State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0123	A. BUILDING: _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WINCHESTER, LLC	110 LAUCK DR WINCHESTER, VA 22603

(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
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 01/07/20 through 01/09/20. One complaint (VA00047235 - unsubstantiated with no deficiencies), was investigated during the survey. Corrections are required for compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 60 bed certified facility was 55 at the time of the survey. The survey sample consisted of 28 current resident reviews and 4 closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-110. Management and administration. Cross reference to F623, F625 12VAC5-371-140. Policies and Procedures. Cross reference to F623, F625, F689, F695, F759, F760, F880 12VAC5-371-150. Resident Rights. Cross reference to F623, F625 12VAC5-371-180. Infection Control. Cross reference to F880 12VAC5-371-200. Director of nursing Cross reference to F759 and F760 12VAC5-371-210. Nurse staffing Cross reference to F759 and F760	F 001		

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

Electronically Signed [signature] Executive Director 1-31-2020

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F 001	Continued From page 1 12VAC5-371-220. Quality of Care Cross reference to F684, F695, F759, F760 12VAC5-371-250. Resident assessment and care planning. Cross reference to F684, F695 Care Planning 12VAC5-371-250 F cross reference F657 Infection Control 12VAC5-371-180 B6 cross reference F880 Nursing Services 12VAC5-371-220 B cross reference Ff695 Resident Assessment and Care Planning 12VAC5-371-250 F,G cross reference to F656	F 001		

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 01/07/20 through 01/09/20. The facility was found to be in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/07/20 through 01/09/20. One complaint (VA00047235-unsubstantiated with no deficiencies), was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 55 at the time of the survey. The survey sample consisted of 28 current Resident reviews and 4 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		

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

Electronically Signed [signature] Executive Director 1-31-2020

Any 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 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.

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain a resident's dignity for one of 32 residents in the survey sample, Resident # 6. The facility staff failed to provide privacy for Resident # 6's catheter, collection bag and urine inside the collection bag was visible from the hallway. The findings include:	F 550	F550 1. Resident #6 had a dignity bag placed on their catheter bag on 1/8/2020. 2. Residents with catheter bags have the potential to be effected. No additional catheters present in the facility at this time. 3. Staff to be re-educated on catheter care and privacy by the Director of Clinical Services (DCS) or designee by 02/15/2020. 4. The DCS/designee to complete the catheter monitoring tool for any resident's with catheters to ensure compliance is maintained three times a week for four weeks. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance 2/15/2020.	

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F 550	Continued From page 2 Resident # 6 was admitted to the facility on 07/02/19 with diagnoses that included but were not limited to: heart failure, stage 4 kidney disease and high cholesterol. Resident # 6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/22/19, coded Resident # 6 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. Resident # 6 was coded as requiring limited assistance of one staff member for activities of daily living. Section H "Bladder and Bowel" coded Resident # 6 as occasional incontinence of bladder and continent of bowel. On 01/07/20 at 1:17 p.m., observation revealed Resident # 6 lying in bed. Observation of the room from the hallway revealed a catheter collection bag hanging on the right lower portion of the bed. Observation of the catheter collection bag failed to evidence a privacy bag over the collection bag and urine inside the collection bag was visible from the hallway. On 01/07/20 at 2:46 p.m., observation revealed Resident # 6 lying in bed. Observation of the room from the hallway revealed a catheter collection bag hanging on the right lower portion of the bed. Observation of the catheter collection bag failed to evidence a privacy bag over the collection bag and urine inside the collection bag was visible from the hallway. On 01/07/20 at approximately 4:10 p.m., during an interview with Resident # 6, the resident was	F 550		

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F 550	Continued From page 3 informed of the observation of the catheter collection bag being visible from the hallway. When asked how it made them feel, Resident # 6 stated, "I wouldn't like everyone to be watching it." The POS [physician's order sheet] dated and signed by the physician on 12/27/19 for Resident # 6 documented, "Foley catheter for comfort measures." The comprehensive care plan for Resident # 6 dated of 01/06/2020 failed to evidence care and services for an indwelling catheter. On 01/08/2020 at 1:00 p.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked about the care of a catheter collection bag for Resident #6, LPN # 4 stated, "It should be positioned off the floor, below the resident's bladder and placed in a privacy bag." When informed of the above observations LPN # 4 stated that the catheter collection bag should have been placed in a privacy bag. When asked if it was dignified for a resident's catheter collection bag to be visible from the hallway LPN # 4 stated no. On 01/09/2020 at 11:14 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing, regarding Resident # 6's catheter collection bag not being covered. When informed of the above observations ASM # 2 agreed it was a dignity issue for Resident #6 and stated, "It should have been covered." On 01/08/2020 at approximately 5:50 p.m., ASM # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical	F 550		

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F 550	Continued From page 4 services and LPN # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit.	F 550		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		

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F 623	Continued From page 5 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 623	F623 1. On 1/9/2020 written notification was sent to Resident Representative and Ombudsman for resident #65. 2. All residents who transfer from the facility have the potential to be effected. Transfer/discharge quality review was completed on 1/23/2020 for all discharges since 1/1/2020. Follow-up based on findings. 3. Nursing staff re-educated on issuing the transfer notice and social worker staff re-educated on notifying the Resident Representative and Ombudsman of transfer by the DCS/designee by 2/15/2020. 4. DCS/designee to complete the transfer/discharge quality monitor for any discharges to ensure compliance is maintained weekly for four weeks. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance 2/15/2020.	

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F 623	Continued From page 6 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide the resident representative and Ombudsman with the required written notification of a hospital transfer for one of 36 residents in the survey sample; Resident #65. The facility staff failed to evidence that a written notification of a hospital transfer for Resident #65 on 12/10/19, was provided to the resident representative and Ombudsman. The findings include:	F 623		

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F 623	Continued From page 7	F 623		

Resident #65 was admitted to the facility on 12/9/19. Diagnoses included, but are not limited to, brain cancer, aphasia, convulsions, epilepsy, obesity, alcohol abuse, and adult failure to thrive. Due to the short amount of time, the resident was in the facility prior to the hospital transfer the MDS (Minimum Data Set) assessment had not been completed. The admission nursing assessment and admission nursing note dated 12/9/19, documented the resident was alert and oriented to person, place and time.

A review of the clinical record revealed that the resident went to the hospital on 12/10/19 and did not return to the facility. The record revealed a doctor's note about 12/11/19 that documented, "....past and current medical history of GBM (glioblastoma multiforme of brain (2)), seizure disorder, recurrent UTI (urinary tract infection) and history of craniotomy for GBM resection admitted with diagnosis of syncope, altered mental status with significant cognitive decline and possibly UTI. She underwent IV (intravenous) antibiotics, continue steroid, Vimpat (1) and follow up with oncology group for immunotherapy. She got transferred to SNF (skilled nursing facility) for PT/OT (physical therapy and occupational therapy) and 24 hour nursing care. She later had erratic behavior with combative nature and not safe for her and other residents, she was sent to ER (emergency room) for psych (psychiatric) admission."

On 1/8/20 at 2:25 PM in an interview with OSM #1 (Other Staff Member - the Director of Social Services), she stated that she usually sends a

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F 623	Continued From page 8	F 623		

notice to the family and the same notice is sent to the Ombudsman. OSM #1 stated that for Resident #65 she did not have the family and ombudsman notice for this hospital transfer. She stated she missed doing it.

A review of a "Notice of Transfer and Bed Hold Policy For residents transferring to ED or hospital" form that OSM #1 stated she sends out but did not in this case, documented:

The purpose of this letter is to inform you that after careful consideration, (resident name) was sent to an acute care medical center on (date). The transfer was necessary for (his/her) welfare and (his/her) medical needs could not be met in this facility. (Resident name) was transferred to (name of hospital and address.)

Notice of Bed Hold Policy:

You are being sent to the hospital today. If you are a Medicaid/Medicare resident and you are admitted to the hospital, Virginia Medicaid and Medicare does not pay to hold your bed. Whatever your payment source, unless the nursing home is paid to reserve the bed while you are in the hospital, the nursing home may move someone else into your room. However, even if the nursing home is not paid to hold your bed, you may have the right to return as soon as a bed is available in a semi-private room in this nursing home as long as you still need the services provided by this nursing home (and, if you are on Medicaid, you are eligible for Medicaid nursing home services.)

If the nursing home does not readmit you to the first available bed in a semi-private room when

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F 623	Continued From page 9 you are ready to leave the hospital - You have the right to appeal..... You may also file a complaint..... For help in filing an appeal or a complaint..... Bed Hold: If you wish to hold your bed at (facility) during your hospitalization, you will be responsible to pay privately for the room at the facilities per diem rate. Once you hold the bed, the only reason that you would not be able to be admitted to (facility) is if: 1. The level of care required is not provided at (facility) 2. The patient is judged by the physician to be of danger to themselves or others. 3. The resident at the time of readmission has an outstanding payment to the nursing home for which they are responsible. On 1/08/20 03:59 PM, in an interview with LPN #2 (Licensed Practical Nurse), when asked about the paper work provided to the hospital for a resident transfer, LPN #2 stated, "Facesheet, med [medication] list, bed hold, care plan, transfer form, SBAR (Situation, Background, Assessment, Recommendation) form, and DNR (Do Not Resuscitate)." When asked where staff document this information provided to the hospital, LPN #2 stated, "Usually documented on the transfer form or make a note of what was sent." Review of the clinical record revealed the "Nursing Home to Hospital Transfer Form" dated 12/10/19. This form did not document that written notification was provided to the resident	F 623		

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F 623	Continued From page 10 representative and Ombudsman. A review of the clinical record failed to reveal any nursing or social worker notes that documented that written notification was provided to the resident representative and Ombudsman. A review of the facility policy, "Transfer/Discharge Notification & Rights to Appeal" documented, "...Notice Before Transfer: Before a center transfers or discharges a resident the center must: *Notify the resident and resident representative(s) of the transfer or discharge and the reasons for the move in writing (in a language and manner they understand); *The Center must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman; *Record the reasons for the transfer or discharge in the resident's medical record. Timing of the Notice: Notice of transfer or discharge must be made 30 days prior to resident is transferred or discharged except when:....An immediate transfer or discharge is required by the resident's urgent medical needs....Notices must be made as soon as practicable before transfer or discharge. *Note: Notices to the ombudsman in these situations can be sent when practicable, such as a list of residents on a monthly basis..." On 1/8/20 at 5:50 PM, ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. References:	F 623		

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F 623	Continued From page 11 1. Vimpat - is used to treat seizures. Information obtained from https://medlineplus.gov/druginfo/meds/a609028.html 2. Glioblastoma is a malignant (cancerous) brain tumor that develops from a specific type of brain cell called an astrocyte. This information was obtained from the website: https://rarediseases.info.nih.gov/diseases/2491/glioblastoma	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for	F 625		

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F 625	Continued From page 12 hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. 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 provide a written bed hold notice upon a hospital transfer for 1 of 36 residents in the survey sample; Resident #65. The facility staff failed to evidence that a bed hold notice was provided upon Resident #65's hospital transfer on 12/10/19. The findings include: Resident #65 was admitted to the facility on 12/9/19. Diagnoses included, but are not limited to, brain cancer, aphasia, convulsions, epilepsy, obesity, alcohol abuse, and adult failure to thrive. Due to the short amount of time, the resident was in the facility prior to the hospital transfer the MDS (Minimum Data Set) assessment had not been completed. The admission nursing assessment and admission nursing note dated 12/9/19, documented the resident was alert and oriented to person, place and time. A review of the clinical record revealed that the resident went to the hospital on 12/10/19 and did not return to the facility. The record revealed a doctor's note about 12/11/19 that documented, "....past and current medical history of GBM (glioblastoma multiforme of brain (2)), seizure disorder, recurrent UTI (urinary tract infection) and history of craniotomy for GBM resection	F 625	F625 1. On 1/9/2020 written notification was sent to Resident Representative for resident #65. 2. All residents who transfer from the facility have the potential to be effected. Transfer/discharge quality review was completed on 1/23/2020 for all discharges since 1/1/2020. Follow-up based on findings. 3. Nursing staff re-educated on issuing the transfer notice and social worker staff re-educated on notifying the Resident Representative and Ombudsman of transfer by the DCS/designee by 2/15/2020. 4. DCS/designee to complete the transfer/discharge quality monitor for any discharges to ensure compliance is maintained weekly for four weeks. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance 2/15/2020.	

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F 625	Continued From page 13 admitted with diagnosis of syncope, altered mental status with significant cognitive decline and possibly UTI. She underwent IV (intravenous) antibiotics, continue steroid, Vimpat (1) and follow up with oncology group for immunotherapy. She got transferred to SNF (skilled nursing facility) for PT/OT (physical therapy and occupational therapy) and 24 hour nursing care. She later had erratic behavior with combative nature and not safe for her and other residents, she was sent to ER (emergency room) for psych (psychiatric) admission." On 1/08/20 03:59 PM, in an interview with LPN #2 (Licensed Practical Nurse), regarding residents transfers to the hospital and the paper work sent to the hospital, LPN #2 stated, "Facesheet, med [medication] list, bed hold, care plan, transfer form, SBAR (Situation, Background, Assessment, Recommendation) form, and DNR (Do Not Resuscitate)." When asked where staff document the paper work provided to the hospital, LPN #2 stated, "Usually documented on the transfer form or make a note of what was sent." Review of the clinical record revealed the "Nursing Home to Hospital Transfer Form" dated 12/10/19. This form did not document that bed hold notice was provided to the resident and or resident representative. A review of the clinical record failed to reveal any nursing or social worker notes that documented that the bed hold notice was provided to the resident and or resident representative on transfer to the hospital on 12/10/19.	F 625		

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F 625	Continued From page 14 On 1/8/20 at 2:25 PM in an interview with OSM #1 (Other Staff Member - the Director of Social Services), she stated that she usually sends a notice to the family and the same notice is sent to the Ombudsman. This form also contained information about bed holds. OSM #1 stated that for Resident #65 she did not have the family and ombudsman notice for this hospital transfer. She stated she missed doing it. A review of a "Notice of Transfer and Bed Hold Policy For residents transferring to ED [emergency department] or hospital" form that OSM #1 stated she sends out but did not in this case, documented: The purpose of this letter is to inform you that after careful consideration, (resident name) was sent to an acute care medical center on (date). The transfer was necessary for (his/her) welfare and (his/her) medical needs could not be met in this facility. (Resident name) was transferred to (name of hospital and address.) Notice of Bed Hold Policy: You are being sent to the hospital today. If you are a Medicaid/Medicare resident and you are admitted to the hospital, Virginia Medicaid and Medicare does not pay to hold your bed. Whatever your payment source, unless the nursing home is paid to reserve the bed while you are in the hospital, the nursing home may move someone else into your room. However, even if the nursing home is not paid to hold your bed, you may have the right to return as soon as a bed is available in a semi-private room in this nursing home as long as you still need the services	F 625		

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F 625	Continued From page 15 provided by this nursing home (and, if you are on Medicaid, you are eligible for Medicaid nursing home services.) If the nursing home does not readmit you to the first available bed in a semi-private room when you are ready to leave the hospital - You have the right to appeal..... You may also file a complaint..... For help in filing an appeal or a complaint..... Bed Hold: If you wish to hold your bed at (facility) during your hospitalization, you will be responsible to pay privately for the room at the facilities per diem rate. Once you hold the bed, the only reason that you would not be able to be admitted to (facility) is if: 1. The level of care required is not provided at (facility) 2. The patient is judged by the physician to be of danger to themselves or others. 3. The resident at the time of readmission has an outstanding payment to the nursinghome for which they are responsible. A review of the facility policy, "Transfer/Discharge Notification & Right to Appeal" did not include any criteria for the provision of a written Bed Hold notice. On 1/8/20 at 5:50 PM, ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey.	F 625		

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F 625	Continued From page 16 References: 1. Vimpat - is used to treat seizures. Information obtained from https://medlineplus.gov/druginfo/meds/a609028.html 2. Glioblastoma is a malignant (cancerous) brain tumor that develops from a specific type of brain cell called an astrocyte. This information was obtained from the website: https://rarediseases.info.nih.gov/diseases/2491/glioblastoma	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a	F 655		

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F 655	Continued From page 17 comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (II) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to develop a baseline care plan for the use of an incentive spirometer [1] for one of 32 residents in the survey sample, Resident # 163. The findings include: Resident # 163 was admitted to the facility on 01/03/2020 with diagnoses that included but were not limited to high blood pressure and chronic obstructive pulmonary disease [2]. The most recent MDS (minimum data set), Resident # 163 was not due at the time of the survey.	F 655	F655 1. The baseline care plan for resident #163 was updated to include incentive spirometer on 1/8/2020. 2. Audit of base line care plans to ensure they include incentive spirometer was completed by 1/10/2020. No other findings were noted. 3. Nursing staff will be re-educated by the DCS/designee on including incentive spirometer and other medical equipment on the care plan by 2/15/2020. 4. The DCS/designee to complete the care plan quality monitor for any residents with incentive spirometers and other medical equipment to ensure compliance is maintained weekly for four weeks. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance 2/15/2020.	

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F 655	Continued From page 18 The facility's "Admission Data Collection" sheet dated 01/03/2020 for Resident # 163 documented in part, "Cognition: Alert,. Oriented to Person." Under "Communication" it documented, "Usually Understood and Understands." Under "Respiratory", it documented, "Special Treatments and Procedures: None per history and/or observation." On 01/07/20 at 1:49 p.m., at 2:43 p.m., and at 4:05 p.m., observations of Resident # 163's over-the-bed table revealed an incentive spirometer. On 01/08/20 at 8:25 a.m., an observation of Resident # 163's over-the-bed table revealed an incentive spirometer. The POS [physician's order sheet] dated 01/01/2020 through 01/31/2020, signed by the physician on 01/04/2020 for Resident # 163 failed to evidence documentation for the use of an incentive spirometer. The facility's baseline care plan for Resident 163 dated 01/03/2020 failed to evidence documentation for the use of an incentive spirometer. On 01/08/20 at 8:30 a.m., during an interview conducted with Resident # 163, when asked if they used the incentive spirometer, Resident # 163 stated sometimes. On 01/08/2020 at 1:00 p.m., during an interview conducted with LPN [licensed practical nurse] # 4, when asked about a baseline care plan for the use of the incentive spirometer, LPN # 4 reviewed the baseline care plan for Resident # 163 and	F 655		

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F 655	Continued From page 19 stated that they could not locate one. On 01/08/20 at 1:43 p.m., an interview was conducted with LPN # 5, traveling MDS coordinator. LPN # 5 stated there was no physician order for Resident # 163's incentive spirometer. LPN # 5 further stated that they had spoken to Resident # 163's nurse practitioner and that Resident # 163 would benefit from the use of the incentive spirometer. LPN # 5 stated they would obtain a physician's order for prn [as needed] use of an incentive spirometer and update the plan of care. On 01/08/2020 at approximately 2:00 p.m., LPN # 5 provided this surveyor with a copy of Resident # 163's revised baseline care plan. The baseline care plan documented, "Altered Cardiac/Resp [Respiratory] Functioning. Encourage use of incentive spirometer PRN (as needed) 1/8/20"." The facility policy "Plans of Care" documented in part the following: "Procedure: Develop and implement an Individualized-Person-Centered baseline care plan within 48 hours of admission that includes, but not limited to, initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, PASARR [Preadmission Screening and Resident Review] recommendations, if applicable, and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the Comprehensive plan of care is completed." On 01/08/2020 at approximately 5:50 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM #	F 655		

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F 655	Continued From page 20 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit. References: [1] A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm. [2] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		

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F 656	Continued From page 21 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, record review, resident interview, staff interview, clinical record review and facility document review it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for six of 32 residents in the survey sample, Residents #47, 41, 61, 37, 3, and 25. The comprehensive care plan for Resident #47, failed to evidence documentation for as needed use of oxygen. The facility staff failed to include the use of an incentive spirometer when they developed Resident #41's comprehensive care plan for altered respiratory status, dated 1/7/20, and failed to develop the comprehensive care plan for care	F 656	F656 1. The care plan for residents #41 was updated to include incentive spirometer on 1/8/2020. The care plan for resident #41 was updated to include the diagnosis of diabetes and interventions on 1/8/2020. Resident #61 was issued scoop mattress and falls mats as fall interventions and the scoop mattress was added to the residents care plan on 1/8/2020. The oxygen flow rate for residents #3 and #25 was adjusted by the nurse to physician ordered flow rate on 1/8/2020. Oxygen saturation levels to be documented on resident MAR and TAR as indicated. Nurses responsible for resident #37s care were re-educated on the policy on medication administration of blood pressure medication on 1/8/2020.The care plan for resident #47 was updated to reflect oxygen prn on 1/8/2020.	

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F 656	Continued From page 22 and services of the resident's disease process of diabetes. The facility staff failed to include an intervention of a scoop mattress on Resident #61's comprehensive care plan that the facility determined was a required intervention, after a fall on 12/29/19; and failed to follow the care plan for the use of fall mats after a fall on 12/29/19. The facility staff failed to implement the comprehensive care plan for the administration of blood pressure medications to Resident #37. The facility staff failed to implement resident # 3's and Resident #25's comprehensive care plan for the administration of oxygen. The findings include: 1. Resident #47 was admitted to the facility 12/13/2019 with diagnoses, that included but were not limited to congestive heart failure (1), pneumonia (2) and chronic obstructive pulmonary disease (3). Resident #47's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/19/19, coded Resident #47 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section O of the MDS documented Resident #47 as receiving oxygen therapy while a resident of the facility. On 1/7/19 at approximately 2:30 p.m., an interview was conducted with Resident #47. Observation of Resident #47's room revealed an oxygen concentrator located on the right side of the bed with a nasal cannula (oxygen delivery device) in a plastic bag and a prefilled humidifier bottle of sterile water dated 12/23/19. When	F 656	2. Audit of care plans to ensure they include incentive spirometer, diabetes diagnosis and interventions, scoop mattresses and physician ordered oxygen usage was completed by 1/10/2020. Review of resident's with fall mats and scoop mattresses was conducted on 1/9/2020 no other findings were noted. Observation of oxygen usage to ensure it reflects physician's orders was completed on 1/31/2020. Follow up based on findings. Observation of medication administration will be completed for nursing staff to ensure the policy on medication administration is followed by 2/15/2020. Follow up based on findings. 3. Nursing staff will be re-educated on including incentive spirometer, diabetes diagnosis and interventions and	

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F 656	Continued From page 23 asked about the oxygen, Resident #47 stated that she did not use it currently. Resident #47 stated that she used her oxygen when she first came into the facility in the middle of December but had not used it recently but it was there in case she felt that she needed it. The order summary report dated 01/01/20 through 01/31/20 documented, "12/14/19 Oxygen @ (at) 2 (two) LPM (liters per minute) via (by way of) N/C (nasal cannula) to maintain sats (oxygen saturations) > (greater than) 92%." The MAR (medication administration record) dated "December 2019," and "January 2020" for Resident #47 failed to evidence documentation of oxygen for Resident #47. The TAR (treatment administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen for Resident #47. The baseline care plan dated "12/15/19" for Resident #47 documented "Altered Cardiac/Resp. (respiratory) functioning)". Under "Interventions:" it documented in part, "O2 (oxygen) therapy as ordered, Monitor O2 saturation as ordered." The baseline care plan further documented, "Below are signatures and dates signifying the final review of the baseline care plan with transition to the Comprehensive Care Plan," signed by [Name of registered nurse] and [Name of Resident #47], dated "12/30/19." The baseline care plan further documented in part, "This baseline care plan will be effective until the development of the Comprehensive Care Plan, which will supersede the baseline care plan. This document will remain a part of the resident's	F 656	clarifying oxygen usage on the care plan, and administering oxygen and blood pressure medication per the plan of care by 2/15/2020 by the DCS/designee. An in-service for staff will be conducted by 2/15/2020 on implementing fall mats and scoop mattresses as care planned by the DCS/designee. 4. The DCS/designee to complete the care plan quality monitor for any residents with incentive spirometer, fall mats, scoop mattresses, diabetes diagnosis and interventions, blood pressure medications and oxygen usage to ensure compliance is maintained weekly for four weeks. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance 2/15/2020.	

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F 656	Continued From page 24 permanent record." The comprehensive care plan for Resident #47 failed to evidence documentation for as needed use of oxygen. On 1/08/20 at 04:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked the purpose of the care plan, LPN #2 stated that it lets you know how to take care of the patient. When asked when care plans are completed, LPN #2 stated that new admissions have baseline care plans completed in 24 hours and then the MDS (minimum data set) staff update them. LPN #2 stated that when new orders are received or changes occur that new interventions are added to the care plan. When asked if oxygen should be on the comprehensive care plan, LPN #2 stated that it should. On 1/8/20 at 5:25 p.m., an interview was conducted with LPN #6, MDS (minimum data set) coordinator. When asked the purpose of the comprehensive care plan, LPN #6 stated that it is used to drive the plan of care of the resident. When asked if oxygen should be on the comprehensive care plan for a resident, LPN #6 stated that it should be. When asked if the oxygen is ordered and available for use in the resident's room should it still be on the care plan LPN #6 stated, "Yes." When asked about the care plan for Resident #47 for oxygen administration as needed, LPN #6 stated that she did not see one in the record for Resident #47. On 1/9/20 at 9:45 a.m., an interview was conducted with LPN #5, traveling MDS coordinator. When asked how long the baseline care plan is effective for residents, LPN #5 stated	F 656		

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F 656	Continued From page 25	F 656		

that they are good for 21 days or until the comprehensive care plan is completed. LPN #5 stated that when the comprehensive care plan is completed it supersedes the baseline care plan and it is kept on the record as a reference afterwards.

On 01/09/20 at approximately 12:30 p.m., a request was made by written list to ASM (administrative staff member) #1, the executive director for the facility policy on developing and implementing the care plan.

On 01/20/20 at approximately 1:30 p.m., ASM (administrative staff member) #2, the director of nursing stated that the facility uses their policies, Lippincott, and Potter & Perry as their standard of practice.

The facility policy "Plans of Care, Effective Date: 11/30/2014; Revision Date: 09/25/2017" documented in part, "Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment."

According to Potter, Patricia A., & Perry, Anne Griffin. (2005). Fundamentals of Nursing, sixth Edition, St. Louis, MO: Mosby, Inc. Page 327, "A nursing care plan is a guide for clinical care. It also serves as a document that communicates a client's nursing care to all members of the health care team. It is made available to the team as a ready reference for nursing care interventions."

On 01/08/20 at approximately 5:50 p.m., ASM (administrative staff member) #1, the executive

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F 656	Continued From page 26 director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and LPN (licensed practical nurse) #5, the travelling MDS coordinator were made aware of the findings. On 1/9/20 at approximately 8:00 a.m., ASM (administrative staff member) #3, the regional director of clinical services provided a copy of "Physician's Interim/Telephone Orders" for Resident #47, which documented, "DC (discontinue) O2 (oxygen), Duonebs (nebulizer medication) & (and) IS (incentive spirometer)" dated "1/8/20, 1610 (4:10 p.m.)." ASM #3 also provided a copy of the baseline care plan for Resident #47 as documented above. No further information was provided prior to exit. Reference: 1. Congestive heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. This information was obtained from the website: https://medlineplus.gov/heartfailure.html 2. Pneumonia - An infection in one or both of the lungs. This information was obtained from the website: https://medlineplus.gov/pneumonia.html. 3. Chronic obstructive pulmonary disease (COPD) is a disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 2a. The facility staff failed to include the use of an Incentive Spirometer when they developed Resident #41's comprehensive care plan for	F 656		

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F 656	Continued From page 27 altered respiratory status, dated 1/7/20. Resident #41 was admitted to the facility on 8/7/19; diagnoses include, but are not limited to, hydrocephalus, psychotic disorder, right kidney cancer with removal of kidney, cardiac defibrillator, high blood pressure, atrial fibrillation, diabetes, bipolar disorder, spinal stenosis with fusion, and cerebral palsy. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/21/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, toileting, dressing, and transfers; supervision for eating and hygiene; and was incontinent of bowel and bladder. A review of the facility policy, "Plans of Care" documented, "....Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment....The individualized Person Centered plan of care may include but is not limited to the following: Resident's strengths and needs; Services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...." A review of the comprehensive care plan revealed one dated 1/7/20 for "(Resident #41) has altered respiratory status/difficulty breathing r/t (related to) Wheezing." This care plan failed to reveal the use of the Incentive Spirometer. On 1/07/20 at 12:10 PM, an observation was made of Resident #41's room. Resident #41 was	F 656		

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F 656	Continued From page 28 not in the room. An Incentive Spirometer was observed on the over bed table. On 1/08/20 at 8:52 AM, the resident was observed inn bed. The Incentive Spirometer remained as previously observed. On 1/08/20 at 1:00 PM, the Resident #41 was observed, and an interview was conducted. The over bed table was across the resident. The incentive spirometer was on the table. Resident #41 stated that he has used it on occasion. On 1/8/20 at 1:07 PM in an interview with RN #1 (Registered Nurse), she stated that there should be an order for the use of the Incentive Spirometer. RN #1 stated that the residents "come in with them from the hospital." On 1/8/19 at 4:04 PM, during in an interview with LPN #2 (Licensed Practical Nurse), when asked about the purpose of a comprehensive care plan, LPN #2 stated, "so that we know how to take care of the patient." When asked if a resident's conditions, treatments, medications, etc., should be care planned, LPN #2 stated, "Yes." On 1/8/19 at 3:13 PM, in an interview with RN #1, she stated that it (Incentive Spirometer) should have been care planned when he came back from the hospital with it on 12/28/19. RN #1 stated that he would benefit from using it since he has been treated for respiratory issues since 1/6/20. On 1/8/20 at 5:50 PM, ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided	F 656		

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F 656	Continued From page 29 by the end of the survey. 2b. The facility staff failed to develop the comprehensive care plan for care and services of the Resident #41's disease process of diabetes. On 1/08/20 at 8:52 AM, RN #1 (Registered Nurse) was observed preparing and administering the following medications to Resident #41: Clonidine (1) 0.1 mg (milligrams), 1 tablet Metoprolol (2) 100 mg, 1 tablet Metformin (3) 500 mg, 1 tablet Depakote (4) ER (extended release) 500 mg, 1 tablet Accupril (5) 20 mg, 1 tablet Folic Acid (6) 1 mg, 1 tablet Azithromycin (7) 250 mg, 1 tablet Prednisone (8) 20 mg, 1 tablet Mucinex (9) 600 mg, 1 tablet (as needed) Upon record review, the following medications were also noted as being ordered but were not prepared and administered to Resident #41: Multivitamin (10), 1 tablet daily. Vitamin D (11) 25 mcg (micrograms) (1000 units), daily. Glimepiride (12) 4 mg tablet daily. The comprehensive care plan was reviewed in relation to the resident's diagnosis of diabetes and the administration of his diabetic medications (Metformin and Glimepiride, specifically the Glimepiride; that was not administered as ordered). There was no documented comprehensive care plan developed for the	F 656		

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F 656	Continued From page 30 provision of care and services related to the resident's diabetes. On 1/8/20 at 4:04 PM, in an interview with LPN #2 (Licensed Practical Nurse), when asked about the purpose of a comprehensive care plan, LPN #2 stated, "so that we know how to take care of the patient." When asked if a resident's conditions, treatments, medications, etc., should be care planned, LPN #2 stated, "Yes." On 1/9/20 at 1:07 PM, ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. References: 1. Clonidine - is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682243.html 2. Metoprolol - is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682864.html 3. Metformin - is used to treat diabetes Information obtained from https://medlineplus.gov/druginfo/meds/a696005.html 4. Depakote ER - is used to treat bipolar disorder Information obtained from https://medlineplus.gov/druginfo/meds/a682412.h	F 656		

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F 656	Continued From page 31 tml 5. Accupril - is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a692026.html 6. Folic Acid - helps the body make healthy new cells. Information obtained from https://medlineplus.gov/folicacid.html 7. Azithromycin - is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a697037.html 8. Prednisone - reduces swelling and redness by changing the way the immune system works. Information obtained from https://medlineplus.gov/druginfo/meds/a601102.html 9. Mucinex - is used to relieve chest congestion. Information obtained from https://medlineplus.gov/druginfo/meds/a682494.html 10. Multivitamin - used to treat or prevent vitamin deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health. Information obtained from https://www.webmd.com/drugs/2/drug-18820-9038/multivitamin-oral/multivitamins-includes-prenatal-vitamins-oral/details 11. Vitamin D - Vitamins are substances that	F 656		

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F 656	Continued From page 32 your body needs to grow and develop normally. Vitamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems. Information obtained from https://medlineplus.gov/vitamind.html 12. Glimepiride - is used to treat diabetes. Information obtained from https://medlineplus.gov/druginfo/meds/a696016.html 3. The facility staff failed to include an intervention of a scoop mattress on Resident #61's comprehensive care plan that the facility determined was a required intervention, after a fall on 12/29/19; and failed to follow the care plan for the use of fall mats after a fall on 12/29/19. Resident #61 was admitted to the facility on 12/23/19; diagnoses include but are not limited to, dementia with behaviors, panic disorder, thyroid disorder, restless leg, anxiety disorder, high blood pressure and delirium. The admission / 5-day MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 12/29/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, toileting, and eating; extensive assistance for ambulation and transfers; and was coded as incontinent of bowel and bladder. A review of the clinical record revealed a nurse's note dated 12/29/19 at 6:30 AM that documented,	F 656		

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F 656	Continued From page 33 "Resident yelling out "help me!" Found on floor in sitting position. MAEW (moves all extremities well), vital signs obtained, neuro (neurological) checks initiated. NP (nurse practitioner), son, and RP (responsible party) notified." A review of a fall investigation dated 12/29/19 documented that the resident stated she had to go to the bathroom but did not ask for help. An Interdisciplinary Team (IDT) meeting note dated 12/30/19 documented, "IDT met to discuss/review resident's fall on 12/29/19. Found sitting on (R) (right) side of bed in floor in sitting position. No injuries. B+B (bowel and bladder), med [medication] review. No further recommendations at this time." An Interdisciplinary Team meeting note dated 1/3/20 documented, "IDT met to discuss/review 60 day look back on falling last 30 days. B+B, med review. No further recommendations at this time." An Interdisciplinary Team meeting note dated 1/6/20 documented, "IDT met to discuss/review fall on 1/3/20 (note: there was no fall noted on 1/3/20. Note refers to the IDT note dated 1/3/20). Found laying (Sic.) on floor beside bed. No injuries. Fall mats, scoop mattress. No further recommendations." On 1/08/20 at 9:57 AM, Resident #61 was observed in bed asleep. There were no fall mats next to the resident's bed and no scoop mattress observed on the bed. A review of the comprehensive care plan dated 12/30/19 for "(Resident #61) has had an actual	F 656		

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F 656	Continued From page 34 fall with no injury r/t (related to) poor balance, poor communication/comprehension." This care plan included the intervention, dated 12/30/19 for "Fall mats on both sides of bed." The care plan did not include any intervention for the scoop mattress. On 1/09/20 at 10:46 AM, LPN #3 (Licensed Practical Nurse) was asked about the fall mats and scoop mattress for Resident #61. She stated that she was not aware the resident was to have fall mats and a scoop mattress. At this time, she checked on Resident #61 and verified that there were no fall mats or scoop mattress in place. When asked about implementing these interventions, LPN #3 stated, "They should have been implemented as soon as it was decided she needed them." When asked about updating and following the care plan for these interventions, LPN #3 stated, "They should have been care-planned and the care plan followed for them." On 1/9/20 at 1:07 PM, ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. 4. The facility staff failed to implement the comprehensive care plan for the administration of blood pressure medications to Resident #37. Resident #37 was admitted to the facility on 12/10/19; diagnoses include but are not limited to, encephalopathy, heart disease, dysphagia, diabetes, atrial flutter, abdominal aortic aneurysm, high blood pressure, cardiac	F 656		

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F 656	Continued From page 35 pacemaker, and pneumonia. The admission / 5-day MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 12/17/19 coded the resident as significantly cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for transfers, dressing, and hygiene; was independent for eating; and incontinent of bowel and bladder. A review of the comprehensive care plan for Resident #37 revealed one dated 1/8/20 for "(Resident #37) has altered cardiovascular status r/t (related to) CVA (cerebral vascular disease), CAD (coronary artery disease), HTN (hypertension - high blood pressure), HLP (hyperlipidemia). This care plan included the intervention, dated 1/8/20, for "Administer cardiac meds [medications] and monitor for side effects." On 1/08/20 at 9:08 AM, RN #1 (Registered Nurse) was observed to prepare and administer the following medications for Resident #37: Allopurinol (1) 100 mg (milligrams), 1 tablet Atenolol (2) 25 mg, 3 tablets for 75 mg (RN #1 only prepared 1 tablet). Eliquis (3) 2.5 mg, 1 tablet Multivitamin (4), 1 tablet Vitamin D3 (5), 1000 units, 2 tablets for 2000 units. On 1/8/19 at 3:27 PM, during an interview with RN#1, when asked about the five rights of medication administration, RN #1 stated, "Right person, right dose, right med, right time, right route."	F 656		

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F 656	Continued From page 36 Review of the clinical record and medications, the physician's orders documented that the resident was to receive three tablets (75 mg) of the Atenolol. RN #1 only administered one tablet during the observation. On 1/09/20 at 9:54 AM, in a follow up interview with RN #1, when asked about the dose of the Atenolol, RN #1 stated, "I don't know. I don't know him that well." When asked if the comprehensive care plan was implemented for the administration of his blood pressure medication, RN #1 stated it was not. On 1/9/20 at 1:07 PM, ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. References: 1. Allopurinol is used to treat gout. Information obtained from https://medlineplus.gov/druginfo/meds/a682673.html 2. Atenolol is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a684031.html 3. Eliquis is used to prevent strokes and blood clots in people with atrial fibrillation. Information obtained from https://medlineplus.gov/druginfo/meds/a613032.html	F 656		

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F 656	Continued From page 37 4. Multivitamin - used to treat or prevent vitamin deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health. Information obtained from https://www.webmd.com/drugs/2/drug-18820-9038/multivitamin-oral/multivitamins-includes-prenatal-vitamins-oral/details 5. Vitamin D - Vitamins are substances that your body needs to grow and develop normally. Vitamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems. Information obtained from https://medlineplus.gov/vitamind.html 5. The facility staff failed to implement resident # 3's comprehensive care plan for the administration of oxygen. Resident # 3 was admitted to the facility on 05/09/2016 with a readmission of 07/22/2019 with diagnoses that included but were not limited to respiratory failure, shortness of breath and chronic obstructive pulmonary disease [1]. Resident # 3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/26/19, coded Resident # 3 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired of cognition for making daily decisions. Resident # 3 was coded as requiring extensive assistance of one staff member for activities of daily living. Section O "Special Treatments, Procedures and	F 656		

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F 656	Continued From page 38 Programs" coded Resident # 3 for the use of oxygen. On 01/07/2020 at approximately 3:15 P.m., an observation of Resident # 3 revealed they were lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observation of the oxygen flow meter on the oxygen concentrator revealed a flow rate of one-and-a-half liters per minute. On 01/08/2020 at 10:39 a.m., an observation of Resident # 3 revealed they were lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observation of the oxygen flow meter on the oxygen concentrator revealed a flow rate of one-and-a-half liters per minute. The POS [physician's order sheet] dated 01/01/2020 through 01/31/2020 and signed by the physician on 1/7/2020 for Resident # 3 documented, "09/04/19 Oxygen at 2L [two liters per minute] via [by] nasal cannula every shift." The comprehensive care plan for Resident # 3 with a revision date of 12/31/2018 documented, "Focus: [Resident # 3] has shortness of breath SOB r/t [related to] Decreased lung expansion. Date Initiated 12/31/2018. Revision on 12/31/2018." Under "Interventions" it documented in part, "Oxygen setting: O2 [oxygen] 2L via NC [nasal cannula]. Date Initiated 12/31/2018. Revision on 04/16/2019." On 01/08/2020 at 1:00 p.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked to describe the procedure for reading the oxygen, flow rate meter on an oxygen	F 656		

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F 656	Continued From page 39	F 656		

concentrator, LPN # 4 stated, "You should be at eye level with the meter and the liter line should pass through the middle of the ball. LPN # 4 was asked to read the flow meter on Resident # 3's oxygen concentrator. After looking at the flow meter, LPN # 4 stated the oxygen flow rate was at one-and-a-half liters per minute. When asked what the flow rate should be, LPN # 4 stated two-liter's per-minute. LPN # 4 then readjusted the flow rate on the oxygen concentrator. After reviewing Resident # 3's comprehensive care plan for oxygen, LPN # 4 was asked if the care plan was being implemented. LPN # 4 stated no.

On 01/08/2020 at approximately 5:50 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

6. The facility staff failed to implement resident # 25's comprehensive care plan for the administration of oxygen.
Resident # 25 was admitted to the facility on 11/20/2019 with diagnoses that included but were not limited to respiratory failure, shortness of breath and chronic obstructive pulmonary disease [1].

Resident # 25's most recent MDS (minimum data

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F 656	Continued From page 40 set), a quarterly assessment with an ARD (assessment reference date) of 11/29/19, coded Resident # 25 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. Resident # 25 was coded as requiring extensive assistance of one staff member for activities of daily living. Section O "Special Treatments, Procedures and Programs" coded Resident # 25 for the use of oxygen. On 01/07/20 at 1:25 p.m., an observation of Resident #25 revealed the resident in bed receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate set at three-and-a-half liters per minute. On 01/07/20 at 2:45 p.m., an observation of Resident #25 revealed they were in bed receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate set at three-and-a-half liters per minute. On 01/07/20 at 4:05 p.m., an observation of Resident #25 revealed the resident in bed receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate set at three-and-a-half liters per minute. On 01/08/20 at 8:30 a.m., an observation of Resident #25 revealed the resident in bed receiving oxygen by nasal cannula connected to an oxygen concentrator that was running.	F 656		

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F 656	Continued From page 41 Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate set at three-and-a-half liters per minute. The POS [physician's order sheet] dated 01/01/2020 through 01/31/2020 and signed by the physician on 1/7/2020 for Resident # 3 documented, "12/17/19 Oxygen @ [at] 4L [four liters per minute] via [by] nasal cannula continuous every shift to maintain SPO2 [oxygen saturation] [2] greater than 90%." The comprehensive care plan for Resident # 25 with a revision date of 12/03/2019 documented, "Focus: [Resident # 25] has Congestive Heart Failure. Revision Date: 12/03/2019." Under "Interventions" it documented in part, "Oxygen setting: O2 [oxygen] via NC [nasal cannula] at 4L. Revision on 12/03/2019." On 01/08/2020 at approximately 1:00 p.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked to describe the procedure for reading the oxygen, flow rate meter on an oxygen concentrator, LPN # 4 stated, "You should be at eye level with the meter and the liter line should pass through the middle of the ball. LPN # 4 was asked to read the flow meter on Resident # 25's oxygen concentrator. After looking at the flow meter, LPN # 4 stated the oxygen flow rate was at three-and-a-half liters per minute. When asked what the flow rate should be, LPN # 4 stated four-liter's per-minute. LPN # 4 then readjusted the flow rate on the oxygen concentrator. After reviewing Resident # 25's comprehensive care plan for oxygen, LPN # 4 was asked if the care plan was being implemented. LPN # 4 stated no.	F 656		

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F 656	Continued From page 42 On 01/08/2020 at approximately 5:50 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit. References: [1] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		

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F 657	Continued From page 43 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 revise the comprehensive care plan, for two of 32 residents in the survey sample, Resident #6 and Resident #25. The facility staff failed to review and revise Resident #6's comprehensive care plan to include hospice care and services and care of an indwelling catheter. The facility staff failed to review and revise the comprehensive care plan for Resident #25 to include the use of an incentive spirometer [1]. The findings include: 1. Resident # 6 was admitted to the facility on 07/02/19 with diagnoses that included but were not limited to: heart failure, stage 4-kidney disease and high cholesterol. Resident # 6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/22/19, coded Resident # 6 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 POS [physician's order sheet] dated and signed by the physician on 12/27/19, for Resident # 6 documented,	F 657		

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F 657	Continued From page 44 "Hospice services to eval [evaluate]. [Name of Hospice and Telephone Number]. Hospice nurse to be @ [at] facility 12/28/2019. Dated: 12/27/2019." "Foley catheter for comfort measures. Dated: 12/27/2019." Review of Resident # 6's clinical record revealed a document entitled, "[Name of Hospice] form." The form documented in part, "Patient Name: [Name of Resident # 6]. This is a patient of [Name of Hospice], INC. as of 12/28/19." The comprehensive care plan for Resident # 6 dated of 01/06/2020 failed to evidence care and services for an indwelling catheter, and failed to evidence documentation for hospice care and services. On 01/08/2020 at 3:20 p.m., an interview was conducted with LPN [licensed practical nurse] # 5, traveling MDS coordinator. When asked to describe the purpose of the resident's comprehensive care plan, LPN # 5 stated, "It is specific to the resident and tells what should be done for the resident." When asked to describe the process for updating the comprehensive care plan, LPN # 5 stated, "When there is a change in the resident's status, condition or treatment the care plan should be updated." LPN # 5 was asked to review the comprehensive care plan for Resident # 6. When asked if the comprehensive care plan for Resident # 6 included hospice care, LPN # 5 stated she was unable to locate it on the care plan. When asked if the care plan should have been updated to include hospice care being provided, LPN # 5 stated, "Yes." When asked if the comprehensive care plan for Resident # 6 included care and services for an indwelling catheter, LPN # 5 stated, "No, there isn't a care	F657	1. The care plan for resident #25 was updated to include incentive spirometer on 1/8/2020. The care plan for resident #6 was updated to include hospice and indwelling catheter care on 1/8/2020. 2. Audit of care plans to ensure they include incentive spirometer, hospice and indwelling catheter care will be completed by 1/10/2020. Follow-up based on findings 3. Nursing staff will be re-educated by the DCS/designee on including incentive spirometer, hospice and indwelling catheter care on the care plan by 1/8/2020. 4. The DCS/designee to complete the care plan quality monitor for any residents with incentive spirometers, hospice and indwelling catheter care to ensure compliance is maintained weekly for four weeks. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance 2/15/2020.	

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F 657	Continued From page 45 plan for it." On 01/09/2020 at approximately 8:10 a.m., ASM [administrative staff member] # 2, director of nursing, provided this surveyor with an updated copy of Resident # 6's comprehensive care plan. The care plan documented, "Focus: [Resident # 6] has a terminal prognosis r/t [related to] end of life hospice care. Date initiated: 01/08/2020" and "Focus: [Resident # 6] has indwelling catheter r/t terminal condition. Date initiated: 01/08/2020." The facility's policy "Plans of Care" documented in part, "Review, update and/or revise the comprehensive care plan based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each OBRA [Omnibus Budget Reconciliation Act] MDS [minimum data set] assessment (except discharge assessment) and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being." On 01/08/2020 at approximately 5:50 p.m., ASM # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit. 2. Resident # 25 was admitted to the facility on 11/20/2019 with diagnoses that included but were not limited to respiratory failure, shortness of breath and chronic obstructive pulmonary disease [2].	F 657		

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F 657	Continued From page 46 Resident # 25's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/29/19, coded Resident # 25 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. Resident # 25 was coded as requiring extensive assistance of one staff member for activities of daily living. Section O "Special Treatments, Procedures and Programs" coded Resident # 25 for the use of oxygen. On 01/07/20 at 1:25 p.m., an observation of Resident # 25's bedside table revealed an incentive spirometer uncovered. When asked if they use the incentive spirometer [1] Resident # 25 stated yes. On 01/07/20 at 2:45 p.m., and at 4:05 p.m., observations of Resident # 25's bedside table revealed an incentive spirometer uncovered. On 01/08/20 at 8:30 a.m., an observation of Resident # 25's bedside table revealed an incentive spirometer uncovered. Review of Resident # 25's clinical record failed to evidence a physician's order for the use of an incentive spirometer. On 01/08/2020 at 1:00 p.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked about a physician's order for the use of the incentive spirometer for Resident # 25, LPN # 4 reviewed the physician's orders and stated that they could not locate one. The comprehensive care plan for Resident # 25	F 657		

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F 657	Continued From page 47 with a revision date of 12/03/2019 failed to evidence documentation for the use of an incentive spirometer. On 01/08/20 at 3:20 p.m., an interview was conducted with LPN # 5, traveling MDS coordinator. After reviewing Resident # 25's comprehensive care plan, LPN # 5 was asked if the care plan had been updated to include the incentive spirometer. LPN # 5 stated, "No, there isn't a care plan for it." On 01/08/2020 at approximately 4:00 p.m., LPN # 5 stated they had spoken to the nurse practitioner and stated, "The nurse practitioner feels she [Resident # 25] doesn't need it [incentive spirometer] so I will remove it. It was something she had in her belonging when she came here." On 01/08/2020 at approximately 5:50 p.m., ASM # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit. References: [1] A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm. [2] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.	F 657		

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and review of facility documentation it was determined the facility staff failed to provide treatment and care in accordance with professional standards of practice for one of 32 residents in the survey sample, Resident #3. The facility staff failed to administer sliding scale insulin per the physician orders to Resident # 3. On 01/07/2020 at 7:30 a.m., 11:30 a.m. and 4:30 p.m., and 01/08/2020 at 7:30 a.m., 11:30 a.m. there was no documentation of the amount of insulin administered or the location of the injections. The findings include: Resident # 3 was admitted to the facility on 05/09/2016 with a readmission of 07/22/2019 with diagnoses that included but were not limited to type 2 diabetes mellitus with complications [1]. Resident # 3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/26/19, coded Resident # 3 as scoring a 12 on the staff assessment for mental status (BIMS) of a score	F 684	F684 1. Nurses responsible for resident #3s care were re-educated on the policy for documentation of insulin administration and site administered on 1/8/2020. 2. Review of resident's receiving insulin medical record was completed on 1/31/2020 to ensure administration is documented as well as site. No other findings were noted. 3. An in-service for nurses was conducted on 1/10/2020 on documentation of insulin administration and site administered by the DCS/designee. 4. The DCS/designee to complete the insulin administration monitor one time a week for four weeks for any residents with physician orders for insulin to ensure compliance is maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance 2/15/2020.	

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F 684	Continued From page 49 of 0 - 15, 12- being moderately impaired of cognition for making daily decisions. Resident # 3 was coded as requiring extensive assistance of one staff member for activities of daily living. Section N "Medications" coded Resident # 3 as receiving insulin injections during the past seven days. The POS [physician's order sheet] dated 01/01/2020 through 01/31/2020 for Resident # 3 documented, "Novolog [2] Flexpen 100/ML [milliliter] Unit. Inject subcutaneously three times daily before meals per sliding scale: 150-199: 3 units, 200-249: 6 units, 250-299: 9 units, 300-349: 12 units, > [greater than] 350 or < [lees than] 60 call provider for diabetes mellitus. Date 09/03/2019." The MAR [medication administration record] for Resident # 3, dated "January 2020" documented the physician's order as above. Review of the MAR revealed Resident # 3's blood sugar on 01/07/20 was 198 at 7:30 a.m., 206 at 11:30 a.m., and 149 at 4:30 p.m. On 01/08/20, Resident # 3's blood sugars were 172 at 7:30 a.m. and 189 at 11:30 a.m. Further review of the MAR failed to evidence the amount of insulin administered and the location of the injection on the dates and times above. The facility's nurse's notes dated 01/07/2020 through 01/08/2020 failed to evidence the amount of insulin administered and the location of the injection on the dates and times above. On 01/08/2020 at 3:00 p.m., an interview was conducted with LPN [licensed practical nurse] # 4 regarding the documentation of Resident # 3's insulin. After reviewing the MAR [medication	F 684		

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F 684	Continued From page 50 administration record] dated January 2020 and nurse's notes dated 01/07/2020 through 01/08/2020. When asked about the lack of documentation showing how much insulin was administered and location of the injection site, LPN # 4 stated, "It doesn't say if she got it [insulin] or where." When asked if they could evidence the sliding scale, insulin was administered as ordered, LPN # stated, "Absolutely not." On 01/09/20 at 11:14 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked to describe the documentation procedure for insulin administration, ASM # 2 stated, "Write down what the insulin is, give according to the sliding scale, document how much was given and I'll ask the resident where they want the injection." When asked if they follow a procedure to rotate the injection site ASM # 2 stated, "Not all the time." When asked about a negative outcome of not rotating the site ASM # 2 stated, "There wouldn't be because were not injecting in the exact same spot." ASM # 2 agreed that it could not be determined how if any insulin was administered per the physician order due to the lack of documentation. The facility's policy "Insulin Administration" documented in part, "Rotate and document injection sites; Document medical record." "Insulin Injection Know How. Select a part of your body that you can see, reach, and access easily. But be sure to use a number of different spots within that body part. This is called "rotating" injection sites. Injecting into the same spot too often can cause skin problems and can impair	F 684		

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F 684	Continued From page 51 insulin absorption." This information was obtained from the website: https://www.diabeteseducator.org/docs/default-source/legacy-docs/_resources/pdf/general/Insulin_Injection_Pro_Tips_AADE.pdf On 01/08/2020 at approximately 5:50 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit. References: [1] A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure environment free of accident hazards and	F 689		

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F 689	Continued From page 52 assistance devices to prevent accidents for one of 32 residents in the survey sample; Resident #61. The facility staff failed to implement fall interventions for Resident #61 after a fall on 12/29/19, fall mats and a scoop mattress were determined by the facility to be required interventions. Neither intervention had been implemented as of the survey date of 1/9/20. The findings include: Resident #61 was admitted to the facility on 12/23/19; diagnoses include but are not limited to dementia with behaviors, panic disorder, thyroid disorder, restless leg, anxiety disorder, high blood pressure and delirium. The admission / 5-day MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 12/29/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, toileting, and eating; extensive assistance for ambulation and transfers; and was coded as incontinent of bowel and bladder. On 1/08/20 at 9:57 AM, Resident #61 was observed in bed asleep. No fall mats were observed next to the resident's bed and no scoop mattress observed on the bed. On 1/09/20 at 10:46 AM, LPN #3 (Licensed Practical Nurse) was asked about the fall mats and scoop mattress for Resident #61. She stated that she was not aware the resident was to have fall mats and a scoop mattress. At this time, she checked on Resident #61 and verified that there were no fall mats or scoop mattress in place. When asked about implementing these	F 689	F689 1. The fall mats and scoop mattress for resident #61 were implemented on 1/9/2020. 2. Review of resident's with fall mats and scoop mattresses was conducted on 1/9/2020 no other findings were noted. 3. An in-service for staff was conducted by the DCS/designee on 1/10/2020 on implementing fall interventions as designated on the care plan. 4. The DCS/designee to complete the fall intervention monitor one time a week for four weeks for any residents with fall interventions to ensure compliance is maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance 2/15/2020.	

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F 689	Continued From page 53 interventions, LPN #3 stated, "They should have been implemented as soon as it was decided she needed them." A review of the admission nursing assessment dated 12/23/19 documented under "Fall Risk: History of Falls: ___No history of falls; ___Fell in past 30 days; ___Fell in past 31-180 days." The box for "Fell in past 30 days" was marked. In addition, a "Fall Risk Evaluation" form was completed which coded the resident as an "18." This form documented, "A resident who scores a 10 or higher is at risk." A review of the clinical record revealed a nurse's note dated 12/29/19 at 6:30 AM that documented, "Resident yelling out "help me!" Found on floor in sitting position. MAEW (moves all extremities well), vital signs obtained, neuro [neurological] checks initiated. NP (nurse practitioner), son, and RP (responsible party) notified." A review of a fall investigation dated 12/29/19 documented that the resident stated she had to go to the bathroom but did not ask for help. An Interdisciplinary Team (IDT) meeting note dated 12/30/19 documented, "IDT met to discuss/review resident's fall on 12/29/19. Found sitting on (R) (right) side of bed in floor in sitting position. No injuries. B+B (bowel and bladder), med [medication] review. No further recommendations at this time." An Interdisciplinary Team meeting note dated 1/3/20 documented, "IDT met to discuss/review 60 day look back on falling last 30 days. B+B, med review. No further recommendations at this time."	F 689		

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F 689	Continued From page 54 An Interdisciplinary Team meeting note dated 1/6/20 documented, "IDT met to discuss/review fall on 1/3/20 (note: there was no fall noted on 1/3/20. Note refers to the IDT note dated 1/3/20). Found laying (Sic.) on floor beside bed. No injuries. Fall mats, scoop mattress. No further recommendations." A review of the comprehensive care plan dated 12/30/19, documented, "(Resident #61) has had an actual fall with no injury r/t (related to) poor balance, poor communication/comprehension." This care plan included the intervention, dated 12/30/19 for "Fall mats on both sides of bed." The care plan did not include any intervention for the scoop mattress. A review of the facility policy, "Fall Management" documented, "B. Fall Mitigation Strategies: 1. Develop resident centered interventions based on resident risk factors. 2. Update the resident's care plan and the Nurse Aide Kardex with interventions...C. Post Fall Strategies:...4. Re-evaluate fall risk utilizing the Post Fall Evaluation; 4. Update Care plan and Nurse Aide Kardex with intervention(s)...8. Update plan of care with new interventions as appropriate...." On 1/9/20 at 1:07 PM, ASM #1 (Administrative Staff Member - the Executive Director and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		

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F 695	Continued From page 55 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, resident interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide respiratory care and services consistent with professional standards of practice, the comprehensive person-centered care plan for four of 32 residents in the survey sample; Residents #41, #3, #163, and #25. The facility staff failed to ensure a physician's order was in place for Resident #41's use of an incentive spirometer and failed to ensure Resident #4's nebulizer mask and incentive spirometer were stored in a sanitary manner when not in use. The facility staff failed to administer Resident # 3's oxygen at the flow rate ordered by the physician. The facility staff failed to store Resident #163's incentive spirometer [1] in a sanitary manner and failed to obtain physician orders for the use of the incentive spirometer. The facility staff failed to administer Resident # 25's oxygen according to the physician's orders and failed to store Resident # 25's nebulizer mask and incentive spirometer in a sanitary manner. The facility staff failed to obtain a physician's order for Resident # 25's use of an incentive spirometer. The findings include:	F 695	F695 1. An order for resident #41 was obtained for the incentive spirometer on 1/8/2020. The incentive Spirometer and nebulizer mask for resident #41 was replaced with a new one and placed in a respiratory bag on 1/8/2020. The oxygen flow rate for resident #3 was adjusted by the nurse to physician ordered flow rate on 1/8/2020. An order for resident #163 was obtained for the incentive spirometer on 1/8/2020. The incentive Spirometer for resident #163 was replaced with a new one and placed in a respiratory bag on 1/8/2020. An order for resident #25 was obtained for the incentive spirometer on 1/8/2020. The incentive Spirometer and nebulizer mask for	

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F 695	Continued From page 56 1a. Resident #41 was admitted to the facility on 8/7/19; diagnoses include but are not limited to, hydrocephalus, psychotic disorder, right kidney cancer with removal of kidney, cardiac defibrillator, high blood pressure, atrial fibrillation, diabetes, bipolar disorder, spinal stenosis with fusion, and cerebral palsy. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 12/21/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, tolleting, dressing, and transfers; supervision for eating and hygiene; and was coded as incontinent of bowel and bladder. On 1/07/20 at 12:10 PM, an observation was made of Resident #41's room. Resident #41 was not in the room. An Incentive Spirometer was observed on the over bed table. On 1/08/20 at 8:52 AM, Resident #41 was observed in bed. The Incentive Spirometer remained on the over bed table as previously observed. On 1/08/20 at 1:00 PM, Resident #41 was observed and an interview conducted. The over bed table was across the resident. The incentive spirometer was on the table. Resident #41 stated that he has used it on occasion. A review of the clinical record failed to reveal any evidence of a physician's order for the use of an Incentive Spirometer. A review of the comprehensive care plan failed to reveal the use of the Incentive Spirometer as	F 695	resident #25 was replaced with a new one and placed in a respiratory bag on 1/8/2020. The oxygen flow rate for resident #25 was adjusted by the nurse to physician ordered flow rate on 1/8/2020. 2. Audit of respiratory care to ensure orders for incentive spirometers were given by the physician and incentive spirometers are stored in respiratory bags, oxygen usage reflects physicians orders and nebulizer masks are stored in respiratory bags was completed and no issues of non-compliance were noted on 1/31/2020.	

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F 695	Continued From page 57 being care planned. On 1/8/20 at 1:07 PM in an interview with RN #1 (Registered Nurse), she stated that there should be an order for the use of the Incentive Spirometer. RN #1 stated that the residents "come in with them from the hospital." A review of the facility policy, "Incentive Spirometer" did not document any criteria for obtaining a physician's order prior to use. On 1/8/20 at 5:50 PM, ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. 1b. The facility staff failed to ensure Resident #41's nebulizer mask and Incentive Spirometer were stored in a sanitary manner when not in use. On 1/07/20 at 12:10 PM, an observation was made of Resident #41's room. Resident #41 was not in the room. An Incentive Spirometer was observed on the over bed table. It was not covered. A nebulizer machine and mask was observed on nightstand next to the bed. The nebulizer mask was not covered. On 1/08/20 at 8:52 AM, Resident #41 was observed in bed. The Incentive Spirometer and nebulizer mask remained uncovered as previously observed. On 1/08/20 at 1:00 PM, Resident #41 was observed and an interview conducted. The over bed table was across the resident. The Incentive	F 695	3. Nursing staff were re-educated by the DCS/designee, including having orders for incentive spirometers, storing incentive spirometers and nebulizer masks in respiratory bags and administering oxygen by the physicians order by 1/10/2020. 4. The DCS/designee to complete the respiratory quality monitor for any residents with incentive spirometer, oxygen and nebulizers to ensure compliance is maintained weekly for four weeks. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance 2/15/2020.	

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F 695	Continued From page 58 spirometer was on the table, uncovered. No bag was observed to store the Incentive Spirometer. The nebulizer mask was now, observed covered in a new bag and dated. The resident stated that he has used both items on occasion and that to his recollection neither item, had been covered. On 1/8/20 at 1:07 PM in an interview with RN #1 (Registered Nurse), she stated that the nebulizer mask should be covered. RN #1 stated the Incentive Spirometer should be wiped clean. RN #1 stated, "I guess it should be stored in a bag but I was never told that." A review of the facility policy, "Nebulizer" documented, "Place entire unit in a bag to be maintained in the resident's room." A review of the facility policy, "Incentive Spirometer" did not document any criteria for maintaining the device in a sanitary manner between uses. On 1/8/20 at 5:50 PM, ASM #1 (Administrative Staff Member - Executive Director) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. 2. Resident # 3 was admitted to the facility on 05/09/2016 with a readmission of 07/22/2019 with diagnoses that included but were not limited to respiratory failure, shortness of breath and chronic obstructive pulmonary disease [1]. Resident # 3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/26/19, coded Resident # 3 as scoring a 12 on the staff	F 695		

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F 695	Continued From page 59	F 695		

assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired of cognition for making daily decisions. Resident # 3 was coded as requiring extensive assistance of one staff member for activities of daily living. Section O "Special Treatments, Procedures and Programs" coded Resident # 3 for the use of oxygen.

On 01/07/2020 at approximately 3:15 p.m., Resident # 3 was observed lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observation of the oxygen flow meter on the oxygen concentrator revealed a flow rate of one-and-a-half liters per minute.

On 01/08/2020 at 10:39 a.m., an observation of Resident # 3 revealed they were lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observation of the oxygen flow meter on the oxygen concentrator revealed a flow rate of one-and-a-half liters per minute.

The POS [physician's order sheet] dated 01/01/2020 through 01/31/2020 and signed by the physician on 1/7/2020 for Resident # 3 documented, "09/04/19 Oxygen at 2L [two liters per minute] via [by] nasal cannula every shift."

The comprehensive care plan for Resident # 3 with a revision date of 12/31/2018 documented, "Focus: {Resident # 3] has shortness of breath (SOB) r/t [related to] Decreased lung expansion. Date Initiated 12/31/2018. Revision on 12/31/2018." Under "Interventions" it documented in part, "Oxygen setting: O2 [oxygen] 2L via NC [nasal cannula]. Date initiated

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ENVOY OF WINCHESTER, LLC	110 LAUCK DR WINCHESTER, VA 22603

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F 695	Continued From page 60 12/31/2018. Revision on 04/16/2019." On 01/08/2020 at 1:00 p.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked to describe the procedure for reading the oxygen, flowrate meter on an oxygen concentrator, LPN # 4 stated, "You should be at eye level with the meter and the liter line should pass through the middle of the ball. LPN # 4 was asked to read the flow meter on Resident # 3's oxygen concentrator. After looking at the flow meter, LPN # 4 stated the oxygen flow rate was at one-and-a-half liters per minute. When asked what the flow rate should be, LPN # 4 stated two-liter's per-minute. LPN # 4 then readjusted the flow rate to 2LPM (liters per minute) on the oxygen concentrator. On 01/08/2020 at approximately 5:50 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit. References: [1] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 3. Resident # 163 was admitted to the facility on 01/03/2020 with diagnoses that included but were not limited to high blood pressure and chronic obstructive pulmonary disease [2].	F 695		

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F 695	Continued From page 61 The most recent MDS (minimum data set), for Resident # 163 was not due at the time of the survey. The facility's "Admission Data Collection" sheet dated 01/03/2020 for Resident # 163 documented in part, "Cognition: Alert, Oriented to Person." Under "Communication" it documented, "Usually Understood and Understands." Under "Respiratory", it documented, "Special Treatments and Procedures: None per history and/or observation." On 01/07/20 at 1:49 p.m., at 2:43 p.m., and at 4:05 p.m., observations of Resident # 163's over-the-bed table revealed an incentive spirometer. Observation of the incentive spirometer [1] failed to evidence that it was placed in a bag or covered. On 01/08/20 at 8:25 a.m., an observation of Resident # 163's over-the-bed table revealed an incentive spirometer. Observation of the incentive spirometer failed to evidence that it was placed in a bag or covered. The POS [physician's order sheet] dated 01/01/2020 through 01/31/2020 and signed by the physician on 01/04/2020 for Resident # 163 failed to evidence documentation for the use of an incentive spirometer. The facility's baseline care plan for Resident 163 dated 01/03/2020 failed to evidence documentation for the use of an incentive spirometer. On 01/08/20 at 8:30 a.m., an interview was conducted with Resident # 163. When asked if they used the incentive spirometer, Resident # 163 stated sometimes.	F 695		

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F 695	Continued From page 62 On 01/08/2020 at 1:00 p.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked if an incentive spirometer was a piece of respiratory equipment, LPN # 4 stated yes. When how the incentive spirometer should be stored when not in use, LPN # 4 stated it should be covered or placed in a bag. LPN # 4 was shown Resident # 163's incentive spirometer on the over-the-bed table. LPN # 4 stated it should be covered. When asked why the incentive spirometer should be covered, LPN # 4 stated, "It could collect germs and could cause an infection when used by the resident." When asked about a physician's order for Resident #163's use of the incentive spirometer, LPN # 4 reviewed the physician's orders and stated that they could not locate one. On 01/08/20 at 1:43 p.m., an interview was conducted with LPN # 5, traveling MDS coordinator. LPN # 5 stated there was no physician order for Resident # 163's incentive spirometer. LPN # 5 further stated that they had spoken to Resident # 163's nurse practitioner and that Resident # 163 would benefit from the use of the incentive spirometer. LPN # 5 stated they would obtain a physician's order for prn [as needed] use of an incentive spirometer. On 01/08/2020 at approximately 2:00 p.m., LPN # 5 provided this surveyor with a copy of a physician's telephone order dated 01/08/2020 for Resident # 163. The order documented, "Encourage use of incentive spirometer PRN." On 01/08/2020 at approximately 5:50 p.m., ASM # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical	F 695		

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F 695	Continued From page 63 services and LPN # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit. References: [1] A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm. [2] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 4a. Resident # 25 was admitted to the facility on 11/20/2019 with diagnoses that included but were not limited to respiratory failure, shortness of breath and chronic obstructive pulmonary disease [1]. Resident # 25's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/29/19, coded Resident # 25 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. Resident # 25 was coded as requiring extensive assistance of one staff member for activities of daily living. Section O "Special Treatments, Procedures and Programs" coded Resident # 25 for the use of oxygen. The POS [physician's order sheet] dated 01/01/2020 through 01/31/2020 and signed by the	F 695		

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F 695	Continued From page 64 physician on 1/7/2020 for Resident # 3 documented, "12/17/19 Oxygen @ [at] 4L [four liters per minute] via [by] nasal cannula continuous every shift to maintain SPO2 [oxygen saturation] [2] greater than 90%." The comprehensive care plan for Resident # 25 with a revision date of 12/03/2019 documented, "Focus: [Resident # 25] has Congestive Heart Failure. Revision Date: 12/03/2019." Under "Interventions" it documented in part, "Oxygen setting: O2 [oxygen] via NC [nasal cannula] at 4L (liter). Revision on 12/03/2019." On 01/07/20 at 1:25 p.m., 2:45 p.m., and at 4:05 p.m., observations revealed Resident #25 in bed receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observations of the flow meter on the oxygen concentrator revealed an oxygen flow rate set at three-and-a-half liters per minute. On 01/08/20 at 8:30 a.m., an observation revealed Resident #25 in bed receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate set at three-and-a-half liters per minute. On 01/08/2020 at approximately 1:00 p.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked to describe the procedure for reading the oxygen, flowrate meter on an oxygen concentrator LPN # 4 stated, "You should be at eye level with the meter and the liter line should pass through the middle of the ball. LPN # 4 was asked to read the flow meter on Resident # 25's oxygen concentrator. After	F 695		

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F 695	Continued From page 65 looking at the flow meter LPN # 4 stated the oxygen flow rate was at three-and-a-half liters per minute. When asked what the flow rate should be per the physician order, LPN # 4 stated four-liter's per-minute. LPN # 4 then readjusted the flow rate on the oxygen concentrator to 4 LPM (liters per minute). On 01/08/2020 at approximately 5:50 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit. References: [1] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 4b. On 01/07/20 at 1:25 p.m., at 2:45 p.m., and at 4:05 p.m., observations of Resident # 25's bedside table revealed a nebulizer and a nebulizer mask sitting on top of the table. Observations of the nebulizer mask revealed it was uncovered. When asked if they receive nebulizer treatments Resident # 25 stated yes. Further observation of the bedside table revealed an incentive spirometer uncovered. When asked if they use the incentive spirometer Resident # 25 stated yes. On 01/08/20 at 8:30 a.m., an observation of Resident # 25's bedside table revealed a nebulizer and a nebulizer mask sitting on top of	F 695		

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F 695	Continued From page 66 the table. Observation of the nebulizer mask revealed it was uncovered. Further observation of the bedside table revealed an incentive spirometer uncovered. The "Physician's Telephone Order" dated 12/27/2019 documented, "Duo nebs Q [every] 4 [four] hours for SOB [shortness of breath]." Further review of the clinical record failed to evidence a physician's order for the use of an incentive spirometer. The comprehensive care plan for Resident # 25 with a revision date of 12/03/2019 documented, "Focus: [Resident # 25] has COPD [chronic obstructive pulmonary disease]. Date Initiated: 12/03/2019." Under "Interventions" it documented, "Give nebulizer treatments and oxygen therapy as ordered. Date Initiated: 12/03/2019." On 01/08/2020 at 1:00 p.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked if an incentive spirometer was a piece of respiratory equipment, LPN # 4 stated yes. When how the incentive spirometer should be stored when not in use, LPN # 4 stated it should be covered or placed in a bag. When asked how a nebulizer mask should be stored when not in use, LPN # 4 stated it should be placed in a bag. When shown Resident # 25's nebulizer mask and incentive spirometer on the bedside table LPN # 4 stated the incentive spirometer and nebulizer mask should be covered. When asked why the incentive spirometer and nebulizer mask should be covered, LPN # 4 stated, "It could collect germs and could cause an infection when used by the resident."	F 695		

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F 695	Continued From page 67 On 01/08/2020 at approximately 5:50 p.m., ASM # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit. References: [1] A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm. 4c. On 01/07/20 at 1:25 p.m., an observation of Resident # 25's bedside table revealed an incentive spirometer uncovered. When asked if they use the incentive spirometer Resident # 25 stated yes. On 01/07/20, at 1:25 p.m., at 2:45 p.m., and at 4:05 p.m., observations of Resident # 25's bedside table revealed an incentive spirometer. On 01/08/20 at 8:30 a.m., an observation of Resident # 25's bedside table revealed an incentive spirometer uncovered. Review of Resident # 25's clinical record failed to evidence a physician's order for the use of an incentive spirometer. On 01/08/2020 at 1:00 p.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked about a physician's order for the	F 695		

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F 695	Continued From page 68 use of the incentive spirometer for Resident # 25, LPN # 4 reviewed the physician's orders and stated that they could not locate one. On 01/08/20 at 1:43 p.m., an interview was conducted with LPN # 5, traveling MDS coordinator. LPN # 5 stated they had spoken to the nurse practitioner (NP) and the NP stated, "The nurse practitioner feels she [Resident # 25] doesn't need it [incentive spirometer] so I will remove it. It was something she had in her belonging when she came here." LPN # 5 verbally confirmed there was no physician's order for the use of an incentive spirometer. On 01/08/2020 at approximately 5:50 p.m., ASM # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit.	F 695		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its	F 757		

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F 757	Continued From page 69 use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure the drug regimen must be free from unnecessary drugs for two of 32 residents in the survey sample, Resident # 3 and # 25. The facility staff failed to attempt non-pharmacological interventions prior to the administration of prn (as needed) pain medications [Oxycodone (1) and Acetaminophen] (2)] to Resident #3 on multiple dates in November and December 2019. The facility staff failed to attempt non-pharmacological interventions prior to the administration of a prn (as needed) pain medication [Hydrocodone-Acetaminophen (2)] to Resident #25 on multiple dates during November, December 2019 and January 2020. The findings include: 1. Resident # 3 was admitted to the facility on 05/09/2016 with a readmission of 07/22/2019 with diagnoses that included but were not limited to lower back pain. Resident # 3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/26/19, coded	F 757	F757 1. Nurses responsible for resident #3 and #25 care were re-educated on the policy for documentation of non-pharmacological interventions and pain level scale prior to administering prn pain medication on 1/8/2020. 2. Audit of records of residents on prn pain medication completed to ensure they include non-pharmacological	

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F 757	Continued From page 70 Resident # 3 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired of cognition for making daily decisions. Resident # 3 was coded as requiring extensive assistance of one staff member for activities of daily living. Section J "Health Conditions" coded Resident # 3 as having occasional pain with a pain level of seven on a scale of zero to ten with ten being the worse pain. The comprehensive care plan with a revision date of 12/31/2018 for Resident # 3 documented, "Focus: [Resident # 3] has chronic pain r/t [related to] arthritis, diabetic neuropathy, peripheral vascular disease. Date Initiated: 12/31/2018." Under "Interventions" it documented, "Administer analgesia as per order. Give ½ [one half] hour before treatments or care Date Initiated: 12/31/2018." The physician's telephone order dated 11/06/2019 for Resident # 3 documented, "Oxycodone 5MG [five milligrams]. 1 [one] tab [tablet] by mouth Q 8 [eight hours] prn for pain." The MAR [medication administration record] for Resident # 3, dated "November 2019" documented the physician orders as above. Review of the MAR revealed Resident # 3 received Oxycodone on the dates and times that follow: 11/12/19 at 2:00 a.m., and at 1:07 p.m., 11/13/19, at 1:45 p.m., and at 9:00 p.m., 11/14/19 at 8:30 p.m., 11/15/19 at 1:10 p.m., 11/17/19 at 4:15 a.m. and at 11:45 a.m., 11/19/19 at 5:00 p.m., 11/20/19 at 1:00 a.m.,	F 757	interventions and pain level scale prior to administration on 1/31/2020. No issues of non-compliance were noted. 3. Nursing staff were re-educated by the DCS/designee on documenting non-pharmacological interventions and pain level scale prior to administering prn medications by 2/15/2020. 4. The DCS/designee to complete the pain quality monitor for 15 random residents with prn pain medications to ensure compliance is maintained weekly for four weeks. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance 2/15/2020.	

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F 757	Continued From page 71 11/30/19 at 10:00 a.m. and at 9:00 p.m. Further review of the MAR failed evidence documentation of non-pharmacological interventions attempted prior to the administration of the pain medication and failed to evidence documentation of Resident # 3's pain level for the above dates and times. The POS [physician's order sheet] dated 12/01/19 through 12/31/2019 for Resident # 3 documented, "Acetaminophen 325MG Tablet. Take 1 tab by mouth every 4 [four] hours as needed for pain. 09/03/2019." The MAR [medication administration record] for Resident # 3, dated "December 2019" documented the same physician order as above. Review of the MAR revealed Resident # 3 received Acetaminophen on the dates and times as follows: 12/01/19 at 2:00 p.m., 12/02/19 at 9:30 a.m., 12/03/19 at 12:15 p.m., 12/04/19 at 12:47 p.m., 12/07/19 at 12:27 p.m., 12/10/19 at 11:00 a.m., 12/11/19 at 12:15 p.m., 12/13/19 at 1:05 p.m., 12/15/19 at 8:30 p.m., 12/16/19 at 8:15 p.m., 12/18/19 at 12:45 p.m., 12/21/19 at 12:05 p.m., and on 12/25/19 at 4:22 p.m. Further review of the MAR failed evidence documentation of non-pharmacological interventions attempted prior to the administration of the as needed pain medication and failed to evidence documentation of Resident # 3's pain level for the above dates and times. The facility's nurse's notes dated 11/08/2019 through 12/28/2019 failed to evidence documentation of Resident # 3's pain level and failed to document non-pharmacological interventions prior to the administration of Oxycodone and Acetaminophen to for the above	F 757		

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F 757	Continued From page 72 dates and times. Review of Resident # 3's pain flow sheets dated November and December 2019 failed to evidence pain levels and non-pharmacological interventions for the above dates and times. On 01/07/2020 at approximately 4:00 p.m., an interview was conducted with Resident # 3. When asked if the staff attempt to alleviate the pain before administering pain medication Resident # 3 stated no. On 01/08/2020 at 4:02 p.m., an interview was conducted with LPN [licensed practical nurse] # 4, regarding the procedure for administering prn [as needed] pain medication. LPN # 4 stated, "Start with non-pharmacological interventions, return in about a half-hour to an hour and reassess, if it is not effective check what is ordered, get the resident's pain level, based on zero to ten, ten being the worse, and minister meds [medication] and recheck in about an hour. When asked about the procedure staff follows for documenting that non-pharmacological interventions were attempted and the pain levels, LPN # 4 stated, "It's documented on the back of the MAR [medication administration record] or the nurse's notes." After reviewing the MAR and nurse's notes for Resident # 3, LPN # 4 stated there was no documentation of non-pharmacological interventions being attempted or the pain levels. When asked about the lack of documentation of non-pharmacological interventions and the pain levels, LPN # 4 stated, "It's not documented can't say it's done." On 01/09/20 at 11:14 a.m., an interview was	F 757		

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F 757	Continued From page 73 conducted with ASM [administrative staff member] # 2, director of nursing. When asked to describe the procedure for prn [as needed] pain medication, ASM # 2 stated, "Rate the pain zero to ten, medicate them, and recheck in about an hour to see if was effective." When asked about attempting non-pharmacological interventions prior to administering as needed pain medication, ASM # 2 stated, "It depends on what the pain is, chronic pain such as cancer pain we don't attempt them. Sometimes the patient will just ask for it and we won't argue with them." When asked if they expected to attempt non-pharmacological interventions if the resident was not experiencing chronic pain, ASM # 2 stated it should document on the pain flow sheet or nurse's notes. ASM # 2 further stated that the location and level of pain should be documented on the pain assessment sheet with the MAR. On 01/08/2020 at approximately 5:50 p.m., ASM # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit. References: [1] Oxycodone is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html. [2] 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	F 757		

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F 757	Continued From page 74	F 757		

reduce fever. 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. Resident # 25 was admitted to the facility on 11/20/2019 with diagnoses that included but were not limited to chest pain.

Resident # 25's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/29/19, coded Resident # 25 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. Resident # 25 was coded as requiring extensive assistance of one staff member for activities of daily living. Section O "Special Treatments, Procedures and Programs" coded Resident # 25 for the use of oxygen.

The POS [physician's order sheet] dated 01/01/20 through 01/31/2020 for Resident # 25 documented, "Hydrocodone-Acetaminophen 10MG-325MG [milligrams] Tablet. Take 1 tab [tablet] by mouth every 8 [eight] hours as needed for moderate to severe pain. 11/26/2019."

The MAR [medication administration record] for Resident # 25 dated "November 2019" documented the physician order as above. Review of the MAR revealed Resident # 25 received Hydrocodone-Acetaminophen on 11/25/19 at 6:00 p.m., 11/26/19 at 5:30 p.m., and on 11/27/19 at 9:30 a.m., and at 6:00 p.m.

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F 757	Continued From page 75 Further review of the MAR failed evidence documentation evidencing that non-pharmacological interventions for the above dates and times were attempted prior to the administration of as needed pain medication. The MAR [medication administration record] for Resident # 25, dated "December 2019" documented the physician order as above. Review of the MAR revealed Resident # 25 received Hydrocodone-Acetaminophen on the dates and times as follows: 12/01/19 at 11:00 a.m., 12/02/19 at 9:05 a.m., 12/03/19 at 9:09 a.m., 12/04/19 at 4:50 a.m., and at 9:00 p.m., 12/06/19 at 8:00 p.m., 12/07/19 at 6:30 a.m. and at 7:55 p.m., 12/13/19 at 5:05 p.m., 12/16/19 at 6:50 a.m., 12/17/19 at 7:18 p.m., 12/18/19 at 12:20 p.m. and at 8:00 p.m., 12/21/19 at 5:56 p.m., 12/22/19 at 9:00 p.m., 12/23/19 at 8:00 p.m., and on 12/30/19 at 9:00 p.m. Further review of the MAR failed evidence documentation non-pharmacological interventions were attempted, prior to administration of as needed pain medication. The MAR failed to evidence documentation of Resident # 25's pain level for the above dates and times. The MAR [medication administration record] for Resident # 25, dated "January 2020" documented the physician order as above. Review of the MAR revealed Resident # 25 received Hydrocodone-Acetaminophen on 01/01/20 at 1:55 p.m., 01/02/20 at 6:00 p.m., 01/03/20 at 9:00	F 757		

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F 757	Continued From page 76 a.m., 01/04/20 at9:19 a.m., 01/05/20 at 4;40 p.m., 01/06/20 at 4:45 p.m., and on 01/07 20 at 9:30 a.m. Further review of the MAR failed evidence documentation of attempted non-pharmacological interventions for the above dates and times. On 01/07/20 at 1:33 p.m., during an interview with Resident # 25, when asked if they received prn [as needed] pain medication. Resident # 25 stated yes and that they have pain in their legs. When asked if the staff attempt to alleviate the pain before administering pain medication, Resident #25 stated no. The facility's nurse's notes dated 11/2019 through 01/07/2020 failed to evidence documentation of Resident # 25's pain level and failed to evidence non-pharmacological interventions were attempted prior to the administration of Hydrocodone-Acetaminophen to Resident # 25 for the above dates and times. Review of Resident # 3's pain flow sheets dated November and December 2019 and January 2020 failed to evidence non-pharmacological interventions for the above dates and times. The comprehensive care plan for Resident # 25 dated 12/03/2019 documented, "Focus: [Resident # 25] has chronic pain r/t [related to] Neurology. Date Initiated: 12/03/2019." Under "Interventions", it documented in part, "Administer analgesia as per orders. Date Initiated: 12/03/2019." On 01/08/2020 at 4:02 p.m., an interview was conducted with LPN [licensed practical nurse] # 4, regarding the procedure for administering prn [as needed] pain medication. LPN # 4 stated,	F 757		

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F 757	Continued From page 77 "Start with non-pharmacological interventions, return in about a half-hour to an hour and reassess, if it is not effective check what is ordered, get the resident's pain level, based on zero to ten, ten being the worse, and minister meds [medication] and recheck in about an hour. When asked about the procedure staff follows for documenting that non-pharmacological interventions were attempted and the pain levels, LPN # 4 stated, "It's documented on the back of the MAR [medication administration record] or the nurse's notes." After reviewing the MAR and nurse's notes for Resident # 25, LPN # 4 stated there was no documentation of non-pharmacological interventions being attempted or the pain levels. When asked about the lack of documentation of non-pharmacological interventions and the pain level, LPN # 4 stated, "It's not documented can't say it's done." On 01/09/20 at 11:14 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked to describe the procedure for prn [as needed] pain medication, ASM # 2 stated, "Rate the pain zero to ten, medicate them, and recheck in about an hour to see if was effective." When asked about attempting non-pharmacological interventions prior to administering as needed pain medication, ASM # 2 stated, "It depends on what the pain is, chronic pain such as cancer pain we don't attempt them. Sometimes the patient will just ask for it and we won't argue with them." When asked if they expected to attempt non-pharmacological interventions if the resident was not experiencing chronic pain, ASM # 2 stated it should document on the pain flow sheet or nurse's notes. ASM # 2 further stated that the	F 757		

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F 757	Continued From page 78 location and level of pain should be documented on the pain assessment sheet with the MAR. On 01/08/2020 at approximately 5:50 p.m., ASM # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit. References: [1] Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. Hydrocodone relieves pain by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601006.html.	F 757		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: The facility staff failed to ensure that two of four residents in the Medication Administration task (Residents #41 and #37) were free of medication errors of less than 5%. Out of 32 opportunities, five errors were observed, resulting in a medication error rate of 15.63%. The facility staff	F 759		

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F 759	Continued From page 79 failed to ensure that Resident #41 was free of medication errors. Resident #41 was administered a medication that was not ordered for him and staff failed to administer ordered medications. The facility staff failed to ensure that Resident #37 was free of medication errors. Resident #37 was administered a partial dose of the blood pressure medication, Atenolol, and not the full dose that was ordered. The findings include: 1. Resident #41 was admitted to the facility on 8/7/19; diagnoses included but are not limited to hydrocephalus, psychotic disorder, right kidney cancer with removal of kidney, cardiac defibrillator, high blood pressure, atrial fibrillation, diabetes, bipolar disorder, spinal stenosis with fusion, and cerebral palsy. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 12/21/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, toileting, dressing, and transfers; supervision for eating and hygiene; and was incontinent of bowel and bladder. On 1/08/20 at 8:52 AM, RN #1 (Registered Nurse) was observed preparing and administering the following medications to Resident #41: Clonidine (1) 0.1 mg (milligrams), 1 tablet Metoprolol (2) 100 mg, 1 tablet Metformin (3) 500 mg, 1 tablet Depakote (4) ER (extended release) 500 mg, 1 tablet	F 759	F759 1. Nurses responsible for resident #41 and #37 care were re-educated on the policy on medication administration on 1/8/2020. 2. Observation of medication administration was completed for nursing staff to ensure the policy on medication is followed by 1/31/2020. No findings were noted. 3. Nursing staff will be re-educated on medication administration by the DCS/designee by 2/15/2020. 4. The DCS/designee to complete the medication administration monitor for 2 random med passes per week for four weeks. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance 2/15/2020.	

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F 759	Continued From page 80 Accupril (5) 20 mg, 1 tablet Folic Acid (6) 1 mg, 1 tablet, observation revealed another resident's name was documented on the pharmacy label of the medication card. Azithromycin (7) 250 mg, 1 tablet Prednisone (8) 20 mg, 1 tablet Mucinex (9) 600 mg, 1 tablet (as needed) Upon record review of the physician's orders, it was verified that Resident #41 was not ordered to receive the Folic Acid that was observed being administered to the resident as documented above from another resident's medication card. In addition, upon record review, the following medications were noted as being ordered but were not prepared and administered: Multivitamin (10) 1 tablet every morning (listed on orders but was not given.) Vitamin D (11) 25 mcg (micrograms) (1000 units) every morning (listed on orders but was not given.) Glimepiride (12) 4 mg tablet daily (listed on orders but was not observed administered.) These medications were not administered and were all listed on the same page of the MAR (Medication Administration Record), evidencing an entire page of medications was missed during the Medication Administration observation. The multivitamin, Vitamin D, Glimepiride, and Folic Acid were all medication errors for Resident #41. On 1/08/20 at 1:07 PM, in an interview with RN #1, when asked how Resident #41 was administered a medication he was not ordered,	F 759		

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F 759	Continued From page 81 the Folic Acid medication that was not listed on Resident #41's MAR, that had another resident's name documented on it, if she was comparing the MAR (Medication Administration Record) to the medication card. RN#1 stated she did not know how that happened. On 1/8/19 at 3:27 PM, in a follow up interview with RN#1, when asked about the five rights of medication administration, RN #1 stated, "Right person, right dose, right med, right time, right route." On 1/09/20 at 9:54 AM, in a second follow up interview with RN #1 after the medication orders were reviewed, when asked about the three missed medications, RN #1 stated that she may have missed the page (of the MAR) that these medications were listed on. A review of the facility policy, "Medication - Oral Administration of" documented, "....Review the MAR or EMAR (Medication Administration Record or Electronic Medication Administration Record) with the Physician's Order Sheet (POS) and seek clarification as indicated....Compare the medication unit/dose label against the MAR or EMAR prior to returning the medication container or card to the medication cart or disposing of the empty container; and prior to supporting the resident to accept and ingesting the medication...." On 1/8/20 at 5:50 PM, ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey.	F 759		

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F 759	Continued From page 82 References: 1. Clonidine - is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682243.html 2. Metoprolol - is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682864.html 3. Metformin - is used to treat diabetes Information obtained from https://medlineplus.gov/druginfo/meds/a696005.html 4. Depakote ER - is used to treat bipolar disorder Information obtained from https://medlineplus.gov/druginfo/meds/a682412.html 5. Accupril - is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a692026.html 6. Folic Acid - helps the body make healthy new cells. Information obtained from https://medlineplus.gov/folicacid.html 7. Azithromycin - is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a697037.html	F 759		

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F 759	Continued From page 83 8. Prednisone - reduces swelling and redness by changing the way the immune system works. Information obtained from https://medlineplus.gov/druginfo/meds/a601102.html 9. Mucinex - is used to relieve chest congestion. Information obtained from https://medlineplus.gov/druginfo/meds/a682494.html 10. Multivitamin - used to treat or prevent vitamin deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health, Information obtained from https://www.webmd.com/drugs/2/drug-18820-9038/multivitamin-oral/multivitamins-includes-prenatal-vitamins-oral/details 11. Vitamin D - Vitamins are substances that your body needs to grow and develop normally. Vitamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems. Information obtained from https://medlineplus.gov/vitamind.html 12. Glimiperide - is used to treat diabetes. Information obtained from https://medlineplus.gov/druginfo/meds/a696016.html	F 759		

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F 759	Continued From page 84 2. The facility staff failed to ensure that Resident #37 was free of medication errors. Resident #37 was administered a partial dose of a medication, and not the full dose that was ordered. Resident #37 was admitted to the facility on 12/10/19; diagnoses included but are not limited to encephalopathy, heart disease, dysphagia, diabetes, atrial flutter, abdominal aortic aneurysm, high blood pressure, cardiac pacemaker, and pneumonia. The admission / 5-day MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 12/17/19 coded the resident as significantly cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for transfers, dressing, and hygiene; was independent for eating; and was coded as incontinent of bowel and bladder. On 1/08/20 at 9:08 AM, RN #1 (Registered Nurse) was observed preparing and administering the following medications for Resident #37: Allopurinol (1) 100 mg (milligrams), 1 tablet Atenolol (2) 25 mg, 3 tablets for 75 mg (RN #1 only prepared 1·25 mg tablet). Eliquis (3) 2.5 mg, 1 tablet Multivitamin (4), 1 tablet Vitamin D3 (5), 1000 units, 2 tablets for 2000 units. On 1/8/19 at 3:27 PM, in an interview conducted with RN#1, when asked about the five rights of medication administration, RN #1 stated, "Right person, right dose, right med, right time, right route."	F 759		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 85 Review of the clinical record revealed, the physician's orders documented that the resident was to get three (3) 25 mg tablets (75 mg) of the Atenolol. RN #1 only administered one 25 mg tablet during the observation. This resulted in a medication error for Resident #37. On 1/09/20 at 9:54 AM, in a follow up interview with RN #1 after the medication orders were reviewed, when asked about the dose of the Atenolol, RN #1 stated, "I don't know. I don't know him that well." When asked if one has to know the resident really well in order to carefully check the MAR (Medication Administration Record) against the pharmacy label on the medication card, and to ensure that the correct amount of medication is prepared per orders, she stated, "Well, yes, one does." A review of the facility policy, "Medication - Oral Administration of" documented, "....Review the MAR or EMAR (Medication Administration Record or Electronic Medication Administration Record) with the Physician's Order Sheet (POS) and seek clarification as indicated....Compare the medication unit/dose label against the MAR or EMAR prior to returning the medication container or card to the medication cart or disposing of the empty container; and prior to supporting the resident to accept and ingesting the medication...." On 1/8/20 at 5:50 PM, ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey.	F 759		

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	495389	A. BUILDING _____ B. WING _____	C 01/09/2020

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F 759	Continued From page 86 References: 1. Allopurinol is used to treat gout. Information obtained from https://medlineplus.gov/druginfo/meds/a682673.html 2. Atenolol is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a684031.html 3. Eliquis is used to prevent strokes and blood clots in people with atrial fibrillation. Information obtained from https://medlineplus.gov/druginfo/meds/a613032.html 4. Multivitamin - used to treat or prevent vitamin deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health. Information obtained from https://www.webmd.com/drugs/2/drug-18820-9038/multivitamin-oral/multivitamins-includes-prenatal-vitamins-oral/details 5. Vitamin D - Vitamins are substances that your body needs to grow and develop normally. Vitamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems. Information obtained from https://medlineplus.gov/vitamind.html	F 759		

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F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure that one of 32 residents in the survey sample, Resident #37 was free significant medication errors. Resident #37 was not administered the correct dose of the blood pressure medication Atenolol (2). The findings include: Resident #37 was admitted to the facility on 12/10/19; diagnoses included but are not limited to encephalopathy, heart disease, dysphagia, diabetes, atrial flutter, abdominal aortic aneurysm, high blood pressure, cardiac pacemaker, and pneumonia. The admission / 5-day MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 12/17/19 coded the resident as significantly cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for transfers, dressing, and hygiene; was independent for eating; and was coded as incontinent of bowel and bladder. A review of the clinical record for Resident #37 revealed that on 1/8/20, during the 11pm on 1/7/20 to 7a.m., on 1/8/20 shift a blood pressure of 126/76 was obtained. On 1/8/20 during the	F 760		

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F 760	Continued From page 88 3pm to 11pm shift, a blood pressure of 136/72 was obtained. On 1/08/20 at 9:08 AM, RN #1 (Registered Nurse) was observed preparing and administering the following medications for Resident #37: Allopurinol (1) 100 mg (milligrams), 1 tablet Atenolol (2) 25 mg, 3 tablets for 75 mg (Note: RN #1 only prepared 1 tablet). Eliquis (3) 2.5 mg, 1 tablet Multivitamin (4), 1 tablet Vitamin D3 (5), 1000 units, 2 tablets for 2000 units. On 1/8/19 at 3:27 PM in an interview conducted with RN#1, when asked about the five rights of medication administration, RN #1 stated, "Right person, right dose, right med, right time, right route." Review of the clinical record revealed the physician's orders documented that the resident was to receive three (3) 25 mg tablets (75 mg) of the Atenolol. RN #1 only administered one 25 mg tablet during the observation. On 1/09/20 at 9:54 AM, in a follow up interview with RN #1, when asked about the dose of the Atenolol, RN #1 stated, "I don't know. I don't know him that well." When asked if one has to know the resident really well in order to carefully check the MAR (Medication Administration Record) against the pharmacy label on the medication card, and to ensure that the correct amount of medication is prepared per orders, she stated, "Well, yes, one does."	F 760	F760 1. Nurses responsible for resident #37s care were re-educated on the policy on medication administration on 1/8/2020. 2. Observation of medication administration will be completed for nursing staff to ensure blood pressure medication is administered per physician order by 1/31/2020. No findings were noted. 3. Nursing staff will be re-educated on medication administration by DCS/designee by 2/15/2020. 4. The DCS/designee to complete the medication administration monitor for 2 random med passes per week for four weeks to ensure compliance with blood pressure medication administration. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance 2/15/2020.	

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F 760	Continued From page 89 A review of the facility policy, "Medication - Oral Administration of" documented, "....Review the MAR or EMAR (Medication Administration Record or Electronic Medication Administration Record) with the Physician's Order Sheet (POS) and seek clarification as indicated....Compare the medication unit/dose label against the MAR or EMAR prior to returning the medication container or card to the medication cart or disposing of the empty container; and prior to supporting the resident to accept and ingesting the medication...." On 1/8/20 at 5:50 PM, ASM #1 (Administrative Staff Member - the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. References: 1. Allopurinol is used to treat gout. Information obtained from https://medlineplus.gov/druginfo/meds/a682673.html 2. Atenolol is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a684031.html 3. Eliquis is used to prevent strokes and blood clots in people with atrial fibrillation. Information obtained from https://medlineplus.gov/druginfo/meds/a613032.html 4. Multivitamin - used to treat or prevent vitamin	F 760		

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F 760	Continued From page 90 deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health. Information obtained from https://www.webmd.com/drugs/2/drug-18820-9038/multivitamin-oral/multivitamins-includes-prenatal-vitamins-oral/details 5. Vitamin D - Vitamins are substances that your body needs to grow and develop normally. Vitamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems. Information obtained from https://medlineplus.gov/vitamind.html	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		

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F 812	Continued From page 91 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT Is not met as evidenced by: Based on observation staff interview and review of facility documents it was determined the facility staff failed to store and prepare food in accordance with professional standards for food service safety. The findings include: On 01/072020 at 12:25 p.m., an observation of the facility's kitchen was conducted with OSM [other staff member] # 2, dietary manager. Observation of the reach-in refrigerator in the facility's kitchen revealed the following: One 46-ounce carton of thickened lemon water with approximately half of the contents remaining. One 46-ounce carton of thickened orange juice with approximately three-quarters of the contents remaining. Further One 46-ounce carton of thickened cranberry juice with approximately three-quarters of the contents remaining. Further observation failed to evidence an open date or a use-by-date. One quart of honey thickened milk with most of the contents remaining. One quart of honey thickened milk with most of the contents remaining. Further observation of all items above failed to evidence any open dates or a use-by-dates. OSM # 2 immediately removed the above items from the refrigerator. OSM # 2 stated that the items should be dated when they are opened, with a labeled use-by-date.	F 812	F812 1. The containers of thickened milk, orange juice, cranberry juice and lemon water were discarded on 1/7/2020. Items found to be wet nesting were removed and re-washed on 1/7/2020. 2. All kitchen refrigerators were checked for any unlabeled open items and no issues were noted on 1/9/2020. 3. Dietary staff will be re-educated on food storage policies and drying washed items by Administrator/designee by 2/15/2020. 4. The Dietary Manager/designee to complete the Food storage monitor for 3 times per week for four weeks to ensure compliance with food storage is maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance 2/15/2020.	

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F 812	Continued From page 92 Observation of the drying rack in the facility's kitchen revealed three quarter pans, four inches deep, wet nesting on the middle shelf of the drying rack. Further observation revealed two half pans, six inches deep wet nesting on the middle shelf of the drying rack. OSM # 2 immediately removed the above item from the drying rack and sent them to the dishwasher. OSM # 2 stated the pans should not be stacked wet. The facility policy "Receiving" documented in part, "All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation." The facility's policy "Manual Warewashing" documented in part, "3. All serviceware and cookware will be air dried prior to storage." On 01/08/2020 at approximately 5:50 p.m., ASM (administrative staff member) #1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN (licensed practical nurse) # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		

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F 842	Continued From page 93 except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-	F 842	F842 1. Nurses responsible for resident #43s care were re-educated on the policy on documentation of treatments on 1/8/2020. 2. Review of resident's receiving wound vac treatment and nystatin topical powder will be completed by 1/31/2020 to ensure documentation is completed. Follow-up based on findings. 3. Nursing staff will be re-educated on treatment administration documentation by DCS/designee by 2/15/2020. 4. The DCS/designee to complete the treatment administration monitor for 2 random treatments per week for four weeks to ensure compliance with documentation is maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance 2/15/2020.	

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F 842	Continued From page 94 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review it was determined that the facility staff failed to maintain a complete and accurate medical record for one of 32 residents in the survey sample, Resident #43. The facility staff failed to maintain an accurate record documenting treatments performed for applying Nystatin (medication used to treat infection) powder topically twice daily and changing the wound vac (The vacuum assisted closure (VAC) therapy (also known as negative pressure wound therapy to assist with wound healing) dressing three times a week. The findings include: Resident #43 was admitted to the facility on 12/11/2019 with diagnoses that included but were	F 842		

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F 842	Continued From page 95 not limited to osteomyelitis (1) and diabetes (2). Resident #43's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/17/2019, coded Resident #43 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. On 1/7/20 at approximately 4:30 p.m., an interview was conducted with Resident #43. Resident #43 was observed lying on top of her bed watching television. When asked about the dressing on her foot Resident #43 stated that she was staying at the facility short term to receive antibiotics for an infection in her foot. Resident #43 stated that she had just returned from the doctor's office having a check up on the foot. When asked if the staff at the facility provide treatment to the foot, Resident #43 stated that the staff change the dressing on it and keep the wound vac on it when she is at the facility. Resident #43 stated that the staff provide her with the antibiotics in her IV (intravenous) in her arm to treat the infection. Resident #43 stated that the physician had changed the dressing on her foot at the office that morning and rewrapped it with a compression bandage. When asked if staff provide the ordered Nystatin powder twice daily, Resident #43 stated that they did. The physicians order summary for Resident #43 dated "01/01/20 through 01/31/20" documented "12/11/19: Nystop (generic name for Nystatin) 100000 Unit/1G (gram) powder for Nystatin-Apply to affected areas topically twice daily" and "12/11/19 Tx (treatment)- Wound vac at pre-programmed setting every shift- change	F 842		

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F 842	Continued From page 96 dressing on Monday-Wednesday-Friday & (and) as needed." The TAR (treatment administration record) dated "01/01/20-01/31/20" for Resident #43 documented the treatment orders listed above. Review of the TAR revealed that it failed to evidence documentation of treatments being performed for the following treatments on the following dates and times: 1. "Nystatin Apply to affected areas topically twice daily." -1/1/20 on "3-11" (3:00 p.m. to 11:00 p.m.) shift. -1/2/20 on "7-3" (7:00 a.m. to 3:00 p.m.) shift and "3-11" shift. -1/3/20 on "7-3" shift and "3-11" shift. -1/5/20 on "3-11" shift. -1/6/20 on "3-11" shift. -1/7/20 on "7-3" shift and "3-11" shift. -1/8/20 on "7-3" shift. 2. "Wound vac at pre-programmed setting every shift- change dressing on Monday-Wednesday-Friday & as needed." -1/3/20. On 1/8/20 at approximately 5:10 p.m., an interview was conducted with RN (registered nurse) #2. When asked how treatments are documented, RN #2 stated that they are documented on the TAR (treatment administration record) when they are performed. When asked what blank boxes on the TAR mean RN #2 stated that she was not sure. RN #2 observed the blank boxes on Resident #43's TAR dated "01/01/20-01/31/20" for the Nystatin topically twice daily and changing the wound vac dressing on the dates listed above. RN #2 stated that the blanks mean that the nurse did not sign	F 842		

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F 842	Continued From page 97 the TAR to document the treatment was done. RN #2 stated that the treatment book might have been in a different area when the nurse was charting, the nurse may have forgotten to sign the TAR, or that the treatment may have not been done. When asked if it could be determined if the treatment was administered according to the documentation on the TAR, RN #2 stated that it could not be determined. RN #2 stated that the treatment should have been signed off on the record to document it as being completed. On 01/09/20 at approximately 12:30 p.m., a request was made by written list to ASM (administrative staff member) #1, the executive director for the facility policy on maintaining an accurate and complete medical record. On 01/09/20 at approximately 1:00 p.m., ASM #3, the regional director of clinical services stated that the facility did not have a policy for maintaining an accurate medical record. On 01/20/20 at approximately 1:30 p.m., ASM (administrative staff member) #2, the director of nursing confirmed that the facility uses their policies, Lippincott, and Potter & Perry as their standard of practice. According to "Fundamentals of Nursing Made Incredibly Easy Lippincott Williams and Wilkins, Philadelphia PA page 23: Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of documentation provides an accurate depiction of patient and family care,	F 842		

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F 842	Continued From page 98	F 842		

quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team."

The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients."

On 01/09/20 at approximately 1:00 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and LPN (licensed practical nurse) #5 were made aware of the findings.

No further information was provided prior to exit.

References:

1. Osteomyelitis
Osteomyelitis is the medical term for inflammation in a bone. It's usually caused by a bacterial infection. It often affects the long bones of the arms and legs, but can happen in any bone. This information was obtained from the website:
https://kidshealth.org/en/parents/osteomyelitis.ht

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F 842	Continued From page 99 ml 2. Diabetes A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		

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F 880	Continued From page 100 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident	F 880	F880 1. Residents #41, #163 and #25s incentive Spirometer replaced with a new one and placed in a respiratory bag on 1/8/2020. Nebulizer mask for residents #41, #47, and #25 replaced with a new one and placed in a respiratory bag on 1/8/2020. The nurse providing care for resident #37 was reeducated on not handling medications with bare hands on 1/8/2020. 2. Audit to ensure incentive spirometers and nebulizer masks are stored in respiratory bags was completed and no issues of non-compliance were noted on 1/31/2020. Observation of medication administration will be completed for nursing staff to ensure medications are not touched by bare hands by 1/31/2020. Follow up based on findings.	

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F 880	Continued From page 101 interview, clinical record review, and facility document review, it was determined that the facility staff failed to follow infection control practices for four of 32 residents in the survey sample; Residents #41, #37, #47, #163, and #25. The facility staff failed to store Resident #41's nebulizer and Incentive spirometer in a manner to prevent infections. Resident #41's nebulizer mask and Incentive spirometer were observed uncovered on the residents over the bed table. The facility staff failed to prepare and administer medications to Resident #37, in a manner to prevent the spread of infection. RN (registered nurse) #1 was observed touching medications in a plastic medication cup with her ungloved finger. The facility staff failed to maintain infection control practices in the storage of a nebulizer for Resident #47, the storage of Resident #163's incentive spirometer and Resident #25's nebulizer and incentive spirometer to prevent infection. The findings include: 1. Resident #41 was admitted to the facility on 8/7/19; diagnoses included but are not limited to hydrocephalus, psychotic disorder, right kidney cancer with removal of kidney, cardiac defibrillator, high blood pressure, atrial fibrillation, diabetes, bipolar disorder, spinal stenosis with fusion, and cerebral palsy. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/21/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, toileting, dressing, and transfers; supervision for eating and hygiene; and was incontinent of bowel and	F 880	3. Nursing staff will be re-educated on Infection control and medication handling, including storing incentive spirometers and nebulizer masks in respiratory bags and not touching medications with bare hands by DCS/designee by 2/15/2020. 4. The DCS/designee to complete the respiratory quality monitor for any residents with incentive spirometer and nebulizers to ensure compliance is maintained weekly for four weeks. The DCS/designee to complete the medication administration monitor for 2 random med passes per week for four weeks to ensure medications are not touched with bare hands. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance 2/15/2020.	

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F 880	Continued From page 102 bladder. A review of the facility policy, "Nebulizer" documented, "Place entire unit in a bag to be maintained in the resident's room." A review of the facility policy, "Incentive Spirometer" did not document any criteria for maintaining the device in a sanitary manner between uses. On 1/07/20 at 12:10 PM, an observation was made of Resident #41's room. Resident #41 was not in the room. An Incentive Spirometer was observed on the over bed table. It was not covered. A nebulizer machine and mask was observed on nightstand next to the bed. The mask was not covered. On 1/08/20 at 8:52 AM, the resident was observed in bed. The Incentive Spirometer and nebulizer mask remained uncovered as previously observed. On 1/08/20 at 1:00 PM, the resident was observed and an interview conducted. The over bed table was across the resident. The incentive spirometer was on the table, uncovered. There was no bag present to cover and store the incentive spirometer. Observation of the nebulizer mask revealed it was now covered, in a new bag and dated. Resident #41 stated that he has used both items on occasion and that to his recollection neither item had been covered. On 1/8/20 at 1:07 PM, in an interview with RN #1 (Registered Nurse), she stated that the nebulizer mask should be covered. She stated the incentive spirometer should be wiped clean. RN	F 880		

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F 880	Continued From page 103 #1 stated, "I guess it should be stored in a bag but I was never told that." On 1/8/20 at 5:50 PM, ASM #1 (Administrative Staff Member - the Excutive Director) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. 2. The facility staff failed to prepare and administer medications to Resident #37, in a manner to prevent the spread of infection. RN (registered nurse) #1 was observed touching medications in a plastic medication cup with her ungloved finger. Resident #37 was admitted to the facility on 12/10/19; diagnoses include but not limited to, encephalopathy, heart disease, dysphagia, diabetes, atrial flutter, abdominal aortic aneurysm, high blood pressure, cardiac pacemaker, and pneumonia. The admission / 5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/17/19 coded the resident as significantly cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for transfers, dressing, and hygiene; was independent for eating; and incontinent of bowel and bladder. On 1/08/20 at 9:08 AM, RN #1 (Registered Nurse) was observed to preparing and administering the following medications to Resident #37: " Allopurinol (1) 100 mg (milligrams), 1 tablet	F 880		

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F 880	Continued From page 104 " Atenolol (2) 25 mg, 3 tablets for 75 mg " Eliquis (3) 2.5 mg, 1 tablet " Multivitamin (4), 1 tablet " Vitamin D3 (5), 1000 units, 2 tablets for 2000 units. The Eliquis was missing from the medication cart. RN #1 closed up the cart and carried the medication cup that contained the other medications to the medication room to obtain the missing Eliquis from the stat box. RN #1was observed with her finger down in the medication cup that contained the medications, touching the pills while she was carrying it. RN #1 returned to the cart with the medications, and then crushed the medications and administered them to Resident #37. On 1/08/20 at 3:16 PM, in an interview conducted with RN #1, she stated that you shouldn't touch the medication with your fingers. RN #1 stated, "I didn't realize I was doing that. I know better than to do that. I know that you are not supposed to touch the pills." A review of the facility policy, "Medication - Oral Administration of" documented, "....Refrain from touching powders, capsules, or pills with hands." On 1/8/20 at 5:50 PM, ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. References: 1. Allopurinol is used to treat gout.	F 880		

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F 880	Continued From page 105 Information obtained from https://medlineplus.gov/druginfo/meds/a682673.html 2. Atenolol is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a684031.html 3. Eliquis is used to prevent strokes and blood clots in people with atrial fibrillation. Information obtained from https://medlineplus.gov/druginfo/meds/a613032.html 4. Multivitamin - used to treat or prevent vitamin deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health. Information obtained from https://www.webmd.com/drugs/2/drug-18820-9038/multivitamin-oral/multivitamins-includes-prenatal-vitamins-oral/details 5. Vitamin D - Vitamins are substances that your body needs to grow and develop normally. Vitamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems. Information obtained from https://medlineplus.gov/vitamind.html 3. The facility staff failed to maintain infection control practices in the storage of a nebulizer (1) for Resident #47.	F 880		

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F 880	Continued From page 106 Resident #47 was admitted to the facility 12/13/2019 with diagnoses, that included but were not limited to congestive heart failure (2), pneumonia (3) and chronic obstructive pulmonary disease (4). Resident #47's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/19/19, coded Resident #47 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. On 1/7/19 at approximately 2:30 p.m., an interview was conducted with Resident #47. Observation of Resident #47's room revealed a nebulizer delivery device on the top of a nightstand, which was located to the right side of the bed. The nebulizer device was observed uncovered with the mouthpiece touching the wood of the nightstand top. When asked about the nebulizer Resident #47 stated that she used it as needed. Resident #47 stated that she had been admitted with pneumonia and had required it frequently on admission and had not used it lately since she had been feeling better. When asked if the nebulizer was ever placed in a bag or covered between uses, Resident #47 stated that she did not remember it being covered. Further observation of Resident #47's room revealed an oxygen concentrator located on the right side of the bed with a nasal cannula (oxygen delivery device) in a plastic bag and a prefilled humidifier bottle of sterile water dated 12/23/19. When asked about the oxygen Resident #47 stated that she had not used it recently. Resident #47 stated that she used her oxygen when she first came	F 880		

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F 880	Continued From page 107 into the facility in the middle of December but had not used it recently but it was there in case she felt that she needed it. The order summary report dated 01/01/20 through 01/31/20 documented, "12/22/19 Duoneb Albuterol (5) inhale 1 (one) unit dose via (by way of) nebulizer every 6 (six) hours as needed," and "12/14/19 Oxygen @ (at) 2 (two) LPM (liters per minute) via (by way of) N/C (nasal cannula) to maintain sats (oxygen saturations) > (greater than) 92%." The "Physician's Interim/Telephone Orders" dated "12/15/19" documented, "Duonebs tx (treatment) via inhalation q6 (every six hours) x3 (for three) days prn (as needed)." The MAR (medication administration record) dated "December 2019" for Resident #47 documented the physician orders above. The MAR documented Resident #47 receiving the Duoneb nebulizer treatment on 12/16/19 and 12/17/19, no time of administration was documented for either date. The MAR further documented Resident #47 receiving the Duoneb nebulizer treatment on 12/18/19 at 6:00 a.m., and 12:00 p.m., on 12/19/19 at 6:00 a.m., 12:00 p.m., 6:00 p.m., and 12:00 a.m., and on 12/20/19 at 6:00 a.m., 12:00 p.m., and 12:00 a.m. The MAR (medication administration record) dated "December 2019," and "January 2020" for Resident #47 failed to evidence documentation of oxygen for Resident #47. The TAR (treatment administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen for Resident #47.	F 880		

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F 880	Continued From page 108 The comprehensive care plan for Resident #47 failed to evidence documentation for nebulizer treatments or oxygen administration. On 1/08/20 at 1:00 p.m., an interview was conducted with LPN (licensed practical nurse) #4, regarding the process staff follows for handling nebulizer delivery devices. LPN #4 stated that they are cleaned after each use, and then stored in a bag. LPN #4 stated that the bags are changed weekly on Sundays. When asked why staff clean and store the nebulizers in this manner, LPN #4 stated that if they, (nebulizer) are left uncovered they could be exposed to germs, which can cause infection when used by the resident. When asked how often sterile water humidifier bottles on the oxygen concentrators are changed, LPN #4 stated that they are changed weekly on Sundays or before if needed. When asked why they are changed weekly, LPN #4 stated that it is an infection control practice. When asked if the oxygen is used as needed would it make a difference in how often the water bottle is changed, LPN #4 stated that it should still be changed weekly. An observation was conducted with LPN #4 of the uncovered nebulizer device with the mouthpiece touching the wood of the nightstand top. LPN #4 stated that it (nebulizer) should be in a bag. An observation was made with LPN #4 of the sterile water humidifier bottle dated "12/23/19" located in Resident #47's room. LPN #4 stated that it (sterile water humidifier bottle) was dated 12/23/19 and that should have been changed 12/30/19. LPN #4 agreed that the oxygen and the nebulizer were available for use for Resident #47.	F 880		

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F 880	Continued From page 109 On 01/09/20 at approximately 12:30 p.m., a request was made by written list to ASM (administrative staff member) #1, the executive director for the facility policy on nebulizers and oxygen. On 01/20/20 at approximately 1:30 p.m., ASM (administrative staff member) #2, the director of nursing stated that the facility uses their policies, Lippincott, and Potter & Perry as their standard of practice. The facility policy "Nebulizer (small volume nebulizer), Effective Date: 11/30/2014; Revision Date: 03/20/2018" documented in part, " ...Disassemble device and rinse the mouthpiece and nebulizer cup with water and air dry. Place the entire unit in a bag to be maintained in the resident's room." The facility policy "Oxygen Therapy, Effective Date: 11/30/2014; Revision Date: 08/28/2017" documented in part, "Follow infection control procedures, as appropriate ...Label tubing and humidifier with date and time." In "Fundamentals of Nursing" 7th edition, 2009; Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment." "The humidification system may be a source of bacteria. Pseudomonas aeruginosa is frequently the organism involved. Oxygen delivery equipment such as cannulas and masks can also harbor organisms." (Ignatavicius, D. & Workman, L. (2002) Medical Surgical Nursing, Critical	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 110 Thinking for Collaborative Care, 4th edition. (p.492) Philadelphia, Pennsylvania: W. B. Saunders Company.) On 01/08/20 at approximately 5:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and LPN (licensed practical nurse) #5 were made aware of the findings. On 1/9/20 at approximately 8:00 a.m., ASM (administrative staff member) #3, the regional director of clinical services provided a copy of "Physician's Interim/Telephone Orders" for Resident #47 which documented, "DC (discontinue) O2 (oxygen), Duonebs (nebulizer medication) & (and) IS (incentive spirometer)" dated "1/8/20, 1610 (4:10 p.m.)." No further information was provided prior to exit. Reference: 1. Nebulizer - "a device used to aerosolize medications for delivery to patients." Taken from Encyclopedia & Dictionary of Medicine, Nursing & Allied Health -Seventh Edition, Miller-Keane, page 1182. 2. Congestive heart failure A condition in which the heart can't pump enough blood to meet the body's needs. This information was obtained from the website: https://medlineplus.gov/heartfailure.html 3. Pneumonia is an infection in one or both of the lungs. This information was obtained from the website: https://medlineplus.gov/pneumonia.html.	F 880		

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F 880	Continued From page 111 4. Chronic obstructive pulmonary disease (COPD) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 5. Duoneb Albuterol The combination of albuterol and ipratropium is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Albuterol and ipratropium combination is used by people whose symptoms have not been controlled by a single inhaled medication. Albuterol and ipratropium are in a class of medications called bronchodilators. Albuterol and ipratropium combination works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html 4. Resident # 163 was admitted to the facility on 01/03/2020 with diagnoses that included but were not limited to high blood pressure and chronic obstructive pulmonary disease [2]. Resident # 163's most recent MDS (minimum data set), was not due at the time of the survey. The facility's "Admission Data Collection" sheet dated 01/03/2020 for Resident # 163 documented in part, "Cognition: Alert, Oriented to Person." Under "Communication" it documented, "Usually	F 880		

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F 880	Continued From page 112 Understood and Understands." Under "Respiratory", it documented, "Special Treatments and Procedures: None per history and/or observation." On 01/07/20 at 1:49 p.m., an observation of Resident # 163's over-the-bed table revealed an incentive spirometer. Observation of the incentive spirometer failed to evidence that it was placed in a bag or covered. On 01/07/20 at 2:43 p.m., an observation of Resident # 163's over-the-bed table revealed an incentive spirometer. Observation of the incentive spirometer failed to evidence that it was placed in a bag or covered. On 01/07/20 at 4:05 p.m., an observation of Resident # 163's over-the-bed table revealed an incentive spirometer. Observation of the incentive spirometer failed to evidence that it was placed in a bag or covered. On 01/08/20 at 8:25 a.m., an observation of Resident # 163's over-the-bed table revealed an incentive spirometer. Observation of the incentive spirometer failed to evidence that it was placed in a bag or covered. The POS [physician's order sheet] dated 01/01/2020 through 01/31/2020 and signed by the physician on 01/04/2020 for Resident # 163 failed to evidence documentation for the use of an incentive spirometer. The facility's baseline care plan for Resident 163 dated 01/03/2020 failed to evidence documentation for the use of an incentive spirometer.	F 880		

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F 880	Continued From page 113 On 01/08/20 at 8:30 a.m., an interview was conducted with Resident # 163. When asked if they used the incentive spirometer, Resident # 163 stated sometimes. On 01/08/2020 at 1:00 p.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked if an incentive spirometer was a piece of respiratory equipment, LPN # 4 stated yes. When how the incentive spirometer should be stored when not in use, LPN # 4 stated it should be covered or placed in a bag. LPN # 4 was shown Resident # 163's incentive spirometer on the over-the-bed table. LPN # 4 stated it should be covered. When asked why the incentive spirometer should be covered, LPN # 4 stated, "It could collect germs and could cause an infection when used by the resident." On 01/08/2020 at approximately 5:50 p.m., ASM # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit. References: [1] A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well inflated and healthy while you heal and helps prevent lung problems, like pneumonia. . This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm.	F 880		

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F 880	Continued From page 114 [2] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 5. The facility staff failed to store nebulizer mask and an incentive spirometer [1] in a sanitary manner. Resident # 25 was admitted to the facility on 11/20/2019 with diagnoses that included but were not limited to respiratory failure, shortness of breath and chronic obstructive pulmonary disease [1]. Resident # 25's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/29/19, coded Resident # 25 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. Resident # 25 was coded as requiring extensive assistance of one staff member for activities of daily living. Section O "Special Treatments, Procedures and Programs" coded Resident # 25 for the use of oxygen. On 01/07/20 at 1:25 p.m., an observation of Resident # 25's bedside table revealed a nebulizer and a nebulizer mask sitting on top of the table. Observation of the nebulizer mask revealed it was uncovered. When asked if they receive nebulizer treatments, Resident # 25 stated yes. Further observation of the bedside table revealed an incentive spirometer uncovered. When asked if they use the incentive spirometer, Resident # 25 stated yes.	F 880		

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F 880	Continued From page 115 On 01/07/20 at 2:45 p.m., an observation of Resident # 25's bedside table revealed a nebulizer and a nebulizer mask sitting on top of the table. Observation of the nebulizer mask revealed it was uncovered. Further observation of the bedside table revealed an incentive spirometer uncovered. On 01/07/20 at 4:05 p.m., an observation of Resident # 25's bedside table revealed a nebulizer and a nebulizer mask sitting on top of the table. Observation of the nebulizer mask revealed it was uncovered. Further observation of the bedside table revealed an incentive spirometer uncovered. On 01/08/20 at 8:30 a.m., an observation of Resident # 25's bedside table revealed a nebulizer and a nebulizer mask sitting on top of the table. Observation of the nebulizer mask revealed it was uncovered. Further observation of the bedside table revealed an incentive spirometer uncovered. The "Physician's Telephone Order" dated 12/27/2019 documented, "Duo nebs Q [every] 4 [four] hours for SOB [shortness of breath]." Further review of the clinical record failed to evidence a physician's order for the use of an incentive spirometer. The comprehensive care plan for Resident # 25 with a revision date of 12/03/2019 documented, "Focus: [Resident # 25] has COPD [chronic obstructive pulmonary disease]. Date Initiated: 12/03/2019." Under "Interventions" it documented, "Give nebulizer treatments and oxygen therapy as ordered. Date Initiated: 12/03/2019."	F 880		

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F 880	Continued From page 116 On 01/08/2020 at 1:00 p.m., an interview was conducted with LPN [licensed practical nurse] # 4. When asked if an incentive spirometer was a piece of respiratory equipment, LPN # 4 stated yes. When how the incentive spirometer should be stored when not in use, LPN # 4 stated it should be covered or placed in a bag. When asked how a nebulizer mask should be stored when not in use, LPN # 4 stated it should be placed in a bag. When shown Resident # 25's nebulizer mask and incentive spirometer on the bedside table LPN # 4 stated the incentive spirometer and nebulizer mask should be covered. On 01/08/2020 at approximately 5:50 p.m., ASM # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of the findings. No further information was provided prior to exit. References: [1] A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. . This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm.	F 880		