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	495368	A. BUILDING _____ B. WING _____	05/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 05/29/19 through 05/31/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 05/29/2019 through 05/31/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 60 certified bed facility was 37 at the time of the survey. The survey sample consisted of 18 current Resident reviews and 5 closed record reviews.	F 000		
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	F 656		7/12/19

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

Electronically Signed | 06/21/2019

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 656	Continued From page 1 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation the facility staff to develop one of 23 residents (Resident #34) comprehensive personal centered care plans in the survey sample. The facility staff failed to develop a person-centered care plan to include the following: *Atrial Fibrillation with the use of anticoagulation, *Psychosis and Major depressive	F 656	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements.	

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F 656	Continued From page 2 disorder with the use of antipsychotic medication use. The findings included: Resident #34 was originally admitted to the nursing facility on 04/30/19. Diagnoses for Resident #34 included, but not limited to, Atrial Fibrillation, Unspecified Psychosis and Major Depressive Disorder. The current Minimum Data Set (MDS) a 14-Day PPS with an Assessment Reference Date (ARD) of 05/14/19 coded the resident with a 15 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. The residents MDS was coded for the usage of antipsychotic and anticoagulation. The section N on the MDS under medications read as follows: Indicate the number of DAYS the resident receiving the medication during the last 7 days, the MDS was coded for receiving an antipsychotic and anticoagulation for 7 days. The review of Resident #34's Physician Order Sheet indicated the following anticoagulation order: Eliquis 5 mg one tablet two times daily starting on 04/30/19 for Atrial Fibrillation. The review of Resident #34's Physician Order Sheet indicated the following antipsychotic/psychosis order: Seroquel 300 mg one tablet by mouth daily at bedtime for psychosis and Abilify15 mg-give one tablet daily starting on 04/30/19 for psychosis and Major Depressive disorder The review of Resident #34's comprehensive care plan did not include a care plan for Atrial	F 656	1. The care plan for Resident #34 was updated to include use of an anticoagulant for the treatment of Atrial Fibrillation and an antipsychotic treating psychosis and depression. 2. The Director of Nursing/ designee will review the care plans of residents currently receiving anticoagulants and/or psychoactive medications to ensure there is a person centered care plan in place addressing the use of these medications. If variances are identified, the care plan will be updated to reflect the current status. 3. RNs and LPNs who are responsible for the care plan process were re-educated on "Person Centered Care Plans" by the Assistant Director of Nursing Operations/ designee. The in-service included a review of the facility policy "Person Centered Baseline and Comprehensive Care Plans." Staff were also educated on the importance of addressing resident conditions that may warrant use of anticoagulant and psychoactive medications. 4. The Director of Nursing/ designee will audit twenty percent of care plans weekly for a period of six weeks to ensure the care plan reflects the use of anticoagulants or psychotropic medications. The Director of Nursing/ designee will identify any patterns or trends and report results to the Quality Assurance and Performance Improvement committee at least quarterly.	

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Fibrillation with the use of an anticoagulation medication and Major depression disorder and psychosis with use a psychoactive medication.

An interview was conducted with the Director of Nursing (DON) on 05/31/19 at approximately 11:10 a.m. When asked who was responsible for the development and revision of the resident person-centered care plan, The DON replied, "We all can but the Assistant Director of Nursing (ADON) is mainly responsible." The DON said there should have been an anticoagulation and psychoactive care plan because the resident was taking Eliquis, Seroquel and Ability. When asked what was the purpose of a having an accurate person-centered-care plan, the DON replied, "It allows everyone to know what is going on with the resident and how to manage their care." She stated the care plan should be accurate according to the physician orders.

An anticoagulation care plan was given to the surveyor that was created on 05/31/19, but only created after it was requested by the surveyor. The review of the anticoagulation care plan included but not limited to the following information: Resident is at risk for bleeding related to anticoagulant use: resident is on Eliquis. The goal: will not experience any negative outcomes from use of the anticoagulant medication. Some of the intervention/approaches to manage goal included to monitor for interaction with other ordered medications, administer medication as ordered, monitor for busing or bleeding after venipuncture and obtain lab work as ordered and report any abnormal findings to the physician.

A psychoactive medication care plan was given to

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F 656	Continued From page 4	F 656		

the surveyor that was created on 05/31/19, but only created after it was requested by the surveyor. The review of the psychoactive care plan included but not limited to the following information: Resident will achieve desired effect from ordered medications and will experience no negative effects from medication use as ordered. Some of the intervention/approaches to manage goal included to observe and report signs/symptoms of tardive dyskinesia, Consulting Pharmacist Medication Regimen Review at least monthly, consult and coordinate care with mental health professional per physician order and targeted behaviors and side effects are being monitored.

A pre-exit meeting was held with the Vice President of Operations Administrator, Director of Nurse Operation, Assistant Director of Nurse Operations, and Director of Nursing on 05/31/19 at approximately 3:05 p.m. The facility did not present any further information about the findings.

The facility's policy: Person-Centered Baseline and Comprehensive Care Plan (Revision date: 05/17/18.)

Goal/Objectives:
-Reflect the outcome(s) desired/anticipated from the care, services, and support provided in response to the specific problems/concerns.

Interventions/Approaches include but not limited to:
-States what is to be done to assist the resident to achieve their outcomes.
-Relates to the cause of the problem identified during assessment.
-Monitor resident for compliance with care plan to

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include approaches.
-The Director of Nursing/designee will be the coordinator of the care plan process.

Comprehensive Care Plans:
-Are oriented toward prevention and resident centered individualized care including his/her preference and goals.

Definitions:

*Atrial Fibrillation is the most common type of arrhythmia. An arrhythmia is a problem with the rate or rhythm of the heartbeat. During an arrhythmia, the heart can beat too fast, too slow, or with an irregular rhythm. (Source: www.Nhlbl.nih.gov)

*Psychosis is a mental disorder characterized by a disconnection from reality.

*Major depression disorder is a chronic (ongoing) type of depression in which a person's moods are regularly low (Mosby's Dictionary Medicine, Nursing & Health Professions 7th edition).

*Eliquis is used help prevent strokes or blood clots in people who have Atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease (https://medlineplus.gov/ency/article/007365.htm).

*Seroquel tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive

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F 656	Continued From page 6 disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods) (https://medlineplus.gov/ency/article/007365.htm). *Abilify is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain (https://medlineplus.gov/ency/article/007365.htm).	F 656		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review, the facility staff failed to ensure 1 of 23 residents (Resident #27) in the survey sample who was unable to carry out activities of daily living, received the necessary services to maintain toenail care. The facility staff failed to provide podiatry services for Resident #27. The findings included:	F 687	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements. 1. Podiatry services were provided to Resident #27 on June 10, 2019. The staff	7/12/19

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F 687	Continued From page 7 Resident #27 was originally admitted to the facility on 10/31/18. The current diagnoses included: Hypotension, Major Depressive Disorder, Difficulty in walking and Type II Diabetes Mellitus. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/07/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #27's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as being a two person physical assist with transfers and one person physical assistance with dressing, eating, bathing and toileting. On 05/29/19 at approximately 1:16 PM, a lower extremity assessment was done by RN (Registered Nurse) #1 with the Resident's permission. Resident #27's 3rd and 4th toenails on his right foot were long and thick; they were hanging over his toes straight out. On 05/29/19 at 3:40 PM, an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #27's nurse, concerning the resident's toenails. She assessed his toenails and stated that she felt that he needed podiatry services. She also stated "We do our skin checks or the CNA's will let us know." She stated, "Then we notify the ADON (Assistant Director of Nursing) and they will notify the podiatrist." "I just notified the charge nurse and she notified the ADON that Resident #27 need podiatry services." On 05/29/19 at approximately 3:46 PM, a review of the facility's podiatry book was made. Per the	F 687	have been re-educated on foot care and the importance of ensuring diabetic residents are seen by the podiatrist on a routine basis. 2. The Charge Nurse/designee will inspect all current residents to ensure foot care and/or podiatry services have been provided as needed. Any variances noted will be corrected and foot care and/or podiatry services will be obtained. 3. The Director of Nursing/designee will re-educate RNs, LPNs and CNAs on "Foot Care." The in-service will include but not limited to a review of the facility foot care policy as well as the process for obtaining podiatry services if facility staff unable to provide sufficient foot care. 4. The Director of Nursing/ designee will inspect twenty percent of current residents weekly for a period of six weeks to ensure foot care and/or podiatry services have been provided to current residents. The Director of Nursing/ designee will identify any patterns or trends and report results to the Quality Assurance and Performance Improvement committee at least quarterly.	

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F 687	Continued From page 8 staff, Resident #27's name was just added to podiatry book. It was also confirmed by LPN #2 that he had not received podiatry services since his admission in October 2018. On 5/31/19 at approximately 9:30 AM the policy on foot care was received and included: Routine foot care should be provided as part of the resident's daily care. When indicated, a podiatrist should be consulted. The Purpose: To prevent infection. To prevent break in skin integrity of the feet. To promote peripheral circulation. To promote cleanliness. The Procedure: NOTES the following: Nail care for residents with thick mycotic nails or other problems should be provided by a licensed nurse or podiatrist. Residents with specific conditions including: IDDM (Insulin Dependent Diabetes Mellitus), PVD (Peripheral Vascular Disease) or long term anticoagulation therapy should have a podiatrist consult. The head/charge nurse should be notified of abnormal findings (corns, calluses, bunions, or breaks in the skin surface etc.) On 05/31/19, at approximately 3:05 PM, the above findings were shared with the Administrator, Director of Nursing and corporate consultant during the exit interview. The DON stated that the nurses and or nurses aides should have referred the resident for podiatry care.	F 687		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		7/12/19

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F 695	Continued From page 9 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide respiratory services consistent with professional standards of care and the comprehensive person-centered care plan for one of 23 residents in the survey sample, Resident #22. For Resident #22, facility staff failed to administer oxygen at the correct liters per minute per order and comprehensive care plan. The findings include: Resident #22 was admitted to the facility on 12/14/16 with diagnoses that included, but were not limited to, adult failure to thrive, vascular dementia, respiratory failure and osteoporosis. Resident #22's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (Assessment Reference Date) of 4/24/19. Resident #22 was coded as being severely impaired in cognitive function scoring 03 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #22 was coded in section O (Special treatments, procedures, and programs) as receiving oxygen therapy. Review of Resident #22's May 2019 MAR (Medication Administration Record) revealed the following order: "Oxygen at 2 L (liters)/minute per nasal cannula PRN (as needed)."	F 695	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements. 1. The liters per minute of oxygen administered to Resident #22 was adjusted to correspond with the current physician's order on May 30, 2019. The resident was assessed and was without negative outcome related to the oxygen liter flow. The staff have been re-educated on the importance of monitoring the flow meter on the oxygen concentrator/ tank to ensure oxygen is administered at the prescribed rate. 2. An audit was conducted for all residents with current oxygen orders. The audit included inspecting all concentrator/tank flow meters to ensure the oxygen was set at the ordered liters per minute. The nursing staff will be responsible for ensuring the oxygen equipment is set at the ordered liters per minute. 3. RNs and LPNs were re-educated on	

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F 695	Continued From page 10 Resident #22's oxygen saturation care plan dated 4/25/18 documented the following: "(Name of Resident) unable to maintain 02 saturation. Receives oxygen at 2 L (liters)/min PRN SOB (shortness of breath)." Observations were made of Resident #22 on 5/30/19 at 9:33 a.m., 10:22 a.m., 2:30 p.m. and 3:11 p.m.. Her oxygen flow meter was set to 3 liters per minute instead of the ordered 2 liters. On 5/30/19 at 2:56 p.m., an interview was conducted with LPN (Licensed Practical Nurse), Resident #22's nurse that shift. When asked how she knew how many liters of oxygen a resident needed to be on, LPN #1 stated that she would look at physician's order to determine the liters of oxygen for that resident. LPN #1 stated that following the order was important because if a resident has COPD (chronic obstructive pulmonary disease) for instance; too much oxygen could drive up with C02 (carbon dioxide). When asked why Resident #22 was on oxygen, LPN #1 stated it was prn (as needed) for comfort but that she wanted to wear it all the time. When asked how many liters Resident #22 should be on; LPN #1 stated that her order was for 2 liters. When asked how often nurses check oxygen concentrator and flow meter, LPN #1 stated that she checked every day. LPN #1 stated that she had been in Resident #22's room that day but that she had so many residents on oxygen, she sometimes gets mixed up with how many liters they need to be on. LPN #1 followed this writer to Resident #22's room and at 3 p.m., LPN #1 confirmed that Resident #22 was on 3 liters. LPN #1 stated,"It's reading at 3 liters." LPN #1 then adjusted Resident #22's oxygen flow meter to 2 liters. A few minutes later LPN #1 then changed	F 695	"Oxygen Settings" by the Director of Nursing/ designee. The in-service included a review of the facility oxygen administration policy as well as the importance of checking the liter flow on the oxygen concentrator/tank ensuring it is set at the appropriate liter per current physician's order. 4. The Charge Nurse/ designee will inspect daily all oxygen concentrator/tanks for residents with current oxygen orders to ensure oxygen is set at prescribed rate. The Director of Nursing/ designee will identify any patterns or trends and report results to the Quality Assurance and Performance Improvement Committee at least quarterly.	

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F 695	Continued From page 11 her first initial observation and stated that the ball (ball used to adjust the flow of oxygen) was actually a little bit above the two line but that she had fixed it. When asked the purpose of the care plan, LPN #1 stated that the purpose of the care plan was to make sure the resident gets everything they need medically. LPN #1 stated that it was important for the care plan to be followed and accurate. When asked if Resident #22's care plan was being followed if her 02 was set at the wrong rate, LPN #1 stated that it was not followed. On 5/31/19 at 3:05 p.m., ASM (Administrative Staff Member) #1, the Administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled,"Oxygen Administration" documents in part, the following: "...Procedure: Check physician's order to verify liter flow and method of administration."	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to maintain a complete pain management program consistent with professional standards of practice and the	F 697	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is	7/12/19

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F 697	Continued From page 12 comprehensive person centered care plan for two of 23 residents in the survey sample, Resident #6 and #22. 1. For Resident #6, facility staff failed to document the location of pain prior to administering pain medications on several occasions in May 2019. 2. For Resident #22, facility staff failed to document the location of pain prior to administering pain medication on two occasions in May of 2019. The findings include: 1. Resident #6 was admitted to the facility on 6/13/15 with diagnoses that included, but were not limited to, atrial fibrillation, high blood pressure, and adult failure to thrive. Resident #6's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/15/19. Resident #6 was coded as being severely impaired in cognitive function scoring 03 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #6 was coded in Section J (Pain Assessment Interview) as having frequent mild pain. Review of Resident #6's May 2019 POS (physician order summary) revealed the following order: "Hydrocodone 5 mg (milligrams)-acetaminophen 325 mg tablet (1) (1 tab) TABLET oral As Needed Every Four Hours Starting 6/01/2017...moderate pain." Review of Resident #6's May MAR (Medication Administration Record) revealed that she	F 697	an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements. 1. The medical record for residents #6 and #22 were updated to reflect documentation of a complete pain assessment to include pain location. The residents were assessed and were without negative outcome. 2. The medical records of all current residents receiving as needed pain medications were reviewed to ensure location of pain has been documented prior to administration of as needed pain medication and any variances have been addressed. The medication nurses will be responsible for documenting location of pain prior to administration of as needed pain medications. 3. RNs and LPNs were re-educated on "Pain Management" by the Director of Education/ designee. The in-service included a review of the "Pain Management" policy as well as the importance of documenting the location of pain on the medication administration record when an as needed pain medication is administered. 4. The Director of Nursing/designee will review ten current resident medication administration records weekly for a period of six weeks to ensure pain location is documented prior to administration of as needed pain medication. The Director of	

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F 697	Continued From page 13 received the above medication 17 times in May. On the corresponding pain assessment on the MAR, location of pain was not documented for the following dates and times: 5/7/2019 at 3:30 a.m., 5/11/19 at 12:19 a.m., 5/11/19 at 9:55 p.m., 5/21/19 at 12:56 a.m., 5/22/19 at 8:52 a.m., 5/23/19 at 7:42 p.m., 5/25/19 at 4:10 a.m., 5/25/19 at 7:06 p.m., 5/27/19 at 4:11 p.m., 5/29/19 at 5:05 p.m., and 5/30/19 at 3:37 a.m. Review of Resident #6's May nursing notes failed to evidence location of pain for the above dates and times. Further review of Resident #6's nursing notes revealed that Resident #6 frequently had pain to her bilateral legs. Resident #6's pain management care plan dated 9/13/18 documented in part the following: "Potential for pain due to BLE (bilateral lower extremity) contractures...Encourage (Name of Resident) to identify intensity, quality, and location of pain." On 5/31/19 at 9:58 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #6's nurse. When asked the process if a resident complains of pain, LPN #2 stated that she would go assess the pain, ask the location, intensity and have the resident rate the pain on a scale of 1-10 (10 being the worst possible pain). LPN #2 stated that for resident who cannot verbalize pain, she would look for non-verbal cues such as grimacing or guarding any part of the body. LPN #2 stated that she would attempt non-pharmacological pain	F 697	Nursing/designee will identify any patterns or trends and report results to the Quality Assurance and Performance Improvement committee at least quarterly.	

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F 697	Continued From page 14	F 697		

interventions prior to administering pain medications and then she would administer pain medications, if non-pharms were ineffective. When asked if she would document her complete pain assessment, LPN #2 stated that she would. When asked where she would document the complete pain assessment, LPN #2 stated that the pain assessment was documented in a nursing note or on the MAR. When asked if location of pain was an important piece to the pain assessment, LPN #2 stated that it was and that location of pain should be documented. LPN #2 stated that the MAR did not give nurses the option to document location but that a nursing note should be written. When asked how she would know the location of Resident #6's pain on previous pain assessments, LPN #2 stated that being her nurse on a consistent basis, she knew that the resident frequently had pain in her legs. When asked if location should still be documented, LPN #2 stated that location should be documented in case she had a new area of pain. LPN #2 stated that it was important to document location of pain so that nursing can keep track of pain complaints.

On 5/31/19 at 3:05 p.m., ASM (Administrative Staff Member) #1, the Administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

Facility policy titled, "Pain Management," documents in part, the following: "...Assessments should include the onset, location, frequency, quality, and intensity of pain with the resident's self-report as the primary indicator of pain."

No further information was presented prior to exit.

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(1) Hydrocodone 5 mg (milligrams)-acetaminophen 325 mg (NORCO)-narcotic analgesic used for the relief of moderate to moderately severe pain. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=44b86290-2391-4b02-abd4-b1c0c611891e.

2. Resident #22 was admitted to the facility on 12/14/16 with diagnoses that included, but were not limited to, adult failure to thrive, vascular dementia, respiratory failure and osteoporosis. Resident #22's most recent MDS (Minimum Data Set) assessment was an annual assessment with an ARD (assessment reference date) of 4/24/19. Resident #22 was coded as being severely impaired in cognitive function scoring 03 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #22 was coded in in Section J (Pain Assessment Interview) as not having pain.

Review of Resident #22's May 2019 POS (physician order summary) revealed the following order: "Tylenol 325 mg (1) (milligrams) (650 mg) TABLET as Needed Every 6 Hours Starting 12/14/16...for mild pain."

Review of Resident #22's May 2019 MAR (Medication Administration Record) revealed that she received the above medication 4 times in May. On the corresponding pain assessment on the MAR, location of pain was not documented for the following dates and times:

5/18/19 at 4:32 p.m. and 5/19/19 at 1:00 p.m.

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F 697	Continued From page 16	F 697		

Review of Resident #22's May nursing notes failed to evidence location of pain for the above dates and times.

Resident #22's pain management care plan dated documented in part the following: "Pain Management...Assess (Name of Resident #22) to determine if experiencing pain. If pain is present, conduct and document pain assessment particularly location, nature, intensity, and duration of pain."

On 5/31/19 at 9:58 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #22's nurse. When asked the process if a resident complains of pain, LPN #2 stated that she would go assess the pain, ask the location, intensity and have the resident rate the pain on a scale of 1-10 (10 being the worst possible pain). LPN #2 stated that for resident who cannot verbalize pain, she would look for non-verbal cues such as grimacing or guarding any part of the body. LPN #2 stated that she would attempt non-pharmacological pain interventions prior to administering pain medications and then she would administer pain medications, if non-pharmacologicals were ineffective. When asked if she would document her complete pain assessment, LPN #2 stated that she would. When asked where she would document the complete pain assessment, LPN #2 stated that the pain assessment was documented in a nursing note or on the MAR. When asked if location of pain was an important piece to the pain assessment, LPN #2 stated that it was and that location of pain should be documented. LPN #2 stated that the MAR did not give nurses the option to document location but that a nursing note should be written. LPN #2

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F 697	Continued From page 17 stated that it was important to document location of pain so that nursing can keep track of pain complaints. On 5/31/19 at 3:05 p.m., ASM (Administrative Staff Member) #1, the Administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. (1) Tylenol Tablet 325 mg (Acetaminophen)-Treats minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.	F 697		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		7/12/19

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F 761	Continued From page 18 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation during the inspection of the medication room, staff interviews and the facility's policy review, the facility staff failed to ensure a Schedule II medication was secured in a permanent affixed locked cabinet. The facility staff failed to ensure a multi-dose vial of Morphine was secured in a permanently affixed locked medication cabinet. The findings included: On 05/30/19 at approximately 2:15 p.m., an inspection of the medication room was made with License Practical Nurse (LPN) #2. The facility only had one medication room. Located inside the medication room was a locked cabinet. The LPN unlocked the cabinet, which contained a large gray "stat box." The surveyor asked the LPN, "Can the stat box be removed from the cabinet" she replied, "Yes." The LPN removed the stat box from the cabinet then placed it back inside the cabinet then locked the cabinet back. The stat box was not permanently affixed inside the locked cabinet. The surveyor reviewed the content of the stat box. The stat box contained a one (1) multi-dose vial of Morphine 20 mg/ml oral solution (Roxanol); a Schedule II medication. On 05/31/19 at approximately 10:35 a.m., another	F 761	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements. 1. The multi-dose vial of morphine has been relocated to a permanently affixed locked medication cabinet. 2. The medication room has been inspected to ensure any multi-dose vials of Schedule II medications are properly secured in a permanently affixed locked medication cabinet. The pharmacy is aware of the importance of ensuring multi-dose medications of Schedule II medications are properly secured. 3. RNs, LPNs and pharmacy staff have been educated on the importance of securing Schedule II medications. The in-service included a review of the regulation for storage of Schedule II medications and facility procedure for properly securing medications.	

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F 761	Continued From page 19 inspection was made of the locked medication cabinet with LPN #1. The medication cabinet remained unchanged; the stat box was not permanently affixed. The stat box remained with the multi-dose vial of Morphine in it. On 05/31/19 at 11:35 a.m., an interview was conducted with the Assistant Director of Nurse Operations. She stated the stat box should have been permanently affixed because it contained a multi-dose vial of Morphine (Schedule II medication.) A pre-exit meeting was held with the Vice President of Operations, Administrator, Director of Nurse Operations, Assistant Director of Nurse Operations and the Director of Nursing on 05/31/19 at approximately 3:05 p.m. The surveyor asked if the stat box containing a multi-dose of Morphine (Schedule II medication), should be permanently affixed inside the medication cabinet. The Director of Nurse Operations replied, "There should have been only a single dose vial of Morphine, basically I thought it was taken care of by our pharmacy." She said the pharmacy was contacted and they were out of the single doses of Morphine so a multi-dose vial was sent instead. She said the decision was made by the pharmacy and we were not aware of the multi-dose vial of Morphine inside the stat box. The surveyor asked, "Since there was a multi-dose vial of Morphine located in the stat box, should the stat box containing the multi-dose vial Morphine be permanently affixed inside the medication cabinet?" The Vice President of Operations stated, "Yes, the box should have been permanently affixed." The facility's policy titled Virginia Health Services	F 761	4. The Director of Nursing/ designee will inspect the medication room daily for a period of six weeks to ensure the Schedule II medications are stored in a permanently affixed locking medication cabinet. The Director of Nursing will report findings to the Quality Assurance and Performance Improvement committee at least quarterly.	

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F 761	Continued From page 20 Pharmacy Services Policy (Revision date: 01/03/17). -Storage of drugs include but not limited to: The separately locked and permanently affixed compartments are provided for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control act of 1976 and other drugs subject to abuse. Definitions: *Morphine is used to relieve moderate to severe pain. Morphine extended-release tablets and capsules are only used to relieve severe (around-the-clock) pain that cannot be controlled by the use of other pain medications (https://medlineplus.gov/ency/article/007365.htm). *Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous. www.DEA (Drug Enforcement Administration).gov.	F 761		