STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/14/20 through 1/16/20. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Four complaints were investigated during this survey. The Life Safety Code survey/report will follow. The census in this 225 certified bed facility was 168 at the time of the survey. The survey sample consisted of 55 current resident reviews and 5 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 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.	F 550		2/17/20

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

Electronically Signed | 02/06/2020

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F 550	Continued From page 1 §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 and staff interview, it was determined that facility staff failed to promote dignity by providing timely incontinence care for one of 60 residents in the survey sample, Residents # 64. The findings include: Resident # 64 was admitted to the facility with diagnoses that included but were not limited to: urinary tract infection [1], muscle weakness and swallowing difficulties. Resident # 64's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/02/19, coded Resident # 64 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition for making daily decisions. Resident # 64 was	F 550	F550-D Resident Rights/Exercise of Rights 1) Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #64 received incontinence care at 3:30pm by the shift supervisor. Skin assessment completed at that time and there was no evidence of skin breakdown or any skin issues. 2) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. All Residents in the facility have the potential to be affected. 3) Systemic Changes put into place to ensure the alleged deficient practice does not recur. In-service for the Licensed Nurses will be completed by the Director of Nursing or	

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F 550	Continued From page 2 coded as requiring extensive assistance of one staff member for activities of daily living. Section H "Bladder and Bowel" Resident # 64 was coded as being frequently incontinent of bowel and bladder. On 01/14/2020 at 3:10 p.m., during an interview with Resident # 64, stated that she let CNA [certified nursing assistant] # 4 know she needed to be changed at 2:00 p.m. Resident # 64 Stated, "I rang my call bell and she [CNA # 4] came in and I told her I need to be cleaned and she said she would be back. No one has come." When asked about being soiled, Resident # 64 stated she had a bowel movement and was wet. When asked how it made her feel to be left soiled for an extended period of time, Resident # 64 stated, "It makes me feel like I'm worthless. I feel like this is a little mistreatment." The comprehensive care plan for Resident # 64 dated 12/05/2019 documented, "Need: Urinary incontinence related to decreased mobility generalized weakness, dementia, multiple health issues. Date Initiated: 12/05/2019." Under "Interventions", it documented, "Provide assistance with toileting or provided incontinence care as needed. Date Initiated: 12/05/2019." On 01/15/20 at 7:39 a.m., an interview was conducted with CNA # 4, regarding the procedure staff follows for responding to and providing care for a resident who requires incontinence care. CNA # 4 stated, "I change them when they ask." When asked to describe the procedure followed when they are providing care for another resident at the same time, CNA # 4 stated, "I let them know I am busy and will get back to them." When asked to describe the procedure followed when	F 550	designee on promoting dignity by providing timely incontinence care, neglect and resident rights for the staff. 4) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing/ Designee will conduct 10 random audits on prompt incontinence care weekly for four weeks and then monthly for three months to assure compliance. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process monthly. 5) Date of compliance- 2/17/2020	

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they are providing care for another resident for a longer period than anticipated, CNA # 4 stated, "I would let them know I'm still tied up or let my nurse know." When asked what would happen if a resident was left soiled for a long period of time, CNA # 4 stated, "Skin could break down or it could contribute to a UTI [urinary tract infection]." When asked if she was assigned to Resident # 64 on 01/14/2020 during the 7:00 a.m. to 3:00 p.m. shift, CNA # 4 stated, yes. When asked if they recalled Resident # 64 asked for incontinence care at 2:00 p.m. that day, CNA # 4 stated, "I recalled the resident telling me. I think she informed me at about 2:30 p.m., or 2:45 p.m." When asked if Resident # 64 soiled should be left soiled for forty-five minutes to an hour, CNA # 4 stated no. CNA # 4 further stated, "I got side tracked." CNA #4 was asked if it was dignified to leave Resident # 64, a soiled for that period of time. CNA # 4 stated no.

The facility policy, "Resident's Rights" documented in part, "[5] To be treated with respect and dignity..."

The facility's policy "Promoting/Maintaining Resident Dignity" documented in part, "Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. 6. Respond to request for assistance in a timely manner."

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F 550	Continued From page 4 On 01/15/2020 at approximately 5:40 p.m. ASM [administrative staff member] # 1, the administrator, ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit. References: [1] An infection in the urinary tract. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm.	F 550		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		2/17/20

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F 578	Continued From page 5 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to meet Advance Directive requirements for sixteen of 60 residents in the survey sample, Residents #135, #61, #3, #78, #149, #22, #73, #53, #44, #47, #80, #81, #57, #136, #40 and #45. The facility staff failed to accurately, document the Advance Directive status on the admission "Advance Directive Acknowledgement" forms and failed to ensure the forms were maintained on the clinical record for Resident #135, #61, and Resident #3. The facility staff failed to accurately, document the Advance Directive status on the admission "Advance Directive Acknowledgement" form and failed to accurately determine the advanced directive status on admission for Resident #149, Resident #22, Resident #44, #47, #80, #81, #53, #73 and #57, and the facility staff failed to have a copy of Resident #78's Resident #40's, Resident #136's, and Resident #45's advanced directives in the	F 578	F578 Request/Refuse/Discontinue Treatment; Formulate an Advanced Directive 1) Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #53 and # 81 have been discharged. Resident #135, #61, #3, #78, #149, #22, #73, #44, #47, #80, #57, #136, #40 and #45 and/or RP will be provided information on formulating an Advanced Directives. 2) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents within the facility and those admitted to facility have the potential to be affected. The social service staff or designee will complete an audit on current residents to review if residents have an Advance Directive on chart or scanned in PCC.	

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F 578	Continued From page 6 clinical record. The findings include: 1. Resident #135 was admitted to the facility on 12/23/19; with the diagnoses of but not limited to type 1 diabetes, orthostatic hypotension, end stage renal disease, neurogenic bladder, osteoporosis, pressure ulcers, hypothermia, hyperparathyroidism, and convulsions. The Admission MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 12/29/19, coded the resident as being cognitively intact in ability to make daily life decisions. The facility policy, Advanced Directives" documented in part, "1. Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written I information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives ....3. Prior to or upon admission of a resident, the Social Services director or designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives. 4. Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record. 5. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decisions. Nursing staff will document in the medical record the offer to	F 578	3) Systemic Changes put into place to ensure the alleged deficient practice does not recur. In-service will be completed by the Director of Nursing or designee to licensed nurses, admissions and social service staff on reviewing, recording and collecting of appropriate Advanced Directive information for Resident□s at admission and during care plan meetings. Ensuring copies of Advanced Directives are placed in Resident chart as necessary. 4) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing or designee will complete audits weekly x4 weeks then monthly x3 on Residents to ensure that Advanced Directives are being reviewed and recorded appropriately on admission and during care plans. Ensuring copies of Advanced Directives are placed in Resident chart as necessary. The audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and revisions as needed. 5) Date of compliance- 2/17/2020	

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assist and the resident's decisions to accept of decline ...15. The Interdisciplinary Team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument (MDS).

A review of the "Advance Directive Acknowledgement" form for Resident #135 revealed the following documentation:

PLEASE READ THE FOLLOWING FOUR STATEMENTS. Place your initials after each statement: (Note, there were 5 statements, not 4 as the form documented there were.)

1. I have been given written materials on Advance Directives and about my right to accept or refuse medical treatments._____ (initialed). The resident and/or the resident representative did not initial this line.

2. I have been informed of my rights to formulate Advance Directives._____ (initialed). The resident and/or the resident representative did not initial this line.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatments at this health care facility._____ (initialed). The resident and/or the resident representative did not initial this line.

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law._____ (initialed). The

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resident and/or the resident representative did not initial this line.

5. It was recommended that I also seek advice from my physician and attorney prior to making this decision._____ (initialed). The resident and/or the resident representative did not initial this line.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:
(___) I HAVE executed an Advance Directive. The resident and/or the resident representative initialed this line.
(___) I HAVE NOT executed an Advance Directive

I would like assistance in obtaining Advance Directive (___) Yes, (___) No. the box for "No" was checked and the resident signed and dated this form on 1/14/20.

Review of the clinical record failed to reveal this form was maintained on the clinical record.

Further review of the clinical record failed to reveal any evidence that the resident had Advance Directives.

An interview was conducted with OSM #4 (Other Staff Member - the social worker) on 1/15/2020 at 12:51 p.m. When asked who obtains the acknowledgement of the Advanced Directive, OSM #4 stated she had spoken to the admissions staff member that there was a misconception that the DNR (do not resuscitate) was the same as the Advanced Directive.

An interview was conducted with OSM #1, the

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admissions staff member, on 1/15/2020. The "Advanced Directive Acknowledgement" was reviewed with OSM #1. OSM #1 stated that before today, it was her understanding that the completion of a DNR was the same as an Advanced Directive. She stated that she just found out today that it wasn't the same thing, so many of the forms (Advanced Directive Acknowledgment forms) are incorrect and the residents may not have an Advanced Directive.

On 1/16/20 at 2:19 PM, OSM #4 stated that the ones ('Advanced Directive' forms) that were not on the chart were found in the business office.

A review of the comprehensive care plan documented one dated 12/24/19 for "Advanced Directive." The only intervention documented, dated 12/24/19, was, "Full Code."

On 1/15/20 at 5:41 PM, ASM #1 (Administrative Staff Member, the Administrator), ASM #2 (the Director of Nursing), ASM #3 (the corporate nurse), and ASM #4 (the Medical Director) were made aware of the findings. No further information was provided by the end of the survey.

2. Resident #61 was admitted to the facility on 1/1/20 with the diagnoses of but not limited to sick sinus syndrome, bradycardia, pacemaker, insomnia, aphasia, high blood pressure, vascular dementia, diabetes, chronic kidney disease, chronic obstructive pulmonary disease, post-traumatic stress disorder, Non-Hodgkin's lymphoma, breast cancer, and stroke. The Admission/5-Day MDS (Minimum Data Set) with

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an ARD (Assessment Reference Date) of 1/7/20 coded the resident as being severely impaired in ability to make daily life decisions.

A review of the "Advance Directive Acknowledgement" form for Resident #61 documented the following:

PLEASE READ THE FOLLOWING FOUR STATEMENTS. Place your initials after each statement: (Note, there were 5 statements, not 4 as the form documented there were.)

1. I have been given written materials on Advance Directives and about my right to accept or refuse medical treatments._____(initialed). The resident representative initialed this line.

2. I have been informed of my rights to formulate Advance Directives._____(initialed). The resident representative initialed this line.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatments at this health care facility._____(initialed). The resident representative initialed this line.

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law._____(initialed). The resident representative initialed this line.

5. It was recommended that I also seek advice from my physician and attorney prior to making this decision._____(initialed). The resident representative initialed this line.

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PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:
(___) I HAVE executed an Advance Directive - This box was checked for this resident.
(___) I HAVE NOT executed an Advance Directive

I would like assistance in obtaining Advance Directive (___) Yes, (___) No. The box for "No" was checked and the resident representative signed and dated this form on 1/2/20.

Review of the clinical record failed to reveal this form was maintained on the clinical record.

Further review of the clinical record failed to reveal any evidence that the resident had Advance Directives.

An interview was conducted with OSM #4 (Other Staff Member - the social worker) on 1/15/2020 at 12:51 p.m. When asked who obtains the acknowledgement of the Advanced Directive, OSM #4 stated she had spoken to the admissions staff member that there was a misconception that the DNR (do not resuscitate) was the same as the Advanced Directive.

An interview was conducted with OSM #1, the admissions staff member, on 1/15/2020. The "Advanced Directive Acknowledgement" was reviewed with OSM #1. OSM #1 stated that before today, it was her understanding that the completion of a DNR was the same as an Advanced Directive. She stated that she just found out today that it wasn't the same thing, so many of the forms (Advanced Directive Acknowledgment forms) are incorrect and the residents may not have an Advanced Directive.

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On 1/16/20 at 2:19 PM, OSM #4 stated that the ones ('Advanced Directive' forms) that were not on the chart were found in the business office.

A review of the comprehensive care plan documented one dated 1/10/20 for "Advanced Directive." The only intervention documented, dated 1/13/20, was, "Full Code."

On 1/15/20 at 5:41 PM, ASM #1 (Administrative Staff Member, the Administrator), ASM #2 (the Director of Nursing), ASM #3 (the corporate nurse), and ASM #4 (the Medical Director) were made aware of the findings. No further information was provided by the end of the survey.

3. Resident #3 was most recently admitted to the facility on 12/30/19 with the diagnoses of but not limited to chronic kidney disease, bipolar disorder, neuromuscular dysfunction of the bladder, pressure ulcer, dysphagia, hypothyroidism, Parkinson's disease, type 2 diabetes, hereditary spastic paraplegia, spinal stenosis, anxiety, depression, obesity, and was on palliative care. The Significant Change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/5/20 coded the resident as being moderately impaired in ability to make daily life decisions.

A review of the "Advance Directive Acknowledgement" form for Resident #3 documented the following:

PLEASE READ THE FOLLOWING FOUR

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STATEMENTS. Place your initials after each statement: (Note, there were 5 statements, not 4 as the form documented there were.)

1. I have been given written materials on Advance Directives and about my right to accept or refuse medical treatments._____(initialed). The resident representative initialed this line.

2. I have been informed of my rights to formulate Advance Directives._____(initialed). The resident representative initialed this line.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatments at this health care facility._____(initialed). The resident representative initialed this line.

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law._____(initialed). The resident representative initialed this line.

5. It was recommended that I also seek advice from my physician and attorney prior to making this decision._____(initialed). The resident representative initialed this line.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:
(___) I HAVE executed an Advance Directive. This box was checked for this resident.
(___) I HAVE NOT executed an Advance Directive

I would like assistance in obtaining Advance Directive (___) Yes, (___) No. The box for "No"

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was checked and the resident representative signed and dated this form on 1/2/20.

Review of the clinical record failed to reveal this form was maintained on the clinical record.

Further review of the clinical record failed to reveal any evidence that the resident had Advance Directives.

On 1/16/20 at 2:19 PM, OSM #4 stated that the ones ('Advanced Directive' forms) that were not on the chart were found in the business office.

A review of the comprehensive care plan documented one dated 5/17/18 for "Advanced Directive." The interventions documented were, "Discuss Advance Directives with Patient, Family or Legal Representative as needed" dated 11/9/18; and "No Code" dated 5/17/18.

On 1/15/20 at 5:41 PM, ASM #1 (Administrative Staff Member, the Administrator), ASM #2 (the Director of Nursing), ASM #3 (the corporate nurse), and ASM #4 (the Medical Director) were made aware of the findings. No further information was provided by the end of the survey.

4. Resident #78 was admitted to the facility on 10/27/19; diagnoses included but are not limited to right fibula fracture, dysphagia, diabetes, hemiplegia, chronic obstructive pulmonary disease, seizures, atrial fibrillation, muscle wasting, contracture, neuromuscular bladder dysfunction, high blood pressure, dysphagia and stroke. The admission MDS (Minimum Data Set)

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with an ARD (Assessment Reference Date) of 11/3/19 coded the resident as severely cognitively impaired in ability to make daily life decisions.

A review of Resident #78's "Advance Directive Acknowledgement" form documented the following:

PLEASE READ THE FOLLOWING FOUR STATEMENTS. Place your initials after each statement: (Note, there were 5 statements, not 4 as the form documented there were.)

1. I have been given written materials on Advance Directives and about my right to accept or refuse medical treatments._____(initialed). The resident and/or resident representative did not initial this line.

2. I have been informed of my rights to formulate Advance Directives._____(initialed). The resident and/or resident representative did not initial this line.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatments at this health care facility._____(initialed). The resident and/or resident representative did not initial this line.
4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law._____(initialed). The resident and/or resident representative did not initial this line.

5. It was recommended that I also seek advice from my physician and attorney prior to making this decision._____(initialed). The resident and/or

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resident representative did not initial this line.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:
(___) I HAVE executed an Advance Directive
(___) I HAVE NOT executed an Advance Directive - This box was checked for this resident.

I would like assistance in obtaining Advance Directive (___) Yes, (___) No. The box for "No" was checked and the resident representative signed and dated this form on 10/27/19.

Review of the clinical record failed to reveal this form was maintained on the clinical record.

On 1/16/20 at 2:19 PM, OSM #4 stated that the ones ('Advanced Directive' forms) that were not on the chart were found in the business office.

A review of the comprehensive care plan documented one dated 12/24/19 for "Advanced Directive." The only intervention documented, dated 12/24/19, was, "Full Code."

On 1/15/20 at 5:41 PM, ASM #1 (Administrative Staff Member, the Administrator), ASM #2 (the Director of Nursing), ASM #3 (the corporate nurse), and ASM #4 (the Medical Director) were made aware of the findings. No further information was provided by the end of the survey.

5. Resident #149 was admitted to the facility on 12/12/19; diagnoses included but are not limited to enterocolitis, sepsis, breast cancer, cardiomyopathy, bile duct calculus,

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neuromuscular dysfunction of the bladder, hypothyroidism, high blood pressure, Takotsubo syndrome (1), atrial fibrillation, and organ transplant. The 5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) coded the resident as being mildly impaired in ability to make daily life decisions.

A review of the clinical record revealed the "Advance Directive Acknowledgement" form for Resident #149. This form documented the following:

PLEASE READ THE FOLLOWING FOUR STATEMENTS. Place your initials after each statement: (Note, there were 5 statements, not 4 as the form documented there were.)

1. I have been given written materials on Advance Directives and about my right to accept or refuse medical treatments._____(initialed). The resident representative initialed this line.

2. I have been informed of my rights to formulate Advance Directives._____(initialed). The resident representative initialed this line.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatments at this health care facility._____(initialed). The resident representative initialed this line.

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law._____(initialed). The resident representative initialed this line.

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5. It was recommended that I also seek advice from my physician and attorney prior to making this decision._____(initialed). The resident representative initialed this line.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:
(___) I HAVE executed an Advance Directive - This box was checked for this resident.
(___) I HAVE NOT executed an Advance Directive

I would like assistance in obtaining Advance Directive (___) Yes, (___) No. The box for, "No" was checked and the resident representative signed and dated this form on 12/20/19.

Review of the clinical record failed to reveal any evidence that the resident had Advance Directives.

A review of the comprehensive care plan documented one dated 12/13/19 for "Advanced Directive." The only intervention documented, dated 12/13/19, was "Full Code."

On 1/15/20 at 5:41 PM, ASM #1 (Administrative Staff Member, the Administrator), ASM #2 (the Director of Nursing), ASM #3 (the corporate nurse), and ASM #4 (the Medical Director) were made aware of the findings. No further information was provided by the end of the survey.

References:
(1) Takotsubo syndrome - Takotsubo cardiomyopathy, or broken heart syndrome, happens when extreme stress leads to heart muscle failure. Though rare, this condition is

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more common in post-menopausal women. Information obtained from https://www.nhlbi.nih.gov/health-topics/cardiomyopathy

6. Resident #22 was admitted to the facility on 12/27/18; diagnoses included but are not limited to high blood pressure, dementia with behaviors, depression, anxiety disorder and chronic kidney disease. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/31/19 coded the resident as being mildly impaired in ability to make daily life decisions.

A review of the clinical record revealed the "Advance Directive Acknowledgement" form for Resident #22. This form documented the following:

PLEASE READ THE FOLLOWING FOUR STATEMENTS. Place your initials after each statement: (Note, there were 5 statements, not 4 as the form documented there were.)

1. I have been given written materials on Advance Directives and about my right to accept or refuse medical treatments._____(initialed). The resident representative initialed this line.

2. I have been informed of my rights to formulate Advance Directives._____(initialed). The resident representative initialed this line.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatments at this health care

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facility._____(initialed). The resident representative initialed this line.

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law._____(initialed). The resident representative initialed this line.

5. It was recommended that I also seek advice from my physician and attorney prior to making this decision._____(initialed). The resident representative initialed this line.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:
(___) I HAVE executed an Advance Directive - This box was checked for this resident.
(___) I HAVE NOT executed an Advance Directive

I would like assistance in obtaining Advance Directive (___) Yes, (___) No. The box for "No" was checked and the resident representative signed and dated this form on 12/27/18.

Review of the clinical record failed to reveal any evidence that the resident had Advance Directives.

A review of the comprehensive care plan documented one dated 1/1/19 for "Advanced Directive." The only intervention documented, dated 1/1/19, was "Full Code."

On 1/15/20 at 5:41 PM, ASM #1 (Administrative Staff Member, the Administrator), ASM #2 (the Director of Nursing), ASM #3 (the corporate nurse), and ASM #4 (the Medical Director) were

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made aware of the findings. No further information was provided by the end of the survey.
7. Resident #44 was admitted to the facility on 8/28/15 with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), osteoarthritis (degenerative changes in the joints) (2), and depression (dejected state of mind with feelings of sadness, discouragement and hopelessness) (3).

The most recent MDS (minimum data set) assessment (after the event), a quarterly assessment, with an ARD (assessment reference date) of 11/14/19, coded Resident #44 as scoring a 6 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, locomotion on/off unit, dressing, and eating. Resident coded as total dependence for transfer, toilet use and personal hygiene.

Review of Resident #44's advance directive, acknowledgement form, in the clinical record, revealed a check in the box next to "I have executed an advance directive." No copy of an advance directive was evidenced in either the paper or electronic medical record.

On 1/15/20 at 12:50 PM, an interview was conducted with OSM (other staff member) #4, the social worker. When asked to provide a copy of Resident #44's executed advance directive, OSM #4 stated, "There is no copy of the executed advance directive." When asked who is responsible for obtaining copies of residents' executed advance directives, OSM #4 stated,

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"The admissions director is responsible for the advance directive documentation."

On 1/15/20 at 1:32 PM, an interview was conducted with OSM #1, the admissions director. When asked about, "I have executed an advance directive" on the "Advance Directive Acknowledgement" form, OSM #1 stated, "It means they either have an advance directive with full measures or they sign a DNR (do not resuscitate). I understand now that what I put in the chart- the DNR's, are separate from advance directives. I went by the CPR (cardiopulmonary resuscitation) forms." OSM #1 stated, When we check the box for "executed an advance directive", we ask for a copy. We would put the copy obtained either in the paper chart or in the business chart. The business chart might contain the documentation. I will look for it there." When asked if staff have access to the business chart at all times of day, OSM #1 stated, "No, the office is locked up at night."

On 1/15/20 at 2:35 PM, OSM #1 stated, "We have no copy of an advance directive for Resident #44 in the business chart."

ASM #1, the administrator, and ASM #3, the corporate representative were made aware of the above concerns on 1/15/20 at 5:05 PM.

An interview was conducted on 1/16/20 at 11:28 AM with ASM #1, the administrator. When asked about executed advance directive location in the medical record, ASM #1 stated, "It seems the admissions office did not understand the difference between advance directive and code status."

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No further information was provided prior to exit.

The facility's "Advance Directives" policy documents "Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record."

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154.
(2) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 420.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 157.

8. Resident #47 was admitted to the facility on 4/27/16 with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), psychotic disorder (detachment from reality and has impaired perceptions, thinking and responses) (2), and hypertension (elevated blood pressure consistently above 140/90) (3).

The most recent MDS (minimum data set) assessment (after the event), a quarterly assessment, with an ARD (assessment reference date) of 11/22/19, coded Resident #47 as scoring a 7 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, locomotion on/off unit, dressing, toilet use and personal hygiene. Resident coded as requiring supervision for eating.

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Review of advance directive, acknowledgement form for Resident #47, in the clinical record, revealed a check in box next to, "I have executed an advance directive." No copy of an advance directive for Resident #47 was evidenced in either the paper or electronic medical record.

On 1/15/20 at 12:50 PM, an interview was conducted with OSM (other staff member) #4, the social worker. When asked to provide a copy of Resident #47's executed advance directive, OSM #4 stated, "There is no copy of the executed advance directive." When asked who is responsible for obtaining copies of the residents' executed advance directives, OSM #4 stated, "The admissions director is responsible for the advance directive documentation."

On 1/15/20 at 1:32 PM, an interview was conducted with OSM #1, the admissions director. When asked about, "I have executed an advance directive" on the "Advance Directive Acknowledgement" form, OSM #1 stated, "It means they either have an advance directive with full measures or they sign a DNR (do not resuscitate). I understand now that what I put in the chart- the DNR's, are separate from advance directives. I went by the CPR (cardiopulmonary resuscitation) forms." OSM #1 stated, When we check the box for "executed an advance directive", we ask for a copy. We would put the copy either in the paper chart or in the business chart. The business chart might contain the documentation. I will look for it there." When asked if staff have access to the business chart at all times of day, OSM #1 stated, "No, the office is locked up at night."

On 1/15/20 at 2:35 PM, OSM #1 stated, "We

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have no copy of advance directive for Resident #47 in the business chart."

ASM #1, the administrator, and ASM #3, the corporate representative were made aware of the above concerns on 1/15/20 at 5:05 PM.

An interview was conducted on 1/16/20 at 11:28 AM with ASM #1, the administrator. When asked about executed advance directive location in the medical record, ASM #1 stated, "It seems the admissions office did not understand the difference between advance directive and code status."

No further information was provided prior to exit.

The facility's "Advance Directives" policy documents "Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record."

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154.
(2) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 480.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 282.

9. Resident #80 was admitted to the facility on 2/26/16 with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), depression (dejected state of mind with feelings of sadness, discouragement and hopelessness) (2), and hypertension (elevated

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blood pressure consistently above 140/90) (3).

The most recent MDS (minimum data set) assessment (after the event), a quarterly assessment, with an ARD (assessment reference date) of 11/22/19, coded the resident as scoring a 3 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, locomotion on unit, toilet use and personal hygiene. Resident coded as total dependence for locomotion off unit and dressing.

Review of Resident #80's clinical record, revealed an advance directive, acknowledgement form, which documented a check in box next to "I have executed an advance directive." No copy of an advance directive for Resident #80 was evidenced in either the paper or electronic medical record.

On 1/15/20 at 12:50 PM, an interview was conducted with OSM (other staff member) #4, the social worker. When asked to provide a copy of Resident #80's executed advance directive, OSM #4 stated, "There is no copy of the executed advance directive." When asked who is responsible in obtaining copies of residents' executed advance directives, OSM #4 stated, "The admissions director is responsible for the advance directive documentation."

On 1/15/20 at 1:32 PM, an interview was conducted with OSM #1, the admissions director. When asked what, "I have executed an advance directive" on the "Advance Directive Acknowledgement" form, meant, OSM #1 stated,

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"It means they either have an advance directive with full measures or they sign a DNR (do not resuscitate). I understand now that what I put in the chart- the DNR's are separate from advance directives. I went by the CPR (cardiopulmonary resuscitation) forms." OSM #1 stated, When we check the box for "executed an advance directive", we ask for a copy. We would put the copy either in the paper chart or in the business chart. The business chart might contain the documentation for Resident #80. I will look for it there." When asked if staff have access to the business chart at all times of day, OSM #1 stated, "No, the office is locked up at night."

On 1/15/20 at 2:35 PM, OSM #1 stated, "We have no copy of advance directive for Resident #80 in the business chart."

ASM #1, the administrator, and ASM #3, the corporate representative were made aware of the above concerns on 1/15/20 at 5:05 PM.

An interview was conducted on 1/16/20 at 11:28 AM with ASM #1, the administrator. When asked about executed advance directive location in the medical record, ASM #1 stated, "It seems the admissions office did not understand the difference between advance directive and code status."

No further information was provided prior to exit.

The facility's "Advance Directives" policy documents "Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record."

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(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154.
(2) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 157.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 282.

10. Resident #81 was admitted to the facility on 11/1/17 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease a non-reversible lung disease) (1), atrial fibrillation (a rapid/random contraction of top part of the heart) (2), glaucoma (high pressure in the eye leading to blurred vision or blindness) (3).

The most recent MDS (minimum data set) assessment (after the event), a quarterly assessment, with an ARD (assessment reference date) of 12/5/19, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring supervision for eating and limited assistance for bed mobility, walk in room; requiring extensive assistance for transfer, walk in corridor, locomotion on/off unit, dressing, toilet use and personal hygiene.

Review of Resident #81's clinical record, revealed an advance directive, acknowledgement form, which documented a check in box next to "I have executed an advance directive." No copy of an advance directive was evidenced in either the paper or electronic medical record.

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On 1/15/20 at 12:50 PM, an interview was conducted with OSM (other staff member) #4, the social worker. When asked to provide evidence of copy of Resident #81's executed advance directive, OSM #4 stated, "There is no copy of the executed advance directive." When asked who is responsible in obtaining copies of residents' executed advance directives, OSM #4 stated, "The admissions director is responsible for the advance directive documentation."

On 1/15/20 at 1:32 PM, an interview was conducted with OSM #1, the admissions director. When asked what, "I have executed an advance directive" on the "Advance Directive Acknowledgement" form, meant, OSM #1 stated, "It means they either have an advance directive with full measures or they sign a DNR (do not resuscitate). I understand now that what I put in the chart- the DNR's are separate from advance directives. I went by the CPR (cardiopulmonary resuscitation) forms." OSM #1 stated, When we check the box for "executed an advance directive", we ask for a copy. We would put the copy either in the paper chart or in the business chart. The business chart might contain the documentation for Resident #81. I will look for it there." When asked if staff have access to the business chart at all times of day, OSM #1 stated, "No, the office is locked up at night."

On 1/15/20 at 2:35 PM, OSM #1 stated, "We have no copy of advance directive for Resident #81 in the business chart."

ASM #1, the administrator, and ASM #3, the corporate representative were made aware of the above concerns on 1/15/20 at 5:05 PM.

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An interview was conducted on 1/16/20 at 11:28 AM with ASM #1, the administrator. When asked about executed advance directive location in the medical record, ASM #1 stated, "It seems the admissions office did not understand the difference between advance directive and code status."

No further information was provided prior to exit.

The facility's "Advance Directives" policy documents "Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record."

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 120.
(2) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 54.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 245.
11. Resident # 73 was admitted to the facility with diagnoses that included but were not limited to: stroke, muscle weakness and swallowing difficulties.

Resident # 73's most recent MDS [minimum data set], a significant change assessment with an ARD (assessment reference date) of 12/08/19, coded Resident # 73 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions.

The comprehensive care plan for Resident # 73 dated 09/03/2019 documented, "Focus: Advance

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Directive. Date Initiated: 09/03/2019." Under 'Interventions" it documented, "Full Code. Date Initiated: 09/03/2019."

Review of the paper clinical record for Resident # 73 revealed a document titled, "Advance Directive Acknowledgment" dated 12/02/2019, for Resident # 73. The "Advance Directive Acknowledgment" form documented, "I HAVE executed an Advance Directive."

Review of the EHR (electronic health record) and paper clinical record for Resident # 73 failed to evidence a copy of the advance directive.

An interview was conducted with OSM [other staff member] # 4, the social worker on 01/15/2020 at 12:51 p.m. When asked who obtains the acknowledgement of the advanced directive, OSM # 4 stated she had spoken to the admissions staff member that there was a misconception that the DNR [do not resuscitate] was the same as the advanced directive.

An interview was conducted with OSM # 1 admissions staff member, on 01/15/2020. The "Advanced Directive Acknowledgement" for Resident # 73 was reviewed with OSM # 1. OSM # 1 stated that before today, it was her understanding that the completion of a DNR [do not resuscitate] was the same as an Advanced Directive. OSM # 1 stated that she just found out today that it wasn't the same thing. OSM # 1 stated that many of the forms (Advanced Directive Acknowledgment) forms are incorrect and the residents may not have an advanced directive. When asked if they had a copy of Resident # 73's advance directive, OSM # 1 stated no.

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On 01/15/2020 at approximately 5:40 p.m. ASM [administrative staff member] # 1, the administrator, ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

12. Resident # 53 was admitted to the facility with diagnoses that included but were not limited to: low iron, high blood pressure and muscle weakness.

Resident # 53's most recent MDS [minimum data set], an admission assessment with an ARD (assessment reference date) of 11/27/19, coded Resident # 53 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 comprehensive care plan for Resident # 53 dated 12/06/2019 documented, "Focus: Advance Directive. Date Initiated: 12/06/2019." Under 'Interventions" it documented, "Full Code. . Date Initiated: 12/06/2019."

Review of the paper clinical record for Resident # 53 revealed a document titled, "Advance Directive Acknowledgment" dated 12/02/2019 for Resident # 53. The Advance Directive Acknowledgment" form documented, "PLEASE READ THE FOLLOWING FOUR STATEMENTS. Place your initials after each statement. [1] I have been given written materials on Advance Directives and about my right to accept or refuse medical treatments. _____ (for initials) [2] I have been informed of my right to formulate an Advance

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Directive. _____(for initials [3] I understand that I am not required to have an Advance Directive in order to receive medical treatments at this health care facility. _____(for initials) [4] I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law. _____ (for initials) [5] It was recommended that I seek advice from my physician and attorney prior to making this decision. _____ (for initials). Further review of the "Advance Directive Acknowledgment" for Resident # 53 revealed the above statements were not initiated and the statement "I HAVE executed an Advance Directive" was checked.

Review of the EHR (electronic health record) and paper clinical record for Resident # 53 failed to evidence a copy of the advance directive.

An interview was conducted with OSM [other staff member] # 4, the social worker on 01/15/2020 at 12:51 p.m. When asked who obtains the acknowledgement of the advanced directive, OSM # 4 stated she had spoken to the admissions staff member that there was a misconception that the DNR [do not resuscitate] was the same as the advanced directive.

An interview was conducted with OSM # 1 admissions staff member, on 01/15/2020. The "Advanced Directive Acknowledgement" for Resident # 53 was reviewed with OSM # 1. OSM # 1 stated that before today, it was her understanding that the completion of a DNR was the same as an Advanced Directive. OSM #1 stated that she just found out today that it wasn't the same thing. She stated that many of the forms (Advanced Directive Acknowledgment

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forms) are incorrect and the residents may not have an advanced directive. When asked if they had a copy of Resident # 53's advance directive, OSM # 1 stated no. When asked if information regarding the development of an advance directive was provided to Resident # 53 and/or Resident # 53's responsible party, OSM # 1 stated no.

On 01/15/2020 at approximately 5:40 p.m. ASM [administrative staff member] # 1, the administrator, ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

13. Resident #57 was admitted to the facility on 11/21/2019. Her diagnoses included joint replacement surgery, muscle weakness, and morbid obesity. Resident #57's most recent Minimum Data Set (MDS) Assessment was a Medicare 5 Day Assessment with an Assessment Reference Date (ARD) of 11/28/2019. The Brief Interview for Mental Status (BIMS) scored Resident #57 at a 15, indicating no impairment. Resident #57 was coded as requiring extensive assistance of one person for most Activities of Daily Living (ADLs).

On the morning of 01/15/2020, the facility staff were asked to locate Resident #57's Advanced Directive, or else provide documentation that Resident #57 had declined to formulate one. Facility staff provided a document titled, "Advanced Directive Acknowledgement." In the middle area of the document, the following statement was typed:

"PLEASE CHECK ONE OF THE FOLLOWING

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STATEMENTS:

[ ] I HAVE executed an Advanced Directive
[ ] I HAVE NOT executed an Advanced Directive"

The first box, indicating an Advanced Directive had been executed, was checked on Resident #57's form.

An interview was conducted with Other Staff Member (OSM) #4, the social worker on 1/15/2020 at 12:51 p.m. When asked who obtains the acknowledgement of the advanced directive, OSM #4 stated she had spoken to the admissions staff member that there was a misconception that the DNR (do not resuscitate) was the same as the advanced directive.

An interview was conducted with OSM #1, admissions staff member, on 1/15/2020. The "Advanced Directive Acknowledgement" for Resident #57 was reviewed with OSM #1. OSM #1 stated that before today, it was her understanding that the completion of a DNR was the same as an Advanced Directive. She stated that she just found out today that it wasn't the same thing. So many of the forms (Advanced Directive Acknowledgment) forms are incorrect and the residents may not have an advanced directive. A copy of Resident #57's advanced directive was requested at this time.

On 01/15/2020 at 2:44 p.m., OSM #1 stated that a copy of Resident #57's Advanced Directive could not be located. OSM #1 stated that the box indicating an Advanced Directive had been executed was likely checked in error due to the misunderstanding of the difference between an Advanced Directive and a DNR.

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Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 01/16/2020. No further documentation was provided.

14. Resident #136 was admitted to the facility on 11/17/17 with diagnoses that included but were not limited to: Alzheimer's disease (a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability) (1), high blood pressure, and stroke.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/26/19, coded the resident as having both short and long-term memories problems and being moderately impaired to make daily cognitive decisions.

The clinical record was reviewed. There was an "Advanced Directive Acknowledgement form dated, 2/5/18 that documented the resident had an advanced directive. Further review of the clinical record failed to evidence a copy of the resident's advanced directive.

A copy of the resident's advanced directive was requested on 1/15/2020.

1/15/20 at 12:51 p.m. OSM (other staff member) #4, the social worker, informed this surveyor that they did not have a copy of Resident # 136's advanced directive.

Administrative staff member (ASM) #1, the

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administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse and ASM #4 the medical director, was made aware of the above concern on 1/15/2020 at 5:42 p.m.

References:
(1) Barron's Dictionary of Medical Terms, 5th edition, Rothenberg and Chapman, page 26.

15. Resident #40 was admitted to the facility on 7/31/17 with diagnoses that included but were not limited to: myasthenia gravis [a disease characterized by chronic fatigability and weakness especially in the face and neck region, but also affecting the muscles of the trunk and limbs (1)], Parkinson's disease [a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability. (2)], high blood pressure, and depression.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/14/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating she was capable of making cognitive decisions.

The clinical record was reviewed. There was an "Advanced Directive Acknowledgement form dated, 7/31/17 that documented the resident had an advanced directive. Further review of the clinical record failed to evidence a copy of the resident's advanced directive.

A copy of the resident's advanced directive was requested on 1/15/2020.

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1/15/20 at 12:51 p.m. OSM (other staff member) #4, the social worker, informed this surveyor that they did not have a copy of Resident # 40's advanced directive.

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse and ASM #4 the medical director, was made aware of the above concern on 1/15/2020 at 5:42 p.m.

On 1/16/2020 at 10:00 a.m., a document was presented for review titled, "Durable General Power of Attorney of (Resident #40)." Review of the document failed to evidence any documentation related to an advanced directive.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 384.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.

16. Resident #45 was admitted to the facility on 12/21/18 with diagnoses that included but were not limited to: stroke, Alzheimer's disease (a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability) (1), and diabetes.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/21/19, coded the resident as scoring a "7" on the BIMS (brief

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interview for mental status) score indicating she was severely impaired to make daily cognitive decisions.

The clinical record was reviewed. There was an "Advanced Directive Acknowledgement form dated, 7/31/17 that documented the resident had an advanced directive. Further review of the clinical record failed to evidence a copy of the resident's advanced directive.

A copy of the resident's advanced directive was requested on 1/15/2020.

1/15/20 at 12:51 p.m. OSM (other staff member) #4, the social worker, informed this surveyor that they did not have a copy of Resident # 45's advanced directive.

On 1/16/2020 a copy of a legal document for guardianship for Resident #45 was presented. The paperwork documented in part, "A. that the (Resident #45)'s Advance Medical Directive attached to this Order as Exhibit A is in full legal effect with respect to the appointment of (name of daughter) formerly known as (name of daughter), as the health care agent for (Resident #45)." There was no Exhibit A attached to this document.

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse and ASM #4 the medical director, was made aware of the above concern on 1/15/2020 at 5:42 p.m.

No further information was provided prior to exit.

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F 578	Continued From page 40 (1) Barron's Dictionary of Medical Terms, 5th edition, Rothenberg and Chapman, page 26.	F 578		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure two of sixty residents, (Resident #462 and #712) were free from abuse. Resident #140 stuck Resident #462 on the left side of the face, on 1/9/19. The facility staff failed to ensure that Resident #712 was free from abuse from Resident #22; Resident #22 struck Resident #712 multiple times with a Reacher on 2/27/19. The findings include: 1. A FRI (Facility Reported Incident) dated, 1/9/19, documented in part, "Incident date: 1/9/19. Resident's involved (Resident #462) and	F 600	F600-D Free from Abuse and Neglect 1) Corrective Action for those residents found to be affected by the alleged deficient practice. Residents # 462 and #712 have since been discharged from the facility. Resident #22 remains in facility in a room by herself with psych services. There have been no recent altercations or issues with her. Resident #140 remains in facility with no behavioral issues. 2) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents within the facility and those admitted to facility have	2/17/20

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F 600	Continued From page 41 (Resident #140). Incident type: resident on resident altercation. Injuries: "No." Describe Incident: "Resident #462 was sitting in her wheel chair in hallway. Resident #140 slapped Resident #462 on the left side of the face." The "FRI Final Report" dated, 1/14/19, documented in part, "CNA (certified nursing assistant) #8 witnessed Resident #140 strike Resident #462 on the left side of her face. There was no injury noted to either resident and both residents were immediately separated. Neither resident remembered the incident the following day. The resident on resident abuse was substantiated." The facility's abuse policy revised 2017 and titled "Abuse Prevention Program" states "Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms." Abuse defined in the policy as "the willful infliction of injury" and "instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish." Resident # 462 was admitted to the facility on 7/20/17, with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), COPD (chronic obstructive pulmonary disease a non-reversible lung disease) (2), Schizoaffective disorder (mental disorder characterized by distortions of reality, disturbances of thought) (3).	F 600	the potential to be affected. The Director of Nursing or designee will audit any current residents with reported altercations. 3) Systemic Changes put into place to ensure the alleged deficient practice does not recur. In-service for the Licensed Nurses will be completed by the Director of Nursing or designee monitoring Residents for agitation and escalation. Care plans to be updated at the time of the incident and a psychosocial assessment to be completed if a resident is involved in a resident to resident altercation. 4) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing/ Designee will complete resident to resident altercation audits weekly x 4 then monthly x 3. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process monthly. 5) Date of compliance 2/17/2020	

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Resident # 462's most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/27/18, coded the resident as scoring a 7 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident had severely impaired cognition. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, locomotion on/off the unit, dressing, toilet use, personal hygiene and requiring supervision in eating.

A nurse's progress note in Resident #462's clinical record dated, 1/9/19 at 3:59 PM, documented in part, "Change in condition noted related to Resident being slapped on the left side of the face by another resident. No injury noted at this time. No complaints of pain. Skin color is within normal limits."

The care plan for Resident #462 dated 1/1/19, documented in part, Problem: "Verbal/physical agitation/aggression related to cognitive loss." The Interventions dated 1/1/19, documented, "Remove from public area when behavior is disruptive/unacceptable, and provide diversion with all activities." Resident #462's care plan was not revised after 1/9/19 incident.

Resident #140 was admitted to the facility on 4/10/17 with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), anxiety disorder (mild to severe apprehension and feelings of panic) (2), depression (feelings of sadness, discouragement or hopelessness) (3).

The most recent MDS (minimum data set)

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assessment (after the event), a quarterly assessment, with an ARD (assessment reference date) of 2/14/19, coded Resident #140 as scoring a 3 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident had severely impaired cognition. A review of the MDS Section G-functional status coded the resident as requiring limited assistance for bed mobility, walk in corridor, dressing, toilet use, personal hygiene and requiring supervision in transfer, walking in room, locomotion on/off unit and eating.

The care plan dated 1/1/19, for Resident #140 documented in part, Problem: "Cognitive loss related to Dementia revised 6/15/18." The Goal dated 7/31/19 documented, "Will display appropriate response to situation." The Interventions dated 4/17/17, documented, "Approach/speak in a calm, positive/reassuring manner." Problem: "Indicators of depression/sadness related to depression, anxiety disorder revised 9/3/18." The Interventions revised 5/11/19, documented, "Offered choices to enhance sense of control whenever possible. Psych consult and treatment as ordered." Resident #140's care plan was not revised after the 1/9/19, resident-to-resident incident with Resident #462.

A nurse's progress note dated, 1/9/19 at 1:24 PM, in Resident #140's clinical record documented in part, "Change in condition noted related to Resident being reported to have hit another resident. This change in condition started on 1/9/19. Since this started, it has gotten better. Both residents were separated and situation diffused. Resident assessed no injuries or distress. Resident offered divisional activities and accepted."

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An interview was conducted on 1/14/20 at 4:35 PM with LPN (licensed practical nurse) #11. When asked definition of abuse, LPN #11 stated, "It can be physically hitting someone, sexual or verbal." When asked if a resident, hits another resident is that considered abuse, LPN #11 stated, "Yes, that's abuse." When asked about the process staff follows when resident-to-resident abuse occurs, LPN #11 stated, "You separate the residents, calm them down and inform manager. The manager completes paperwork for reporting and updates the care plan."

An interview was conducted on 1/15/20 at 9:28 AM with Resident #140. When asked if she remembered any physical altercation or striking another resident, Resident #140 stated, "No I don't."
ASM (Administrative staff member) #1, the administrator and ASM #3, the corporate representative were made aware of the above concerns on 1/15/20 at 5:05 PM.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154.
(2) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 120.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 518.

2. Resident #712, who was no longer residing in

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the facility, was admitted to the facility on 5/4/17; diagnoses include but are not limited to cerebrovascular disease, convulsions, hemiplegia, aphasia, dysphagia, contracture of unspecified hand, depression, non-traumatic intracranial hemorrhage, non-traumatic subarachnoid hemorrhage, and cognitive communication deficit. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/25/19 coded the resident as being moderately impaired for daily decision-making. The resident was coded as requiring total care for bathing and toileting; extensive care for bed mobility, dressing, and hygiene; supervision for eating; and was incontinent of bowel and bladder.

Resident #22 was admitted to the facility on 12/27/18; diagnoses include but are not limited to high blood pressure, dementia with behaviors, depression, anxiety disorder and chronic kidney disease. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/31/19 coded the resident as being mildly impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing; limited assistance for transfers, dressing, and toileting; supervision for ambulation, eating and hygiene; and was continent of bowel and bladder.

A review of the facility policy, "Abuse Prevention Program" documented, "Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not

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required to treat the resident's symptoms. As part of the resident abuse prevention , the administration will: 1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual."

Review of a Facility Reported Incident (FRI) dated 2/27/19 documented, "An (sic) physical altercation happened between two residents...Residents were separated and made safe. Both residents assessed for injury. (Resident #712) sent to hospital for further assessment."

A review of the follow up report, dated 3/4/19, documented, "On Wednesday 3/27/19 (sic, 2/27/19), approximately 5:00pm, (LPN #12) (Licensed Practical Nurse) responded to the nurse call system for resident (#712). Upon entering room, (Resident #22) had a reacher in her hand and was sitting on side of bed of (Resident #712). (Resident #712) had blood on the bridge of her nose. (LPN #12) attempted to assist (Resident #22) off of bed and away from (Resident #712). At this point (Resident #22) started swinging reacher at (Resident #712) and struck her 4-5 times before LPN (#12) could safely separate them and secure the reacher from (Resident #22). LPN called out for assistance. (CNA #9) (Certified Nursing Assistant) and (LPN #1) bot (sic) responded and assisted with leading (Resident #22) out of the room. During this time period of being separated (Resident #22) said "I told her to turn her TV down." Medical care was given to (Resident #712) and then sent to ER (emergency room) to

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primarily evaluate her hand which (Resident #712) was complaining of pain. (Resident #712) showed signs such as redness of skin in multiple areas, skin tear, which can be assumed to be from being struck many times beyond the 4-5 hits that were witnessed. (Resident #712) was transferred back to us in the same evening with no broken bones. The police were notified and they arrived before (Resident #712) was transferred to ER. (Resident #712) husband has not decided if he will be pressing charges. (Resident #22) and (Resident #712) are no longer roommates. It has been substantiated the (sic) (Resident #712) was the victim of (Resident #22) aggression."

A review of the clinical record for Resident #712, revealed the following nurses notes:
- 2/27/19 at 4:45 PM: "Change in condition noted related to Upon responding to call bell, nurse observed resident being struck w/ (with) a reacher by her roommate at bedside. As the nurse attempted to separate residents, w/ each attempt, the roommate continued to strike the other resident....SKIN: Noted to have the following skin conditions present: Laceration. Resident noted to have multiple hematomas w/ swelling, redness to facial area, laceration to top of head, laceration to bridge of nose w/ swelling, laceration x 2 w/ swelling to rt (right) hand, first/second knuckles, redness w/ swelling to right axilla, redness to left axilla. Evidence of PAIN noted related to change in condition/status. New onset of pain noted. Most recent pain level noted at 10 on a 1-10 scale. c/of (complains of) pain to right hand/knuckles, limited ROM (range of motion), otherwise WNL (within normal limits) for resident...."

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- 2/27/19 at 5:00 PM: "Resident alert, verbal and oriented x 3, no changes in neuro status noted upon assessment, Neuro [neurological] checks initiated at this time."

- 2/27/19 at 5:00 PM: "MD/RP/SS (medical doctor/responsible party/social services), Administration, state and law enforcement agencies notified, facility investigation initiated. Ice applied to affected areas, resident medicated x 1 for c/of pain to right hand, will monitor. N.O.O. (new order obtained) send resident to ER [emergency room] for evaluation, RP [responsible party] aware...."

- 2/28/19 at 5:18 AM: "Pt (patient) returned to facility via ambulance at 2300 (2/27/19 at 11:00 PM) with husband at side. New order - Ibuprofen (1) 200mg (milligrams) 1-2 tablets by mouth every 8 hours PRN (as needed). No complaints of pain at this time. 2 (two) person assist with ADLs (activities of daily living). Pt able to make needs known and voice concerns. Right hand knuckles and chest bruised. Cuts to center of forehead and bridge of nose. Sites open to air; no drainage noted. Raised areas to left chin and right forehead. Pt refused ice application at this time. Stated she just wanted to rest. Neuro assessments initiated. Full ROM to right hand. Pt noted eating snacks and watching television during shift. Incontinent to bowel and bladder. Repositioned with assistance without discomfort or pain. Monitored frequently during shift. HOB (head of bed) elevated. Turned and repositioned. Call bell within reach."

- A hospital "Discharge Summary" dated 2/27/19 documented, "Contusions...Ibuprofen (Motrin) 200 Milligrams # 1 bottle 1-2 tablets every 8 hours

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as needed...You have deep bruise (contusion). Contusions are areas of tenderness and swelling in the soft tissues. They are the result of trauma and bleeding in the injured area. Minor trauma will give you a painless bruise; more severe contusions may stay painful and swollen for a few weeks. There are no broken bones. This injury takes a few days to a few weeks to heal."

A review of the incident report revealed a social worker note dated 2/27/19 that documented, "Informed by staff that resident was struck by roommate and received laceration and hematoma. In to see resident who confirmed that roommate was physically aggressive towards her. Prior to conversation, resident and roommate separated and put in different rooms. Resident calm during conversation, but did state she was anticipating being sent to the emergency room. Provided support and reassurance. Resident indicated she was not in emotional distress. Encouraged resident to express her concerns and she indicated she was not in distress emotionally. Spoke with RP (name of RP) to discuss situation. Informed RP that the police had been contacted. RP indicated that he did not wish for charges to be pressed; however, also indicated that he wished for resident to be sent to the emergency room [ER] for evaluation. Assured RP that resident will be evaluated through ER. Spoke with resident again who stated she was calm and did not feel in danger. Advised resident that counseling services through (counseling service group) were available to assist with managing emotions related to the incident; however, resident declined to be seen by (counseling service group), indicating she did not feel the need. Resident stated she will let

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writer know should she feel the need for supportive counseling. Inquired again with RP as to whether or not he wished for charges to be filed against resident's roommate. RP re-iterated that he did not wish for charges to be filed. Will continue to assist with needs as they arise."

A review of the comprehensive care plan revealed no documentation or evidence of a review or revision related to this incident.

A review of the clinical record for Resident #22 revealed no documented behaviors towards other residents prior to the 2/27/19 incident and revealed the following nurses notes:

- 2/27/19 at 5:00 PM: "Resident transferred to room (new room number), RP aware. There are no noted injuries to resident and resident denies any injuries as a result of the incident at this time. Staff will remain with and monitor resident for the duration of the night.

- 2/27/19 at 5:15 PM: "Change in condition noted related to c/of headache, BP (blood pressure) noted to be 183/99. This change in condition started 2/27/19...." This note did not document anything regarding the incident with Resident #712.

A Mental Health Consult - Progress Note [for Resident #22] dated 3/5/19 documented, "Client stated she was "doing alright" now that she does not have to be in the same room as her former roommate....An assessment was requested on an emergent basis following an incident in which client physically assaulted her roommate with her grabber....Client acknowledged the incident and was not apologetic, stating that "this is what

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happens when someone raises my blood pressure". She talked further about her former roommate being "irritating" and difficult with staff as well as with her....Client is currently in a private room which appears to be most appropriate placement for her at this time. She is choosing to leave her door to her room shut most of the time to decrease possibility of unpleasant interactions. Client makes no promises or guarantees that she will not lash out physically again if anyone causes her "blood pressure to rise again". If she is to be placed in a room with a new roommate, she would need to be with a resident who is fairly passive and easy to get along with. Client presents as someone with longstanding, chronic PTSD [post traumatic stress disorder] symptoms and, as such, can be easily triggered into defensive action, which in her case, results in physically defending herself. This is a condition which is not easily remediated and would require long term counseling services to begin to effect a change. Recommend that client remain in private room or, if with roommate, one that is carefully chosen in order to avoid future physical incidents. Client reports that she does not watch much TV but would enjoy entertaining herself with word puzzles, coloring or other similar activities...."

A review of the comprehensive care plan revealed no documentation or evidence of a review or revision related to this incident.

Observation made of Resident #22 on 1/15/20 at 8:46 AM, revealed the resident to be in a semi private room, but without a roommate. The resident was up in her chair waiting for breakfast, had multiple personal items in reach around her, and the TV on. Resident #22 was dressed and groomed. The door to the room had been closed.

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On 1/15/20 at 8:50 AM, in an interview with LPN #8 (Licensed Practical Nurse), she stated that the resident has been residing in a room by herself since behavior issues with roommates. She stated that the resident has had no further issues with behaviors since being in a room by herself. She stated the resident does attend some social activities without behavior incidents. She stated that staff were surprised by the resident's behavior towards Resident #22, as prior to this incident she had not displayed such behavior towards any residents.

On 1/16/20 at 10:11 AM, an interview was conducted with OSM #4 (Other Staff Member) the Social Worker, and ASM #1 (Administrative Staff Member) the Administrator. OSM #4 stated that "they were in a large room, and there was discussion over the volume of the TV and a disagreement related to that. (Resident #22) went to the other resident to make her turn down the TV by being physically aggressive. She (Resident 712) was sent out for an evaluation. The family was offered the opportunity to talk with the police and press charges. They did not press charges. To my knowledge, (Resident #22) had not previously displayed potentially aggressive behaviors. She was removed from any type of triggers to a private room. The triggers seems to be having to share space with someone else. (Counseling services group) came in, and an LCSW (licensed clinical social worker) follows her. A psych (psychiatric) eval (evaluation) indicated she felt her behaviors were stemming from her choice of TV programming and she was watching shows aggressive in nature. She was being counseled on TV choices to calm her mood. (Resident #22) watched police shows,

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horror movies, etc. She is better now from what I have seen. (Counseling services group) is still working with her. She was given another roommate after some time, because documentation by the counselor was that she was appropriate for another roommate. She had no demonstrated outbursts. (Another FRI dated 8/19/19 documented a verbal altercation with a new roommate). I don't think there was physical contact with the second incident. She was verbally aggressive and threatening, she was again placed without a roommate after that because having someone else in her space seemed to trigger her. Alternative placement has been attempted. The issue is finding appropriate placement with anyone agreeable to taking her. For Medicaid residents, no one has private Medicaid beds. Her resources does not support ALF (assisted living facility). By default, she is a long-term care Medicaid resident. She will remain in a room by herself. She has had no altercations with residents outside her room. No issues with residents outside her room. In the 2 months from admission until the incident, she had no behavior towards other residents. Only had resisted care and treatment at times. She was docile until then. She has not demonstrated any behavior issues towards other residents anytime she has a room to herself, not even when she is outside her room. She will remain in a private room."

No further information was provided by the end of the survey.

References:
(1) Ibuprofen - is used to relieve pain, tenderness,

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F 600	Continued From page 54 and swelling. Information obtained from https://medlineplus.gov/druginfo/meds/a682159.html	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, 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 implement the abuse policy to report an allegation of abuse within two hours for one of sixty residents in the survey sample, Resident #462. The Facility reported incident (FRI) documented that Resident #140 struck resident #462 on the left side of the face on 1/9/19 at 12:46 p.m. The facility failed to implement the abuse policy to report the allegation of abuse within 2 hours to State Agency [VDH-OLC (Virginia Department of Health-Office Licensure / Certification)]. The incident was not reported until on 1/9/19 at 4:29 PM (three hours and forty-three minutes after alleged abuse).	F 607	F607D Abuse and Neglect Policies 1) Corrective Action for those residents found to be affected by the alleged deficient practice. Resident # 462 has been discharged from facility. Resident #140 remains in facility and has not been involved in any altercations. 2) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents within the facility and those admitted to facility have the potential to be affected. The Director of Nursing or designee will audit any current residents with reported allegations of abuse FRI (facility reported incident) have been reported to OLC (Office of	2/17/20

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F 607	Continued From page 55 The findings include: A FRI (Facility Reported Incident) dated, 1/9/19, documented in part, "Incident date: 1/9/19, time: 12:46 PM. Resident's involved (Resident #462) and (Resident #140). Incident type: resident on resident altercation. Injuries: "No." Describe Incident: Resident #462 was sitting in her wheel chair in hallway. Resident #140 slapped Resident #462 on the left side of the face." The FRI was faxed to VDH-OLC (Virginia Department of Health-Office Licensure / Certification) on 1/9/19 at 4:29 PM (three hours and forty-three minutes after alleged abuse). The facility's abuse policy revised July 2017 and titled "Abuse Investigation and Reporting" states "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly be reported to local, state and federal agencies (as defined by current regulations). Two hours if the alleged violation involves abuse OR has resulted in serious bodily injury." Resident # 462 was admitted to the facility on 7/20/17 with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), COPD (chronic obstructive pulmonary disease a non-reversible lung disease) (2), Schizoaffective disorder (mental disorder characterized by distortions of reality, disturbances of thought) (3). Resident # 462's most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/27/18, coded the resident as scoring a 7 out of	F 607	Licensure), APS (Adult Protected Services) and Ombudsman, VDH (VA dept. Of Health) within 2 hours. 3) Systemic Changes put into place to ensure the alleged deficient practice does not recur. Administrator or Designee will in-service facility staff on reporting allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and/or misappropriation of resident property are to be reported immediately and Administrator or designee has no later than 2 hours after the allegation of abuse is made , involves serious injury to their Supervisor and the Supervisor will inform the Administrator submit FRI to OLC, APS, Ombudsman and VDH. 4) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. The Administrator will audit grievances, be informed of allegations immediately and the Administrator or designee will submit FRI (facility report incident) within 2 hours to OLC, APS, Ombudsman and VDH when meets criteria weekly x 4 and then monthly x 3. The audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and revisions as needed. 5) Date of compliance-2/17/2020	

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15 on the BIMS (brief interview for mental status) score, indicating the resident had severely impaired cognition. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, locomotion on/off the unit, dressing, toilet use, personal hygiene and requiring supervision in eating.

A nurse's progress note in Resident # 462's clinical record dated, 1/9/19 at 3:59 PM, documented in part, "Change in condition noted related to Resident being slapped on the left side of the face by another resident. No injury noted at this time. No complaints of pain. Skin color is within normal limits."

Resident #140 was admitted to the facility on 4/10/17 with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), anxiety disorder (mild to severe apprehension and feelings of panic) (2), depression (feelings of sadness, discouragement or hopelessness) (3).

The most recent MDS (minimum data set) assessment (after the event), a quarterly assessment, with an ARD (assessment reference date) of 2/14/19, coded Resident #140 as scoring a 3 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident had severely impaired cognition. A review of the MDS Section G-functional status coded the resident as requiring limited assistance for bed mobility, walk in corridor, dressing, toilet use, personal hygiene and requiring supervision in transfer, walking in room, locomotion on/off unit and eating.

The care plan dated 1/1/19, for Resident #140

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documented in part, Problem: "Cognitive loss related to Dementia revised 6/15/18." The Goal dated 7/31/19 documented, "Will display appropriate response to situation." The Interventions dated 4/17/17, documented, "Approach/speak in a calm, positive/reassuring manner." Problem: "Indicators of depression/sadness related to depression, anxiety disorder revised 9/3/18." The Interventions revised 5/11/19, documented, "Offered choices to enhance sense of control whenever possible. Psych consult and treatment as ordered." Resident #140's care plan was not revised after the 1/9/19, resident-to-resident incident with Resident #462.

A nurse's progress note dated, 1/9/19 at 1:24 PM, in Resident #140's clinical record documented in part, "Change in condition noted related to Resident being reported to have hit another resident. This change in condition started on 1/9/19. Since this started, it has gotten better. Both residents were separated and situation diffused. Resident assessed no injuries or distress. Resident offered divisional activities and accepted."

On 1/14/20 at 4:35 PM, An interview was conducted with LPN (licensed practical nurse) #11. When asked about the definition of abuse, LPN #11 stated, "It can be physically hitting someone, sexual or verbal." When asked if a resident, hitting another resident is that considered abuse, LPN #11 stated, "Yes, that's abuse." When asked about the process staff follows regarding resident-to-resident abuse, LPN #11 stated, "You separate the residents, calm them down and inform manager. The manager completes paperwork for reporting and updates

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F 607	Continued From page 58 the care plan." An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/16/20 at 11:20 AM, regarding the time frame for reporting allegations of abuse. ASM #2 stated, "It is two hours. I know that we did not report this FRI within the regulated period. I don't know what else to say about that." An interview was conducted on 1/16/20 at 11:28 AM with ASM #1, the administrator, when asked the time frame to reporting allegations of abuse, ASM #1 stated, "I know we have two hour rule as it states in this policy that was in effect 1/9/19, the time of this FRI [facility reported incident]. ASM #1, the administrator, and ASM) #3, the corporate representative were made aware of the above concerns on 1/15/20 at 5:05 PM. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154. (2) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 120. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 518.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		2/17/20

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F 609	Continued From page 59 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to immediately report an allegation of abuse for one of sixty residents in the survey sample, Resident #462. The Facility reported incident (FRI) documented that Resident #140 struck resident #462 on the left side of the face on 1/9/19 at 12:46 p.m. The facility failed to report the allegation of abuse immediately to VDH-OLC (Virginia Department of Health-Office Licensure / Certification). The incident was not reported until on 1/9/19 at 4:29 PM (three hours and forty-three minutes after the alleged abuse).	F 609	F609 Reporting of Alleged Violations 1) Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #462 has been discharged from the facility. 2) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents within the facility and those admitted to facility have the potential to be affected. The Director of Nursing or designee will audit any current residents with reported allegations of abuse FRI (facility reported incident)	

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F 609	Continued From page 60 The findings include: The facility's abuse policy revised July 2017 and titled "Abuse Investigation and Reporting" states "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly be reported to local, state and federal agencies (as defined by current regulations). Two hours if the alleged violation involves abuse OR has resulted in serious bodily injury." A FRI (Facility Reported Incident) dated, 1/9/19, documented in part, "Incident date: 1/9/19, time: 12:46 PM. Resident's involved (Resident #462) and (Resident #140). Incident type: resident on resident altercation. Injuries: "No." Describe Incident: Resident #462 was sitting in her wheel chair in hallway. Resident #140 slapped Resident #462 on the left side of the face." The FRI was faxed to VDH-OLC (Virginia Department of Health-Office Licensure / Certification) on 1/9/19 at 4:29 PM (three hours and forty-three minutes after alleged abuse). Resident # 462 was admitted to the facility on 7/20/17 with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), COPD (chronic obstructive pulmonary disease a non-reversible lung disease) (2), Schizoaffective disorder (mental disorder characterized by distortions of reality, disturbances of thought) (3). Resident # 462's most recent MDS (minimum	F 609	have been reported to OLC (Office of Licensure), APS (Adult Protected Services) and Ombudsman, VDH (VA dept. Of Health) within 2 hours. 3) Systemic Changes put into place to ensure the alleged deficient practice does not recur. Administrator or Designee will in-service facility staff on reporting allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and/or misappropriation of resident property are to be reported immediately and Administrator or designee has no later than 2 hours after the allegation of abuse is made , involves serious injury to their Supervisor and the Supervisor will inform the Administrator submit FRI to OLC, APS, Ombudsman and VDH. 4) Monitoring of corrective action to ensure the alleged deficient practice does not recur. The Administrator will audit grievances, be informed of allegations immediately and the Administrator or designee will submit FRI (facility report incident) within 2 hours to OLC, APS, Ombudsman and VDH when meets criteria weekly x 4 and then monthly x 3. The audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and revisions as needed. 5) Date of compliance- 2/17/2020	

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data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/27/18, coded the resident as scoring a 7 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident had severely impaired cognition. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, locomotion on/off the unit, dressing, toilet use, personal hygiene and requiring supervision in eating.
A nurse's progress note in Resident # 462's clinical record dated, 1/9/19 at 3:59 PM, documented in part, "Change in condition noted related to Resident being slapped on the left side of the face by another resident. No injury noted at this time. No complaints of pain. Skin color is within normal limits."
Resident #140 was admitted to the facility on 4/10/17 with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), anxiety disorder (mild to severe apprehension and feelings of panic) (2), depression (feelings of sadness, discouragement or hopelessness) (3).

The most recent MDS (minimum data set) assessment (after the event), a quarterly assessment, with an ARD (assessment reference date) of 2/14/19, coded Resident #140 as scoring a 3 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident had severely impaired cognition. A review of the MDS Section G-functional status coded the resident as requiring limited assistance for bed mobility, walk in corridor, dressing, toilet use, personal hygiene and requiring supervision in transfer, walking in room, locomotion on/off unit and eating.

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The care plan dated 1/1/19, for Resident #140 documented in part, Problem: "Cognitive loss related to Dementia revised 6/15/18." The Goal dated 7/31/19 documented, "Will display appropriate response to situation." The Interventions dated 4/17/17, documented, "Approach/speak in a calm, positive/reassuring manner." Problem: "Indicators of depression/sadness related to depression, anxiety disorder revised 9/3/18." The Interventions revised on 5/11/19, documented, "Offered choices to enhance sense of control whenever possible. Psych consult and treatment as ordered." Resident #140's care plan was not revised after the 1/9/19, resident-to-resident incident with Resident #462.

A nurse's progress note dated, 1/9/19 at 1:24 PM, in Resident #140's clinical record documented in part, "Change in condition noted related to Resident being reported to have hit another resident. This change in condition started on 1/9/19. Since this started, it has gotten better. Both residents were separated and situation diffused. Resident assessed no injuries or distress. Resident offered divisional activities and accepted."

On 1/14/20 at 4:35 PM, An interview was conducted with LPN (licensed practical nurse) #11. When asked about the definition of abuse, LPN #11 stated, "It can be physically hitting someone, sexual or verbal." When asked if a resident, hitting another resident is that considered abuse, LPN #11 stated, "Yes, that's abuse." When asked about the process staff follows regarding resident-to-resident abuse, LPN #11 stated, "You separate the residents, calm them down and inform manager. The manager

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F 609	Continued From page 63 completes paperwork for reporting and updates the care plan." An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/16/20 at 11:20 AM, regarding the time frame for reporting allegations of abuse. ASM #2 stated, "It is two hours. I know that we did not report this FRI within the regulated period. I don't know what else to say about that." An interview was conducted on 1/16/20 at 11:28 AM with ASM #1, the administrator, when asked the time frame to reporting allegations of abuse, ASM #1 stated, "I know we have two hour rule as it states in this policy that was in effect 1/9/19, the time of this FRI. ASM #1, the administrator, and ASM) #3, the corporate representative were made aware of the above concerns on 1/15/20 at 5:05 PM. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154. (2) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 120. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 518.	F 609		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to	F 622		2/17/20

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F 622	Continued From page 64	F 622		

remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

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F 622	Continued From page 65 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary,	F 622		

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F 622	Continued From page 66 consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility documentation review, and staff interview, the facility staff failed to evidence the required documentation was provided to the receiving hospital for two of 60 residents in the survey sample, (Residents #70 and #73). The facility staff failed to ensure a copy of Resident #70's comprehensive care plan goals was sent with the resident for a facility initiated transfer to the hospital on 1/5/2020. The facility staff failed to evidence that the appropriate paperwork was provided to the receiving provider for a facility-initiated transfer of Resident # 73 on 11/19/2019. The findings included: 1. Resident #70 was admitted to the facility on 11/30/2019. Diagnoses included but are not limited to stroke, pneumonia, and diabetes. Resident #70's most recent Minimum Data Set (MDS) assessment was a Medicare 5 Day Assessment with an Assessment Reference Date (ARD) of 12/07/2019. The Brief Interview for Mental Status (BIMS) scored Resident #70 at an 11, indicating mild to moderate cognitive impairment. Resident #70 was coded as requiring extensive assistance of one person for most Activities of Daily Living (ADLs). Review of the clinical record revealed that Resident #70 was hospitalized on 01/05/2020. On the afternoon of 01/15/2020 at 4:00 p.m., ASM (administrative staff member) #2, the director of	F 622	F622 Transfer and Discharge Requirements 1) Corrective Action for those residents found to be affected by the alleged deficient practice. Facility will provide documentation in Resident medical record that appropriate information is sent to receiving Hospital including Comprehensive Care Plan Goals. 2) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents within the facility and those admitted to facility have the potential to be affected. The Director of Nursing or designee will complete an audit on current residents that are transferred to Hospital have documentation that transfer form completed and comprehensive care plan goals were sent with resident. 3) Systemic Changes put into place to ensure the alleged deficient practice does not reoccur. The Director of Nursing or designee will in-service the Licensed nurses on procedure for information required including transfer form and comprehensive care plan goals to be sent with resident to hospital with discharge documentation with information sent including transfer form and comprehensive care plan goals. 4) Monitoring of corrective action to ensure the alleged deficient practice does not recur. The Director of Nursing or	

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F 622	Continued From page 67 nursing was asked to provide documentation of required paperwork being sent at the time of the resident's transfer to the hospital on 1/05/2020. On the morning of 01/16/2020, facility staff provided and left papers on the conference table evidencing documentation that all required items were sent to the Responsible Party, the Hospital, and the Ombudsman, except for the comprehensive care plan goals. On 01/16/2020 at 10:41 a.m., Administrative Staff Member #3, the Corporate Nurse, confirmed that the facility did not have any evidence to support that Resident #70's care plan goals had been sent with the resident to the hospital. On 01/16/2020 at 11:06 a.m., an interview was conducted with Registered Nurse (RN) #3. RN #3 was asked to describe the process staff follows to prepare a resident's paperwork for transfer to the hospital. RN #3 pointed out a checklist on the wall stating, "We follow the checklist". Upon review, the checklist did not contain any reference to the resident's comprehensive care plan goals. When asked if comprehensive care plan goals are sent with the resident to the hospital, RN #3 stated, "yes, we send the care plan, I don't know why it's not on there." Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 01/16/2020. No further documentation was provided. 2. Resident # 73 was admitted to the facility with diagnoses that included but were not limited to: stroke, muscle weakness and swallowing difficulties.	F 622	designee will review discharge residents have discharge documentation information was sent with resident to hospital including transfer form and comprehensive care plan goals x 4 weeks and monthly x 3 months .The audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and revisions as needed. 5) Date of compliance- 2/17/2020	

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Resident # 73's most recent MDS [minimum data set], a significant change assessment with an ARD (assessment reference date) of 12/08/19, coded Resident # 73 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions.

The nurse's note for Resident # 73 dated 11/19/2019 documented, "Resident is A&O [alert and oriented] x3 [times three] and able to make her needs known. No complaints of pain when asked. Resident is her [sic] r/t [related to] CHF [congestive heart failure], therapy is working with her to gain her strength back. She is continent of B&B [bowel and bladder]. Resident weight was increasing. NP [nurse practitioner] notified the MD [medical doctor] and resident was sent out at this time to the ER [emergency room]. NP called and talked to the daughter. No complaints of pain and no sign of distress from resident when she just left via [by] ambulance."

Review of the EHR [electronic health record] and the paper clinical record for Resident # 73 failed to evidence documentation that the contact information of the practitioner responsible for the care of Resident #73 was provided to the receiving hospital at the time of transfer on 11/19/2019. Further review of the clinical record failed to evidence the resident representative (RP) information including their contact information, Advance Directive information for Resident #73, all special instructions or precautions for ongoing care, as appropriate, and Resident #73's comprehensive care plan goals, were provided to the receiving hospital at the time of the facility initiated transfer 11/19/2019.

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F 622	Continued From page 69 On 01/16/2020 at 10:14 a.m., an interview was conducted with ASM [administrative staff member] # 3, regional director of clinical services. After reviewing the nurse's note for Resident # 73 dated 11/19/2019, ASM # 3 stated there was no documentation of what paperwork/information was sent to the receiving facility upon Resident # 73's transfer to the hospital on 11/19/2019. On 01/16/2020 at 11:06 AM, an interview was conducted with RN [registered nurse] # 3. RN #3 was asked to describe the process staff follows when transferring a resident to the hospital. RN #3 stated that the staff have a detailed checklist that lists each item that needs to be printed and where the items is to go. This includes providing a written notice to the RP (responsible party) or, if the RP is not in the building at the time, sending the written notice by certified mail. RN # 3 was asked if the resident's care plan goals were included in the items sent to the hospital. RN # 3 stated yes, the care plan goals are sent with the residents to the hospital. When asked who verifies that all required papers have been assembled for transfer to the hospital, RN # 3 stated that typically the unit manager or director of nursing would audit the papers. RN # 3 stated that in the event that a transfer occurs after hours, the shift supervisor would verify the papers were ready. On 01/16/2020 at approximately 1:40 p.m. ASM [administrative staff member] # 1, the administrator, ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit.	F 622		
F 656	Develop/Implement Comprehensive Care Plan	F 656		2/17/20

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F 656 SS=E	Continued From page 70 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights 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.	F 656		

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F 656	Continued From page 71 (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 resident interview, staff interview and clinical record review it was determined that the facility staff failed to implement the comprehensive care plan for four of 60 residents in the survey sample, (Residents # 64, # 53, # 135 and # 144). The facility staff failed to implement the comprehensive care plans for the use of non-pharmacological interventions for Resident #64, #53 and #135. The facility staff failed to implement Resident #144's comprehensive care plan for the treatment of pain. The findings include: 1. Resident # 64 was admitted to the facility with diagnoses that included but were not limited to: specified joint disorder, unspecified hip, and cancer of the nasal cavity [inside the nose]. Resident # 64's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/02/19, coded Resident # 64 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being cognitively intact for making daily decisions. Resident # 64 was coded as requiring extensive assistance of one staff member for activities of daily living. Section J "Health Conditions" coded Resident # 64 as having frequent pain with a pain level of four on a scale of zero to ten with ten being the worse pain.	F 656	F656 Develop/Implement Comprehensive Care Plan 1) Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #53 and #64 have been discharged. Resident #135 and #144 care plans have been updated. 2) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents within the facility and those admitted to facility have the potential to be affected. The Director of Nursing or designee will complete an audit on current resident□s pain care plan to evaluate for non-pharmacological interventions and review (electronic medication record) EMAR for administration of prn pain medications per pain level rating is administered to the pain level parameter per physician order. 3) Systemic Changes put into place to ensure the alleged deficient practice does not reoccur. Inservice by the Director of Nursing or designee will be completed by the Licensed nursing on procedures for non-pharmacological intervention on the pain care plan and administration of prn pain medications per pain level rating is administered to the pain level parameter per physician order.	

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F 656	Continued From page 72 The POS [physician's order sheet] dated 01/01/2020 for Resident # 64 documented, "Oxycodone Tablet 5MG [five milligrams]. Give 0.5 mg by mouth every 12 hours as needed for severe pain. Give ½ [half] of 5mg tablet to equal 2.5mg. Order Date: 11/30/2019." The comprehensive care plan for Resident # 64 dated 12/05/2019 documented, "Focus: Pain to left hip related to chronic left hip pain. Date Initiated: 12/05/2019." Under "Interventions" it documented, "Implement nondrug therapies such as repositioning, activities, to assist with pain and monitor for effectiveness. Date Initiated: 11/26/2019." Resident # 64's eMAR [electronic medication administration record] dated December 2019 documented the physician's order as above. The eMAR also documented, "Pain Score every shift; 1,2,3,4 [one, two, three, four] = Mild Pain; 5, 6, 7 [five, six, seven] = Moderate Pain; 8,9,10 [eight, nine, ten] = Severe Pain." The eMAR failed to evidence documentation of non-pharmacological interventions. Further review of the eMAR revealed the administration of Oxycodone on the dates at the times as follows: 12/01/19 at 8:43 p.m. with a pain level of five. 12/05/19 at 8:37 p.m. with a pain level of four. 12/06/19 at 9:30 p.m. with a pain level of four. 12/16/19 at 8:17 p.m. with a pain level of nine. 12/17/19 at 2:37 p.m. with a pain level of six. 12/19/19 at 9:22 p.m. with a pain level of five. 12/22/19 at 12:39 p.m. with a pain level of eight. 12/26/19 at 12:00 a.m., with a pain level of six and at 9:14 p.m. with a pain level of four. 12/28/19 at 9:51 p.m. with a pain level of three. 12/29/19 at 9:23 p.m. with a pain level of four. 12/30/19 at 9:30 p.m. with a pain level of three.	F 656	4) Monitoring of corrective action to ensure the alleged deficient practice does not recur. Audits by the Director of Nursing or designee on resident□s pain care plan to evaluate for non-pharmacological interventions and review (electronic medication record) EMAR for administration of prn pain medications per pain level rating is administered to the pain level parameter per physician order. weekly x 4 weeks and then monthly x 3 months. The audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and revisions as needed. 5) Date of compliance- 2/17/2020	

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F 656	Continued From page 73	F 656		

Resident # 64's eMAR [electronic medication administration record] dated January 2020 documented the physician's order as above. The eMAR also documented, "Pain Score every shift; 1,2,3,4 [one, two, three, four] = Mild Pain; 5, 6, 7 [five, six, seven] = Moderate Pain; 8,9,10 [eight, nine, ten] = Severe Pain." The eMAR failed to evidence documentation of non-pharmacological interventions. Further review of the eMAR revealed the administration of Oxycodone at the times and on the dates as follows:
01/03/20 at 9:33 p.m. with a pain level of three.
01/06/20 at 10:19 p.m. with a pain level of two.
01/07/20 at 9:00 p.m. with a pain level of four.
01/08/20 at 8:23 p.m. with a pain level of three.
01/11/20 at 8:16 p.m. with a pain level of three.
01/12/20 at 8:24 p.m. with a pain level of four.

Review of the nurse's notes dated 12/01/2019 through 01/15/2020 failed to evidence documentation of non-pharmacological interventions.

On 01/14/20 at 3:51 p.m., an interview was conducted with Resident # 64. When asked if the staff attempt to alleviate her pain before administering the as needed oxycodone pain medication, Resident # 64 stated, "No."

On 01/15/20 at 2:02 p.m., an interview was conducted with LPN [licensed practical nurse] # 4 unit manager. When asked to describe the purpose of a care plan, LPN # 4 stated, "To identify the resident's needs and the goals to meet the needs and interventions in place to help meet the resident' needs." LPN # 4 was asked if the statement "Implement nondrug therapies such as repositioning, activities, to assist with

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pain and monitor for effectiveness" under "Interventions", on Resident # 64's care plan implied the use of non-pharmacological interventions. LPN # 4 stated yes. LPN # 4 reviewed the eMARs for the administration of oxycodone to Resident # 64 for the dates and times listed above and the nurse's notes dated 12/01/2019 through 01/15/2020 and Resident # 64's comprehensive care plan for pain. LPN #4 was asked if the care plan was being implemented for the use of non-pharmacological interventions. LPN # 4 stated, "Not that we can show."

On 01/15/2020 at approximately 5:40 p.m. ASM [administrative staff member] # 1, the administrator, ASM # 2, director of nursing, 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. Resident # 53 was admitted to the facility with diagnoses that included but were not limited to osteoarthritis [2], osteoporosis [3] and polyneuropathy [4].

Resident # 53's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/27/2019, coded Resident # 53 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making

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daily decisions. Resident # 53 was coded as requiring extensive assistance of one staff member for activities of daily living. Section J "Health Conditions" coded Resident # 53 as having severe frequent pain.

The POS [physician's order sheet] dated 01/01/2020 for Resident # 53 documented, "Acetaminophen Tablet 325MG [milligrams]. Give 2 [two] tablet by mouth every 6 [six] hours as needed for mild pain. Order Date: 11/21/2019."

Resident # 53's eMAR [electronic medication administration record] dated November 2019 documented the physician order above. The eMAR also documented, "Pain Score every shift; 1,2,3,4 [one, two, three, four] = Mild Pain; 5, 6, 7 [five, six, seven] = Moderate Pain; 8,9,10 [eight, nine, ten] = Severe Pain." The eMAR failed to evidence documentation of non-pharmacological interventions. Further review of the eMAR revealed the administration of Acetaminophen on the dates and times as follows:
11/23/19 at 12:51 p.m. with a pain level of three and at 8:22 p.m. with a pain level of three.
11/25/19 at 4:48 p.m. with a pain level of four.
11/26/19 at 12:37 a.m. with a pain level of four and at 8:47 p.m. with a pain level of five.
11/27/19 at 8:32 p.m. with a pain level of four.

Review of the nurse's notes dated 1/01/2019 through 11/30/2019 failed to evidence documentation of non-pharmacological interventions.

On 01/15/20 at 4:00 p.m., an interview was conducted with Resident # 53. When asked if the staff attempt to alleviate the pain before administering the as needed pain medication

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oxycodone, Resident # 53 stated, "No."

On 01/15/20 at 2:02 p.m., an interview was conducted with LPN [licensed practical nurse] # 4 unit manager. When asked to describe the purpose of a care plan, LPN # 4 stated, "To identify the resident's needs and the goals to meet the needs and interventions in place to help meet the resident' needs." LPN # 4 was asked if the statement "Implement nondrug therapies such as repositioning, activities, to assist with pain and monitor for effectiveness" under "Interventions", on Resident # 53's care plan implied the use of non-pharmacological interventions. LPN # 4 stated yes. LPN # 4 reviewed the eMAR for the administration of Acetaminophen to Resident # 53 for the dates and times listed above and the nurse's notes dated 11/23/2019 through 11/30/2019 and Resident # 53's comprehensive care plan for pain. LPN #4 was then asked if the care plan was being implemented for the use of non-pharmacological interventions. LPN # 4 stated, "Not that we can show."

On 01/15/2020 at approximately 5:40 p.m. ASM [administrative staff member] # 1, the administrator, ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis

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caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html.

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

[3] Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.

[4] Poly meaning many: several: much: multi-. This information was obtained from the website: https://www.merriam-webster.com/dictionary/poly. Peripheral nerves carry information to and from the brain. They also carry signals to and from the spinal cord to the rest of the body. Peripheral neuropathy means these nerves don't work properly. Peripheral neuropathy may occur because of damage to a single nerve or a group of nerves. It may also affect nerves in the whole body. This information was obtained from the website: https://medlineplus.gov/ency/article/000593.htm.

3. Resident #135 was admitted to the facility on 12/23/19 with the diagnoses of but not limited to

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type 1 diabetes, orthostatic hypotension, end stage renal disease, neurogenic bladder, osteoporosis, pressure ulcers, hypothermia, hyperparathyroidism, convulsions, arthritis, dialysis dependent, diabetic retinopathy, dumping syndrome, pituitary micro adenoma, postural orthostatic tachycardia syndrome, and history of 3rd degree burn. The Admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/29/19 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, ambulation out of the room and transfers out of bed; limited assistance for bed mobility, ambulation in the room and hygiene; supervision for eating; and was frequently incontinent of bowel and bladder.

A review of the comprehensive care plan for Resident #135 revealed one dated 12/24/19 that documented, "Pain related to arthritis, Neuropathy, wound, rib pain." This care plan included the intervention, dated 12/24/19, documented, "Implement nondrug therapies such as activities, positioning, ice/heat as indicated to assist with pain and monitor for effectiveness."

A review of the clinical record revealed the following physician's orders:
- 12/23/19 for "Acetaminophen (1) Tablet, 325 MG (milligrams) Give 2 tablet orally every 6 hours as needed for pain."
- 12/23/19 for "Diclofenac (2) Sodium Gel 1% Apply 2 gram transdermally as needed for right rib pain four times a day."

A review of the December 2019 MAR (Medication Administration Record) revealed that the

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Acetaminophen was administered on 12/24/19, 12/25/19, 12/26/19, 12/27/19, and 12/31/19.

A review of the December 2019 MAR revealed that the Diclofenac Sodium Gel 1% was applied as ordered on 12/24/19, 12/25/19, 12/27/19, and 12/31/19.

Further review of the clinical record, failed to reveal any documented evidence of non-pharmacological interventions, being offered or attempted.

On 1/16/20 at 9:13 AM, in an interview conducted with LPN #8. When asked about the procedure staff follows for a resident complaining of pain, LPN #8 stated, "Ask for a number (0-10), intensity of the pain, aggravating factors, what makes it worse or better, offer non-pharmacological's (non-pharmacological interventions) first, then check the medication list to see what they have PRN. If it is a trend, mention it to the doctor for something different. Document the non-pharmacological. Document pre and post pain scale."

On 1/16/20 at 9:23 AM, in an interview conducted with LPN #9, the unit manager, LPN #9 stated, "I don't see anything about non-pharmacological in the notes." When asked if the comprehensive care plan for Resident #135 was followed for providing non-pharmacological interventions for pain, LPN #9 stated, "I can't say that it was followed."

A review of the facility policy, "Care Plans, Comprehensive Person-Centered" documented, "A comprehensive, person-centered care plan that includes measurable objectives and

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timetables to meet the residents' physical, psychosocial and functional needs is developed and implemented for each resident."

On 1/16/20 at approximately 1:40 PM, ASM #1 (Administrative Staff Member, the Administrator), ASM #2 (the Director of Nursing), ASM #3 (the corporate nurse), and ASM #4 (the Medical Director) were made aware of the findings. No further information was provided by the end of the survey.

References:
(1) Acetaminophen - is used to relieve mild to moderate pain.
Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html

(2) Diclofenac - is used to relieve pain from osteoarthritis
Information obtained from https://medlineplus.gov/druginfo/meds/a611002.html
4. Resident #144 was admitted to the facility on 12/28/19 with diagnoses that included but were not limited to: non-displaced fracture of the humerus (arm), repeated falls, muscle weakness, anemia, malnutrition, dementia, anxiety disorder, and high blood pressure.

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 1/2/2020, coded the resident as scoring a five on the BIMS (brief interview for mental status) score indicating the resident was severely impaired to make daily cognitive decisions. Resident #144 was coded as requiring extensive assistance for all of her

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activities of daily living. In Section J - Health Conditions the resident was coded as having no pain upon interview.

The comprehensive care plan dated, 12/30/19 documented in part, "Focus: Pain related to fractures." The "Interventions" documented in part, "Administer pain medications per physician orders. Implement nondrug therapies such as repositioning, activities, to assist with pain and monitor for effectiveness.

The physician order dated, 12/28/19, documented, "Acetaminophen (Tylenol) (used to treat mild to moderate pain) (1) tablet 325 MG (milligram); Give 2 tablet by mouth every 6 hours as needed for Mild Pain. Oxycodone tablet (used to treat moderate to severe pain) (2) 5 MG; give 1 tablet by mouth every 6 hours as needed for mod (moderate)/severe pain."

The December 2019 MAR (medication administration record) documented a "Pain Score every shift: 0 = No pain; 1, 2, 3, 4 = Mild Pain; 5, 6, 7 = Moderate pain; 8, 9, 10 = severe pain."

The above physician medication orders were documented on the December 2019 MAR. In December, the resident was administered the Tylenol on the following dates and times for pain scale ratings as follows:
12/28/19 at 5:16 p.m. - pain level = 3
12/29/19 at 8:05 a.m. - pain level = 5
12/31/19 at 5:35 a.m. - pain level = 6
The December 2019 MAR documented the Oxycodone was administered on the following dates, times and the pain scale:
12/28/19 at 9:03 p.m. - pain level = 2
12/29/19 at 3:37 p.m. - pain level = 4

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The January 2020 MAR documented the above physician medication orders. The Tylenol was not documented as having been given. The Oxycodone was documented as being administered on the following dates, times for pain scale ratings as follows:
1/2/2020 at 6:38 a.m. - pain level 4
1/4/2020 at 6:11 p.m. - pain level 3
1/5/2020 at 8:47 p.m. - pain level 6
1/8/2020 at 3:35 p.m. - pain level 4
1/9/2020 at 6:00 p.m. - pain level 6
1/10/2020 at 7:17 p.m. - pain level 4
1/11/2020 at 5:54 p.m. - pain level 6
1/12/2020 at 6:15 a.m. - pain level 4
1/12/2020 at 2:13 p.m. - pain level 5
1/13/2020 at 8:41 a.m. - pain level 6
Of these ten doses administered, only four were per the physician order for moderate pain.

Review of the nurse's notes for the above times and dates in December 2019 and January 2020 failed to document any non-pharmacological interventions provided prior to the administration of the pain medications.

An interview was conducted with RN (registered nurse) #6, the quality assurance nurse/unit manager, on 1/16/2020 at 9:00 a.m. The resident care plan documenting to give medications as ordered, and to try non-drug interventions prior to the administration of medication, the nurse's notes and MAR without documentation of non-pharmacological interventions and the physician ordered parameter of moderate to severe pain and the oxycodone administered with the pain ratings, were reviewed with RN #4. When asked if the staff were implementing the comprehensive care plan and administering pain

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F 656	Continued From page 83 medications as ordered by the physician, RN #6 stated, "No." Administrative staff member (ASM) #1, the administrator and ASM #3, the corporate nurse, were made aware of the above concern on 1/16/2020 at 1:05 p.m. No further information was provided prior to exit. References: (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html (2) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=oxycodone	F 656		
F 657 SS=E	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	F 657		2/17/20

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F 657	Continued From page 84 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for four of sixty residents in the survey sample, (Resident #462, Resident #140, Resident #712 and Resident #22). The facility staff failed to review and revise the comprehensive care plans for Resident # 462 and Resident #140 to address a witnessed abuse incident of Resident #140 striking the left slide of Resident #462's face, on 1/9/2020. The facility staff failed to review and revise the comprehensive care plans for Resident #712 and Resident #22 after Resident #22 struck Resident #712 multiple times with a Reacher on 2/27/2019. The findings include: 1. Resident #462's most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/27/18, coded the resident as scoring a 7 out of	F 657	F657 Care Plan Timing and Revision 1) Corrective Action for those residents found to be affected by the alleged deficient practice. Resident□s #462 and #712 have been discharged. Residents #22 and #140 care plans have been revised. 2) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents within the facility have the potential to be affected. The Director of Nursing or designee will complete an audit on current residents change of condition, incident reports that involve one or more residents have care plan revisions completed. 3) Systemic Changes put into place to ensure the alleged deficient practice does not recur. Inservice by the Director of Nursing or designee to Licensed nurses on revising care plans at the time of change of condition or incidents that involve change of condition, injury or more than one resident must have care plan	

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F 657	Continued From page 85 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. indicating the resident had severely impaired cognition. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, locomotion on/off the unit, dressing, toilet use, personal hygiene and requiring supervision in eating. A FRI (Facility Reported Incident) dated, 1/9/19, documented in part, "Incident date: 1/9/19, time: 12:46 PM. Resident's involved (Resident #462) and (Resident #140). Incident type: resident on resident altercation. Injuries: "No." Describe Incident: Resident #462 was sitting in her wheel chair in hallway. Resident #140 slapped Resident #462 on the left side of the face." Resident #462 was admitted to the facility on 7/20/17 with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), COPD (chronic obstructive pulmonary disease a non-reversible lung disease) (2), Schizoaffective disorder (mental disorder characterized by distortions of reality, disturbances of thought) (3). The care plan for Resident #462 dated 1/1/19, documented in part, Problem: "Verbal/physical agitation/aggression related to cognitive loss." The Interventions dated 1/1/19, documented, "Remove from public area when behavior is disruptive/unacceptable, and provide diversion with all activities." Resident #462's care plan was not revised after 1/9/19 incident as documented above. The nurse's progress note in Resident #462's clinical record dated, 1/9/19 at 3:59 PM,	F 657	revisions for each resident. 4) Monitoring of corrective action to ensure the alleged deficient practice does not reoccur The Director of Nursing or designee will complete an audit of the 24 hour report to review revision of care plans for change of condition were completed and review incidents reports that involves change of condition ,injury or more than one resident had care plan revised on each resident weekly x 4 weeks and then monthly x 3 months. The audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and revisions as needed. 5) Date of compliance- 2/17/2020	

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documented in part, "Change in condition noted related to Resident being slapped on the left side of the face by another resident. No injury noted at this time. No complaints of pain. Skin color is within normal limits."

An interview was conducted on 1/14/20 at 4:35 PM with LPN (licensed practical nurse) #11, regarding the process staff follows for resident-to-resident abuse. LPN #11 stated, "You separate the residents, calm them down and inform manager. The manager completes paperwork for reporting and updates the care plan."

An interview was conducted with RN (registered nurse) #7, the staff development coordinator, on 1/15/20 at 8:29 AM. When asked about staff education regarding documentation and care plans, RN #7 provided an education calendar for 2020 with topics outlined and stated care plan documentation education is provided in orientation. When asked about the purpose of comprehensive care plans, RN #7 stated, "Care Plans set goals of care for the resident." When asked if she participates in care plan development, RN #7 stated, "Yes, I do."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/16/20 at 11:20 AM1/16/20 at 11:20 AM. When asked the procedure staff follows for a resident on resident altercation, ASM #2 stated, "Residents are separated and assessed for injury. Reporting forms are completed and faxed. The physician/nurse practitioner and RP (responsible party) are informed. Witness statements are obtained and progress notes /care plan is revised." When asked about the

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purpose of the comprehensive care plan, ASM #2 stated, "It is to develop plans needed for the specific care of the resident." When asked if care plan for Resident #462 should have been revised to reflect the 1/9/2020 incident, ASM #2 stated, "Yes, it should have been revised."
ASM #1, the administrator, and ASM) #3, the corporate representative were made aware of the above concerns on 1/15/20 at 5:05 PM.
No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154.
(2) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 120.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 518.

2. Resident #140 was admitted to the facility on 4/10/17 with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), anxiety disorder (mild to severe apprehension and feelings of panic) (2), depression (feelings of sadness, discouragement or hopelessness) (3).

The most recent MDS (minimum data set) assessment (after the event), a quarterly assessment, with an ARD (assessment reference date) of 2/14/19, coded Resident #140 as scoring a 3 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident had severely impaired cognition. A review of the MDS Section G-functional status coded the resident as requiring limited assistance for bed mobility, walk

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in corridor, dressing, toilet use, personal hygiene and requiring supervision in transfer, walking in room, locomotion on/off unit and eating.

A FRI (Facility Reported Incident) dated, 1/9/19, documented in part, "Incident date: 1/9/19, time: 12:46 PM. Resident's involved (Resident #140) and (Resident #462). Incident type: resident on resident altercation. Injuries: "No." Describe Incident: Resident #462 was sitting in her wheel chair in hallway. Resident #140 slapped Resident #462 on the left side of the face." The alleged abuse).

The care plan dated 1/1/19, for Resident #140 documented in part, Problem: "Cognitive loss related to Dementia revised 6/15/18." The Goal dated 7/31/19 documented, "Will display appropriate response to situation." The Interventions dated 4/17/17, documented, "Approach/speak in a calm, positive/reassuring manner." Problem: "Indicators of depression/sadness related to depression, anxiety disorder revised 9/3/18." The Interventions revised 5/11/19, documented, "Offered choices to enhance sense of control whenever possible. Psych consult and treatment as ordered." Resident #140's care plan was not revised after the 1/9/19, resident-to-resident incident with Resident #462.

A nurse's progress note dated, 1/9/19 at 1:24 PM, in Resident #140's clinical record documented in part, "Change in condition noted related to Resident being reported to have hit another resident. This change in condition started on 1/9/19. Since this started, it has gotten better. Both residents were separated and situation diffused. Resident assessed no injuries or

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distress. Resident offered divisional activities and accepted."

An interview was conducted on 1/14/20 at 4:35 PM with LPN (licensed practical nurse) #11. When asked about the procedure staff follows for resident-to-resident altercations, LPN #11 stated, "You separate the residents, calm them down and inform manager. The manager completes paperwork for reporting and updates the care plan."

An interview was conducted with RN (registered nurse) #7, the staff development coordinator, on 1/15/20 at 8:29 AM. When asked about staff education regarding documentation and care plans, RN #7 provided an education calendar for 2020 with topics outlined and stated care plan documentation education is provided in orientation. When asked about the purpose of comprehensive care plans, RN #7 stated, "Care Plans set goals of care for the resident." When asked if she participates in care plan development, RN #7 stated, "Yes, I do."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/16/20 at 11:20 AM1/16/20 at 11:20 AM. When asked the procedure staff follows for a resident on resident altercation, ASM #2 stated, "Residents are separated and assessed for injury. Reporting forms are completed and faxed. The physician/nurse practitioner and RP (responsible party) are informed. Witness statements are obtained and progress notes /care plan is revised." When asked about the purpose of the comprehensive care plan, ASM #2 stated, "It is to develop plans needed for the specific care of the resident." When asked if care

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plan for Resident #140 should have been revised to reflect the 1/9/2020 incident, ASM #2 stated, "Yes, it should have been revised."

ASM #1, the administrator, and ASM) #3, the corporate representative were made aware of the above concerns on 1/15/20 at 5:05 PM.
No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154.
(2) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 42.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 157..

3. Resident #712, who was no longer residing in the facility, was admitted to the facility on 5/4/17 with the diagnoses of but not limited to cerebrovascular disease, convulsions, hemiplegia, aphasia, dysphagia, contracture of unspecified hand, depression, non-traumatic intracranial hemorrhage, non-traumatic subarachnoid hemorrhage, and cognitive communication deficit. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 7/25/19 coded the resident as being moderately impaired for daily decision-making. The resident was coded as requiring total care for bathing and toileting; extensive care for bed mobility, dressing, and hygiene; supervision for eating; and was incontinent of bowel and bladder.

A review of the facility policy, "Care Plans, Comprehensive Person-Centered" documented,

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"13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change."

Review of a Facility Reported Incident (FRI) dated 2/27/19 documented, "An (sic) physical altercation happened between two residents...Residents (Resident #22 and #712) were separated and made safe. Both residents assessed for injury. (Resident #712) sent to hospital for further assessment."

(Resident #22 was admitted to the facility on 12/27/18; diagnoses included but are not limited to high blood pressure, dementia with behaviors, depression, anxiety disorder and chronic kidney disease. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/31/19 coded the resident as being mildly impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing; limited assistance for transfers, dressing, and toileting; supervision for ambulation, eating and hygiene; and was continent of bowel and bladder.)

A review of the follow FRI up report, dated 3/4/19, documented, "On Wednesday 3/27/19 (sic, 2/27/19), approximately 5:00pm, (LPN #12) (Licensed Practical Nurse) responded to the nurse call system for resident (#712). Upon entering room, (Resident #22) had a reacher in her hand and was sitting on side of bed of (Resident #712). (Resident #712) had blood on the bridge of her nose. (LPN #12) attempted to assist (Resident #22) off of bed and away from (Resident #712). At this point (Resident #22) started swinging reacher at (Resident #712) and struck her 4-5 times before LPN (#12) could

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safely separate them and secure the reacher from (Resident #22). LPN called out for assistance. (CNA #9) (Certified Nursing Assistant) and (LPN #1) bot (sic) responded and assisted with leading (Resident #22) out of the room. During this time period of being separated (Resident #22) said "I told her to turn her TV down." Medical care was given to (Resident #712) and then sent to ER (emergency room) to primarily evaluate her hand which (Resident #712) was complaining of pain. (Resident #712) showed signs such as redness of skin in multiple areas, skin tear, which can be assumed to be from being struck many times beyond the 4-5 hits that were witnessed. (Resident #712) was transferred back to us in the same evening with no broken bones. The police were notified and they arrived before (Resident #712) was transferred to ER. (Resident #712) husband has not decided if he will be pressing charges. (Resident #22) and (Resident #712) are no longer roommates. It has been substantiated the (sic) (Resident #712) was the victim of (Resident #22) aggression."

A review of the incident report revealed a social worker note dated 2/27/19 that documented, "Informed by staff that resident was struck by roommate and received laceration and hematoma. In to see resident who confirmed that roommate was physically aggressive towards her. Prior to conversation, resident and roommate separated and put in different rooms. Resident calm during conversation, but did state she was anticipating being sent to the emergency room. Provided support and reassurance. Resident indicated she was not in emotional distress. Encouraged resident to express her concerns and she indicated she was not in distress

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emotionally. Spoke with RP (name of RP [responsible party]) to discuss situation. Informed RP that the police had been contacted. RP indicated that he did not wish for charges to be pressed; however, also indicated that he wished for resident to be sent to the emergency room for evaluation. Assured RP that resident will be evaluated through ER [emergency room]. Spoke with resident [#712] again who stated she was calm and did not feel in danger. Advised resident that counseling services through (counseling service group) were available to assist with managing emotions related to the incident; however, resident declined to be seen by (counseling service group), indicating she did not feel the need. Resident [#712] stated she will let writer know should she feel the need for supportive counseling. Inquired again with RP as to whether or not he wished for charges to be filed against resident's roommate. RP re-iterated that he did not wish for charges to be filed. Will continue to assist with needs as they arise."

Further review of the incident report revealed a line item that documented, "Response/Action Plan (include recommendations to physician & (and) new interventions on the interdisciplinary care plan). _____Current plan is effective to prevent recurrences; no recommendations are being made at this time. RECOMMENDATIONS:_____"

The line for "Current plan is effective..." was not marked.

The line for "RECOMMENDATIONS" was completed for Resident #712 with the following: "send to ER for evaluation." There was no evidence that the comprehensive care plan for

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Resident #712 was reviewed and revised to address this resident to resident incident.

A review of the clinical record revealed the following notes:

2/27/19 at 4:45 PM: "Change in condition noted related to Upon responding to call bell, nurse observed resident being struck w/ (with) a reacher by her roommate at bedside. As the nurse attempted to separate residents, w/ each attempt, the roommate continued to strike the other resident....SKIN: Noted to have the following skin conditions present: Laceration. Resident noted to have multiple hematomas w/ swelling, redness to facial area, laceration to top of head, laceration to bridge of nose w/ swelling, laceration x 2 w/ swelling to rt (right) hand, first/second knuckles, redness w/ swelling to right axilla, redness to left axilla. Evidence of PAIN noted related to change in condition/status. New onset of pain noted. Most recent pain level noted at 10 on a 1-10 scale. c/of (complains of) pain to right hand/knuckles, limited ROM (range of motion), otherwise WNL (within normal limits) for resident...."

2/27/19 at 5:00 PM: "Resident alert, verbal and oriented x 3, no changes in neuro [neurological] status noted upon assessment, Neuro checks initiated at this time."

2/27/19 at 5:00 PM: "MD/RP/SS (medical doctor/responsible party/social services), Administration, state and law enforcement agencies notified, facility investigation initiated. Ice applied to affected areas, resident medicated x 1 for c/of pain to right hand, will monitor.

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N.O.O. (new order obtained) send resident to ER for evaluation, RP aware...."

2/28/19 at 5:18 AM: "Pt (patient [Resident #712]) returned to facility via ambulance at 2300 (2/27/19 at 11:00 PM) with husband at side. New order - Ibuprofen (1) 200mg (milligrams) 1-2 tablets by mouth every 8 hours PRN (as needed). No complaints of pain at this time. 2 (two) person assist with ADLs (activities of daily living). Pt able to make needs known and voice concerns. Right hand knuckles and chest bruised. Cuts to center of forehead and bridge of nose. Sites open to air; no drainage noted. Raised areas to left chin and right forehead. Pt refused ice application at this time. Stated she just wanted to rest. Neuro assessments initiated. Full ROM [range of motion] to right hand. Pt noted eating snacks and watching television during shift. Incontinent to bowel and bladder. Repositioned with assistance without discomfort or pain. Monitored frequently during shift. HOB (head of bed) elevated. Turned and repositioned. Call bell within reach."

A hospital "Discharge Summary" dated 2/27/19 documented, "Contusions...Ibuprofen (Motrin) 200 Milligrams # 1 bottle 1-2 tablets every 8 hours as needed...You have deep bruise (contusion). Contusions are areas of tenderness and swelling in the soft tissues. They are the result of trauma and bleeding in the injured area. Minor trauma will give you a painless bruise; more severe contusions may stay painful and swollen for a few weeks. There are no broken bones. This injury takes a few days to a few weeks to heal."

A review of the comprehensive care plan revealed no documentation or evidence of a review or revision related to this incident.

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On 1/16/20 at 10:11 AM, an interview was conducted with OSM #4 (Other Staff Member) the Social Worker, and ASM #1 (Administrative Staff Member) the Administrator. OSM #4 stated, "They [Resident #712 and Resident #22] were in a large room, and there was discussion over the volume of the TV and a disagreement related to that. [Resident #22] went to the other resident to make her turn down the TV by being physically aggressive. She [Resident #712] was sent out for an evaluation. The family was offered the opportunity to talk with the police and press charges. They did not press charges. When asked about the care plan for Resident #712 not being reviewed and revised after the incident, OSM #4 had no information on this.

No further information was provided by the end of the survey.

References:
(1) Ibuprofen - is used to relieve pain, tenderness, and swelling.
Information obtained from https://medlineplus.gov/druginfo/meds/a682159.html

4. Resident #22 was admitted to the facility on 12/27/18; diagnoses included but are not limited to high blood pressure, dementia with behaviors, depression, anxiety disorder and chronic kidney disease. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/31/19 coded the resident as being mildly impaired in ability to make daily life decisions. The resident was coded as requiring extensive

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care for bathing; limited assistance for transfers, dressing, and toileting; supervision for ambulation, eating and hygiene; and was continent of bowel and bladder.

A review of the facility policy, "Care Plans, Comprehensive Person-Centered" documented, "13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change."

Review of a Facility Reported Incident (FRI) dated 2/27/19 documented, "An (sic) physical altercation happened between two residents...Residents were separated and made safe. Both residents assessed for injury. (Resident #712) sent to hospital for further assessment."

(Resident #712, who was no longer residing in the facility, was admitted to the facility on 5/4/17 with the diagnoses of but not limited to cerebrovascular disease, convulsions, hemiplegia, aphasia, dysphagia, contracture of unspecified hand, depression, non-traumatic intracranial hemorrhage, non-traumatic subarachnoid hemorrhage, and cognitive communication deficit. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/25/19 coded the resident as being moderately impaired for daily decision-making. The resident was coded as requiring total care for bathing and toileting; extensive care for bed mobility, dressing, and hygiene; supervision for eating; and was incontinent of bowel and bladder.)

A review of the follow up report, dated 3/4/19, documented, "On Wednesday 3/27/19 (sic,

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2/27/19), approximately 5:00pm, (LPN #12) (Licensed Practical Nurse) responded to the nurse call system for resident (#712). Upon entering room, (Resident #22) had a reacher in her hand and was sitting on side of bed of (Resident #712). (Resident #712) had blood on the bridge of her nose. (LPN #12) attempted to assist (Resident #22) off of bed and away from (Resident #712). At this point (Resident #22) started swinging reacher at (Resident #712) and struck her 4-5 times before LPN (#12) could safely separate them and secure the reacher from (Resident #22). LPN called out for assistance. (CNA #9) (Certified Nursing Assistant) and (LPN #1) bot (sic) responded and assisted with leading (Resident #22) out of the room. During this time period of being separated (Resident #22) said "I told her to turn her TV down." Medical care was given to (Resident #712) and then sent to ER (emergency room) to primarily evaluate her hand which (Resident #712) was complaining of pain. (Resident #712) showed signs such as redness of skin in multiple areas, skin tear, which can be assumed to be from being struck many times beyond the 4-5 hits that were witnessed. (Resident #712) was transferred back to us in the same evening with no broken bones. The police were notified and they arrived before (Resident #712) was transferred to ER. (Resident #712) husband has not decided if he will be pressing charges. (Resident #22) and (Resident #712) are no longer roommates. It has been substantiated the (sic) (Resident #712) was the victim of (Resident #22) aggression."

A review of the incident report revealed a social worker note dated 2/27/19 was conducted. This incident report addressed Resident #712 and not

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Resident #22.

Further review of the incident report revealed a line item that documented, "Response/Action Plan (include recommendations to physician & (and) new interventions on the interdisciplinary care plan). _____Current plan is effective to prevent recurrences; no recommendations are being made at this time. RECOMMENDATIONS:_____"

The line for "Current plan is effective..." was not marked.

The line for "RECOMMENDATIONS" was completed for Resident #712 to "send to ER for evaluation." No new interventions were documented for Resident #22, nor evidence that the comprehensive care plan for Resident #22 was reviewed.

A review of the clinical record revealed the following notes:

2/27/19 at 5:00 PM: "Resident [Resident #22] transferred to room (new room number), RP aware. There are no noted injuries to resident and resident denies any injuries as a result of the incident at this time. Staff will remain with and monitor resident for the duration of the night.

A Mental Health Consult - Progress Note dated 3/5/19 documented, "Client stated she was "doing alright" now that she does not have to be in the same room as her former roommate....An assessment was requested on an emergent basis following an incident in which client physically assaulted her roommate with her grabber....Client acknowledged the incident and was not

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apologetic, stating that "this is what happens when someone raises my blood pressure". She talked further about her former roommate being "irritating" and difficult with staff as well as with her....Client is currently in a private room which appears to be most appropriate placement for her at this time. She is choosing to leave her door to her room shut most of the time to decrease possibility of unpleasant interactions. Client makes no promises or guarantees that she will not lash out physically again if anyone causes her "blood pressure to rise again". If she is to be placed in a room with a new roommate, she would need to be with a resident who is fairly passive and easy to get along with. Client presents as someone with longstanding, chronic PTSD [post-traumatic stress disorder] symptoms and, as such, can be easily triggered into defensive action, which in her case, results in physically defending herself. This is a condition which is not easily remediated and would require long-term counseling services to begin to effect a change. Recommend that client remain in private room or, if with roommate, one that is carefully chosen in order to avoid future physical incidents. Client repots that she does not watch much TV [television] but would enjoy entertaining herself with word puzzles, coloring or other similar activities...."

A review of the comprehensive care plan revealed no documentation or evidence of a review or revision related to this incident.

On 1/16/20 at 10:11 AM, an interview was conducted with OSM #4 (Other Staff Member) the Social Worker, and ASM #1 (Administrative Staff Member) the Administrator. OSM #4 stated, "They were in a large room, and there was

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discussion over the volume of the TV and a disagreement related to that. (Resident #22) went to the other resident to make her turn down the TV by being physically aggressive. She [Resident #712] was sent out for an evaluation. The family was offered the opportunity to talk with the police and press charges. They did not press charges. To my knowledge, (Resident #22) had not previously displayed potentially aggressive behaviors. She [Resident #22] was removed from any type of triggers to a private room. The triggers seems to be having to share space with someone else. (Counseling services group) came in, and an LCSW (licensed clinical social worker) follows her. A psych (psychiatric) eval indicated she felt her behaviors were stemming from her choice of TV programming and she was watching shows aggressive in nature. She was being counseled on TV choices to calm her mood. (Resident #22) watched police shows, horror movies, etc. She is better now from what I have seen. (Counseling services group) is still working with her. She was given another roommate after some time, because documentation by the counselor was that she was appropriate for another roommate. She had no demonstrated outbursts. (Another FRI dated 8/19/19 documented a verbal altercation with a new roommate). I don't think there was physical contact with the second incident. She was verbally aggressive and threatening. She [Resident #22] was again placed without a roommate after that because having someone else in her space seemed to trigger her. Alternative placement has been attempted. The issue is finding appropriate placement with anyone agreeable to taking her. For Medicaid residents, no one has private Medicaid beds. Her resources does not support ALF (assisted living

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F 657	Continued From page 102 facility). By default, she is a long-term care Medicaid resident. She will remain in a room by herself. She has had no altercations with residents outside her room. No issues with residents outside her room. In the 2 months from admission until the incident, she had no behavior towards other residents. Only had resisted care and treatment at times. She was docile until then. She has not demonstrated any behavior issues towards other residents anytime she has a room to herself, not even when she is outside her room. She will remain in a private room." When asked about the care plan for Resident #22 not being reviewed and revised, after the resident to resident indecent with Resident #712, OSM #4 had no information on this. No further information was provided by the end of the survey.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined that the facility staff failed to follow the professional standards of practice for three of sixty residents in the survey sample, (Resident #81, Resident #57 and Resident #139). The facility staff failed to follow professional standards for the administration of medication to Resident #81. Resident #81 was	F 658	F658 Services Provided Meet Professional Standards 1) Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #57 has been discharged from the facility. Resident #81 nurses were educated on remaining with Resident during medication administration. Resident #139 nursing	2/17/20

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F 658	Continued From page 103 observed receiving a nebulizer treatment without staff present and was not observed in the line of sight of any staff. The facility staff failed to follow professional standards to clarify a physician's orders for the prescribed as needed pain medication Oxycodone 20mg [milligram] (a narcotic painkiller) to determine the pain level parameters for when the prescribed as needed medication should be administered to Resident #57. The facility staff failed to follow professional standards to clarify multiple prescribed as needed pain medication orders without prescribed pain level parameters for administration, to determine which, and when each as needed pain medication should be administered to #139, on multiple occasions in November, December 2019 and January 2020. The findings include: 1. Resident #81 was admitted to the facility on 11/1/17 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease a non-reversible lung disease) (1), atrial fibrillation (a rapid/random contraction of top part of the heart) (2), glaucoma (high pressure in the eye leading to blurred vision or blindness) (3). The most recent MDS (minimum data set) assessment (after the event), a quarterly assessment, with an ARD (assessment reference date) of 12/5/19, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring supervision for eating and limited assistance for bed mobility, walk in room;	F 658	staff were educated on administering PRN medication according to physician□s order. 2) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents that have jet nebulizers treatments and prn pain medications have the potential to be affected. The Director of Nursing or designee will complete an audit on current residents with Jet Nebulizers orders are administered to physician orders. The EMAR (electronic medication administration record), 24-hour report documentation to review administration of prn pain medications per pain level rating is administered to the pain level parameter per physician order 3) Systemic Changes put into place to ensure the alleged deficient practice does not reoccur. In-services for the Licensed Nurses will be completed by the Director of Nursing or designee on procedure of jet nebulizer treatments will be observed by the Licensed Nurse until completed, for a resident to perform independently, a self -administration assessment will be completed to determine if able to self-administer. The procedure for administration of prn pain medications per pain level rating is administered to the pain level parameter per physician order 4) Monitoring of corrective action to ensure the alleged deficient practice does not recur. The Director of Nursing or designee will complete observation audits on 3 residents per week x 4 weeks then monthly x 3 months on Licensed nurses administering Jet nebulizers treatments	

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F 658	Continued From page 104 requiring extensive assistance for transfer, walk in corridor, locomotion on/off unit, dressing, toilet use and personal hygiene. Section O-special treatments, procedures and programs coded the resident as receiving respiratory therapy seven out of seven days for at least 15 minutes a day. The physician order dated 10/22/19 documented, "Albuterol Sulfate (anti-asthmatic, bronchodilator) (4) Nebulization Solution 2.5 milligram/3 milliliter give one vial inhale orally via nebulizer two times a day for wheezing. The MAR (medication administration record), for Resident #81 documented the administration of the Albuterol nebulizer two times a day as ordered by the physician since the date the order was initiated on 10/22/19. The care plan dated 8/27/18, documented in part, Problem: "At risk for respiratory impairment related to asthma revised 12/13/19." The Interventions dated 8/27/18, documented, "Administer medications/treatments per physician orders. Nebulizer treatment and medications as ordered. Revised 12/13/19." The physician progress note dated, 12/30/19 at 12:28 PM, documented in part, "Patient assessed and evaluated. Medications and allergies were reviewed, continue as ordered." On 1/14/20 at 11:40 AM, observation revealed Resident #81 holding nebulizer to her mouth/nose area. The medication nurse was not in Resident #81's room nor within line of sight of the resident. On 1/15/20 at 10:10 AM, An interview was conducted with LPN (licensed practical nurse)	F 658	remain room until completed per physician orders .An audit of the EMAR and 24 hour report to review the administration of prn pain medications per pain level rating is administered to the pain level parameter per physician order weekly x 4 weeks and then monthly x 3 months. The audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and revisions as needed. 5) Date of compliance- 2/17/2020	

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#10, regarding the procedure staff follows when administering nebulizer treatments to residents. LPN #10 stated, "We check the resident's respiratory and pulse rate, and recheck about 10 minutes after the nebulizer treatment. We stay with the resident while they are getting the nebulizer treatment, then when they are finished; we place it [nebulizer] in a plastic bag. We may need to clean the mask with soap and water. We document the administration of the nebulizer [treatment]."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/15/20 at 4:00 PM. When asked to describe the nebulizer administration procedure, ASM #2 stated, "The resident's heart and respiratory rates are monitored, and the nebulizer is administered." When asked about the process staff follows for monitoring the resident during the nebulizer treatment, ASM #2 stated, "I expect them to see the resident. They do not have to be in their room as long as they are in their line of sight. If the resident has a self-medication assessment, that allows them to self-administer, the nurse does not have to watch them. We don't have anyone that can self-administer nebulizers in the facility now." When asked what professional standards of care the facility follows, ASM #2 stated, "We follow our policies and procedures first, and then we may use Lippincott."

The facility's "Specific Medication Administration Procedures-Oral Inhalation Administration Policy" dated 2/2019, documents, "Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer."

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ASM #1, the administrator, and ASM #3, the corporate representative were made aware of the above concerns on 1/15/20 at 5:05 PM.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 120.
(2) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 54.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 245.
(4) 2019 Lippincott Pocket Drug Guide for Nurses, Wolters and Kluwer, page 9.
2. Resident #57 was admitted to the facility on 11/21/2019. Diagnoses included but are not limited to joint replacement surgery, muscle weakness, and morbid obesity. Resident #57's most recent Minimum Data Set (MDS) Assessment was a Medicare 5 Day Assessment with an Assessment Reference Date (ARD) of 11/28/2019. The Brief Interview for Mental Status (BIMS) scored Resident #57 at a 15, indicating no cognitive impairment. Resident #57 was coded as requiring extensive assistance of 1 person for most Activities of Daily Living (ADLs).

A review of Resident #57's medical record revealed that Resident #57 had had an order for Oxycodone 20mg (a narcotic painkiller) as needed for pain, dated from 12/27/2019 to 01/06/2020. The order did not have or include any pain level parameters, for the administartion of the medication to the resident. Further review of Resident #57's medication orders revealed that

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another order, for Tylenol 325mg 2 tablets every 6 hours as needed for mild pain, was in place from 11/21/2019 to the present. Further review of the Medication Orders revealed that "mild pain" was defined in the pain scale order as "pain rating of 1, 2 , 3, or 4". The oxycodone was listed as administered with a pain rating of 1 to 4 on 5 occasions as follows:
The morning of 01/02/2020 for a rating of 3
The afternoon of 01/02/2020 for a rating of 4
The evening of 01/04/2020 for a rating of 4
The afternoon of 01/05/2020 for a rating of 4
The morning of 01/06/2020 for a rating of 1

On 01/15/2020 at 3:32p.m. an interview was conducted with Registered Nurse (RN) #4 regarding treatment of pain. RN #4 was asked what should be done if an order of as-needed pain medication did not have a parameter included for what level of pain to administer the medication. RN #4 stated "We would call the doctor to get parameters." When asked how staff decides what medication to give if more than one as needed pain medication is presribed, RN #4 stated "We would offer non-pharmacological options first. Then we would give medication based on how the resident rates their pain. We try to go with the less intense medication first." When asked if she would ever offer Oxycodone before Tylenol for "mild" pain, RN #4 stated she would follow the parameters of the orders, but generally they try to offer things like Tylenol first.

A review of the facility policy titled, "Administering Pain Medication" revealed the following under the heading "Steps in the Procedure": "... 6. Administer pain medication as ordered...."

The facility policy "Pain-Clinical Protocol,

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Assessment and Recognition, 2001, revised March 2018" documented in part, "Treatment/Management ...2. a. Pain medications should be selected based on pertinent treatment guidelines. Generally, and to the extent possible, an analgesic regimen should utilize the simplest regimen and lowest risk medications before using more problematic or higher risk approaches."

According to "Lippincott Manual of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate ...orders. c. Notify all involved medical and nursing personnel.... d. Document clearly."

Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 01/16/2020. No further documentation was provided.

3. Resident #139 was admitted to the facility on 10/21/2015 with a readmission on 08/02/2016, with diagnoses that included but were not limited to: osteoarthritis (1), muscle weakness and asthma.

Resident #139's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/02/20, coded Resident #139, as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making

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daily decisions. Section J coded Resident #139 as having pain almost constantly.

On 01/14/19 at approximately 1:45 p.m., an interview was conducted with Resident #139. Resident #139 stated that she frequently has pain due to her osteoarthritis and being confined to the bed. When asked if the staff assess her pain, Resident #139 stated that the staff ask her to rate her pain on a one to ten scale before she takes her as needed pain medication. Resident #139 stated that she is on scheduled pain medication and takes as needed pain medication for break through pain.

The POS (physicians order sheet) dated "Jan (January) 8, 2020" for Resident #139 documented the following as needed orders for pain medication:
-"Hydroco/Apap (medication used to treat pain) tab 5-325 mg (milligram) Give 1 (one) tablet orally every 6 (six) hours as needed for breakthrough pain, Order Date: 6/12/2017, Start Date: 05/15/2019."
-"Oxycodone Tab (tablet) 20 mg Give 1 (one) tablet orally every 4 (four) hours as needed for breakthrough pain, Order Date: 03/27/2019, Start Date: 05/16/2019."
-"Oxycodone Tab 20 mg Give 2 (two) tablet orally every 4 (four) hours as needed for breakthrough pain, Order Date: 03/27/2019, Start Date: 05/16/2019."
The POS failed to evidence parameters for the administration of the multiple ordered as needed pain medications.

The comprehensive care plan for Resident #139 documented, "Resident is at risk for increase pain related to obesity and debilitated ...Date Initiated:

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10/21/2015; Revision on 10/22/2019." Under "Interventions/Tasks" it documented, "Administer PRN (as needed) medications as ordered for breakthru [sic] pain as needed. Date Initiated 01/09/2020."

The eMAR (electronic medication administration record) dated "11/1/2019-11/30/2019" documented the same orders, that were documented above in the POS, review of the eMAR revealed Hydrocod/Apap Tab 5-325 mg was administered on the following dates and time:
-On "11/10/19 0641 (6:41 a.m.) Pain Level 5."
Further review of the eMAR revealed that Oxycodone Tab 20 mg 1 (one) tablet was administered on the following dates and time:
-On "11/1/19 0619 (6:19 a.m.), Pain Level 5,
-11/3/19 0611 (6:11 a.m.), Pain Level 4,
-11/4/19 0602 (6:02 a.m.), Pain Level 7,
-11/6/19 0620 (6:20 a.m.), Pain Level 5,
-11/6/19 1321 (1:21 p.m.), Pain Level 9,
-11/8/19 0611 (6:11 a.m.), Pain Level 6,
-11/9/19 0618 (6:18 a.m.), Pain Level 5,
-11/10/19 1335 (1:35 p.m.), Pain Level 9,
-11/11/19 0641 (6:41 a.m.), Pain Level 5,
-11/14/19 0636 (6:36 a.m.), Pain Level 5,
-11/16/19 0817 (8:17 a.m.), Pain Level 4,
-11/17/19 0555 (5:55 a.m.), Pain Level 4,
-11/18/19 0555 (5:55 a.m.), Pain Level 6,
-11/19/19 0626 (6:26 a.m.), Pain Level 6,
-11/20/19 0617 (6:17 a.m.), Pain Level 6,
-11/20/19 1322 (1:22 p.m.), Pain Level 9,
-11/22/19 0544 (5:44 a.m.), Pain Level 5,
-11/23/19 0641 (6:41 a.m.), Pain Level 6,
-11/24/19 0550 (5:50 a.m.), Pain Level 6,
-11/25/19 0639 (6:30 a.m.), Pain Level 6,
-11/26/19 0603 (6:03 a.m.), Pain Level 4,
-11/29/19 0542 (5:42 a.m.), Pain Level 6,

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-11/30/19 0646 (6:46 a.m.), Pain Level 6."
Further review of the eMAR revealed that Oxycodone tab 20 mg 2 (two) tablets was administered on the following dates and times:
-On "11/7/19 0604 (6:04 a.m.), Pain Level 4,
-11/12/19 0644 (6:44 a.m.) Pain Level 4,
-11/13/19 0606 (6:06 a.m.) Pain Level 5,
-11/26/19 1639 (4:39 p.m.) Pain Level 5,
-11/28/19 0609 (6:09 p.m.) Pain Level 5."

The eMAR (electronic medication administration record) dated "12/1/2019-12/31/2019" documented the same physician orders documented in the POS above, review of the eMAR revealed Hydrocod/Apap Tab 5-325 mg was administered on the following dates and time:
-On "12/25/19 1546 (3:46 p.m.) Pain Level 8."
Further review of the eMAR revealed that Oxycodone Tab 20 mg 1 (one) tablet was administered on the following dates and time:
-On "12/2/19 0604 (6:04 a.m.), Pain Level 8,
-12/4/19 0612 (6:12 a.m.), Pain Level 7,
-12/5/19 0026 (12:26 a.m.), Pain Level 6,
-12/5/19 0623 (6:23 a.m.), Pain Level 5,
-12/6/19 0653 (6:53 a.m.), Pain Level 5,
-12/7/19 0555 (5:55 a.m.), Pain Level 6,
-12/7/19 1356 (1:56 p.m.), Pain Level 9,
-12/8/19 0617 (6:17 a.m.), Pain Level 6,
-12/9/19 1712 (5:12 p.m.), Pain Level 7,
-12/10/19 0624 (6:24 a.m.), Pain Level 4,
-12/10/19 1731 (5:31 p.m.), Pain Level 6,
-12/11/19 0600 (6:00 a.m.), Pain Level 4,
-12/12/19 0625 (6:25 a.m.), Pain Level 6,
-12/12/19 1629 (4:29 p.m.), Pain Level 7,
-12/13/19 1414 (2:14 p.m.), Pain Level 9,
-12/14/19 1237 (12:37 p.m.), Pain Level 9,
-12/15/19 0607 (6:07 a.m.), Pain Level 4,
-12/16/19 0550 (5:50 a.m.), Pain Level 5,

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-12/17/19 0622 (6:22 a.m.), Pain Level 6,
-12/18/19 0645 (6:45 a.m.), Pain Level 5,
-12/19/19 0551 (5:51 a.m.), Pain Level 6,
-12/20/19 0608 (6:08 a.m.), Pain Level 5,
-12/22/19 0621 (6:21 a.m.), Pain Level 6,
-12/23/19 1629 (4:29 p.m.) Pain Level 8,
-12/25/19 0542 (5:42 a.m.) Pain Level 6,
-12/26/19 0724 (7:24 a.m.) Pain Level 6,
-12/27/19 0602 (6:02 a.m.) Pain Level 2,
-12/27/19 1249 (12:49 p.m.) Pain Level 9,
-12/28/19 0614 (6:14 a.m.) Pain Level 6,
-12/28/19 1506 (3:06 p.m.) Pain Level 5
-12/30/19 0553 (5:53 a.m.) Pain Level 6,
-12/30/19 1131 (11:31 a.m.) Pain Level 6."
Further review of the eMAR revealed that Oxycodone tab 20 mg 2 (two) tablets was administered on the following dates and times:
-On "12/1/19 0600 (6:00 a.m.), Pain Level 5,
-12/3/19 0609 (6:09 a.m.) Pain Level 5,
-12/9/19 0630 (6:30 a.m.) Pain Level 6,
-12/13/19 0732 (7:32 p.m.) Pain Level 6,
-12/21/19 0619 (6:19 a.m.) Pain Level 6,
-12/24/19 0606 (6:06 a.m.) Pain Level 5,
-12/29/19 0644 (6:44 a.m.) Pain Level 4,
-12/30/19 1605 (4:05 p.m.) Pain Level 7."

The eMAR (electronic medication administration record) dated "1/1/2020-1/31/2020" documented the same physician orders as documented in the POS above, review of the eMAR revealed that Oxycodone Tab 20 mg 1 (one) tablet was administered on the following dates and time:
-On "1/3/20 0545 (5:45 a.m.), Pain Level 6,
-1/3/20 1645 (4:45 p.m.), Pain Level 7,
-1/4/20 1705 (5:05 p.m.), Pain Level 8,
-1/5/20 1644 (4:44 p.m.), Pain Level 8,
-1/6/20 0624 (6:24 a.m.), Pain Level 6,
-1/6/20 1659 (4:59 p.m.), Pain Level 8,
-1/7/20 0604 (6:04 a.m.), Pain Level 4,

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-1/8/20 1600 (4:00 p.m.), Pain Level 8,
-1/9/20 1549 (3:49 p.m.), Pain Level 7,
-1/10/20 0703 (7:03 a.m.), Pain Level 6,
-1/11/20 0620 (6:20 a.m.), Pain Level 6,
-1/12/20 0602 (6:02 a.m.), Pain Level 4,
-1/13/20 0605 (6:05 a.m.), Pain Level 5,
-1/13/20 1329 (1:29 p.m.), Pain Level 9,
-1/14/20 1228 (12:28 p.m.), Pain Level 8,
-1/14/20 1735 (5:35 p.m.), Pain Level 9,
-1/15/20 0620 (6:20 a.m.), Pain Level 6."

On 01/15/20 at 2:30 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. When asked how staff know which to administer if a resident has multiple as needed pain medications ordered, LPN #4 stated that the physician's orders have a scale to determine which to give for each severity of pain. LPN #4 stated that the orders should say for mild, moderate or severe pain so that the staff can determine which to give based on the pain scale used. When asked about orders for multiple as needed, pain medications without any ordered, pain scale level for administration, LPN #4 stated that the nurse should contact the provider to clarify the orders. LPN #4 then reviewed the POS for Resident #139 which documented the orders for Hydroco/Apap tab 5-325 mg 1 (one) tablet orally every 6 (six) hours as needed for breakthrough pain. Oxycodone Tab 20 mg 1 (one) tablet orally every 4 (four) hours as needed for breakthrough pain; and Oxycodone Tab 20 mg 2 (two) tablets orally every 4 (four) hours as needed for breakthrough pain. LPN #4 reviewed the eMAR's for November 2019, December 2019 and January 2020. LPN #4 stated that the orders failed to evidence any parameters for staff to follow for the administration of the as needed pain medications. When asked how staff could

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determine which of the as needed pain medications to administer to Resident #139, LPN #4 stated that she was not sure unless the resident had a preference. LPN #4 stated that she would have the orders clarified to have pain level parameters for staff to follow for the administration of the as needed pain medications for Resident #139.

The facility policy "Pain-Clinical Protocol, Assessment and Recognition, 2001, revised March 2018" documented in part, "Treatment/Management ...2. The physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain. a. Pain medications should be selected based on pertinent treatment guidelines. Generally, and to the extent possible, an analgesic regimen should utilize the simplest regimen and lowest risk medications before using more problematic or higher risk approaches."

On 01/15/20 at approximately 5:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #4, the medical director were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Osteoarthritis is a joint disease that happens when the tissues in the joint break down over time. It is the most common type of arthritis and is more common in older people. Information obtained from the website:https://www.niams.nih.gov/health-topics/o

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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 staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide care and services consistent with professional standards of practice, and the comprehensive person-centered plan of care for two of 60 residents in the survey sample, (Residents # 64, and #144). The facility staff failed to follow the physician prescribed pain level parameter of severe pain for the administration of as needed Oxycodone and administered the as needed medication to Resident #64 for pain ratings below the prescribed parameter of severe pain on multiple occasions in December 2019 and January 2020. The facility staff administered prescribed as needed pain medications to Resident #144 for pain level ratings that were below the physician prescribed parameters. The findings include: 1. Resident # 64 was admitted to the facility with diagnoses that included but were not limited to:	F 684	F684 Quality of Care 1) Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #64 has been discharged. Resident #144 nurses were educated on administration of prn pain medications pain level rating is administered to the pain level parameter per physician order and documentation supports nonpharmacological interventions are attempted prior to administration of prn pain medication. 2) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents that have prn pain medications have the potential to be affected. The Director of Nursing or designee will complete an audit of the EMAR (electronic medication administration record), 24 hour report documentation to review administration of prn pain medications per pain level rating is administered to the pain level	2/17/20

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F 684	Continued From page 116 specified joint disorder, unspecified hip, and cancer of the nasal cavity [inside the nose]. Resident # 64's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/02/19, coded Resident # 64 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being cognitively intact for making daily decisions. Resident # 64 was coded as requiring extensive assistance of one staff member for activities of daily living. Section J "Health Conditions" coded Resident # 64 as having frequent pain with a pain level of four on a scale of zero to ten with ten being the worse pain. The POS [physician's order sheet] dated 01/01/2020 for Resident # 64 documented, "Oxycodone Tablet 5MG [five milligrams]. Give 0.5 mg by mouth every 12 hours as needed for severe pain. Give ½ [half] of 5mg tablet to equal 2.5mg. Order Date: 11/30/2019." Resident # 64's eMAR [electronic medication administration record] dated December 2019 documented the physician's order as above. The eMAR also documented, "Pain Score every shift; 1,2,3,4 [one, two, three, four] = Mild Pain; 5, 6, 7 [five, six, seven] = Moderate Pain; 8,9,10 [eight, nine, ten] = Severe Pain." The eMAR failed to evidence documentation of non-pharmacological interventions. Further review of the eMAR revealed the administration of Oxycodone on: 12/01/19 at 8:43 p.m. with a pain level of five. 12/05/19 at 8:37 p.m. with a pain level of four. 12/06/19 at 9:30 p.m. with a pain level of four. 12/17/19 at 2:37 p.m. with a pain level of six. 12/19/19 at 9:22 p.m. with a pain level of five.	F 684	parameter per physician order and documentation supports nonpharmacological interventions are attempted prior to administration of prn pain medication. 3) Systemic Changes put into place to ensure the alleged deficient practice does not reoccur. In-service for the Licensed Nurses will be completed by the Director of Nursing or designee on the procedure for administration of prn pain medications per pain level rating is administered to the pain level parameter per physician order and documentation supports nonpharmacological interventions are attempted prior to administration of prn pain medication. 4) Monitoring of corrective action to ensure the alleged deficient practice does not reoccur. The Director of Nursing or designee will complete an audit of the EMAR and 24 hour report to review the administration of prn pain medications per pain level rating is administered to the pain level parameter per physician order and documentation supports nonpharmacological interventions are attempted prior to administration of prn pain medication weekly x 4 weeks and then monthly x 3 months. The audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and revisions as needed. 5)Date of compliance- 2/17/2020	

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12/26/19 at 12:00 a.m., with a pain level of six and at 9:14 p.m. with a pain level of four.
12/28/19 at 9:51 p.m. with a pain level of three.
12/29/19 at 9:23 p.m. with a pain level of four.
12/30/19 at 9:30 p.m. with a pain level of three.

Resident # 64's eMAR [electronic medication administration record] dated January2020 documented the physician's order as above. The eMAR also documented, "Pain Score every shift; 1,2,3,4 [one, two, three, four] = Mild Pain; 5, 6, 7 [five, six, seven] = Moderate Pain; 8,9,10 [eight, nine, ten] = Severe Pain." The eMAR failed to evidence documentation of non-pharmacological interventions. Further review of the eMAR revealed the administration of Oxycodone on:
01/03/20 at 9:33 p.m. with a pain level of three.
01/06/20 at 10:19 p.m. with a pain level of two.
01/07/20 at 9:00 p.m. with a pain level of four.
01/08/20 at 8:23 p.m. with a pain level of three.
01/11/20 at 8:16 p.m. with a pain level of three.
01/12/20 at 8:24 p.m. with a pain level of four.

Review of the nurse's notes dated 12/01/2019 through 01/15/2020 failed to evidence documentation of attempted non-pharmacological interventions prior to the administartion of the as needed pain medication and failed to evidence the physician was informed the medication was administered for pain rating levels less than servere [eight, nine, ten] as ordered.

On 01/15/20 at 2:02 p.m., an interview was conducted with LPN [licensed practical nurse] # 4, the unit manager regarding pain management. LPN #4 asked to describe the procedure staff follows for the administration of a prn [as needed] pain medication. LPN # 4 stated, "Assess level of pain, one to ten, with ten being the worse pain,

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the location of the pain, check to see what is prescribed, attempt non-pharmacological interventions to alleviate the pain, if it was not helpful offer the pain medication for the severity of pain. If pain medication is not available and non-pharmacological interventions are not effective you would call the physician." When asked how often the pain level of a resident is checked, LPN # 4 stated, "The pain level is documented every shift at any time during the shift on the eMAR [electronic medication administration record] or in the nurse's notes." After review of the "Pain Scores" on Resident # 64's eMAR, LPN # 4 stated that is what the nurse's would follow to determine the resident's pain scale. After reviewing, the eMAR for the administration of Oxycodone on the dates and times listed above LPN # 4 was asked if the physician order was being followed. LPN # 4 stated no.

The facility policy "Pain - Clinical Protocol" documented in part, "Treatment/Management: [2] The physician will order appropriate non-pharmacological and medication interventions to address the individual's pain. a. Pain medications should be selected based on pertinent treatment guidelines. Generally, and to the extent possible, an analgesic regimen should utilize the simplest regimen and lowest risk medications before using more problematic or high risk approaches."

On 01/15/2020 at approximately 5:40 p.m. ASM [administrative staff member] # 1, the administrator, ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

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2. Resident #144 was admitted to the facility on 12/28/19 with diagnoses that included but were not limited to: nondisplaced fracture of the humerus (arm), repeated falls, muscle weakness, anemia, malnutrition, dementia, anxiety disorder, and high blood pressure.

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 1/2/2020, coded the resident as scoring a five on the BIMS (brief interview for mental status) score indicating the resident was severely impaired to make daily cognitive decisions. Resident #144 was coded as requiring extensive assistance for all of her activities of daily living. In Section J - Health Conditions the resident was coded as having no pain upon interview.

The physician order dated, 12/28/19, documented, "Acetaminophen (Tylenol) (used to treat mild to moderate pain) (1) tablet 325 MG (milligram); Give 2 tablet by mouth every 6 hours as needed for Mild Pain. Oxycodone tablet (used to treat moderate to severe pain) (2) 5 MG; give 1 tablet by mouth every 6 hours as needed for mod (moderate)/severe pain."

The December 2019 MAR (medication administration record) documented a "Pain Score every shift: 0 = No pain; 1, 2, 3, 4 = Mild Pain; 5, 6, 7 = Moderate pain; 8, 9, 10 = severe pain."

The December 2019 MAR documented the Oxycodone was administered on the following dates, times and for pain scale ratings as follows:
12/28/19 at 9:03 p.m. - pain level = 2
12/29/19 at 3:37 p.m. - pain level = 4
The documentation evidenced the oxycodone

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was administered to Resident #144 for mild pain ratings and not for moderate to severe pain as ordered by the physician.

The January 2020 MAR documented the physician order above for medications. The Tylenol was, not documented as administered. The Oxycodone was, documented as administered on the following dates, time and the pain scale:
1/2/2020 at 6:38 a.m. - pain level 4
1/4/2020 at 6:11 p.m. - pain level 3
1/5/2020 at 8:47 p.m. - pain level 6
1/8/2020 at 3:35 p.m. - pain level 4
1/9/2020 at 6:00 p.m. - pain level 6
1/10/2020 at 7:17 p.m. - pain level 4
1/11/2020 at 5:54 p.m. - pain level 6
1/12/2020 at 6:15 a.m. - pain level 4
1/12/2020 at 2:13 p.m. - pain level 5
1/13/2020 at 8:41 a.m. - pain level 6

Of these ten doses administered, only four were per the physician order for moderate/severe pain. The remaining doses were administered for mild pain ratings.

Review of the nurse's notes for the above times and dates in December 2019 and January 2020 failed to document any non-pharmacological interventions provided prior to the administration of the pain medications.

The comprehensive care plan dated, 12/30/19 documented in part, "Focus: Pain related to fractures." The "Interventions" documented in part, "Administer pain medications per physician orders. Implement nondrug therapies such as repositioning, activities, to assist with pain and monitor for effectiveness.

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An interview was conducted with LPN (licensed practical nurse) #7, a nurse that had administered the pain medications above, on 1/16/2020 at 8:45 a.m. When asked what mild, moderate and severe pain is, LPN #7 stated it could be different things depending on the patient. If they are alert and oriented they can tell me about their pain and tell me what level on the pain scale." When asked if there is a definition of the levels of the pain scale, LPN #7 stated, "It's listed as zero to ten, as it (pain) goes up on the scale, I don't know." The above MAR with the pain scale definition was reviewed with LPN #7. When asked if she was aware of the above pain rating scale when giving pain medication to Resident #144, LPN #7 stated she was aware of the scale. The MARs above, some with her initials, were reviewed with LPN #7. When asked if she was following the physician order when she gave the pain medication for pain ratings below the physician prescribed pain level parameter, LPN #7 stated, "No Ma'am."

Administrative staff member (ASM) #1, the administrator and ASM #3, the corporate nurse, were made aware of the above concern on 1/16/2020 at 1:05 p.m.

No further information was provided prior to exit.

References:
(1) This information was obtained from the following website:
https://medlineplus.gov/druginfo/meds/a681004.html
(2) This information was obtained from the

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F 684	Continued From page 122 following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=oxycodone	F 684		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure the medication regimen for three of 60 sampled residents, (Resident #64, and #53), was free from unnecessary medication. The facility staff failed to implement and monitor the effectiveness of non-pharmacological	F 757	F757 Drug Regimen is Free from Unnecessary Drugs 1) Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #53, #64 have been discharged, #135 and #144 nurses were educated on administration of	2/17/20

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F 757	Continued From page 123 interventions per the plan of care prior to administering as needed (prn) Oxycodone pain medication to Resident # 64 and the staff administered the as needed pain medication for pain level ratings that were below the physician prescribed parameters. The facility staff failed to attempt non-pharmacological interventions prior to the administration of the prn (as needed) pain medication Acetaminophen [1] to Resident # 53 and Resident # 135. The facility staff failed to attempt non-pharmacological interventions prior to the administration of as needed pain medication to Resident #144 and the staff administered prescribed as needed pain medications to Resident #144 for pain level ratings that were below the physician prescribed parameters. The findings include: 1. Resident # 64 was admitted to the facility with diagnoses that included but were not limited to: specified joint disorder, unspecified hip, and cancer of the nasal cavity [inside the nose]. Resident # 64's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/02/19, coded Resident # 64 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being cognitively intact for making daily decisions. Resident # 64 was coded as requiring extensive assistance of one staff member for activities of daily living. Section J "Health Conditions" coded Resident # 64 as having frequent pain with a pain level of four on a scale of zero to ten with ten being the worse pain. The POS [physician's order sheet] dated	F 757	medications per physician orders and nonpharmacological interventions prior to administration of prn pain medication. 2) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents that have prn pain medications have the potential to be affected. The Director of Nursing or designee will complete an audit of the EMAR (electronic medication administration record), physician orders and 24-hour report documentation to review for administration of prn pain medication and documentation supports non-pharmacological interventions were attempted prior to administration of the prn pain medication. 3) Systemic Changes put into place to ensure the alleged deficient practice does not reoccur. In-service for the Licensed Nurses will be completed by the Director of Nursing or designee on documentation to support non-pharmacological interventions were attempted prior to the administration of a prn pain medication. 4) Monitoring of corrective action to ensure the alleged deficient practice does not recur. The Director of Nursing or designee will complete an audit of the EMAR, physicians orders and 24 hour report documentation to review if prn pain medication administered has documentation supports nonpharmacological interventions were attempted prior to administration of the prn pain medication weekly x 4 weeks and then monthly x 3 months. The audits will be reviewed in the quality assurance and	

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F 757	Continued From page 124 01/01/2020 for Resident # 64 documented, "Oxycodone Tablet 5MG [five milligrams]. Give 0.5 mg by mouth every 12 hours as needed for severe pain. Give ½ [half] of 5mg tablet to equal 2.5mg. Order Date: 11/30/2019." The comprehensive care plan for Resident # 64 dated 12/05/2019 documented, "Focus: Pain to left hip related to chronic left hip pain. Date Initiated: 12/05/2019." Under "Interventions" it documented, "Implement nondrug therapies such as repositioning, activities, to assist with pain and monitor for effectiveness. Date Initiated: 11/26/2019." Resident # 64's eMAR [electronic medication administration record] dated December 2019 documented the physician's order as above. The eMAR also documented, "Pain Score every shift; 1, 2, 3, 4 [one, two, three, four] = Mild Pain; 5, 6, 7 [five, six, seven] = Moderate Pain; 8, 9, 10 [eight, nine, ten] = Severe Pain." The eMAR failed to evidence documentation of non-pharmacological interventions. Further review of the eMAR revealed the administration of Oxycodone on the dates and times for pain scale ratings as follows: 12/01/19 at 8:43 p.m. with a pain level of five. 12/05/19 at 8:37 p.m. with a pain level of four. 12/06/19 at 9:30 p.m. with a pain level of four. 12/16/19 at 8:17 p.m. with a pain level of nine. 12/17/19 at 2:37 p.m. with a pain level of six. 12/19/19 at 9:22 p.m. with a pain level of five. 12/22/19 at 12:39 p.m. with a pain level of eight. 12/26/19 at 12:00 a. m., with a pain level of six and at 9:14 p.m. with a pain level of four. 12/28/19 at 9:51 p.m. with a pain level of three. 12/29/19 at 9:23 p.m. with a pain level of four. 12/30/19 at 9:30 p.m. with a pain level of three.	F 757	performance improvement process for tracking/trending and revisions as needed. 5) Date of compliance- 2/17/2020	

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Resident # 64's eMAR [electronic medication administration record] dated January 2020 documented the physician's order as above. The eMAR also documented, "Pain Score every shift; 1, 2, 3, 4 [one, two, three, four] = Mild Pain; 5, 6, 7 [five, six, seven] = Moderate Pain; 8, 9, 10 [eight, nine, ten] = Severe Pain." The ear failed to evidence documentation of non-pharmacological interventions. Further review of the eMAR revealed the administration of Oxycodone on the dates and times for pain scale ratings as follows:
01/03/20 at 9:33 p.m. with a pain level of three.
01/06/20 at 10:19 p.m. with a pain level of two.
01/07/20 at 9:00 p.m. with a pain level of four.
01/08/20 at 8:23 p.m. with a pain level of three.
01/11/20 at 8:16 p.m. with a pain level of three.
01/12/20 at 8:24 p.m. with a pain level of four.

Review of the nurse's notes dated 12/01/2019 through 01/15/2020 failed to evidence documentation of non-pharmacological interventions.

On 01/14/20 at 3:51 p.m., an interview was conducted with Resident # 64. When asked if the staff attempt to alleviate the pain before administering the oxycodone, Resident # 64 stated, "No."

On 01/15/20 at 2:02 p.m., an interview was conducted with LPN [licensed practical nurse] # 4-unit manager regarding pain management. LPN #4 was asked to describe the procedure for the administration of a prn [as needed] pain medication. LPN # 4 stated, "Assess level of pain, one to ten, with ten being the worse pain, the location of the pain, check to see what is prescribed, and attempt non-pharmacological

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interventions to alleviate the pain, if it was not helpful offer the pain medication for the severity of pain. If pain medication is not available and non-pharmacological interventions are not effective you would call the physician." After LPN # 4 reviewed the eMARs for the administration of oxycodone to Resident # 64 for the dates and times listed above and the nurse's notes dated 12/01/2019 through 01/15/2020, LPN # 4 was asked if there was documentation of non-pharmacological interventions. LPN # 4 stated no. When asked what the lack of documentation indicated LPN # 4 stated, "You don't know if it is being done if it is not documented." When asked how often the pain level of a resident is checked, LPN # 4 stated, "The pain level is documented every shift at any time during the shift on the eMAR [electronic medication administration record] or in the nurse's notes." After reviewing the "Pain Scores" on Resident # 64's eMAR, LPN # 4 stated that is what the nurse's would follow to determine the resident's pain scale. After reviewing, the eMAR for the administration of Oxycodone on the dates and times listed above, LPN # 4 was asked if the physician order was being followed. LPN # 4 stated no.

The facility policy "Pain - Clinical Protocol" documented in part, "Treatment/Management: [2] The physician will order appropriate non-pharmacological and medication interventions to address the individual's pain. a. Pain medications should be selected based on pertinent treatment guidelines. Generally, and to the extent possible, an analgesic regimen should utilize the simplest regimen and lowest risk medications before using more problematic or high risk approaches."

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On 01/15/2020 at approximately 5:40 p.m. ASM [administrative staff member] # 1, the administrator, ASM # 2, director of nursing, 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. Resident # 53 was admitted to the facility with diagnoses that included but were not limited to osteoarthritis [2], osteoporosis [3] and polyneuropathy [4].

Resident # 53's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/27/2019, coded Resident # 53 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 # 53 was coded as requiring extensive assistance of one staff member for activities of daily living. Section J "Health Conditions" coded Resident # 3 as having severe frequent pain.

The POS [physician's order sheet] dated 01/01/2020 for Resident # 53 documented, "Acetaminophen Tablet 325MG [milligrams]. Give 2 [two] tablet by mouth every 6 [six] hours as needed for mild pain. Order Date: 11/21/2019."

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Resident # 53's eMAR [electronic medication administration record] dated November 2019 documented the physician order above. The eMAR also documented, "Pain Score every shift; 1, 2, 3, 4 [one, two, three, four] = Mild Pain; 5, 6, 7 [five, six, seven] = Moderate Pain; 8, 9, 10 [eight, nine, ten] = Severe Pain." The eMAR failed to evidence documentation of non-pharmacological interventions. Further review of the eMAR revealed the administration of Acetaminophen on the dates and times as follows:
11/23/19 at 12:51 p.m. with a pain level of three and at 8:22 p.m. with a pain level of three.
11/25/19 at 4:48 p.m. with a pain level of four.
11/26/19 at 12:37 a.m. with a pain level of four and at 8:47 p.m. with a pain level of five.
11/27/19 at 8:32 p.m. with a pain level of four.

Review of the nurse's notes dated 1/01/2019 through 11/30/2019 failed to evidence documentation of non-pharmacological interventions.

On 01/15/20 at 4:00 p.m., an interview was conducted with Resident # 53. When asked if the staff attempt to alleviate the pain before administering the oxycodone Resident # 53 stated, "No."

On 01/15/20 at 2:02 p.m., an interview was conducted with LPN [licensed practical nurse] # 4-unit manager regarding pain management. LPN #4 was asked to describe the procedure for the administration of a prn [as needed] pain medication. LPN # 4 stated, "Assess level of pain, one to ten, with ten being the worse pain, the location of the pain, check to see what is

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prescribed, and attempt non-pharmacological interventions to alleviate the pain, if it was not helpful offer the pain medication for the severity of pain. If pain medication is not available and non-pharmacological interventions are not effective you would call the physician." After LPN # 4 reviewed the eMAR for the administration of Acetaminophen to Resident # 53 for the dates and times listed above and the nurse's notes dated 11/23/2019 through 11/30/2019, LPN # 4 was asked if there was documentation of the attempt of non-pharmacological interventions. LPN # 4 stated no. When asked what the lack of documentation indicated LPN # 4 stated, "You don't know if it is being done if it is not documented."

On 01/15/2020 at approximately 5:40 p.m. ASM [administrative staff member] # 1, the administrator, ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

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

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tml.

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

[3] Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.

[4] Poly meaning many: several: much: multi-. This information was obtained from the website: https://www.merriam-webster.com/dictionary/poly. Peripheral nerves carry information to and from the brain. They also carry signals to and from the spinal cord to the rest of the body. Peripheral neuropathy means these nerves don't work properly. Peripheral neuropathy may occur because of damage to a single nerve or a group of nerves. It may also affect nerves in the whole body. This information was obtained from the website: https://medlineplus.gov/ency/article/000593.htm.

3. Resident #135 was admitted to the facility on 12/23/19 with the diagnoses of but not limited to type 1 diabetes, orthostatic hypotension, end stage renal disease, neurogenic bladder, osteoporosis, pressure ulcers, hypothermia, hyperparathyroidism, convulsions, arthritis, dialysis dependent, diabetic retinopathy, dumping syndrome, pituitary micro adenoma, postural orthostatic tachycardia syndrome, and history of 3rd degree burn. The Admission MDS (Minimum

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Data Set) with an ARD (Assessment Reference Date) of 12/29/19 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, ambulation out of the room and transfers out of bed; limited assistance for bed mobility, ambulation in the room and hygiene; supervision for eating; and was frequently incontinent of bowel and bladder.

A review of the facility policy, "Pain - Clinical Protocol" documented, "....Staff will provide the elements of a comforting environment and appropriate physical and complementary interventions; for example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain...."

A review of the clinical record revealed the following physician's orders:

12/23/19 for "Acetaminophen (1) Tablet, 325 MG (milligrams) Give 2 tablet orally every 6 hours as needed for pain."

12/23/19 for "Diclofenac (2) Sodium Gel 1% Apply 2 gram transdermally as needed for right rib pain four times a day."

A review of the December 2019 MAR (Medication Administration Record) revealed that the Acetaminophen was administered on 12/24/19, 12/25/19, 12/26/19, 12/27/19, and 12/31/19.

A review of the December 2019 MAR revealed that the Diclofenac was administered on 12/24/19, 12/25/19, 12/27/19, and 12/31/19.

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Further review of the clinical record failed to reveal any documented evidence of non-pharmacological interventions being offered or attempted.

On 1/16/20 at 9:13 AM, in an interview with LPN #8, when asked about the procedures for a resident complaining of pain, she stated, "Ask for a number (0-10), intensity of the pain, aggravating factors, what makes it worse or better, offer non-pharmacological first, then check the medication list to see what they have PRN. If it is a trend, mention it to the doctor for something different. Document the non-pharmacological's. Document pre and post pain scale."

On 1/16/20 at 9:23 AM, in an interview with LPN #9, the unit manager, she stated, "I don't see anything about non-pharmacological's in the notes."

A review of the comprehensive care plan for Resident #135 revealed one dated 12/24/19 that documented, "Pain related to arthritis, Neuropathy, wound, rib pain." This care plan included the intervention, dated 12/24/19, for "Implement nondrug therapies such as activities, positioning, ice/heat as indicated to assist with pain and monitor for effectiveness."

On 1/16/20 at approximately 1:40 PM, ASM #1 (Administrative Staff Member, the Administrator), ASM #2 (the Director of Nursing), ASM #3 (the corporate nurse), and ASM #4 (the Medical Director) were made aware of the findings. No further information was provided by the end of the survey.

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References:
(1) Acetaminophen - is used to relieve mild to moderate pain.
Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html

(2) Diclofenac - is used to relieve pain from osteoarthritis
Information obtained from https://medlineplus.gov/druginfo/meds/a611002.html

4. Resident #144 was admitted to the facility on 12/28/19 with diagnoses that included but were not limited to: non-displaced fracture of the humerus (arm), repeated falls, muscle weakness, anemia, malnutrition, dementia, anxiety disorder, and high blood pressure.

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 1/2/2020, coded the resident as scoring a five on the BIMS (brief interview for mental status) score indicating the resident was severely impaired to make daily cognitive decisions. Resident #144 was coded as requiring extensive assistance for all of her activities of daily living. In Section J - Health Conditions the resident was coded as having no pain upon interview.

The physician order dated, 12/28/19, documented, "Acetaminophen (Tylenol) (used to treat mild to moderate pain) (1) tablet 325 MG (milligram); Give 2 tablet by mouth every 6 hours as needed for Mild Pain. Oxycodone tablet (used to treat moderate to severe pain) (2) 5 MG; give 1 tablet by mouth every 6 hours as needed for mod

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(moderate)/severe pain."

The December 2019 MAR (medication administration record) documented a "Pain Score every shift: 0 = No pain; 1,2,3,4 = Mild Pain; 5, 6, 7 = Moderate pain; 8,9,10 = severe pain."

The above physician orders for the medications were documented on the December 2019 MAR. In December, the resident was administered the Tylenol on the following dates and times for pain scale ratings as follows:
12/29/19 at 8:05 a.m. - pain level = 5
12/31/19 at 5:35 a.m. - pain level = 6

The December 2019 MAR documented the Oxycodone was administered on the following dates, times for pain scale ratings as follows:
12/28/19 at 9:03 p.m. - pain level = 2
12/29/19 at 3:37 p.m. - pain level = 4

The January 2020 MAR documented the physician order above for medications. The Tylenol was, not documented as administered. The Oxycodone was, documented as administered on the following dates, times for pain scale ratings as follows:
1/2/2020 at 6:38 a.m. - pain level 4
1/4/2020 at 6:11 p.m. - pain level 3
1/5/2020 at 8:47 p.m. - pain level 6
1/8/2020 at 3:35 p.m. - pain level 4
1/9/2020 at 6:00 p.m. - pain level 6
1/10/2020 at 7:17 p.m. - pain level 4
1/11/2020 at 5:54 p.m. - pain level 6
1/12/2020 at 6:15 a.m. - pain level 4
1/12/2020 at 2:13 p.m. - pain level 5
1/13/2020 at 8:41 a.m. - pain level 6

Of these ten doses administered, only four were

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per the physician order for moderate pain. The remaining doses were administered for mild pain ratings.

Review of the nurse's notes for the above times and dates in December 2019 and January 2020 failed to document any non-pharmacological interventions provided prior to the administration of the pain medications.

The comprehensive care plan dated, 12/30/19 documented in part, "Focus: Pain related to fractures." The "Interventions" documented in part, "Administer pain medications per physician orders. Implement non-drug therapies such as repositioning, activities, to assist with pain and monitor for effectiveness.

An interview was conducted with LPN (licensed practical nurse) #7, a nurse that had administered the pain medications above, on 1/16/2020 at 8:45 a.m. When asked what mild, moderate and severe pain is, LPN #7 stated it could be different things depending on the patient. If they are alert and oriented they can tell me about their pain and tell me what level on the pain scale." When asked if there is a definition of the levels of the pain scale, LPN #7 stated, "It's listed as zero to ten, as it (pain) goes up on the scale, I don't know." The above MAR with the pain scale definition was reviewed with LPN #7. When asked if she was aware of the above pain rating scale when giving pain medication to Resident #144, LPN #7 stated she was aware of the scale. The MARs above, some with her initials, were reviewed with LPN #7. When asked if she was following the physician order when she gave the pain medication for pain ratings below the physician prescribed pain level parameter, LPN #7 stated,

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"No Ma'am." When asked about the process followed for resident complaints of pain, LPN #7 stated, "I ask the pain level, the location and sometimes offer Tylenol. If they are alert and oriented, I ask them their preference for medication. For the confused resident I watch to see what they are doing, flinching, guarding the area, facial grimaces." When asked if she attempts anything prior to giving medication, LPN #7 stated, "Sometimes, it depends on where the pain is." When asked where staff document if non-medication interventions were attempted before administering as needed pain medications, LPN #7 stated it should be in the nurse's notes."

An interview was conducted with RN (registered nurse) #6, the quality assurance nurse/unit manager, on 1/16/2020 at 9:00 a.m. When asked what is mild/moderate/severe pain, RN #6 stated mild pain is one to four on the pain scale, moderate pain is five to seven on the pain scale and severe pain is eight to ten on the pain scale. The pain scale on the MAR was reviewed with RN #6. When asked about the process staff follows for resident complaints of pain, RN #6 stated the nurse would do an assessment, with the location, type and intensity of the pain. The nurse should attempt non-pharmacological interventions, such as repositioning, ice, massage, music, something to divert their attention on the pain. When asked where staff document the non-medication interventions attempted, RN #6 stated it should be documented in the progress notes.

Administrative staff member (ASM) #1, the administrator and ASM #3, the corporate nurse, were made aware of the above concern on

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F 757	Continued From page 137 1/16/2020 at 1:05 p.m. No further information was provided prior to exit. References: (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html (2) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=oxycodone	F 757		
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 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	F 842		2/17/20

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§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-
(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

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F 842	Continued From page 139 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 staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure a complete and accurate clinical record for one of 60 residents in the survey sample, Resident #144. The facility staff failed to document non-pharmacological interventions attempted in the clinical record prior to administering as needed antianxiety medication to Resident #144. The findings include: Resident #144 was admitted to the facility on 12/28/19 with diagnoses that included but were not limited to: non-displaced fracture of the humerus (arm), repeated falls, muscle weakness, anemia, malnutrition, dementia, anxiety disorder, and high blood pressure. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 1/2/2020, coded the resident as scoring a five on the BIMS (brief interview for mental status) score indicating the resident was severely impaired to make daily cognitive decisions. Resident #144 was coded as requiring extensive assistance for all of her activities of daily living. In Section N - Medications, the resident was coded as receiving one dose of an anti-anxiety medication during the look back period.	F 842	F842 Resident Records □ Identifiable Information 1) Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #144 PRN Ativan order has been discontinued. 2) Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents that have PRN psychoactive medications ordered by a physician have the potential to be affected. The Director of Nursing or designee will complete an audit of the EMAR (electronic medication administration record), physician orders and 24-hour report to review for administration of prn psychoactive medication has documentation of non-pharmacological interventions to support were attempted prior to administration of the prn psychoactive medication. 3) Systemic Changes put into place to ensure the alleged deficient practice does not recur. In-service for the Licensed Nurses will be completed by the Director of Nursing or designee on documentation of non-pharmacological interventions to support were attempted prior to the administration of a prn psychoactive medications. 4) Monitoring of corrective action to	

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F 842	Continued From page 140 The physician's order dated, 1/2/2020 documented, "Ativan Tablet (used to treat anxiety) (1) 1 MG (milligram); give 1 tablet by mouth every 8 hours as needed for anxiety." The MAR (medication administration record) for January 2020 documented the above physician medication order. The MAR documented the medication had been administered on the following dates and times: 1/2/2020 at 8:49 p.m. 1/3/2020 at 3:02 p.m. and 11:36 p.m. 1/4/2020 at 6:11 p.m. 1/5/2020 at 8:46 p.m. 1/6/2020 at 2:56 p.m. and 10:59 p.m. 1/7/2020 at 11:57 a.m. and 9:06 p.m. 1/8/2020 at 8:19 p.m. 1/9/2020 at 9:59 a.m. and 5:59 p.m. 1/11/2020 at 9:46 a.m. and 5:54 p.m. 1/12/2020 at 6:16 a.m. and 2:13 p.m. 1/13/2020 at 8:41 a.m. Review of the nurse's notes for the above dates and times documented, the medication was given for "increased agitation/anxiety" or it was blank as to why it was administered to Resident #144 and failed to reveal any documented non pharmacological interventions attempted prior to administering the antianxiety medication to Resident #144 on the dates and time above. The comprehensive care plan dated, 12/30/2020 documented in part, "Focus: At risk for adverse effects related to use of anti-depressant medication, use of antipsychotic medication and use of anti-anxiety medication." The "Interventions" documented in part, "Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic	F 842	ensure the alleged deficient practice does not recur. The Director of Nursing or designee will complete an audit of the EMAR , physicians orders and 24 hour report to review if prn psychoactive medication administered and documentation supports nonpharmacological interventions were attempted prior to administration of the prn psychoactive medication weekly x 4 weeks and then monthly x 3 months. The audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and revisions as needed. 5) Date of compliance- 2/17/2020	

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drugs. Notify physician of decline in ADL (activities of daily living) ability or mood/behavior related to a dosage change. Psychiatrist consult and follow-up as needed. Report to physician signs of adverse reaction such as decline in mental status, decline in positioning/ambulation ability, lethargy, complaints of dizziness, tremors, etc."

An interview was conducted with LPN (licensed practical nurse) #7 on 1/16/2020 at 8:45 a.m. LPN #7 was documented as having administered the Ativan to Resident #144. When asked why the Ativan is given, LPN #7 stated the resident has very high anxiety and attempts to stand constantly. When asked if she tries non-medication interventions before giving the antianxiety medication, LPN #7 stated the staff bring her to the nurse's station and try diversional things, but it doesn't work for her. When asked if the interventions attempted are documented anywhere, LPN #7 stated they are documented in the nurse's notes.

An interview was conducted with RN (registered nurse) #6; the quality assurance/unit manager on 1/16/2020 at 9:00 a.m. RN #6 was asked when staff would administer as needed Ativan. RN #6 stated it should be given when non-pharmacological interventions don't work. When asked where staff document if they tried non-pharmacological interventions, RN #6 stated it should be documented in the record.

According to Lippincott Nursing Procedures, "Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members. Document information as soon as

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F 842	Continued From page 142 possible to ensure the accuracy of the information and to reflect ongoing care. Delayed documentation increases the potential for omissions, errors and inaccuracy due to memory lapse." (4) Administrative staff member (ASM) #1, the administrator and ASM #3, the corporate nurse, were made aware of the above concern on 1/16/2020 at 1:05 p.m. No further information was provided prior to exit. References: (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682053.html.	F 842		