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	495211	A. BUILDING _____ B. WING _____	C 11/08/2019

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MOUNT VERNON HEALTHCARE CENTER	8111 TISWELL DRIVE ALEXANDRIA, VA 22306

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/05/19 through 11/08/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/05/19 through 11/08/19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Four complaints were investigated during the survey. The census in this 130 certified bed facility was 117 at the time of the survey. The survey sample consisted of 43 resident 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.	F 550		12/10/19

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

Electronically Signed | 12/01/2019

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to maintain respect and dignity for one resident (Resident #261) in a sample size of 43 residents. The findings included: 1. For Resident # 261, the facility staff failed to ensure a dignified experience during an admission skin assessment. Resident # 261 was woken up between 1:00 am and 1:30 am for a skin assessment.	F 550	Upon receipt of the complaint, the facility acted in the interest of resident #261 and her representative and facilitated a transfer to another skilled nursing facility. Residents reviewed for resident rights/exercise of rights with skin assessment to identify those residents that have potential to be affected. All new admissions have the potential to be affected by the alleged deficient practice. All licensed nurses were educated on the	

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F 550	Continued From page 2 Resident # 261 was a 74 year old female admitted to the facility on 6/22/2018 with the diagnoses of, but not limited to, Anxiety Disorder, Insomnia, Gastroesophageal Reflux Disease, Wedge Compression Fracture of first Lumbar Vertebra, Low Back Pain, muscle weakness and lack of coordination. Resident #261 did not have a Minimum Data Set (MDS) because she had only recently been admitted. Resident # 261 stayed in the facility for 3 days and was discharged on 6/25/2018. Review of the clinical record was conducted on 11/6/2019 at 2:30 PM. Review of a Facility Reported Incident (FRI) dated 6/25/2018 revealed: "The report stated that on 6-25-18, the Administrator received a voicemail from Resident # 261's son on 6/25/2018 reporting that his mother (Resident # 261) alleged that "she had been violated by a staff member on 6-22-2018, day of admission. Per the son, ____(Resident # 261) called him the morning of 6/23/18 to report that nurse _____ (LPN E) had performed a cavity search on her without her consent and was indelicate during the procedure. The son reports that his mother denied any penetration occurred during the alleged cavity check but was alarmed by the forced examination and expressed pain and discomfort in her back as result of being turned and repositioned. The son requested a change in caregiver and it was facilitated; however, he elected not to disclose the rationale for this request with the staff on duty. The son admitted that he waited to share the details of the incident with facility management.	F 550	company policy regarding "Admission Evaluation." Nurses were taught to perform invasive assessments, examinations, and procedures exclusively during waking hours. Waking hours are defined as between the hours of 0600 and 2300 hours. Nurses were also educated to articulate the details of all procedures and assessments prior to obtaining consent. QA/ SDC will audit new admission assessments weekly x 4 and monthly x 3. This audit shall consist of interviewing patients and reviewing assessment documentation to assure all required assessments and procedures are performed within 24 hours, during appropriate waking hours and with full informed consent of the patient.	

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Local law enforcement was called and reported to the facility on 6-25-18.
The son requested to have his mother moved to another SNF (Skilled Nursing Facility). Facility complied with this request and discharged the patient on 6/25/18 to the facility chosen by the patient and her son. Patient discharged at approximately 7:30 p.m."

Review of the FRI update form dated 6/29/2018 revealed the following documentation:
"We are unable to substantiate the patient's claim that she was subjected to a forced cavity check by Nurse (LPN E) or any other staff member. The facility has initiated education for all staff on reporting and escalating allegations of abuse to the appropriate personnel in real time. We have also begun educating all nurses on the proper method to admit a patient, including performing all assessments with another caregiver present, explaining all procedures to the patient in a manner that is easily understood, and ensuring the patient is fully awake and coherent before commencing with any tests, procedures, or medication administration."

On 11/7/2019 at 10:10 a.m., an interview was conducted with the Administrator who stated he remembered the incident and FRI that was submitted to the State Agency. The Administrator was asked to present the investigation file of the FRI for Resident # 261 for the surveyor to review. The Administrator returned with the investigation file at approximately 10:25 a.m.

Review of the investigation file included the Facility Reported Incident forms, several witness statements and documentation of portions of the

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clinical record.

Review of typed witness statements revealed documentation included but not limited to statements from Resident # 261, the nurse accused of performing a "cavity search" LPN (Licensed Practical Nurse) E, the nurse who actually performed the skin assessment (LPN F), the RN (Registered Nurse) Supervisor, the Acting Director of Nursing (Employee G) and the Administrator.

Review of a typed statement from Resident # 261 revealed this statement:
"I came to the center from _____(name of hospital) on Friday, 6/22/2018 after 6 pm. I was walking trying to do some exercise on the hallway and to the second floor dining room on and off till approximately 11:30 pm and went to sleep. I asked ____ (LPN E) to give me my flexeril and she told me she was in the process of getting it form (sic) the pharmacy which later on gave it to me before I went to bed. I also met most of the staff and patients on the hallway and in the nursing station. At 1:30 am, the nurse,_____ (LPN E) woke me up from my deep sleep and she was ripping off all my clothes rough without asking for permission and she rolled me on my side which caused me to have pain and muscle spasm on my back surgical site. I was yelling at ___ (LPN E) what she was doing and to leave me alone and I tried to push her away and she was strong. Again, I asked her why are you doing this to me again and again and she told me she was checking my skin. I told her that she was lying and she was not checking my skin and she was trying to put something in my rectum, she stopped. Then I called my son at around 1:50 am and gave him all the details of what happened. I

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did not go to sleep till 7 am in the morning, I was frightened. On Saturday 6/23/2018, my son called _____ (RN-Registered Nurse G), the nurse who was taking care of me on the day shift and told him that LPN E the nurse should not come back to my room and if that happened he will call a police. On the night shift of 6/24/2018, the nurse ____(LPN H) took care of me and he was good." The name of Resident # 261 was typed at top and the bottom of the statement. It was not signed and was not dated.

Review of the typed witness statements from the nurse who actually performed the skin assessment (LPN F), revealed documentation:

"On 6/23/2018, approximately 12 am, I took report from the outgoing nurse _____ (LPN E) about _____ (Resident # 261). _____(Resident # 261) was admitted to the facility on 6/23/18 around 6:30 pm to room _____(room number) per the outgoing nurse report. Approximately between 1:00 am and 1:30 am, _____(Resident # 261) was sleeping and I woke her up and I told her that my name was _____. (LPN F) her nurse and I explained to her that I was performing admission head to toe assessment and she gave the ok and I started taking her pant off first and her top and all her clothing. _____(Resident # 261) assisted me with the process by raising her bottom and rolling over to the side. First, I assessed the upper part of her body and I asked her to roller over on her side so that can see her back surgical scar and her bottom. While she was on her side, I assessed her buttocks, coccyx, and the sacrum. I opened her buttock and assessed her inner buttock to make sure she did not have any pressure injury. _____ Resident # 261 was

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asking me why I was checking her buttocks and if I was looking for drugs. I explained to _____(Resident # 261) that I was completing the skin assessment and it was a part of my duty to complete skin assessment. _____(Resident # 261) was repeatedly telling me that I was searching drugs and I again told her that I was not looking for drugs. After the completion of my skin assessment, I gave her gown and helped her to put it on. Again _____(Resident # 261) was telling me I was doing drug search and again I told her sorry that I was doing skin assessment. The whole time I was completing the skin assessment, ____ (Resident # 261) did not scream or raise her voce.(sic) After 10 minutes, I went back to her room with the vital sign machine and obtained her vitals. While I was checking her vitals, _____ (Resident # 261) was telling me that _____(LPN E) the nurse woke her up and ripped her cloth (sic) off her and she was upset about it. I explained to _____(Resident #261) that ____(LPN E) left the floor before midnight and I was the one I who woke her up and did the skin assessment however _____(Resident #261) stated that (LPN E) was the one who ripped her cloth (sic) off of her. I again told her that I was the one and she stated that I was not the one. I told her that I am (LPN F). _____(Resident # 261) seems ok the whole time except that she was repeating about the drug search and her cloth (sic) was stripped off of her by (LPN E)."
The form had the typed name of LPN F at the top and the bottom of the form. It was not signed. There was no date on the form indicating when the statement was typed.

On 11/7/2019 at 3:35 p.m., an interview was conducted with the Administrator who stated the

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facility had the expectation for admission skin assessments to be completed within a certain number of hours after admission. The Administrator stated he would check the facility policy to determine the exact time frame for admission skin assessments to be completed.

The Administrator returned to the conference room and stated that the admission skin assessments should be completed within the first 24 hours and presented a copy of the facility policy on Admission assessments. The Administrator stated the nurse had time to wait until a more appropriate hour to complete the skin assessment. The Administrator stated after he became aware of the situation on 6/25/2018 and completed the investigation, he made changes to the admission process. The Administrator stated the nurse (LPN F) should have had another staff member with her during the assessment and could have waited until later to complete the assessment since the resident was asleep. The Administrator stated the nursing staff had been educated on completing assessments with another staff member present, making sure the resident is fully awake, alert and understands the assessment and gives consent.

Review of the facility policy entitled "Admission Evaluation" Effective: 1/24/2007, Revised: 10/30/2013, 9/21/2016. Reviewed: 5/29/2019 revealed the definition: Admission: the first 24 hours the resident is in the facility or returning to the facility. Under "Policy" was written:
"It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. A systematic evaluation is completed by a licensed nurse upon

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admission/readmission to assist in determining the most effective and appropriate care needs of each resident admitted to the center.

Procedure:

1. Complete the admit/Readmit/Quarterly Screener assessment and appropriately triggered assessments electronically as soon as feasible but within 24 hours.

On 11/7/2019 at 4:05 p.m., an interview was conducted with the Assistant Director of Nursing (Employee F). Employee F stated the resident (Resident # 261) nurses should perform nursing assessments with another staff member present after they obtain consent for the assessment. Employee F stated Resident # 261 was assessed by her physician at the facility and transferred to another skilled nursing facility. Employee F stated the resident and her son were upset.

Review of the Nurses Notes revealed no documentation of the skin assessment performed by LPN F and/ or the response by Resident # 261.

Review of the Admission Assessments (Admission Observation Tool and Skin Grid Pressure Assessment revealed both were dated 6/23/2018 were signed by LPN F. There was no documentation either of those documents of Resident # 261's response during the assessments.

LPN F was no longer employed at the facility at the time of survey. Two attempts to reach her via telephone were unsuccessful-voicemail message stated "voicemail is full."

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F 550	Continued From page 9 On 11/8/2019 at 12:30 PM, attempt to reach Resident # 261's son via telephone was unsuccessful. The phone rang several times but no voicemail was available. Another attempt to reach Resident # 261's son via telephone, the son answered but stated it was not a convenient time. The resident's son stated he would return the call to the surveyor. During the end of day debriefings on 11/7/2019 and 11/8/2019, the facility Administrator and Director of Nursing were informed that the facility staff performed an admission skin assessment between 1:00 am and 1:30 am, and continued with the assessment when the resident was upset indicated by the fact that she verbalized more than once that she thought it was a drug search. No further information was provided.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to assess a Resident to determine if they were safe to administer medications, before leaving medications at the bedside for one Resident (Resident #86) in a survey of 43 Residents. The findings included:	F 554	Resident #86 medication removed from bedside; attending physician notified and issued order to check blood pressure and to administer the missed medication. Medication was ingested by patient. Residents reviewed for self-administered medications appropriately to identify those residents that have potential to be affected. All skilled level residents have	12/10/19

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F 554	Continued From page 10 For Resident #86 the facility staff left medications at the bedside for the Resident when the Resident had not been assessed or determined to be clinically appropriate to self administer medications. Resident #86 was admitted to the facility on 10/10/19. Resident #86's diagnoses included but were not limited to: Spinal Stenosis, Urinary tract infection, obstructive and reflux uropathy, degenerative disease of the nervous system, cirrhosis of liver, acute kidney failure, hemochromatosis, hydronephrosis, and muscle weakness. Resident #86's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 10/15/19 was coded as an admission assessment. Resident #86 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated intact cognitive skills. Resident #86 was coded as required extensive assistance in transfers, bed mobility, dressing, personal hygiene, and toileting. Resident #86 was coded as having been frequently incontinent of bowel and occasionally incontinent of bladder. On 11/6/19 at 9:19 AM during facility rounds, Resident #86 was observed to not be in his room. Observation of the room revealed, on the over-bed table at the bedside, was a medicine cup with a small, 1/2 of a white, round pill and a cup of water beside it. No staff were present. On 11/6/19 at approximately 9:40 AM, RN D was asked to accompany Surveyor C to Resident #86's room. When RN D was asked what the cup was, RN D stated "I didn't give him his meds	F 554	the potential to be affected by the alleged deficient practice. Licensed nurses educated on the 7 rights of medication administration, focusing on ingestion of all medications prior to leaving the patient's side. Nurse unit manager/designee to perform twice weekly self-administration audits for 4 weeks and twice monthly for 3 months. All findings reported to monthly QAPI committee for process improvement.	

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[medications] but I think it is Metoprolol". When Surveyor C asked RN D if it is routine to leave medications at the bedside, RN D stated, "usually we stand there to make sure they taken them". RN D was asked if Resident #86 self-administers medications, RN D stated "No".

On 11/6/19 at approximately 9:50 AM, RN D and Surveyor C returned to the nursing station. RN D approached LPN D and told LPN D, "he left this at his bedside, we have to call the doctor and let him know". LPN D confirmed the 1/2 of a pill was metoprolol.

On 11/6/19 a review of Resident #86's current physician orders revealed an order "Metoprolol Tartrate Tablet, give 12.5 mg by mouth two times a day for HTN [hypertension]". The order date was 10/10/19 and continued as an active order for Resident #86.

On 11/6/19 a complete review of Resident #86's entire clinical record was conducted, to include the careplan and revealed no assessment of, or determination that Resident #86 had been assessed for self-administration of medication.

On 11/6/19 at 11:37 AM, a request was made for any assessments or determination that Resident #86 had been assessed to self administer medications. The facility Director of Nursing stated they had no such documents.

On 11/07/19 at 04:31 PM the facility Administrator was asked his expectations regarding medication administration, the Administrator stated, "I expect them to follow the 7 rights of medication administration". When asked if medications can be left at the bedside, the Administrator stated,

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F 554	Continued From page 12	F 554		

"of course not, she has to observe the resident take the meds".

On 11/8/19 at 9:00 AM a review of Resident #86's electronic clinical record revealed a nursing note dated 11/6/19 at 10:52 AM, written by RN D that read, "Patient was given his morning medications today, however, it was noted that he did not take his blood pressure medication metoprolol 12.5mg. Medication was noted on his bedside table, and patient went down for therapy. MD was called and informed of the above. New order given to re-check patient's blood pressure upon return on the floor since patient blood pressure this morning was within normal limit (124/79), and to give the blood pressure medication after". Another nursing note entry was made by LPN D at 12:34 PM that read, "patient returned to the floor, was informed that he had not taken his blood pressure medication, patient its "oh I didn't, it must have been stick [sic] to the bottom of the cup".

Review of the facility policy titled "Resident Self-Administration of Medications" with a review date of 5/29/19 read on page 2, "a. Resident may not self-administer medication until the assessment is completed by the IDT team and determined to be safe to do so".

Review of the facility policy titled "Medication Administration" with a review date of 5/29/19 read on page 4, "remain with resident until the medication is swallowed, do not leave medication at bedside".

The facility administrator and Director of Nursing (DON) were advised during an end of day meeting on 11/7/19 at 4:31 PM and again at end

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F 554	Continued From page 13 of day meeting on 11/8/19, of medications being left at the bedside of Resident #86. No further information was provided.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed to provide accommodations to call for assistance for 1 resident (Resident #41) in a survey sample of 43 residents. The findings include: For Resident #41, the callbell was located beyond his reach, making it unavailable for him to call for assistance. Resident #41, an 80 year old male who was admitted to the facility on 11/22/2017 with diagnoses to include but not limited to muscle weakness, anemia, and contracture of the right knee. Resident #41's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/18/2019 was coded as an annual assessment. Resident #41 was coded with a Brief Interview of Mental Status (BIMS) score of "9" out	F 558	Resident #41 call bell was placed within reach. Residents reviewed for reasonable accomodations of needs to identify those residents that have the potential to be affected. Nurses and certified nursing assistants will be educated on patient accommodation of needs. Certified nursing assistants will be educated on principles of nurse aide rounds. Maintenance to audit call bells and accommodations weekly x 4 weeks and monthly x 3. All findings reported monthly to QAPI committee for process improvement.	12/10/19

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F 558	Continued From page 14 of possible 15, indicating moderately impaired cognition. He was coded requiring extensive assistance for all of his ADL's (activities of daily living). On 11/5/19 at approximately 10:15 am during initial tour, Resident #41 was observed lying awake in his bed with his callbell located on the wall to the right of the head of his bed, wrapped around a soap dispenser. He stated that he did not know where his callbell was located and when it was pointed out that it was dangling from the soap dispenser on the wall, he stated, "I have no idea how it ended up there, I didn't put it there, I cannot get out of bed or even reach over there". Employee A was observed in the hallway and asked to come into Resident #41's room. An interview was conducted with Employee A with regard to the location of Resident #41's callbell and he stated, "I do not know why the callbell is hanging off the wall, he is not on my assignment today". When asked if he thought Resident #41 could reach his callbell to call for assistance, he stated "No, it should be kept within his reach at all times so he can use it". Employee A removed the callbell from the wall and secured it to Resident #41's bedspread. On 11/6/19, a facility policy regarding callbells was requested and received. The facility policy entitled, "Resident Rights", policy #NS 1021-00, dated 8/11/2017, page 2, item c(i) read, "Call light or bell access will be within reach of the resident as one method to communicate needs to staff".	F 558		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)	F 577		12/10/19

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F 577	Continued From page 15 §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, the facility staff failed to post and have readily accessible the results of the survey reports for the three preceding years, to include any plan of corrections. The facility only had two of the last three years available. In addition the facility did not have plans of corrections that were finalized for two of the three surveys that were available. The findings included: On 11/6/19 at approximately 3:00 PM, the survey	F 577	Survey results and accepted Plan of Correction from 2016 Annual Survey placed in survey binder. All residents have the potential to be affected by the alleged deficient practice. ED to educate department heads (social services, business manager, director of nursing, dietary manager, environmental service director, maintenance director, admission director, activities director,	

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F 577	Continued From page 16 binder was observed to be located on a table on the first floor as you enter the nursing facility through the lobby. The binder contained survey results from the following surveys: * May 2018 Standard Survey * June 2018 Life Safety Survey * March 2017 Standard Survey On 11/7/19 at 9:11 AM the survey binder was observed to contain the following surveys: * 5/22/18- 5/24/18 Emergency Preparedness Survey and Standard Survey which had a watermark that read "POC [plan of correction] not final" * 6/15/18 Life Safety Survey * 3/7/17-3/9/17 Standard Survey and Biennial State Licensure Survey report, which revealed the biennial state licensure survey report had a watermark that read "POC [plan of correction] not final" On 11/7/19 at 3:53 PM, during an end of day meeting the facility Administrator was asked about the survey results binder. The Administrator stated it is located "in the lobby at the nurses station". When asked about the contents, the Administrator stated "it is our last survey results and plan of correction for the last 2 years". When asked if he was aware that the regulations require it to include the last 3 years of results, the administrator stated, "I should have been". The Administrator was given the survey results binder during this meeting. On 11/8/19 at approximately 8:10 AM, the facility survey results binder was observed again and revealed the following survey information, and the three years of survey results had not been included:	F 577	human resources manager, front office manager) on tenets of 483.10 (g) (10) (11) to ensure 3 years of survey results are maintained in designated survey binders in conspicuous and accessible areas within the center. Activity Director/ designee to audit survey binder 3 times weekly x 4, then once weekly x 3 months. Deficiencies will be corrected immediately and reported to QAPI committee for process improvement.	

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F 577	Continued From page 17 * 5/22/18- 5/24/18 Emergency Preparedness Survey and standard survey which had a watermark that read "POC [plan of correction] not final" * 6/15/18 life safety survey * 3/7/17-3/9/17 standard survey and biennial state licensure survey report, which revealed the biennial state licensure survey report had a watermark that read "POC [plan of correction] not final" No further information was provided.	F 577		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the	F 582		12/10/19

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F 582	Continued From page 18 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to: 1) provide notification of non-coverage in a timely fashion for one of three sampled residents (Resident #315) and 2) complete an Advanced Beneficiary Notice (ABN) for one of three sampled residents	F 582	Resident # 315 converted to Long Term Care and remained in the center. The resident experienced no adverse affects from this alleged deficient practice. Resident #12 succesfully discharged home with the support of family and Home Health services. The resident experienced no adverse affects from this deficient practice.	

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F 582	Continued From page 19 (Resident #12) The findings included: A review of Resident #315's Notice to Medicare Provider Non-Coverage (NOMNC) while on survey revealed that the effective date coverage would end was 07/17/2019 and Resident #315 signed and dated the NOMNC 07/16/2019. A review of the ABN for Resident #12 revealed that although it was signed and dated by the responsible party, an option pertaining to the care and cost was not selected. On 11/08/19 at 09:33 AM, an interview with Employee P, the social worker, was conducted. When asked about the process for issuing NOMNCs and ABNs, Employee P stated that the NOMNC and ABN should be signed "48 to 72 hours, mostly 72 hours in advance." When asked why it was important to have more than a one day notice, Employee P stated "To have enough notice for the appeal process." When Employee P was informed Resident #315 signed the NOMNC the day before services would end and the option selection on the ABN for Resident #12 was not completed, Employee P stated "I can get back with you on that." Policies for obtaining NOMNCs and ABNs were requested. On 11/08/2019 at approximately 1:00 PM, the administrator and DON were notified of findings. The administrator verified that the facility does not have a policy pertaining to obtaining NOMNCs and ABNs.	F 582	Residents reviewed for Medicare/Medicaid liability notices to identify those residents that have potential to be affected. Social Work and Business Office personell educated on requirements of Medicare/ Medicaid Liability Notices using CMS-20052- Beneficiary Notice. Social Services Director will review all issued Medicare/ Medicaid Liability Notices for timeliness and accuracy. Any identified deficiencies will be addressed immediately for correction to assure residents have adequate time to make informed decision regarding coverage options. Business Office Manager to audit issued Liability Notices 3 x weekly for 4 weeks, then 1 x weekly for three months. Findings will be reported to QAPI committee monthly x 3 for process improvement.	

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F 656	Continued From page 20	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights 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	F 656		12/10/19

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F 656	Continued From page 21 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, Resident and staff interview facility documentation and clinical record review the facility staff failed to develop and implement a comprehensive care plan for 3 Residents (#73, 75, #66) in a survey sample of 43 Residents. The findings included: 1. For Resident #73 the facility staff failed to care plan scheduled nebulizer treatments and changing of tubing for nebulizer. Resident #73, a 66 year old woman admitted to the facility on 4/6/19 with diagnoses of but not limited to Chronic Respiratory Failure, COPD (chronic obstructive pulmonary disease), Trach, G-Tube, dysphagia, dementia, major depressive disorder, psychosis, anxiety disorder, and seizures. Resident # 73's most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/9/19 codes the Resident as being extensive assist with 2 person physical assistance for bed mobility, transfers and dressing and total assistance with physical assistance of 1 for bathing, feeding, and mobility. Resident #73 uses a wheel chair for transport and is unable to propel herself, she has a g-tube for feeding and a trach. On 11/5/19 at 3:00 PM during tour noted that	F 656	Resident #73 Care plan updated. Resident #75 Care plan updated. Resident #66 Care plan updated. Residents reviewed for development and implementation of comprehensive care plans to identify those residents that have potential to be affected. RNs and LPNs in serviced on company policy "Continuous Aerosol Therapy Equipment and Maintenance" with focus on label/dating and frequency of equipment changes. ED educated unit managers, MDS, and DON on facility specific Care Plan procedure which includes instructions for executing Baseline and Comprehensive Care Plans. MDS assigned responsibility for validating Comprehensive Care Plans and Unit Managers assigned responsibility for Care Plan updates/revision. DON or designee to audit Care Plan 3 times weekly x 4weeks, then monthly x 3. All findings reported to QAPI committee for process improvement.	

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Resident # 73 had undated tubing to her nebulizer.

On 11/5/19 at approximately 3:05 PM an interview was conducted with LPN A and she stated the tubing should be changed weekly by night shift.

On 11/7/19 at 9:55 AM during clinical record review it was noted that the Residents care plan addressed the trach care and oxygen usage along with the scheduled tube changing weekly however they omitted the nebulizer treatment on the care plan.

2. For Resident # 75 the facility staff failed to develop and implement plan to include nebulizer treatments and scheduled tubing change.

Resident #75 a 73 year old woman admitted to the facility on 2/21/18 with diagnoses of but not limited to CHF (Congestive Heart Failure), acute respiratory failure, major depressive disorder, COPD, Acute Kidney Failure and heart disease of coronary artery.

Resident #75's most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/10/19 codes resident #75 as having a (Brief Interview of Mental Status) BIMS of 15 indicating no cognitive impairment. The Resident was also coded as needing extensive assistance of 2 person physical assistance for bed mobility and transfers and unable to walk. She required extensive assistance of 1 person physical assist for bathing dressing and hygiene and toileting.

On 11/5/19 at 3:00 PM during tour noted that

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Resident # 75 had a nebulizer.

The clinical record review and it was noted that the Residents care plan addressed the PRN use of oxygen along with the scheduled tube changing weekly however it omitted the nebulizer treatment on the care plan.

On 11/7/19 at 1:00 PM an interview was conducted with RN A who stated all treatments should be care planned. She also stated that Nebulizer tubing like oxygen tubing should be dated and changed weekly by night shift staff.

The facility policy for "Continuous Aerosol Therapy" [nebulizer] read:

Page # 2 Paragraph II.
Equipment and Maintenance
a. Aerosol/Trach masks are to be changed once a week and PRN
b. Disposable aerosol tubing and drain bags are to be changed once a week and PRN.
c. Non - refilled nebulizers are to be changed 3 times a week and filled as needed by respiratory or nursing staff
d. Refilled nebulizers are to be changed when empty or once a week.

On 11/7/19 at 2:30 PM the DON stated that it was her expectation that the Nebulizer tubing be changed weekly and care planned as such.

On 11/8/19 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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3. For Resident #66 the careplan did not address the current infections of osteomyelitis, C-Diff, receiving IV antibiotics, being on contact precautions, the need for assistance with ADL's, the presence of wounds, the need for wound care, the use of an anticoagulant or history of falls as identified in the comprehensive assessment

Resident #66 was admitted to the facility on 9/30/19, with a readmission date of 10/24/19. Resident #66's diagnoses included but were not limited to: chronic osteomyelitis with draining sinus of right femur, pyogenic arthritis, infection following a procedure, broken internal right knee prosthesis, local infection of the skin and subcutaneous tissue, pressure ulcer of the sacral region stage 4, and enterocolitis due to clostridium difficile (C-Diff).

Resident #66's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 10/7/19 was coded as an admission assessment. Resident #66 was coded as having had a BIMS (brief interview for mental status) score of 14, which indicated intact cognitive skills. Resident #66 was coded as having required extensive assistance for dressing, personal hygiene, bed mobility and toileting. Ambulation and transfers were coded as having not occurred. Resident #66 was coded as having been always incontinent of bowel and bladder. This same MDS was also coded to indicate Resident #66 had diagnoses of deep vein thrombosis and received anticoagulants (blood thinner), received scheduled pain management regimen, and had a

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fall in the month prior to admission.

On 11/5/19 during rounds it was observed that contact isolation supplies were outside of Resident #66's room. The nurse was asked about this and indicated that Resident #66 was on contact precautions due to C-Diff.

On 11/5/19 review of the electronic clinical record for Resident #66 revealed that the careplan did not address the current infections of osteomyelitis, C-Diff, receiving IV antibiotics, being on contact precautions, the need for assistance with ADL's, the presence of wounds, the need for wound care, the use of an anticoagulant or history of falls as identified in the comprehensive assessment.

On 11/7/19 at 5:10 PM an interview was conducted with RN F, who was the MDS Coordinator who writes the electronic careplan's. When asked about the process for developing and initiating careplan's, RN F stated, "we do a 48 hour baseline careplan and after 21 days we put it in the computer". When asked what should be careplanned, RN F stated "diagnosis, health conditions, medications like psychotropic, if have falls or behaviors the nurse taking care of the patient takes care of that". When asked where the paper careplans can be found, RN F stated, "the unit manager has a binder with it". When shown the careplan for Resident #66 that included only the 3 focus areas of: discharge, CPR and weight changes, RN F stated, "his careplan should be on paper, his assessment was done 10/21/19".

On 11/7/19 at approximately 5:15 PM, an interview was conducted with RN C, Charge

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Nurse. RN C was asked what the importance of a careplan is, RN C stated, "the careplan is to give information to the staff to be able to take care of a resident, it is like a guideline".

On 11/7/19 at approximately 5:20 PM, surveyor C asked the Unit Manager, RN E for the paper careplan for Resident #66. RN E provided a document titled "48 hour baseline careplan V3- V 3", which had an effective date of 9/30/19. There were multiple handwritten entries on page 7 which read,

"Focus problems"
"safety/fall precautions"
"infection control"
"skin/wound care management, prevent surgical wound complications"
"emotional support, prevent emotional breakdown"
"monitor PICC site to prevent complications"
"pain management with appropriate interventions as indicated"
"assist with d/c planning needs"
"monitor ABT [antibiotic] therapy with interventions as indicated"

On the back of page 7 the following was written:
"monitor ext [external] fixator and do pin site as indicated"
"contact precautions/isolation"

It was observed that none of these entries were dated as to when written and failed to have measurable objectives and timeframes to meet the Resident's medical and nursing needs.

On 11/7/19 at 5:28 PM an interview was conducted with the facility DON (Director of Nursing) and RN E. The DON and RN E were

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F 656	Continued From page 27 asked when the handwritten entries were made on the "48 hour baseline careplan" and the DON stated, "we write on it during the clinical meeting that was held when it was signed" which had a date of 10/1/19. However, the contact precautions were not ordered until 10/2/19 so this wasn't the case. On 11/8/19 a review of the facility policy titled "Plan of Care Overview" with a review date of 5/30/19 read, "for the purpose of this policy the plan of care, also care plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care. The purpose of the policy is to provide guidance to the facility to support the inclusion of the resident or resident representative in all aspects of persona-centered care planning and that this planing includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to the their [sic] daily routines and goals to potentially return to a community setting". On 11/8/19 during an end of day meeting the facility Administrator and Director of Nursing were made aware of the facility staff's failure to develop a comprehensive person-centered careplan. No further information was provided.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		12/10/19

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F 657	Continued From page 28 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed, for one resident (Resident # 79) in the survey sample of 43 residents, to review and revise the plan of care. The Findings included: 1. For Resident #79, the facility staff failed to review and revise the care plan after the development of unstageable pressure ulcers on	F 657	Resident #79 care plan updated. All patients have the potential to be affected by the alleged deficient practice. Educate nursing supervisors, unit managers, ADON, MDS, DON on facility specific care plan procedure for initiation and episodic care plan revisions timely. DON or desginee to audit Care Plan 3 times weekly x 4 weeks, then monthly x 3 months. All findings reported monthly to	

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F 657	Continued From page 29 his left ankle and left heel. Resident #79 was a 76 year old who was admitted to the facility on 4/10/19. Resident #79's diagnoses included Cerebral Infarction, Generalized Muscle Weakness, Dementia, Major Depressive Disorder Hypertension, and Congestive Heart Failure. The Minimum Data Set, which was a Significant Change Assessment with an Assessment Reference Date of 10/11/19 was reviewed. Resident #79 had a Brief Interview of Mental Status Score of 12, indicating mildly impaired cognition. He was coded as requiring the extensive physical assistance of at least two people for bed mobility, and transfers. Resident #79's range of motion was impaired in both of his upper and lower extremities. He was coded as having unstageable pressure ulcers. His previous MDS, which was a Quarterly Assessment, with an Assessment Reference Date of 8/26/19 was reviewed. He was not coded for any pressure ulcers. On 11/5/19 a review was conducted of Resident #79's clinical record. According to a wound care note, on 9/11/19, an unstageable pressure ulcer was initially identified by a wound care physician. Resident #79's care plan was reviewed. It did not document anything regarding his pressure ulcers, including their existence or treatment. The Plan of Care Overview policy dated 5/30/19 was reviewed. An excerpt read, "Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal	F 657	QAPI committee for process improvement.	

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F 657	Continued From page 30 personalized care. Review care plans quarterly and/or with significant changes in care. Nurses are expected to participate in the resident plan of care for reviewing and revising the care plan of residents they provide care for as the resident's condition warrants." On 11/6/19 an interview was conducted with the facility Administrator (Employee A) in the conference room. When asked about his expectation about when a care plan must be revised, he stated that it should be revised within 24 hours of the change in condition, with focused goals and interventions to mitigate further pressure injuries.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to follow professional standards for three Residents (Resident #86, #107, #2) in a survey sample of 43 Residents. The findings included: 1. For Resident #86 the facility staff failed to following nursing standard of practice by failure to observe a Resident (Resident #86) take medication, and left medication at the bedside.	F 658	Resident #86, the RN removed the medication from the patient room, notified the attending physician and received an order to administer the medication.The RN administered the medication and witnessed its ingestion. The patient suffered no adverse effect. For resident #107 the facility nurse management identified the missed order entry for IV ABT medication and consulted the Infectious Disease and attending Physicians. The ID evaluated the patient and confirmed the original orders. The	12/10/19

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F 658	Continued From page 31 Resident #86 was admitted to the facility on 10/10/19. Resident #86's diagnoses included but were not limited to: Spinal Stenosis, Urinary tract infection, obstructive and reflux uropathy, degenerative disease of the nervous system, cirrhosis of liver, acute kidney failure, hemochromatosis, hydronephrosis, and muscle weakness. Resident #86's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 10/15/19 was coded as an admission assessment. Resident #86 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated intact cognitive skills. Resident #86 was coded as required extensive assistance in transfers, bed mobility, dressing, personal hygiene, and toileting. Resident #86 was coded as having been frequently incontinent of bowel and occasionally incontinent of bladder. On 11/6/19 at 9:19 AM during facility rounds, Resident #86 was observed to not be in his room. Observation of the room revealed on the over-bed table at the bedside, was a medicine cup with a small, 1/2 of a white, round pill and a cup of water beside it. No staff were present. On 11/6/19 at approximately 9:40 AM, RN D was asked to accompany Surveyor C to Resident #86's room. When asked if it is routine to leave medications at the bedside, RN D stated, "usually we stand there to make sure they taken them". On 11/6/19 a review of Resident #86's current physician orders revealed an order "Metoprolol Tartrate Tablet, give 12.5 mg by mouth two times a day for HTN [hypertension]". The order date	F 658	attending Physician extender evaluated the patient and likewise agreed to start the original IV ABT therapy. The patient received the first dose of her medication on 10/31/19. For the insulin, a medication error was completed and medical team notified of missed insulin. For Resident #2, the facility documented the late administration occurrences as a medication error and notified the attending Physician of the medication error. Residents reviewed for services provided meet professional standards for medication administration to identify those residents that have potential to be affected. All residents have the potential to be affected by the alleged deficient practice. RNs and LPNs were educated on the 7 rights of medication adminstration and the preocedures for documenting and reporting medication errors. RNs and LPNs were also trained on ordering all IV antibiotics with reassessment requirement post order discontinuation. This will populate an alert for all nurses to reassess patient due to discontinuation of antibiotic. Medication error rates will be monitored by the QAPI committee for benchmarking and process improvement. Staff Development/ Quality Nurse will audit medication administration 3 times weekly x 4 weeks, then monthly x 3 with all findings reported to the QAPI committee.	

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was 10/10/19 and continued as an active order for Resident #86.

On 11/07/19 at 04:31 PM the facility Administrator was asked his expectations regarding medication administration, the Administrator stated, "I expect them to follow the 7 rights of medication administration". When asked if medications can be left at the bedside, the Administrator stated, "of course not, she has to observe the resident take the meds".

Review of the facility policy titled "Medication Administration" with a review date of 5/29/19 read on page 4, "remain with resident until the medication is swallowed, do not leave medication at bedside, medications will be charted when given, medications that are refused or withheld or not given will be documented".

The DON stated the facility uses Lippincott as their nursing standard of practice.

Guidance from Lippincott's Nursing Center.com (www.nursingcenter.com)
Rights of Medication Administration
1. Right patient Check the name on the order and the patient. Use 2 identifiers. Ask patient to identify himself/herself. When available, use technology (for example, bar-code system).
2. Right medication Check the medication label. Check the order.
3. Right dose Check the order. Confirm appropriateness of the dose using a current drug reference. If necessary, calculate the dose and have another nurse calculate the dose as well.
4. Right route Again, check the order and appropriateness of the route ordered. Confirm that the patient can take or receive the

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medication by the ordered route.
5. Right time Check the frequency of the ordered medication. Double-check that you are giving the ordered dose at the correct time. Confirm when the last dose was given.
6. Right documentation Document administration AFTER giving the ordered medication. Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.
7. Right reason Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication? Revisit the reasons for long-term medication use.
8. Right response Make sure that the drug led to the desired effect. If an anti-hypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant? Be sure to document your monitoring of the patient and any other nursing interventions that are applicable.
Reference: Nursing2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania. www.nursingcenter.com Accessed online 3/8/18.

The facility administrator and Director of Nursing (DON) were advised during an end of day meeting on 11/7/19 at 4:31 PM and again at end of day meeting on 11/8/19, of medications being left at the bedside of Resident #86.

No further information was provided.

2a. For Resident #107 the facility staff failed to

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administer insulin as ordered by the physician on 6 of 16 scheduled doses.

Resident #107, was admitted to the facility on 10/21/19. Resident #107's diagnoses included but were not limited to: sepsis, osteomyelitis of vertebra sacral and sacrococcygeal region, pressure ulcer sacral region stage 4, pressure ulcer of right upper back stage 4, unspecified dementia without behavioral disturbance, type 2 diabetes mellitus without complications, and hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side.

Resident #107's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 10/26/19 was coded as an admission assessment. Resident #107 was coded as having not been interviewable for a BIMS (brief interview for mental status) score. The staff assessment indicated the Resident is severely cognitively impaired. Resident #107 was coded as required total assistance of staff for transfers, bed mobility, dressing, personal hygiene, toileting, and bathing. Resident #107 was coded as having been always incontinent of bowel.

On the afternoon of 11/7/19 a review of Resident #107's clinical record revealed a physician order dated 10/21/19 that read, "Toujeo Solostar Solution Pen-Injector 300 unit/ML (insulin Glargine) Inject 14 unit subcutaneously at bedtime for DM [diabetes mellitus]". Review of the Medication Administration Record (MAR) for October and November 2019 revealed that Resident #107 was not administered 6 of the

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scheduled 16 doses, (10/21/19, 10/24/19, 10/28/19, 10/31/19, 11/2/19, and 11/3/19) which were due from admission on 10/21/19 through 11/5/19.

On 11/8/19 at 8:45 AM, an interview was conducted with LPN C. LPN C was asked about the physician order for Resident #107's Toujeo, LPN C stated, "she gets 14 units at bedtime". When asked if this is every night, LPN C stated, "yes, she gets it every night". LPN C was asked if there was any indications as to when he would not give the scheduled medication, LPN C stated, "it depends on the blood sugar, if the blood sugar is very low, I would hold it and confirm with the doctor". LPN C was asked if that would be documented in the clinical record, LPN C stated, "yes".

On 11/8/19 at approximately 9:10 AM, RN B, the unit manager was asked what "NC" on the MAR for Toujeo indicated. RN B looked at the legend attached to the MAR and indicated it meant "no insulin coverage required". RN B added, "if the blood sugar falls below certain range they don't give". Surveyor C asked what that range was, RN B stated, "I will have to look". RN B went on to state, "the nurse does the accu check and long acting insulin doesn't have a range so they use their judgement, if they hold it they call the doctor". RN B was asked if it would be expected that a nursing note entry would be entered into the clinical record regarding this and RN B stated, "I believe so, yes".

A review of the nursing notes for Resident #107 revealed no notes on the dates of 10/21/19, 10/24/19, 10/28/19, 10/31/19, 11/2/19, and 11/3/19 to indicate why the Toujeo was not

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administered as per the physician order.

On 11/8/19 at 10:58 AM, RN B returned to Surveyor C after reviewing the clinical record for Resident #107. RN B stated, "those days are the same nurse [referencing the dates of the missed medication], the sliding scale insulin has parameters but the long acting does not. That nurse is a new nurse and just finished orientation, he is the only nurse recording NC and I didn't see any communication with the doctor". RN B was asked if she would have administered the Toujeo on the days in question, RN B stated, "yes I would have given, I wouldn't have just held without communicating with the doctor". RN B was asked why it is important to give insulin as ordered, RN B stated, "this is important for them to see if they need to make adjustments to insulin doses. Before we hold a medication we need to consult the doctor". RN B also stated that she had attempted to reach the nurse that had failed to administer the insulin but didn't reach them via telephone but would be doing some education upon their return to work for their next shift.

2b. For Resident #107 the facility staff failed to administer IV antibiotics for sepsis, osteomyelitis and wound infection, for 28 doses (four times daily/every 6 hours on 10/24/19-10/30/19), as ordered by the physician.

On the afternoon of 11/7/19 a review of Resident #107's clinical record revealed the following physician orders:

*On 10/22/19 an order read, "Unasyn Solution Reconstituted 3 (2-1) GM (Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 5 hours for sepsis,

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osteomyelitis". This order was discontinued on 10/22/19. The MAR for October revealed that this order was administered to Resident #107.

* On 10/22/19 another order read, "Unasyn Solution Reconstituted 3 (2-1) GM (Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 5 hours for sepsis, osteomyelitis until 10/31/19". This order was carried out and administered on 10/23/19 at 12:48 AM, 5:02 AM, 1:28 PM. The order was then discontinued on 10/23/19 at 12:22 PM.

* On 10/23/19 an order read, "Unasyn Solution Reconstituted 3 (2-1) GM (Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 6 hours for sepsis, osteomyelitis until 10/23/19", which was in error. This order was carried out and administered on 10/23/19 at 6:00 PM.

* On 10/30/19 an order read, "Unasyn Solution Reconstituted 3 (2-1) GM (Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 6 hours for wound infection for 6 weeks". This order was then carried out and administered as ordered for the duration of the month of Oct. and through the time of this review.

A nursing note entry dated 10/22/19 at 18:53 read, "unasyn Solution Reconstituted 3 (2-1) GM use 3 gram intravenously every 5 hours for sepsis, osteomyelitis until 10/31/19", confirming the order was to continue this medication. It further stated that the facility was "awaiting pharmacy to deliver".

On 11/8/19 at approximately 9:10 AM, RN B, the unit manager was asked about Resident #107's multiple IV antibiotic orders. RN B stated, "someone entered it wrong, so as an interdisciplinary team we go back and change it".

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RN B was asked to clarify what she meant that it was entered wrong, RN B stated, "it didn't have a stop date, we like all of our antibiotics to have an end date". RN B was then questioned about the multiple days that Resident #107 didn't receive the IV antibiotics, RN B stated, "I don't know unless there was a delay from the pharmacy" and agreed to look into this further.

On 11/8/19 at 10:58 AM, RN B returned to Surveyor C after reviewing the clinical record for Resident #107. RN B stated, "when this medication was first ordered it said every 5 hours, that was communicated with the doctor and it had not stop date. The doctor was called and an order was given to change to every 6 hours until 10/29/19 and then consult infectious disease. The nurse that entered the order had a start date of 10/23/19 and had a stop date of 10/23/19, so it didn't populate to the MAR and it was caught on review on 10/30/19 and infectious disease gave the order to continue it for 6 weeks".

Review of the facility policy titled "Physician Orders" with a review date of 5/30/19 read on page 2, "taking the order: a. do not try to memorize the order b. write down the order as stated, c. provide a read-back to validate, d. spell out/clarify sound alike drugs, e. discontinue any previous contradicting order, f. place orders in the electronic medical record, g. print copy for physician to sign and place in paper chart, h. contact pharmacy for changes".

The facility Director of Nursing indicated that the facility staff uses Lippincott as their nursing standard of practice.

Lippincott Manual of Nursing Practice eighth

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edition, states on page 18, box 2-3 "Common Legal Claims for Departure from Standards of Care" as "failure to implement a physician order properly or in a timely fashion".

"Fundamentals of Nursing, by Lippincott", stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients."

Guidance is given from Lippincott Solutions, "Safe Medication Administration Practices, General" 10/02/2015. "Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions."

The Administrator and Director of Nursing were informed on 11/8/19 during a end of day meeting held in the Administrator's office with Surveyor C of the facility staff's failure to following nursing standards of practice.

No further information was provided.

3. For Resident #2, the facility staff failed to administer cardiac medication (Diltiazem) as scheduled.

Resident #2, a 93 year old female, was admitted

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to the facility on 3/24/2018. Her diagnoses included but are not limited to heart rhythm abnormality, congestive heart failure, high blood pressure, stroke, dementia, and inability to speak.

Resident #2's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/2019 was coded as a quarterly review. Resident #2 was coded with severely impaired cognition.

On 11/7/19 at approximately 3:15 PM, a family interview was conducted with Resident #2's son who was also her Responsible Party. He expressed concern that Resident #2's medications were occasionally given later than scheduled on the night shift.

On 11/7/19, clinical record review was conducted for Resident #2. The physician orders dated 1/28/2019 read, "Diltiazem HCl tablet 30mg, give 30 mg via G-Tube every 6 hours for high blood pressure/chest pain". Her dose was scheduled to be given at 6:00 AM, 12:00 PM, 6:00 PM, and 00:00 AM every day.

A Medication Administration Audit Report for the month of November 2019 was requested and provided by facility staff. Resident #2 received Diltiazem HCl as follows:

11/01/19, time scheduled 00:00 AM, time administered 05:14 AM
11/01/19, time scheduled 6:00 AM, time administered 05:15 AM

11/04/19, time scheduled 00:00 AM, time administered 02:23 AM
11/04/19, time scheduled 6:00 AM, time

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F 658	Continued From page 41 administered 05:39 AM On 11/16/19 at approximately 9:45 AM, the Director of Nursing (DON, Employee B) was interviewed and stated, "my expectations for med pass include [medication to be given] one hour before and one hour after [the] scheduled time". When asked about the possible outcomes if Diltiazem HCl is not given as ordered at the scheduled time intervals for Resident #2, she stated, "if the resident does not receive the Diltiazem as scheduled at the correct times, it could cause problems with her blood pressure. If it is administered too close together, it could cause her blood pressure to drop too much, that would not be good" and "I expect the medication nurses to document the actual time that medication is administered". Review of the facility's policy entitled, "Medication Administration" (revision date 12/14/17), under subheading "Procedure", item ff, "Medications will be administered within the time frame of one hour before up to one hour after time ordered".	F 658		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		12/10/19

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F 686	Continued From page 42 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, facility documentation and clinical record review the facility staff failed to provide care to promote healing prevent infection and prevent new pressure ulcers from forming for 2 Resident (#161 and #79) in a survey sample of 43 Residents. The findings included: 1. For Resident #161 the facility staff failed to identify a pressure ulcer to the coccyx before it was found at an advanced stage with necrotic tissue. In addition, the resident went the hospital and the coccyx wound was diagnosed with an infection. Resident #161, a 67 year old woman admitted to the facility on 4/3/14 with diagnoses of but not limited to Multiple Sclerosis, arthritis, cellulitis, reflux and muscle weakness. Resident #161's most recent MDS (minimum data set) coded the Resident as having a (Brief Interview of Mental Status) BIMS score of 15 indicating no cognitive impairment. Resident #161 was also coded as needing extensive assistance of 2 person physical assistance for bed mobility, toilet use, dressing and personal hygiene. She was coded as total dependence with 2 person physical assistance for transfer, and extensive assistance with 1 person physical assistance for mobility on and off unit via wheel chair.	F 686	Resident #79 receives treatment to pressure ulcer sites as ordered and weekly visits by wound team which includes facility RN and Wound Pyhisician. Prostat and ensure supplements ordered and provided. Dietitan consulted for evaluation. Arterial Doppler study performed. Other interventions intitated include: float heels, pressure relieving mattress, and pressure reducing cushion when out of bed. Resident #161 discharged. Residents with a braden score at 12 or below have the potential to be affected by the alleged deficient practice. RNs and LPNs to receive education on pressure ulcer/skin condition escalation and reporting/notification procedure, pressure ulcer staging principles, identifying and securing appropriate adaptive equipment/interventions and accommodation for residents deemed high risk for skin breakdown or with active skin conditions. Certified nursing assistance to be educated on completion of skin documentation, reporting procedures, and incontinence protocol. Unit Managers or designee to oversee the performance of skin sweeps weekly x 4 weeks, then monthly x 3. Skin sweep audit weekly x 4, then monthly x 3. Care	

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F 686	Continued From page 43 On 11/7/19 during clinical record review it was discovered Resident #161 developed pressure ulcers. The progress notes read: "10/24/18 - New skin issue" and "10/24/18 6:51 AM - Redness and open areas noted on bilateral buttocks and left inner thigh area" However, the progress notes also show the discovery of another wound. The note reads; "11/1/18 3:05 AM new skin issue Resident has open area on the coccyx area approximately 4 cm [centimeters] circular area with necrotic tissue present 2.5 cm depth and has foul odor present with moderate amount of dark foul smelling drainage. Area cleaned with wound cleansed and covered with dry dressing. Resident is followed by wound team." "Resident has dressing intact to the bilateral buttocks open areas no drainage noted to these areas." This note shows that the coccyx area was a new area not previously known and it shows that the area was found with necrotic tissue. The wound care physician notes read: "11/7/18- At the request of the referring provider [MD name redacted} a thorough wound care assessment and evaluation was performed today. She has a stage 4 pressure wound to coccyx of at least 1 day duration. There is moderate serous exudate." "Stage 4 Pressure Wound Coccyx" "Etiology - Pressure" "MDS 3.0 Stage - 4" "Wound Size - 4 x 2 x 3.5 cm" "Thick adherent devitalized necrotic tissue - 20%" "Granulation Tissue - 80%"	F 686	plan audit weekly x 4 weeks, then monthly x 3. Shower sheets audit weekly x 4, then monthly x 3.	

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"Surgical Excisional Debridement Procedure"
"The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade was used to surgically excise 1.6 cm of devitalized tissue and necrotic muscle and surrounding facial fibers were removed. "

In addition, Resident #161 went to the local hospital on 11/12/18 and was discharged on 11/21/18 excerpts from the hospital record are as follows.
" Discharge Diagnosis:"
"Principal Diagnosis : Sepsis due to Methicillin resistant Staphylococcus Aureus.(MRSA)"
"Sacral Ulcer"

"Hospital Course:"
"67 year old female with history of multiple sclerosis, chronic lower extremity ulcers / wounds who was brought in from nursing facility with altered mental status and new sacral ulcers. The change in mental status was due to metabolic Encephalopathy in the setting of infected sacral ulcer. Patient underwent debridement and irrigation with sacral wound VAC placement on 11/15/19. Wound culture positive for MRSA, E-Coli and Proteus. Patient seen by ID [Infectious Disease]. Discharge recommendation is Vancomycin, Rocephin and Flagyl for 4 weeks followed by Bactrim for 4 weeks. She will continue to have wound VAC changed 3 times per week."

On 11/8/19 an interview was held with the DON who stated that ideally wounds should be found before a stage IV. She stated that wounds are usually found during bathing by the CNA or on skin assessment by the nurse.

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On 11/8/19 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

2. For Resident #79, the facility staff failed to prevent the development of a pressure wound on the left ankle, and identify the wound prior to it becoming unstageable. In addition, the facility failed to prevent and identify a pressure ulcer on his left Lateral Tibia prior to it becoming Stage 3.

Resident #79 was a 76 year old who was admitted to the facility on 4/10/19. Resident #79's diagnoses included Cerebral Infarction, Generalized Muscle Weakness, Dementia, Major Depressive Disorder Hypertension, and Congestive Heart Failure.

The Minimum Data Set, which was a Significant Change Assessment with an Assessment Reference Date of 10/11/19 was reviewed. Resident #79 had a Brief Interview of Mental Status Score of 12, indicating mildly impaired cognition. He was coded as requiring the extensive physical assistance of at least two people for bed mobility, and transfers. Resident #79's range of motion was impaired in both of his upper and lower extremities. He was coded as having unstageable pressure ulcers.

His previous MDS, which was a Quarterly Assessment, with an Assessment Reference Date of 8/26/19 was reviewed. He was not coded for any pressure ulcers.

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On 11/5/19 a review was conducted of Resident #79's clinical record.

According to a nursing progress note dated 9/5/19, a weekly skin assessment was completed. No findings were documented in the note, or on a skin assessment form.

According to a wound care note, on 9/11/19, an unstageable pressure ulcer was initially identified by a wound care physician. An excerpt from the note read, "Location: Left Lateral Malleolus. Etiology: Pressure injury/ulcer - Unstageable Pressure Injury. Dressing used: Santyl. Wound Description: Odor-None, Exudate - Scant Serous, Periwound - Stable, Wound Edge - Normal, Pain-0/10. Tissue: 50% Granulation, 50% Necrotic. Length 0.5 x Width 1.0, Depth 0.1. Wound Progress - First Visit.

For the week prior to 10/2/19, there was no documentation of a skin assessment, including the nursing progress notes.

An excerpt from another wound care note read, "10/2/19. "Location: Left Lateral Heel. Etiology: Pressure injury/ulcer - Unstageable Pressure Injury. Dressing used: Betadine and Paint with Betadine daily and float heels. Wound Description: Odor-None, Exudate - None, Wound Edge - Eschar, Tissue- 100% Eschar - Length 0.5 x Width 1.7, Depth Undetermined. Wound progress - Undetermined: First Visit."

In addition, Resident #79's care plan was reviewed. It did not document anything regarding his pressure ulcers, including their existence or treatment.

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On 11/6/19 at 11:20 A.M., an observation was conducted of Resident #79's pressure ulcers by Surveyor D (Registered Nurse). "The pressure ulcer on his left outer ankle measured 2 cm x 2 cm x .1 cm. It was unstageable, with a black center, and contained slough. It had rolled edges, and moderate drainage. In addition, Resident's left outer leg pressure ulcer had a reddened area, necrotic center with slough. It was unstageable. It measured 3 cm x 2.8. cm no depth, moderate serous, sanguineous (bloody) drainage."

On 11/06/19 at 2:09 P.M., an Interview was conducted with the Director of Nursing (DON Employee B). She was asked about her expectation of when pressure ulcers are identified. She stated that they do weekly skin assessments. They have different disease processes. It may be found at unstageable. She stated, "our job was to prevent any pressure wounds, to find them at stage 1, and resolve them quickly. The DON further stated that sometimes they floated the residents' heels.

Resident #79's diet orders were reviewed. Since 4/18/19, his order was as follows: "Regular Diet, Regular Texture, Thin consistency, No pork, Prefers fish. The dietary orders related to wound healing were initiated on 7/9/19. "Prostat 30 ml 2 x daily for wound healing." (Resident #79 was admitted with a sacral wound that healed and reopened)

On 11/6/19 a review of facility documentation was conducted, revealing a Skin Care & Wound Management Policy dated 5/30/19. An excerpt read, "The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds... Each resident is

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F 686	Continued From page 48 evaluated upon admission and weekly thereafter for changes in clinical condition, prior to transfer to the hospital and upon return from the hospital." On 11/6/19 an interview was conducted with the facility Administrator (Employee A) in the conference room. He stated that on October 1, 2019 the facility changed wound care providers. He further stated that the facility had a wound care nurse until mid-October.	F 686		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on facility documentation review and clinical record review the facility staff failed to ensure residents are free of significant medication errors for one Resident (Resident #107) in a survey sample of 43 Residents. The findings include: 1a. For Resident #107 the facility staff failed to administer insulin as ordered by the physician on 6 of 16 scheduled doses. Resident #107, was admitted to the facility on 10/21/19. Resident #107's diagnoses included but were not limited to: sepsis, osteomyelitis of vertebra sacral and sacrococcygeal region, pressure ulcer sacral region stage 4, pressure ulcer of right upper back stage 4, unspecified dementia without behavioral disturbance, type 2 diabetes mellitus without complications, and	F 760	For resident #107, the medication error report was completed and attending physician practice notified of missed insulin. All residents have the potential to be affected by this alleged deficient practice. RNs and LPNs were educated on the 7 rights of medication adminstration and the procedures for documenting and reporting medication errors. Medication error rates will be monitored by the QAPI committee for benchmarking and process improvement. Staff Development/ Quality Nurse will audit medication administration 3 times weekly x 4 weeks, then monthly x 3 with all findings reported to the QAPI committee	12/10/19

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hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side.

Resident #107's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 10/26/19 was coded as an admission assessment. Resident #107 was coded as having not been interviewable for a BIMS (brief interview for mental status) score. The staff assessment indicated the Resident is severely cognitively impaired. Resident #107 was coded as required total assistance of staff for transfers, bed mobility, dressing, personal hygiene, toileting, and bathing. Resident #107 was coded as having been always incontinent of bowel.

On the afternoon of 11/7/19 a review of Resident #107's clinical record revealed a physician order dated 10/21/19 that read, "Toujeo Solostar Solution Pen-Injector 300 unit/ML (insulin Glargine) Inject 14 unit subcutaneously at bedtime for DM [diabetes mellitus]". Review of the Medication Administration Record (MAR) for October and November 2019 revealed that Resident #107 was not administered 6 of the scheduled 16 doses, (10/21/19, 10/24/19, 10/28/19, 10/31/19, 11/2/19, and 11/3/19) which were due from admission on 10/21/19 through 11/5/19.

Review of Resident #107's careplan revealed a focus initiated on 10/30/19 that read "[Resident name redacted] has diabetes mellitus", the interventions stated "diabetes medication as ordered by doctor".

On 11/8/19 at approximately 9:10 AM, RN B, the

for process improvement.

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unit manager was asked what "NC" on the MAR for Toujeo indicated. RN B looked at the legend attached to the MAR and indicated it meant "no insulin coverage required". RN B added, "if the blood sugar falls below certain range they don't give". Surveyor C asked what that range was, RN B stated, "I will have to look". RN B went on to state, "the nurse does the accu check and long acting insulin doesn't have a range so they use their judgement, if they hold it they call the doctor". RN B was asked if it would be expected that a nursing note entry would be entered into the clinical record regarding this and RN B stated, "I believe so, ,yes".

A review of the nursing notes for Resident #107 revealed no notes on the dates of 10/21/19, 10/24/19, 10/28/19, 10/31/19, 11/2/19, and 11/3/19 to indicate why the Toujeo was not administered as per the physician order.

On 11/8/19 at 10:58 AM, RN B returned to Surveyor C after reviewing the clinical record for Resident #107. RN B stated, "those days are the same nurse [referencing the dates of the missed medication], the sliding scale insulin has parameters but the long acting does not. That nurse is a new nurse and just finished orientation, he is the only nurse recording NC and I didn't see any communication with the doctor". RN B was asked if she would have administered the Toujeo on the days in question, RN B stated, "yes I would have given, I wouldn't have just held without communicating with the doctor". RN B was asked why it is important to give insulin as ordered, RN B stated, "this is important for them to see if they need to make adjustments to insulin doses. Before we hold a medication we need to consult the doctor". RN B also stated that she

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had attempted to reach the nurse that had failed to administer the insulin but didn't reach them via telephone but would be doing some education upon their return to work for their next shift.

1b. For Resident #107 the facility staff failed to administer IV antibiotics for sepsis, osteomyelitis and wound infection, for 28 doses (four times daily/every 6 hours on 10/24/19-10/30/19), as ordered by the physician.

On the afternoon of 11/7/19 a review of Resident #107's clinical record revealed the following physician orders:

*On 10/22/19 an order read, "Unasyn Solution Reconstituted 3 (2-1) GM (Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 5 hours for sepsis, osteomyelitis". This order was discontinued on 10/22/19. The MAR for October revealed that this order was administered to Resident #107.

* On 10/22/19 another order read, "Unasyn Solution Reconstituted 3 (2-1) GM (Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 5 hours for sepsis, osteomyelitis until 10/31/19". This order was carried out and administered on 10/23/19 at 12:48 AM, 5:02 AM, 1:28 PM. The order was then discontinued on 10/23/19 at 12:22 PM.

* On 10/23/19 an order read, "Unasyn Solution Reconstituted 3 (2-1) GM (Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 6 hours for sepsis, osteomyelitis until 10/23/19", which was in error. This order was carried out and administered on 10/23/19 at 6:00 PM.

* On 10/30/19 an order read, "Unasyn Solution Reconstituted 3 (2-1) GM

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(Ampicillin-Sulbactam Sodium) Use 3 gram intravenously every 6 hours for wound infection for 6 weeks". This order was then carried out and administered as ordered for the duration of the month of Oct. and through the time of this review.

A nursing note entry dated 10/22/19 at 18:53 read, "unasyn Solution Reconstituted 3 (2-1) GM use 3 gram intravenously every 5 hours for sepsis, osteomyelitis until 10/31/19", confirming the order was to continue this medication. It further stated that the facility was "awaiting pharmacy to deliver".

On 11/8/19 at approximately 9:10 AM, RN B, the unit manager was asked about Resident #107's multiple IV antibiotic orders. RN B stated, "someone entered it wrong, so as an interdisciplinary team we go back and change it". RN B was asked to clarify what she meant that it was entered wrong, RN B stated, "it didn't have a stop date, we like all of our antibiotics to have an end date". RN B was then questioned about the multiple days that Resident #107 didn't receive the IV antibiotics, RN B stated, "I don't know unless there was a delay from the pharmacy" and agreed to look into this further.

On 11/8/19 at 10:58 AM, RN B returned to Surveyor C after reviewing the clinical record for Resident #107. RN B stated, "when this medication was first ordered it said every 5 hours, that was communicated with the doctor and it had not stop date. The doctor was called and an order was given to change to every 6 hours until 10/29/19 and then consult infectious disease. The nurse that entered the order had a start date of 10/23/19 and had a stop date of 10/23/19, so it didn't populate to the MAR and it was caught on

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F 760	Continued From page 53 review on 10/30/19 and infectious disease gave the order to continue it for 6 weeks". Review of the facility policy titled "Physician Orders" with a review date of 5/30/19 read on page 2, "taking the order: a. do not try to memorize the order b. write down the order as stated, c. provide a read-back to validate, d. spell out/clarify sound alike drugs, e. discontinue any previous contradicting order, f. place orders in the electronic medical record, g. print copy for physician to sign and place in paper chart, h. contact pharmacy for changes". The Administrator and Director of Nursing were informed on 11/8/19 during a end of day meeting held in the Administrator's office with Surveyor C of the facility staff's failure to provide essential medications to Resident #107 as ordered by the physician. No further information was provided.	F 760		
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	F 842		12/9/19

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must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(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.

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F 842	Continued From page 55 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to maintain an accurate clinical record for one Resident (Resident #86) in a survey sample of 43 Residents. The findings included: For Resident #86 the facility staff documented administration of medication which had been left at the bedside and was not taken. Resident #86 was admitted to the facility on 10/10/19. Resident #86's diagnoses included but were not limited to: Spinal Stenosis, Urinary tract infection, obstructive and reflux uropathy, degenerative disease of the nervous system, cirrhosis of liver, acute kidney failure, hemochromatosis, hydronephrosis, and muscle weakness. Resident #86's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 10/15/19 was coded as an admission assessment. Resident	F 842	For resident #86, the RN removed the medication from the patient room, notified the attending physician and received an order to administer the medication. The RN administered the medicaition and witnessed its ingestion. The patient suffered no adverse affect. All residents have the potential to be affected by the alleged deficient practice. The responsible nurse was educated by the DON on medication administration and documentation standards. Additionally, licensed nurses were educated on the 7 rights of medication administration. Medication error rates will be monitored by the QAPI committee for benchmarking and process improvement. Staff Development/ Quality Nurse will audit medication administration three times weekly x 4 weeks, then monthly x 3 with all findings reported to the QAPI committee for process improvement.	

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#86 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated intact cognitive skills. Resident #86 was coded as required extensive assistance in transfers, bed mobility, dressing, personal hygiene, and toileting. Resident #86 was coded as having been frequently incontinent of bowel and occasionally incontinent of bladder.

On 11/6/19 at 9:19 AM during facility rounds, Resident #86 was observed to not be in his room. Observation of the room revealed on the over-bed table at the bedside, was a medicine cup with a small, 1/2 of a white, round pill and a cup of water beside it. No staff were present.

On 11/6/19 at approximately 9:40 AM, RN D was asked to accompany Surveyor C to Resident #86's room. When RN D was asked what the cup was, RN D stated "I didn't give him his meds [medications] but I think it is Metoprolol". When Surveyor C asked RN D if it is routine to leave medications at the bedside, RN D stated, "usually we stand there to make sure they taken them". RN D was asked if Resident #86 self-administers medications, RN D stated "No".

On 11/6/19 at approximately 9:50 AM, RN D and Surveyor C returned to the nursing station. RN D approached LPN D and told LPN D, "he left this at his bedside, we have to call the doctor and let him know". LPN D confirmed the 1/2 of a pill was metoprolol.

On 11/6/19 a review of Resident #86's current physician orders revealed an order "Metoprolol Tartrate Tablet, give 12.5 mg by mouth two times a day for HTN [hypertension]". The order date was 10/10/19 and continued as an active order

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F 842	Continued From page 57 for Resident #86. On 11/6/19 a complete review of Resident #86's entire clinical record was conducted, to include the medication administration record (MAR). The MAR had been recorded as Resident #86 being administered his Metoprolol on 11/6/19 at the 9 AM dose. Review of the facility policy titled "Medication Administration" with a review date of 5/29/19 read on page 4, "remain with resident until the medication is swallowed, do not leave medication at bedside, medications will be charted when given, medications that are refused or withheld or not given will be documented". The facility administrator and Director of Nursing (DON) were advised during an end of day meeting on 11/7/19 and again at end of day meeting on 11/8/19 of medications being left at the bedside of Resident #86 and documented as being administered by nursing staff. No further information was provided.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		12/10/19

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The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

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F 880	Continued From page 59 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility staff failed to maintain shower equipment and the shower room in a sanitary manner to prevent the spread of infection in 1 of 4 shower rooms. The findings included: On 11/6/19 at approximately 2:18 PM during the group Resident Council meeting, it was shared that the shower room on the 2nd floor was dirty. The Resident council reported specifically that the floor drain was clogged and the shower bench was dirty and discolored. On 11/6/19 at 2:47 PM the bathing suite on the 2nd floor was observed and the following was noted: * the shower drain was obstructed with a gray matter covering 1/2 of the drain holes in the floor drain of the shower stall. * the shower bench back was observed and	F 880	The shower bench was removed and replaced once the Administrator and DON were made aware of its condition. Housekeeping cleaned the shower drain and removed all hardened scale and soap scum from the exterior surface. All residents have the potential to be affected by the alleged deficient practice. RNs, LPNs, and CNAs were educated on infection control principles and practices with a focus on cleaning shared equipment after each use. Environmental service director will inspect all shower rooms and bathing equipment regularly. Environmental service director will inspect all shower rooms and bathing equipment three times weekly x4, then three times monthly x 3. Any observed environmental deficits will be corrected and reported to	

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F 880	Continued From page 60 revealed heavy discoloration of pink and black substances throughout the entire back. On 11/6/19 at approximately 3:15 PM, Employee N, the housekeeping supervisor accompanied the surveyor to the 2nd floor bathing suite. When asked about the process for cleaning, the housekeeping supervisor stated, "we do the toilet and floors, the nurses are supposed to wipe down the shower chairs when they are done. I just took that project on, on Monday [referencing shower equipment, such as shower chairs/bench]". When asked about the shower drain, Employee N stated, "I will get them right on that". When asked about the shower bench and Employee N was asked to observe the back of the shower bench, the housekeeping supervisor stated, "my housekeeper brought that to my attention yesterday and we have ordered a new one". On 11/6/19 during the end of day meeting the facility Administrator was made aware of the shower room's lack of sanitary conditions as expressed by Resident Council. The Centers for Disease Control and Prevention (CDC) recognizes in their Emerging Infectious Disease article Volume 25, Number 11-November 2019 "Serratia marcescens, which can cause nosocomial outbreaks,and urinary tract and wound infections, is abundant in damp environments. It can be easily found in bathrooms, including shower corners and basins, where it appears as a pink-orange-red discoloration, due to the pigment known as prodigiosin." article accessed online at : https://wwwnc.cdc.gov/eid/article/25/11/et-2511_article	F 880	the Administrator. Environmental service director will maintain a record of all inspections and present findings to the QAPI committee monthly x 3.	

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F 880	Continued From page 61 No further information was provided.	F 880		