: (name of another resident) (Resident #61). Describe incident, including action, and action taken: (name of another resident) slapped (Resident #61), unable to state why. No injuries noted..." Review of Resident #61's comprehensive care plan dated 12/21/17 failed to reveal the care	F657		

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F657	Continued From page 151 plan was reviewed and/or revised after the resident was slapped on 7/8/19. On 8/5/19 at 3:44 p.m., an interview was conducted with RN (registered nurse) #8. RN #8 was asked if a resident's care plan should be reviewed and/or revised if the resident is hit by another resident. RN #8 stated, "Yes." When asked why, RN #8 stated, "Because the care plan could help us. Maybe change her care, to help her in the future." On 8/6/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 3. The facility staff failed to revise the comprehensive care plan for Resident # 70 with interventions implemented after a fall that occurred on 07/11/2019. Resident # 70 was admitted to the facility 12/06/2018 with diagnoses, that included but were not limited to cerebral infarction (1), and muscle weakness (generalized). Resident # 70's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/15/19, coded Resident # 70 as scoring a 0 (zero) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 0- being severely impaired for making daily decisions. Resident # 70 was coded as requiring extensive to total assistance of one staff member for all ADLs (activities of daily	F657		

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F657	Continued From page 152 living). The progress notes dated 07/11/2019 19:00 (7:00 p.m.) documented "writer was in the room at 5:50pm giving roommate [sic] meds [medications] and noted that guest was not in the bed, on looking over guest [Resident #70] was noted lying on the floor on the left side of the bed, face down to the floor, r (right) arm tucked to her stomach, ...md (medical doctor) on call made aware at 6:15pm, order given to send guest to ER (emergency room), 911 was called who picked up guest at 6:40pm ...v/s (vital signs) 97.8 (temperature)-80 (pulse)- 18 (respirations)-119/69 (blood pressure)." On 08/01/19 at approximately 12:40 p.m., the facility fall investigation was reviewed with ASM # 3, director of nursing. The fall investigation report dated 07/11/2019 documented "found on left side of bed." The fall investigation documented "bilateral (one half) side rails to bed" as an immediate intervention for Resident # 70 dated 07/11/2019. Further investigation dated 07/12/2019 documented the addition of bed bolsters as a further intervention for Resident # 70. The comprehensive care plan for Resident #70 was reviewed and documented, "[Name of Resident (#70)] is at risk for fall related injury and falls R/T (related to): history of falls, Unaware of safety needs, dependent for transfers. Date initiated 12/19/2018 Revision on 06/24/2019." Further review of the care plan failed to evidence bolsters and side rails as interventions following the fall on 7/11/19 for Resident # 70. On 08/01/19 at 3:10 p.m., an interview was conducted with RN (registered nurse) # 4, MDS	F657		

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F657	Continued From page 153 (minimum data set) coordinator regarding care plans. When asked about the process for updating care plans, RN # 4 stated that care plans are updated on admission, as needed, when there are new orders, patient reviews and on discharge assessments. When asked if a fall is considered a reason to update the care plan, RN # 4 stated, "Yes, there should be an intervention added." RN # 4 reviewed Resident # 70's care plan and stated she would have to investigate to see if it was updated after the fall. On 08/01/19 at 4:20 p.m., RN # 4 confirmed that Resident # 70 fell on 07/11/19 and half side rails were added as an intervention. RN # 4 stated, "The care plan should have been updated, it needs to be revised." On 08/05/19 at approximately 07:30 a.m., an updated copy of the comprehensive care plan was submitted by ASM (administrative staff member) # 1, administrator. Review of the copy provided documented on the care plan "[Name of Resident (#70)] is at risk for fall related injury and falls R/T (related to): history of falls, Unaware of safety needs, dependent for transfers." Under "Interventions", it documented "Guest has bilateral half side rails date initiated 08/01/2019. Revision 08/04/2019." On 08/02/19 at approximately 2:00 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 2, regional clinical coordinator and ASM # 3, director of nursing were made aware of the findings. No further information was provided prior to exit. Reference: 1. cerebral infarction	F657		

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F657	Continued From page 154 A stroke occurs when blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm. 4. The facility staff failed to revise Resident # 59's care plan to include and reflect the use of an incentive spirometer as ordered by the physician. Resident # 59 was admitted to the facility on 05/22/2015 with diagnoses that included but were not limited to: shortness of breath and atelectasis (1). Resident # 59's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/09/19, coded Resident # 59 as scoring a eight on the brief interview for mental status (BIMS) of a score of 0 - 15, eight - being moderately impaired of cognition for making daily decisions. On 07/30/19 at 5:05 p.m., 07/31/19 at 7:40 a.m., 07/31/19 at 8:55 a.m., and at 3:06 p.m., observations of Resident # 59's room revealed an incentive spirometer uncovered sitting the over-the-bed table next to the resident's bed. The POS (physician's order sheet) for Resident # 59 dated July 2019 documented, "Incentive spirometer 10xhr (ten times per hour) while awake every shift for atelectasis for 30 days. Oder Date: 07/09/2019. End Date: 08/08/2019."	F657		

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F657	Continued From page 155 The comprehensive care plan for Resident # 59, with a revision date of 12/28/2018 failed to evidence documentation for the use of an incentive spirometer. On 07/31/19 at 3:08 p.m., an interview was conducted with RN (registered nurse) # 2, unit manager. When asked if an incentive spirometer was a piece of respiratory equipment, RN # 2 stated, "Yes." When asked to about the purpose of a resident's care plan, RN # 2 stated, "Goals for the patient and lets us know their orders specific to them and the different devises they may use." On 07/31/19 at 3:50 p.m., an interview was conducted with RN # 4, MDS coordinator regarding Resident # 59's care plan. When asked to describe the process for obtaining information for a resident's care plan, RN # 4 stated, "We get the information from the physician's orders, interdisciplinary team meeting, clinical operations meeting daily, direct observations anything from incident reports or documentation we come across." After reviewing Resident # 59's care plan for the use of an incentive spirometer, RN # 4 stated, "It's not there it should have been care planned." The facility's policy "Interdisciplinary Care Plan" documented, "4. Care plans are revised as dictated by change(s) in the guest's condition. Reviews are done at least quarterly." On 07/031/19 at approximately 6:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, and ASM # 3, regional clinical coordinator were made aware of the above findings. No further information was provided prior to exit.	F657		

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F657	Continued From page 156 References: (1) The collapse of part or, much less commonly, all of a lung. Atelectasis is caused by a blockage of the air passages (bronchus or bronchioles) or by pressure on the outside of the lung. This information was obtained from the website: https://medlineplus.gov/ency/article/000065.htm.	F657		
F658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) 483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of practice for transcribing physician directives into orders in the electronic clinical record for seven of 72 residents in the survey sample, Residents #189, #527, #45, #13, #129, #8, and #116. The facility staff failed to transcribe physician directives for Coumadin dose changes, and laboratory tests (PT [prothrombin]/INR [international normalized ratio]), into orders in the electronic health record (EHR), to ensure adequate monitoring and the safe administration of Coumadin (anticoagulant medication) to Residents #189, #527, #45, #13, #129, #8, and #116. The findings include:	F658	Ftag 658 Resident #189: No negative outcome occurred as a result of this practice. A stat PT/INR was ordered and a revised Coumadin log was initiated for the resident corresponding physician orders were transcribed into the EMR. Resident #527: Resident no longer resides at the facility. Resident #45: No negative outcome occurred as a result of this practice. A stat PT/INR was ordered and a revised Coumadin log was initiated for the resident corresponding physician orders were transcribed into the EMR. Resident #13: No negative outcome occurred as a result of this practice. A stat PT/INR was ordered and a revised Coumadin log was initiated for the resident corresponding physician orders were transcribed into the EMR. Resident # 129: Resident has discharged from the facility.	9/20/19

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F658	Continued From page 157 1. The facility staff failed to transcribe physician directives for Coumadin dose changes and laboratory test PI (prothrombin)/INR (international normalized ration) on the "Anticoagulant Record" into the electronic medical record on multiple dates for Resident #189. On 8/13/19 staff failed to transcribe the directed increase in Coumadin 5.5 mg into an order and onto the MAR and the resident received on 5 mg of Coumadin on 8/13 and 8/14/18. Resident #189 was admitted to the facility on 9/16/17, with a most recent readmission on 7/16/19 with diagnoses that included but were not limited to: mechanical heart valve, stroke, high blood pressure and atrial fibrillation. (Atrial fibrillation is a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria)(1). The most recent MDS (minimum data set) assessment, a Medicare five day admission, with an assessment reference date of 7/23/19, coded the resident as scoring a "11" on the BIMS (brief interview for mental status score) indicating the resident was moderately impaired to make daily decisions. In Section N - Medications, the resident was coded as receiving an anticoagulant for the seven days of the look back period. *Coumadin is an anticoagulant/blood thinner that keeps your body from forming blood clots. (2) The comprehensive care plan dated, 12/19/18 and revised on 3/7/19, documented in part, "Focus: (Resident #189) is at risk for abnormal bleeding/bruising R/T (related to) medication	F658	Resident #8: No negative outcome occurred as a result of this practice. A stat PT/INR was ordered and a revised Coumadin log was initiated for the resident corresponding physician orders were transcribed into the EMR. Resident #116: Resident no longer resides in the facility. Residents receiving Coumadin have the potential to be affected. The DON or designee will educate licensed nursing staff on the process for Coumadin management and transcription of orders into the EMR. The DON or designee will audit Coumadin logs and orders for residents receiving Coumadin for accuracy and completion. Nursing administration or designee will monitor Coumadin logs 5 days a week for 1 week, 3 days a week for 2 weeks, weekly for 4 weeks, and monthly for 3 months. Any variances will be corrected and additional education or counseling will be provided as needed Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facilitys quality assurance program. Additional education and monitoring will be initiated for any identified	

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F658	Continued From page 158 use, anticoagulant diagnosis of A-Fib (atrial fibrillation), stroke." The "Interventions" documented in part, "Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician. Obtain labs (laboratory) and diagnostics as ordered and report abnormal findings to the physician. Observe and report to physician PRN (as needed) s/sx (signs and symptoms) of complications: blood tinges/frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain , lethargy, bruising, blurred vision, SOB (shortness of breath), loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs - blood pressure, heart rate, respirations), bleeding gums, petechiae (tiny reddish or purple flat spot appearing on the skin as the results of tiny hemorrhages within the skin or subcutaneous layers) (3), back or abdominal pain and nosebleeds." The nurse practitioner note dated, 8/10/18, documented, "INR goal 2.5 - 3.5." "Prothrombin time (PT) is a blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot." "PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio)." "The most common reason to perform this test is to monitor your levels when you are taking a blood-thinning medicine called warfarin. You are likely taking this medicine to prevent blood clots. Normal Results: PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio). If you are taking warfarin to prevent blood clots, your provider will most likely, choose to	F658	concerns. Completion Date: September 20, 2019	

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F658	Continued From page 159 keep your INR between 2.0 and 3.0."(4) Resident #189's clinical record including physician orders, nurse practitioner notes, nurse notes, and the medication administration record (MAR) were reviewed from 7/19/18 through 7/29/19. Resident #189's "Anticoagulant Record" (a flow sheet used by the facility for monitoring Coumadin that was maintained separately from the clinical record with physician directives documented by the nurses and or physician that were not signed by the doctor) was reviewed from 7/19/18 through 7/29/19. The review revealed the following failure to transcribe physician directives from the anticoagulant record into the physician orders in the electronic medical record: The Anticoagulant Record dated, 7/19/18, documented the physician directive to "Hold (Coumadin) x (times) 2 d (days), recheck in 1 d." Review of the electronic medical record (EMR) failed to evidence a physician order to hold the Coumadin on 7/19/18 and 7/20/18. Review of the July 2018 MAR (medication administration record) revealed the resident did not receive any Coumadin on 7/19/18 and 7/20/18. The Anticoagulant Record dated, 7/20/18, documented the physician's directive to "Hold [Coumadin] x 2 d, recheck in 3 d [days]." Review of the electronic medical record (EMR) failed to evidence a physician order was transcribed to hold the Coumadin on 7/20/18 and 7/21/18. Review of the July 2018 MAR revealed the resident did not receive any Coumadin on 7/20/18 and 7/21/18. The "Anticoagulant Record" revealed the date 8/15/18 was written and crossed off and the date 8/13/18 was entered and documented the	F658		

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F658	Continued From page 160 physician directive, "Increase dose [Coumadin] to 5.5 mg recheck INR 8/17/18." There was no documented physician order transcribed into the EMR to increase the dose of Coumadin to 5.5 mg, and no order to recheck the INR on 8/17/18. Review of the August 2018 MAR documented the resident received Coumadin 5 mg on 8/13/18 and 8/14/18, instead of the 5.5 mg as documented under the physician directive above on anticoagulant log for 8/13/18. On the "Anticoagulant Record" dated, 8/27/18, the current Coumadin dose was documented as 5.5 mg, INR 5.8." Under "Action Taken By Physician" was documented, "Hold today, recheck 8/28/18. Review of the EMR failed to evidence a physician's order was transcribed to hold Resident #189's Coumadin on 8/27/18. Review of the August MAR revealed an "H" indicating, "Hold" documented on 8/27/18 for the 5.5 mg dose of Coumadin on that date. On 8/28/18, the "Anticoagulant Record", documented the physician directives, "Hold recheck 8/30/18." A nurse practitioner note dated, 8/28/18, documented in part, "On Coumadin: INR today 5.2. Hold Coumadin x 1 and recheck 8/29/18 The "Anticoagulant Record" dated 8/29/18, documented the current Coumadin dose as "HOLD," INR, 3.5." Under "Action Taken By Physician" it documented, "Hold x 1 d (8/29/18), start (Coumadin) 4 mg qd [everyday] (8/30/18) and recheck in 1 wk (week) (9/5/18)." A review of the EMR failed to evidence a physician's order was transcribed from the	F658		

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F658	Continued From page 161 "Anticoagulant Record" into the EMR to hold the Coumadin for Resident #189, for one day on 8/29/18, or an order for the physician's directive to start the Coumadin 4 mg on 8/30/18. The MAR for August 2018 failed to evidence that Resident #189 received any Coumadin on 8/30/18 and 8/31/18 per documented physician directive on the "Anticoagulant Record" dated 8/29/18. The September 2018 MAR failed to document the 8/29/18 physician's directive from the "Anticoagulant Record" for Coumadin 4 mg qd (every day) to start on 8/30/18. The MARs failed to evidence that Resident #189 received any Coumadin on 9/1/18, 9/2/18, 9/3/18, and 9/4/18. There were no nurse's note related to the Coumadin or PT/INR levels from 8/29/18 through 9/4/18. The next documented INR level was on 9/5/18 at 1.1 [below the identified goal level placing the resident at risk for the development of blood clots]. Review of the EMR failed to evidence any documentation related to the resident not receiving the Coumadin on the above dates. The nurse practitioner note dated 9/5/18, documented in part, "Sub therapeutic INR - 1.1 on 4 mg Coumadin daily...On Coumadin, INR 1.1 today. Will increase dose to 4.5 mg daily and recheck 9/7/18." The note failed to evidence any documentation regarding the resident not receiving Coumadin for six days on 8/30/18, 8/31/18, 9/1/18, 9/2/18, 9/3/18, and 9/4/18. Review of the February 2019 MAR documented the physician order for "Coumadin 5 mg by mouth in the evening." The MAR documented the resident received it as ordered every day of February except on 2/12/19. On 2/12/19, an "H"	F658		

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F658	Continued From page 162 was documented for that day. An "H" indicates to "Hold/See Nurse Note." The nurse's note dated, 2/12/19 at 11:14 a.m. documented, "Dialysis nurse called writer, reported that (name of doctor) with dialysis center has put in an order for guest to have tunneled catheter removed and replaced before next dialysis appointment. Per MD (medical doctor), hold Coumadin today only, and guest will be NPO (nothing by mouth) after midnight. Procedure is scheduled for 7 am at (initials of hospital)." Review of the EMR failed to evidence a physician order was transcribed to hold the Coumadin on 2/12/19. The Anticoagulant Record dated, 2/6/19, documented the physician directive to "Recheck [PT/INR] in 21 days." Review of the EMR failed to evidence a physician order to recheck the INR in 21 days (2/27/19). The Anticoagulant Record dated, 2/17/19, documented the PT/INR was completed on 2/27/19. The Anticoagulant Record dated, 2/27/19, documented the physician directive to "Recheck (PT/INR) in 1 wk (week) 3/6/19. The review of the EMR failed to evidence a physician order to recheck the PT/INR on 3/6/19." The Anticoagulant Record dated, 3/6/19, documented the PT/INR was completed on 3/6/19. The "Anticoagulant Record" dated, 5/8/19, failed to evidence documentation of the resident's current Coumadin dose. The INR was documented as 4.6. The action taken by physician directive documented, "Hold x 1 recheck 5/9/19." The nurse practitioner note dated, 5/8/19, documented in part, "Elevated INR of 4.6. Hold x 1 and recheck 5/9/19. Review of the EMR failed to evidence a	F658		

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F658	Continued From page 163 physician's order to hold the Coumadin on 5/8/19 was transcribed from the "Anticoagulant Record" into the EMR and onto the MAR (medication administration record). The May 2019 MAR documented "Coumadin 5.5mg" and on 5/8/19, the Coumadin was documented as administered when the physician directive on the "Anticoagulant Record" documented to hold it on 5/8/19. The "Anticoagulant Record" dated, 5/10/19, documented the resident's current Coumadin dose as "HOLD." The INR was documented as 4.7. The action taken by physician directive documented, "Hold today and recheck 5/11/19. There was no nurse's note dated, 5/10/19. There was no transcribed physician order in the EMR for the directive on the "Anticoagulant Record" to hold the Coumadin in the on 5/10/19. The May 2019 MAR documented an order for Coumadin 5.5.mg and documented the Coumadin was administered on 5/10/19, when the physician directive on the "Anticoagulant Record" documented to hold the Coumadin. On 8/1/19 at approximately 10:45 a.m., ASM #1 was asked to provide the anticoagulant policies. On 8/1/19 at approximately at approximately 2 p.m. ASM #1, the administrator provide the policy titled Anticoagulant Therapy. The facility policy titled, "ANTICOAGULANT THERAPY" (revised 10/10) failed to document any information regarding the anticoagulant records. The facility was not aware of or using a policy for the "Anticoagulant Record" which was maintained separately from the clinical record until it was full.	F658		

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F658	Continued From page 164 8/2/19 at 3:20 p.m., during a telephone call by the team coordinator with ASM #1, the administrator and ASM #2, (the regional clinical coordinator), ASM #2 stated that they had located a policy on the "Anticoagulation Record." On 8/5/19 at 2:30 p.m., an interview was conducted with ASM #1, ASM #2 and ASM #3. When asked if they were aware of the situation that was uncovered (regarding the ineffective process for the safe administration of Coumadin and monitoring), ASM #3 stated, "No. The nurses were not necessarily doing the process and they assumed the doctor was putting the orders in the system and the doctors assumed the nurses were putting the order in the EMR (electronic medical record)." An interview was conducted with ASM (administrative staff member) #7, the nurse practitioner for Resident #189 on 8/6/19 at 7:53 a.m. ASM #7 was asked what happens if changes need to be made based on the current INR. ASM #7 stated she writes the directive for the needed changes in the "Action Taken By Physician" column on the anticoagulant record, and then the nurse is supposed to check the record and write the orders for the needed changes. ASM #7 stated at times, she gives verbal directives then the nurses document the directives on the anticoagulant record. ASM #7 was asked if the directives written in the "Action Taken By Physician" column on the anticoagulant records have the full weight of a physician's order. ASM #7 stated, "Yes." ASM #7 was asked if she signs off on the directives the nurses write on the anticoagulant records. ASM #7 stated she does not sign the directives but she thought most of the time, the nurses take the directives and enter them as orders into	F658		

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F658	Continued From page 165 the computer system. ASM #7 stated the nurses take that information, and enter orders into the computer system for medication changes but as far as how the orders are entered into the system would be a question to ask the assistant director of nursing. An interview was conducted with RN (registered nurse) #8, the assistant director of nursing, on 8/6/19 at 3:12 p.m. When asked about the process for obtaining orders for Coumadin from the "Anticoagulant Record", RN #8 stated the nurse obtains the INR and documents it in the Anticoagulant Record. The nurse practitioner or physician will review the results and then write in the end column (Action Taken by Physician). The nurse is to then, transcribe what is documented in the "Action Taken by Physician" column regarding changes in the Coumadin dose and/or when the PT/INR is to be repeated, into the computer (EMR). Resident #189's "Anticoagulant Record," MARs and physician orders for the above dates were reviewed with RN #8. RN #8 stated, "Those orders should have been transcribed into the electronic medical record." When asked if there should be a physician's order to hold Coumadin and to repeat the PT/INR, RN #8 stated, "Absolutely." The facility policy titled, "MEDICATION ADMINISTRATION" documented, "All medications and treatments shall be initiated, administered, and/or discontinued in accordance with written physician orders (either written or per telephone order)..." The facility policy titled, "PHYSICIAN SERVICES" documented, "Attending physicians' responsibilities include, but are not limited to: 4. Prescribing a planned regimen of complete guest care based on the medical evaluation of	F658		

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F658	Continued From page 166 the guest's immediate and long term needs. 7. Writing and signing a progress note at the time of each visit and signing all physician's orders as well as other documents required by state and federal regulations..." On 8/6/19 at 10:18 a.m., ASM #2 was asked which professional standard of practice the facility follows. ASM #2 stated, "We follow our policies and use Lippincott." According to "Fundamentals of Nursing-Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. ASM #1, the administrator, ASM #2, the regional clinical coordinator, and ASM #3, the director of nursing were made aware of all of the above concerns on 8/6/19 at 5:19 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55 (2) This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682277.html (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 41. (4) This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-	F658		

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F658	Continued From page 167 3asources=medlineplus-bundle&query=laboratory%20tests%20for%20PT%20calculation%20of%20INR&2.No further information was provided prior to exit. 2. The facility staff failed to follow professional standards of practice for the transcription of physician orders for the monitoring and administration of Coumadin (1), a high-risk medication to Resident #527. The facility staff failed to transcribe the provider's directive to obtain a PT/INR (prothrombin time/international normalized ratio) (2) laboratory test on 7/20/19, and failed to transcribe a Coumadin dosage increase to 3 mg (milligram) to start on (7/17/19) from the Anticoagulant (3) Record to Resident #527's EHR (electronic health record). Staff failed to obtain a PT/INR on 7/20/19 and Resident #527 received only Coumadin 2 mgs on 7/18/19 and 7/21/19, instead of 3 mg. Additionally, the staff failed to clarify an unclear, incomplete directive from the physician/NP on the Anticoagulant Record on 7/15/19. Resident #527 was admitted to the facility on 7/12/19 with diagnoses including, but not limited to: broken rib, broken arm, broken hip which had been repaired by recent surgery, and a history of a DVT (deep vein thrombosis) (4) and PE (pulmonary embolism) (5). On the most recent MDS (Minimum Data Set), an admission assessment with an ARD (assessment reference date) of 7/19/19, Resident #527 was coded as being severely cognitively impaired for daily decision making, having scored 3 out of 15 on the BIMS (brief interview for mental status). In Section N of this assessment, she was coded as receiving an anticoagulant on all seven days of the look back period.	F658		

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F658	Continued From page 168 On 8/6/19 at 10:20 a.m., Resident #527 was observed in the therapy gym. Both arms were covered with clothing. There were no bruises or wounds visible on her hands. Resident #527's clinical record including physician orders, nurse practitioner notes, nurse notes, and the medication administration record (MAR) were reviewed. Resident #527's "Anticoagulant Record" (a flow sheet used by the facility for monitoring Coumadin that was maintained separately from the clinical record with physician directives documented by the nurses and or physician that were not signed by the doctor) was reviewed. The review revealed the following: On Resident #527's Anticoagulant Record dated 7/17/19. In the column "Current Anticoagulant Drug and Dose," the record documented "Warfarin 3 mg MWF (Monday, Wednesday, Friday); Warfarin 2 mg T TH S S (Tuesday, Thursday, Saturday, Sunday)." The resident's PT/INR was documented as "22.2/1.9." In the column "Action Taken by Physician," the record documented "3 mg QD (every day). Re [check] [PT/INR] 7/20."(6) A review of the EHR (electronic health record) for July 2019 for Resident #527 revealed no evidence that the PT/INR directed on the 7/20/19 Anticoagulant Record was done. This record review revealed no evidence that the recommendation to perform a PT/INR on 7/20/19 was transcribed as an order from the anticoagulant record into the EHR. Further review #527's EHR for July 2019 revealed no evidence that Resident #527's Coumadin dosage was increased to 3 mg daily as directed by the physician/NP on the	F658		

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F658	Continued From page 169 Anticoagulant Record for 7/17/19. By way of nurses' initials on these dates, the MAR (medication administration record) documented that Resident #257 received Coumadin 2 mg at 5:00 p.m. on 7/18/19 (Thursday), and 7/21/19 (Sunday) instead of 3 mg daily. A review of Resident #527's comprehensive care plan initiated on 7/12/19 revealed, in part, the following: "[Resident #527] is at risk for abnormal bleeding/bruising R/T (related to): medication use. Anticoagulant...Date Initiated 8/1/19. Created on 8/1/19...Will have no signs of active bleeding through next review...Administer medications as ordered ...Obtain labs [laboratory tests] and diagnostics as ordered and report abnormal findings to the physician." On 7/31/19 at 2:36 p.m., an interview was conducted with ASM (administrative staff member) #5 (Resident #527's physician at the facility). ASM #5 was asked why Coumadin must be monitored. ASM #5 stated Coumadin (levels) could quickly become out of control because the medication can variably react with food and other medications. ASM #5 stated this is why the medication has to be monitored. ASM #5 was asked how often PT/INRs should be obtained to monitor Coumadin and stated that depends on the patient and other variables. When asked where the staff document monitoring of Coumadin and PT/INRs, ASM #5 stated they are documented in the Coumadin book (anticoagulant record). When asked how orders for Coumadin changes and PT/INRs are communicated, ASM #5 stated those are written in the anticoagulant record and she does not write actual orders for those. On 8/1/19 at 8:55 a.m., ASM #6, a nurse practitioner, was interviewed. When asked about	F658		

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F658	Continued From page 170 the therapeutic INR range for a resident taking Coumadin for DVT prevention, she sated the said goal is usually 2 to 3. On 8/1/19 at 3:15 p.m., LPN (licensed practical nurse) #3 was interviewed. She stated she is a floor nurse who floats to various units, and that she usually works during the daytime shift (7:00 a.m. until 3:30 p.m.). She reviewed Resident # 527's Anticoagulant Records, providers' orders, MAR (medication administration record), TAR (treatment administration record), and laboratory administration record for July 2019. When asked if she saw evidence that the PT/INR had been obtained on 7/20/19 for Resident #527, she stated she could not. She stated the PT/INR "must not have been done" on 7/20/19. She stated she could identify her handwriting on both the 7/17/19 and the 7/22/19 Anticoagulant Record. She stated the recheck of the PT/INR was definitely not done on 7/20/19. LPN #3 stated it was not common practice for her to transcribe the directives from the Anticoagulant Record to a provider's order prior to this survey. She stated she now understands the facility's practice to require such an order. When asked if she saw evidence that the Coumadin had been increased to 3 mgs daily on 7/17/19, and that Resident #527 had received the Coumadin as ordered, LPN #3 said she could not. LPN #3 stated the flow sheet instructions were to give 3 mgs every day. She stated she would have discontinued the old order for Coumadin, and entered a new one for the new dosage. LPN #3 stated, "From what I see on the MAR, she did not get the 3 mgs every day until July 22nd." Since she was the nurse responsible for completing the Anticoagulant Record and making the changes in the orders, she stated, "I probably thought I had done it, but I just did not."	F658		

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F658	Continued From page 171 Further review of Resident #527's Anticoagulant Record revealed an entry on 7/15/19. In the column "Action Taken by Physician," the record documented "[Increase] Coumadin 3 mg q Re [check] in 2 d (days)." On 8/1/19 at 3:15 p.m., LPN #3 was interviewed. She reviewed Resident # 527's Anticoagulant Record. When asked about the physician directive for 7/15/19, she stated, "I can't make it out. They are illegible." When asked what was missing from the directive, LPN #3 stated, "It doesn't say how often to give the 3 milligrams. You have to know that." On 8/5/19 at 2:30 p.m., an interview was conducted with ASM #1, ASM #2 and ASM #3. When asked if they were aware of the situation that was uncovered (regarding the ineffective process for the safe administration of Coumadin and monitoring), ASM #3 stated, "No. The nurses were not necessarily doing the process and they assumed the doctor was putting the orders in the system and the doctors assumed the nurses were putting the order in the EMR (electronic medical record)." On 8/6/19 at 10:18 a.m. administrative staff member (ASM) #2, the regional clinical coordinator, was asked what standard of practice the facility follows for the monitoring of anticoagulants, ASM #2 stated, "We follow our policies and Lippincott." According to "Lippincott Manual Of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." According to Fundamentals of Nursing-	F658		

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F658	Continued From page 172 Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. Be sure to look for order duplications that could cause your patient to receive a medication in error...." On 8/6/19 at 11:15 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional clinical coordinator, and ASM #3, the director of nursing, were informed of these concerns. No further information was provided prior to exit. (1) "Warfarin (generic for Coumadin) is used to prevent blood clots from forming or growing larger in your blood and blood vessels. This information is taken from the National Institutes of Health website https://medlineplus.gov/druginfo/meds/a682277.html. "Coumadin: Maintaining Clotting Profiles: Prothrombin time (PT) and international normalized ratio (INR) are the coagulation tests used to monitor the anticoagulation effects of Coumadin. The patient's INR should be 2 to 3.5 times the control. Note: the desired levels of the INR are determined by the health care provider. Obtain PT/INR levels daily or as ordered. Coumadin dose will be adjusted to achieve the desired level of anticoagulation. Preventing Bleeding: Have on hand the antidotes to reverse anticoagulants being used: Warfarin-phytonadione (vitamin K, AquaMEPHYTON). Patient Education and Health Maintenance: Instruct patient about taking anticoagulants. Follow instructions	F658		

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F658	Continued From page 173 prescribed; if a dose is missed, do NOT double up dose". This information is taken from Lippincott Manual of Nursing Practice. (2) "Prothrombin time (PT) and the associated international normalized ratio (INR) are routinely tested to assess the risk of bleeding or thrombosis and to monitor response to anticoagulant therapy in patients." This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5569083/. (3) Anticoagulant - "Anticoagulant...which means that it thins the blood, preventing blood clots from forming." This information is taken from the National Institutes of Health website https://ghr.nlm.nih.gov/condition/warfarin-resistance. (4) "Thrombosis is the medical term for the formation of a blood clot in a blood vessel. In deep vein thrombosis (DVT), the blood clot forms in one of the larger, deeper veins that run through the muscles. Deep vein thrombosis usually occurs in the lower leg. This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/books/NBK425364/. (5)"A pulmonary embolism (PE) is a sudden blockage in a lung artery. It usually happens when a when a blood clot breaks loose and travels through the bloodstream to the lungs." This information is taken from the National Institutes of Health website https://medlineplus.gov/pulmonaryembolism.html.	F658		

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F658	Continued From page 174 necessitates frequent monitoring and dose adjustment to prevent fatal consequences of hemorrhages and recurrent venous thrombosis/pulmonary embolism from either over or under anticoagulation." This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2887034/ 3. The facility staff failed to transcribe the physician/NP (nurse practitioner) directive on 8/1/18 for a PT/INR (prothrombin time/international normalized ratio) (2) blood test to be performed in three weeks [8/22/18]. Failed to transcribe an increase in Resident #45's Coumadin dosage on 3/15/19 and 3/22/19, as directed by the physician/NP from the Anticoagulant Record to orders in the EHR. The facility staff failed to transcribe the provider's directive for PT/INR monitoring from the Anticoagulant Record to Resident # 45's EHR (electronic health record) on multiple dates in September and November 2018, and in January, February, March, and June of 2019. Additionally, the staff failed to clarify an unclear, incomplete directive from the physician/NP on the 8/1/18 and 9/4/18. Resident #45 was admitted to the facility on 12/14/13, with diagnoses that included, but not limited to, a history of a stroke, and the presence of a prosthetic (artificial) heart valve (4). On the most recent MDS (Minimum Data Set), a quarterly assessment with the ARD (assessment reference date) of 5/6/19, Resident #45 was coded as having no cognitive impairment for daily decision making, having scored 15 on the BIMS (brief interview for mental status). In section N of this assessment, he was coded as	F658		

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F658	Continued From page 175 having received an anticoagulant on all seven days of the look back period. On 8/6/19 at 10:15 a.m., Resident #45 was observed lying on his back in bed. His eyes were closed. There was no bruising and there were no wounds visible on his skin. Resident #45's clinical record including physician orders, nurse practitioner notes, nurse notes, and the medication administration record (MAR) were reviewed. Resident #45's "Anticoagulant Record" (a flow sheet used by the facility for monitoring Coumadin that was maintained separately from the clinical record with physician directives documented by the nurses and or physician that were not signed by the doctor) was reviewed. The review revealed the following: On Resident #45's Anticoagulant Record dated 8/1/18. In the column "Action Taken by Physician," the record documented the resident's PT/INR on 8/1/18 as 29.8/2.5. Under the "Action Taken by Physician", the following was documented, "[No change]. Re [check] [PT/INR] in 3." A review of Resident #45's nurses' note dated 8/2/18 revealed, in part, the following: "New order for Coumadin (sic) 5mg recheck PT/INR IN 3 WEEKS left message for RP (responsible party)." The next entry on the Anticoagulant Record was dated 8/22/18. There was no information in any of the columns for this date; the entire line was blank. On 9/4/18, in the "Action Taken by Physician," the record documented "No [change]. Re [check]."	F658		

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F658	Continued From page 176 A review of the EHR (electronic health record) for August 2018 for Resident #45 revealed no evidence that the PT/INR directed by the physician/NP on 8/1/18 on the Anticoagulation record, and documented in the 8/2/18 nurses' note, was ever completed on 8/22/18. This record review revealed no evidence that the physician/NP directive to perform a PT/INR on 8/22/18 was transcribed as an order into the EHR. A review of Resident #45's comprehensive care plan dated 11/23/17 revealed, in part, the following: "BLEED101: At risk for abnormal bleeding/bruising R/T (related to)anticoagulation use ...Date Initiated: 11/23/17. Created on 11/23/17...Will have no signs of active bleeding...Administer medications as ordered ...Obtain labs as ordered. Report abnormal findings to the physician." On 7/31/19 at 2:36 p.m., an interview was conducted with ASM (administrative staff member) #5 (Resident #45's physician at the facility). ASM #5 was asked why Coumadin must be monitored. ASM #5 stated Coumadin (levels) could quickly become out of control because the medication can variably react with food and other medications. ASM #5 stated this is why the medication has to be monitored. ASM #5 was asked how often PT/INRs should be obtained to monitor Coumadin and stated that depends on the patient and other variables. When asked where the staff document monitoring of Coumadin and PT/INRs, ASM #5 stated they are documented in the Coumadin book (anticoagulant record). When asked how orders for Coumadin changes and PT/INRs are communicated, ASM #5 stated those are written in the anticoagulant record and she does not write actual orders for those.	F658		

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F658	Continued From page 177 On 8/6/19 at 10:25 a.m., LPN (licensed practical nurse) #1 was interviewed regarding these findings. LPN #1 reviewed Resident #45's Anticoagulant Record, providers' orders, and laboratory test records for August 2018. When asked if she could find any evidence that Resident #45 received a laboratory test for PT/INR on 8/22/18, LPN #1 stated she could not. When asked if this was concerning for the patient, LPN #1 stated, "Oh yes. The PT and INR need to be done as they are written in the book (anticoagulant record)." When asked why this is important, she stated, "The patient's blood could be too thick or too thin. We have to know from the test." She stated that, in looking at the Anticoagulant Flow Sheet, it appeared that on 8/31/18, she was caring for Resident #45 and realized the 8/22/18 PT/INR had not been done, and she went ahead and performed the test on 8/31/18. When asked about the directive on the 9/4/18 entry, LPN #1 stated, "It's unclear. It doesn't say when it [Resident #45's PT/INR] should be rechecked. It needs to be clarified." Further review of Resident #45's Anticoagulant Record revealed an entry on 3/15/19. In the column "Current Anticoagulant Drug and Dose," the record documented, "3 mg." In the column "Action Taken by Physician," the record documented: "[Increase Coumadin] 3.5 mg (milligrams) QD (every day). Recheck [PT/INR] 3/22." A review of the nurse practitioner's note written by ASM #7 for Resident #45 dated 3/15/19 revealed, in part, the following: "INR: 1.9. DX (diagnosis): prosthetic heart valve. Previous Order Coumadin: 3 mg daily. New Order Coumadin: 3.5 mg. Recheck date: 3/22/19."	F658		

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F658	Continued From page 178 A review of Resident #45's EHR for March 2019 revealed no evidence that Resident #45's Coumadin dosage was increased to 3.5 mg daily as directed by the physician/NP on the Anticoagulant Record. The PT/INR results for the next test date, 3/22/19, were 20.5/1.7. A review of Resident #45's Anticoagulant Record revealed an entry on 3/22/19. In the column "Current Anticoagulant Drug and Dose," the record documented, "3.5 mg." In the column "Action Taken by Physician," the record documented: "[Increase Coumadin] 4 mg QD. Recheck [PT/INR] 4/3." A review of Resident #45's EHR for March 2019 revealed no evidence that Resident #45's Coumadin dosage was increased to 4 mg daily, as directed by the physician/NP on the Anticoagulant Record, until 3/27/19. The PT/INR results for the next test date, 4/3/19, were 32.9/2.7. Further review of Resident #45's March 2019 MAR (medication administration record) revealed, by way of nurses' initials on these dates, that the resident received Coumadin 3 mg by mouth each day from 3/15/19 through 3/26/19. The review of the MAR also revealed that the resident received Coumadin 4 mg daily from 3/27/19 through the end of the month. Further review of the EHR failed to reveal any evidence that the directives from the physician/NP referenced on 3/15/19 and 3/22/19 for Coumadin dose changes were transcribed from the Anticoagulant Record to the EHR as physician's orders. On 8/6/19 at 10:25 a.m., LPN #1 was interviewed regarding these findings. LPN #1	F658		

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F658	Continued From page 179 reviewed Resident #45's Anticoagulant Record, providers' orders, and MAR (medication administration record) for March 2019. When asked if she could find evidence to verify that Resident #45's Coumadin dosages were increased as directed in the Anticoagulant record on 3/15/19 and 3/22/19, LPN #1 stated she could not. When asked the significance of the lack of evidence, LPN #1 stated, "It looks like we missed these increases. I don't think the medication was given like it was supposed to be. I don't see anything else." A review of Resident #45's Anticoagulant Record revealed that on the following dates, that laboratory tests for PT/INR were performed: 9/4/18, 9/20/18, 11/15/18, 11/23/28, 1/24/19, 2/21/19, 3/15/19, 3/22/19, and 6/26/19. A review of Resident #45's EHR for the above referenced dates in 2018 and 2019 revealed no evidence that these tests were transcribed from the directives on the Anticoagulant Record to providers' orders in the EHR. On 8/6/19 at 10:18 a.m. administrative staff member (ASM) #2, the regional clinical coordinator, was asked what standard of practice the facility follows for the monitoring of anticoagulants, ASM #2 stated, "We follow our policies and Lippincott." On 8/6/19 at 10:25 a.m., LPN #1 was interviewed regarding these findings. LPN #1 reviewed, Resident #45's Anticoagulant Record, providers' orders, and MAR for the above referenced dates in 2018 and 2019. When asked if the directives on the Anticoagulant Record should be transcribed to a provider's order, she stated, "Well, that's not how we were doing it before [this survey], but I know it's how	F658		

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THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

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F658	Continued From page 180 we should have been doing it. We are doing it now." On 8/6/19 at 11:15 a.m., ASM #1, the administrator, ASM #2, the regional clinical coordinator, and ASM #3, the director of nursing, were informed of these concerns. No further information was provided prior to exit. 4. The facility staff failed to transcribe increases in Resident #13's Coumadin dosage to physician orders on 8/6/18, 8/16/18, and 8/27/18, as directed by the physician/NP (nurse practitioner) on the Anticoagulant (2) Record. The documented directive was for the facility to administer Coumadin to 3 mgs (milligrams) daily starting 8/6/18, Coumadin 3.5 mgs daily starting 8/16/18, and Coumadin 4.5 mgs daily starting 8/27/18. Resident #13 received only Coumadin 2 mg by mouth each day from 8/1/18 through 8/20/18, and Coumadin 4 mg daily from 8/21/18 through 8/30/18. The facility staff also failed to transcribe the provider's directive for PT/INR (prothrombin time/international normalized ratio)] (3) monitoring from the Anticoagulant Record to orders in Resident #13's EHR (electronic health record) on multiple dates in July, August, and September 2018, and in February, March, and May 2019. Resident #13 was admitted to the facility on 10/6/11, and most recently readmitted on 6/19/17, with diagnoses including, but not limited to cerebral palsy and history of DVT (deep vein thrombosis) (3) . On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/23/19, Resident #13 was coded as being cognitively intact for making daily decisions, having scored	F658		

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F658	Continued From page 181 15 out of 15 on the BIMS (brief interview for mental status). In Section N of this assessment, he was coded as receiving an anticoagulant on all seven days of the look back period. On 8/6/19 at 10:12 a.m., Resident #13 was observed lying in bed. His eyes were closed, his arms were outside the blanket, and the blanket was pulled up to his chin. There was no bruising or other wounds visible on his arms. Resident #13's clinical record including physician orders, nurse practitioner notes, nurse notes, and the medication administration record (MAR) were reviewed. Resident #13's "Anticoagulant Record" (a flow sheet used by the facility for monitoring Coumadin that was maintained separately from the clinical record with physician directives documented by the nurses and or physician that were not signed by the doctor) was reviewed. The review revealed the following: On Resident #13's Anticoagulant Record dated 8/6/18, in the column "Current Anticoagulant Drug and Dose," the record documented, "Coumadin 2 mg." In the column "Action Taken by Physician," the record documented, "Re [check] [PT/INR] 1 week. Increase Coumadin to 3 mg (milligrams). " A review of Resident #13's August 2018 EHR (electronic health record) revealed no evidence that Resident #13's Coumadin dosage was increased to 3 mg daily as directed by the physician/nurse practitioner on the Anticoagulant Record. The PT/INR results for the next test date, 8/16/18, were 21.3/1.8. (5) Further review of Resident #13's Anticoagulant Record revealed an entry on 8/16/18. In the	F658		

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F658	Continued From page 182 column "Current Anticoagulant Drug and Dose," the record documented. "Coumadin 3 mg." In the column "Action Taken by Physician," the record documented, "Re [check] [PT/INR] 8/20/18. [Increase Coumadin to] 3.5 [mg] QD (every day)." A review of Resident #13's August 2018 EHR revealed no evidence that Resident #13's Coumadin dosage was increased to 3.5 mg daily as directed by the physician/nurse practitioner on the Anticoagulant Record. The PT/INR results for the next test date, 8/20/18, were 19.8/1.7. Further review of Resident #13's Anticoagulant Record revealed an entry on 8/27/18. In the column "Current Anticoagulant Drug and Dose," the record documented, "Coumadin 4 mg." In the column "Action Taken by Physician," the record documented, "[Increase Coumadin to] 4.5 [mg]. Re [check] [PT/INR] 8/31/18." A review of Resident #13's August 2018 EHR revealed no evidence that Resident #13's Coumadin dosage was increased to 3.5 mg daily as directed by the physician/nurse practitioner on the Anticoagulant Record. The PT/INR results for the next test date, 8/31/18, were 74.2/6.2. By way of nurses' initials on these dates, a further review of Resident #13's August 2018 MAR (medication administration record) revealed that the resident received Coumadin 2 mg by mouth each day from 8/1/18 through 8/20/18. The MAR documented that the resident received Coumadin 4 mg daily from 8/21/18 through 8/20/18. This review of the resident's EHR for August 2018 revealed no evidence that the recommendations to increase the Coumadin	F658		

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F658	Continued From page 183 dosages on the Anticoagulant Record were transcribed as orders into the EHR. A review of Resident #13's comprehensive care plan dated 11/13/17 revealed, in part, the following: "BLEED101: At risk for abnormal bleeding/bruising R/T (related to)anticoagulation use ...Date Initiated: 11/13/17. Created on 11/13/17...Will have no signs of active bleeding ...Administer medications as ordered." On 7/31/19 at 2:36 p.m., an interview was conducted with ASM (administrative staff member) #5 (Resident #13's physician at the facility). ASM #5 was asked why Coumadin must be monitored. ASM #5 stated Coumadin (levels) can quickly become out of control because the medication can variably react with food and other medications. When asked how orders for Coumadin changes and PT/INRs are communicated, ASM #5 stated those are written in the anticoagulant record and she does not write actual orders for those. On 8/6/19 at 10:18 a.m. administrative staff member (ASM) #2, the regional clinical coordinator, was asked what standard of practice the facility follows for the monitoring of anticoagulants, ASM #2 stated, "We follow our policies and Lippincott." On 8/6/19 at 10:25 a.m., LPN (licensed practical nurse) #1 was interviewed regarding these findings. LPN #1 reviewed Resident #13's Anticoagulant Record, providers' orders, and MAR for August 2018. When asked if she could find evidence to verify that Resident #13's Coumadin dosages were increased as directed in the Anticoagulant record on 8/6/18, 8/16/18, and 8/27/18, she stated she could not. When asked the significance of the lack of evidence,	F658		

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F658	Continued From page 184 LPN #1 stated, "It looks like we missed these increases. I don't think the medication was given like it was supposed to be." A review of Resident #13's Anticoagulant Record revealed that on the following dates, PT/INR laboratory tests were performed: 7/5/18, 7/19/18, 8/6/18, 8/16/18, 8/20/18, 8/27/18, 9/2/18, 9/19/18, 2/16/19, 2/18/19, 3/25/19, and 5/20/19. A review of Resident #13's EHR for the above referenced dates in 2018 and 2019 revealed no evidence that these tests were transcribed from physician/NP directives on the Anticoagulant Record to providers' orders. On 8/6/19 at 10:25 a.m., LPN #1 was interviewed regarding these findings. LPN #1 reviewed Resident #13's Anticoagulant Record, providers' orders, and MAR for the above referenced dates in 2018 and 2019. When asked if the directives on the Anticoagulant Record should be transcribed to a provider's order, LPN #1 stated, "Well, that's not how we were doing it before [this survey], but I know it's how we should have been doing it. We are doing it now." According to Fundamentals of Nursing-Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. Be sure to look for order duplications that could cause your patient to receive a medication in error...." On 8/6/19 at 11:15 a.m., ASM #1, the administrator, ASM #2, the regional clinical	F658		

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F658	Continued From page 185 coordinator, and ASM #3, the director of nursing, were informed of these concerns. No further information was provided prior to exit. (1) "Warfarin (generic for Coumadin) is used to prevent blood clots from forming or growing larger in your blood and blood vessels." This information was taken from the National Institutes of Health website https://medlineplus.gov/druginfo/meds/a682277.html. "Coumadin: Maintaining Clotting Profiles: Prothrombin time (PT) and international normalized ratio (INR) are the coagulation tests used to monitor the anticoagulation effects of Coumadin. The patient's INR should be 2 to 3.5 times the control. Note: the desired levels of the INR are determined by the health care provider. Obtain PT/INR levels daily or as ordered. Coumadin dose will be adjusted to achieve the desired level of anticoagulation. Preventing Bleeding: Have on hand the antidotes to reverse anticoagulants being used: Warfarin-phytonadione (vitamin K, AquaMEPHYTON). Patient Education and Health Maintenance: Instruct patient about taking anticoagulants. Follow instructions carefully and take medications exactly as prescribed; if a dose is missed, do NOT double up dose." This information is taken from Lippincott Manual of Nursing Practice. (2) "Anticoagulant...which means that it thins the blood, preventing blood clots from forming." This information is taken from the National Institutes of Health website https://ghr.nlm.nih.gov/condition/warfarin-resistance.	F658		

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F658	Continued From page 186 the formation of a blood clot in a blood vessel. In deep vein thrombosis (DVT), the blood clot forms in one of the larger, deeper veins that run through the muscles. Deep vein thrombosis usually occurs in the lower leg." This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/books/NBK425364/ . (4) "Prothrombin time (PT) and the associated international normalized ratio (INR) are routinely tested to assess the risk of bleeding or thrombosis and to monitor response to anticoagulant therapy in patients." This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5569083/. (5) "The target levels of warfarin therapy are disease specific. A target therapeutic INR of 2.0 and 3.0 has long been considered as the safest range for DVT/PE. Achieving this range necessitates frequent monitoring and dose adjustment to prevent fatal consequences of hemorrhages and recurrent venous thrombosis/pulmonary embolism from either over or under anticoagulation." This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2887034/ 5. The facility staff failed to follow professional standards of practice for the transcription of physician orders for the monitoring and administration of Coumadin (1), a high-risk medication to Resident #129. The facility staff failed to transcribe the directive to hold /not	F658		

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F658	Continued From page 187 the EMR (Electronic Medical Record) and the MAR (Medication Administration Record), and as a result administered the Coumadin to Resident #129 on these dates. Warfarin (also known by the brand names Coumadin....) is a blood thinner prescribed to prevent and treat blood clots. Warfarin therapy may be prescribed for patients with certain types of irregular heartbeat, blood clots in the legs or lungs, and patients who have certain medical device implants such as artificial heart valves. Warfarin must be monitored to ensure it is working effectively and being used safely. Achieving the correct warfarin dosage can be difficult but is extremely important. If the dose of warfarin is too low, the patient is at risk of developing harmful blood clots. If the dose of warfarin is too high, the patient may be at risk of serious bleeding. An INR [International normal ratio] target range is set by a health care provider. It is typically between 2.0 and 3.0 for basic blood-thinning needs, though the range may vary based on a patient's specific conditions. An INR above the patient-specific target range may increase the risk of bleeding, while an INR below the target range may increase the risk of developing a blood clot. [1] Resident #129 was admitted to the facility on 6/25/19, diagnoses that included but are not limited to: acute embolism, [a clot that travels from the site where it formed to another location in the body where it can lodge in an artery at the new location and block the flow of blood there] (2) and thrombosis of unspecified deep veins of right lower extremity [a blood clot that forms in a vein deep in the body] (3), fracture of one rib, diabetes and hypertension. The MDS (minimum data set) assessment, a 14	F658		

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F658	Continued From page 188 day Medicare Payment assessment, with an ARD (assessment reference date) of 7/9/19, coded the resident as scoring a 6 out of 15 on the BIMS (brief interview for mental status) score, indicating severe cognitive impairment. In Section N- Medications, the resident was coded as receiving an anticoagulant for the seven days of the look back period. Resident #129's "Anticoagulant Record [A record maintained separately from the clinical record with physician directives documented by the nurses and or physician that were not signed by the doctor], and electronic record including physician order, physician and nurse practitioner notes, nurses notes and the MAR (medication administration record) was conducted. The comprehensive care plan dated 7/10/19, documented in part, "Need": (Resident #129) "is at risk for abnormal bleeding/bruising related to anticoagulant use Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician." A physicians order documented on the POS (physicians order sheet) for June 2019, documented, "Order Date: 6/25/19, 18:29 (6:29 P.M.) Communication Method: Phone, Order Summary: Coumadin Tablet 5MG (milligram) (Warfarin Sodium) Give 1 tablet by mouth in the evening related to ACUTE EMBOLISM AND THROMBOSIS OF UNSPECIFIED DEEP VEINS OF RIGHT LOWER EXTREMITY." On 7/5/19 Resident #129's "Anticoagulant Record" documented in part: "Current Anticoagulant Drug Dose: On hold, with results PT 39.3 INR 3.3; action taken by physician Take 4 mg (milligrams) qd (every day) and recheck on	F658		

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F658	Continued From page 189 Mon. (Monday [7/8/19])." There were physician orders transcribed into the electronic health record for the PT/INR laboratory test obtained on 7/5/19 and orders to decrease Resident #129's Coumadin to 4 mg on 7/5/19. The "Anticoagulant Record" documented in part; "7/8/19 Current Anticoagulant Drug Dose: Coumadin 4 mg with results PT 62.3 INR 5.2; action taken by physician hold x 2 days, recheck 7/10/19". There were physician orders in the electronic health record for the PT/INR laboratory test obtained on 7/8/19. The nurse practitioner's note on 7/8/19, documented in part "Right popliteal DVT (on Coumadin) 4mg QD-INR elevated today. Hold x 2 and recheck 7/10/19. No s/s of bleeding. Monitor closely". There were no orders transcribed into the electronic medical record to hold Resident #129's Coumadin for two days (7/8/19 and 7/9/19) as directed in the NP note above and on the anticoagulant record. A nurse practitioner's note on 7/9/19, documented in part, "Right popliteal DVT (on Coumadin) 4mg QD-held yesterday and today for elevated INR. recheck 7/10/19. No s/s of bleeding. Monitor closely". [Note the nurse practitioner documented that Coumadin was held on 7/8 and 7/9/19 when the MAR below documented the staff had administered Coumadin 4 mg to Resident #129 on these dates. In addition, there was an order transcribed to the electronic medical record to obtain a PT/INR test on 7/10/19.]	F658		

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F658	Continued From page 190 Review of the July 2019 MAR (medication administration record) for Resident #129 documented, "Coumadin Tablet 4 MG (warfarin Sodium) give 4 mg by mouth in the evening. The MAR further documented staff failed to hold the Coumadin on 7/8/19 and 7/9/19, per the physician's directive on the anticoagulant log and administered Coumadin 4 mg to the resident. The "Anticoagulant Record" documented in part; "7/10/19 Coumadin 4 mg with results PT 58.7 INR 4.9; action taken by physician hold x 2 days, recheck 7/12/19". An interview was conducted with LPN #1, the LPN for Resident #129, on 8/7/19 at 9:53 am. When asked about the process to monitor anticoagulation on newly admitted residents, LPN #1 stated, "I make a flow sheet for them to know their baseline and get a physician order to get PT/INR the next day". When asked if this is the policy and procedure for monitoring anticoagulation, LPN #1 stated, "No each person may have their own way. I'm saying what I do." [Note the facility did not have a policy for the use of the "Anticoagulant Record" at the time of the survey. A policy was not obtained until after the facility was notified of the concern.] When asked about the process followed for transcribing what is written on the log sheets into orders in the electronic medical record, LPN #1 stated, "I go to the book, take what is written, and enter it into the computer. I write myself a note so if I'm not near the logbook when the physician comes, I can provide them with the information. The above lack of orders transcribed into the electronic medical record to hold Resident #129's Coumadin for two days (7/8/19 and 7/9/19) as directed in the NP note	F658		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F658	Continued From page 191 above and on the anticoagulant record was reviewed and confirmed with LPN #1. LPN #1 stated we are now doing both the book and the EMR (electronic medical record) for documentation of results and all orders". On 8/6/19 at 10:18 a.m. administrative staff member (ASM) #2, the regional clinical coordinator, was asked what standard of practice the facility follows for the monitoring of anticoagulants, ASM #2 stated, "We follow our policies and Lippincott". According to "Lippincott Manual of Nursing Practice", pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate ...orders. c. Notify all involved medical and nursing personnel.... d. Document clearly." Administrative staff members (ASM) # 1, the administrator, (ASM) # 2, the regional clinical coordinator and (ASM) #3 the director of nursing, were made aware of the above concerns on 8/7/19 at 3:15 pm No further information was provided prior to exit. References: 1. This information was obtained from the webiste: https://www.fda.gov/medical-devices/vitro-diagnostics/warfarin-inr-test-meters 2. This information was retrieved from the following website: https://medlineplus.gov/ency/imagepages/18076.htm 3. This information was retrieved from the following website: https://medlineplus.gov/deepveinthrombosis.	F658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE