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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/10/20 through 3/13/20. 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 3/10/2020 through 3/13/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 90 certified bed facility was 83 at the time of the survey. The survey sample consisted of 41 current Resident reviews and 3 closed record reviews.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		4/27/20

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

Electronically Signed | 03/26/2020

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F 578	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide evidence that 4 of 44 residents in the survey sample, were given the opportunity to formulate an advance directive; Residents #24, #81, #73, and #37. The findings included: 1. Resident #24 was admitted to the facility on 10/06/15 and readmitted on 9/19/19 with	F 578	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged	

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F 578	Continued From page 2 diagnoses that included but were not limited to muscle weakness, difficulty walking, high blood pressure and type two diabetes mellitus. Resident #24's most recent MDS (Minimum Data Set) assessment was a quarterly MDS with an ARD (assessment reference date) of 12/27/19. Resident #24 was coded as being moderately impaired in cognitive function scoring 09 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #24's March 2020 POS (physician order summary) revealed that she had an order to be a DNR (Do Not Resuscitate). This order was initiated on 9/19/19. Review of Resident #24's clinical record revealed a DDNR (Durable Do Not Resuscitate Order) signed and dated by the resident and physician on 9/11/19. Review of Resident #24's "Advanced Directive Acknowledgement Form" revealed that the from was blank. This form however was signed by Resident #24's RP (Responsible Party) on 9/19/19. There was no evidence that Resident #24 was given the opportunity to formulate an Advanced Directive. On 3/12/20 at 11:27 a.m., an interview was conducted with ASM (administrative staff member) #1, the facility Administrator. When asked the process for obtaining advanced directives, ASM #1 stated that upon admission, the admissions department would go through the admission contract and if the resident has an advanced directive, the staff would request that the family bring a copy for the facility. ASM #1 stated that if the resident did not have an	F 578	deficiencies cited have been or will be completed by the dates indicated. F578 1-Residents # 24, 81, 73 and 37 were reviewed and given the opportunity to formulate an advance directive. 2-Current residents were reviewed to ensure that an opportunity to formulate an advance directive was given. 3-The Administrator will educate Administrative staff on ensuring that an opportunity to formulate an advance directive is given at time of admission. 4-The Administrator or designee will complete a random weekly review of documentation that an opportunity to formulate an advance directive was given at time of admission. Results of the monitoring will be presented to the Quality Assurance Committee for review and recommendation. 5-Completion date 4/27/20	

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advanced directive and wanted to formulate one, then the staff would assist with formulating one. ASM #1 stated that if the resident requested to have an advanced directive, it should be scanned into the electronic record under the miscellaneous tab. When asked why Resident #24's advanced directive was signed but blank, ASM #1 stated that there was a glitch in their computer system and that they go over the questions with the resident, but that the answers were not saving and showing up when printed. ASM #1 stated that she was working on resolving that problem. ASM #1 stated that if there was not an advanced directive under the miscellaneous tab, then the resident probably did not want to formulate one. When asked how this writer would know that the resident was offered to formulate an advanced directive, ASM #1 stated that there was no way she could provide evidence that Resident #24 was offered to formulate an advanced directive; or if the resident refused to formulate an advanced directive. When asked during an acute transfer to the hospital, how nursing staff would access advanced directives if the responses to were not saving onto the computer system, ASM #1 stated that nursing staff would just send what they could such as code status order. ASM #1 stated that if the resident had a living will, nursing staff would print that off and send with the resident also.

On 3/12/20 at 5:11 p.m., ASM #1, the Administrator, ASM #3, the Corporate Nurse Consultant was made aware of the above concerns. No further information was presented prior to exit.

2. Resident #81 was admitted to the facility on 11/21/19 with diagnoses that included but were

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not limited to metabolic encephalopathy, chronic kidney disease, adult failure to thrive. Resident #81's most recent MDS (minimum data set) assessment was a quarterly MDS with an ARD (assessment reference date) of 2/27/20. Resident #81 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #81's March 2020 POS (physician order summary) revealed that she had an order to be a DNR (Do Not Resuscitate). This order was initiated on 11/21/19.

Review of Resident #81's clinical record revealed a DDNR (Durable Do Not Resuscitate Order) signed and dated by the resident and physician on 10/28/19.

Review of Resident #81's "Advanced Directive Acknowledgement Form" revealed that the from was blank. This form however was signed by Resident #81's RP (Responsible Party) on 11/21/19. There was no evidence that Resident #81 was given the opportunity to formulate an Advance Directive.

On 3/12/20 at 11:27 a.m., an interview was conducted with ASM (administrative staff member) #1, the facility Administrator. When asked the process for obtaining advanced directives, ASM #1 stated that upon admission, the admissions department would go through the admission contract and if the resident has an advanced directive, the staff would request that the family bring a copy for the facility. ASM #1 stated that if the resident did not have an advanced directive and wanted to formulate one, then the staff would assist with formulating one.

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ASM #1 stated that if the resident requested to have an advanced directive, it should be scanned into the electronic record under the miscellaneous tab. When asked why Resident #81's advanced directive was signed but blank, ASM #1 stated that there was a glitch in their computer system and that they go over the questions with the resident, but that the answers were not saving and showing up when printed. ASM #1 stated that she was working on resolving that problem. ASM #1 stated that if their was not an advanced directive under the miscellaneous tab, then the resident probably did not want to formulate one. When asked how this writer would know that the resident was offered to formulate an advanced directive, ASM #1 stated that there was no way she could provide evidence that Resident #81 was offered to formulate an advanced directive; or if the resident refused to formulate an advanced directive. When asked during an acute transfer to the hospital, how nursing staff would access advanced directives if the responses to were not saving onto the computer system, ASM #1 stated that nursing staff would just send what they could such as code status order. ASM #1 stated that if the resident had a living will, nursing staff would print that off and send with the resident also.

On 3/12/20 at 5:11 p.m., ASM #1, the Administrator, ASM #3, the Corporate Nurse Consultant was made aware of the above concerns. No further information was presented prior to exit.

3. Resident #73 was initially admitted to the facility on 11/29/2019 with diagnoses including but not limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus, morbid obesity, heart failure.

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Resident #73's most recent MDS (Minimum Data Set) assessment was an Admissions Assessment with an ARD (Assessment Review Date) of 12/06/2019. Resident #73 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (brief interview for mental status) exam.

A review of Resident #73's facility business contract revealed, with the exception of a signature, the advance directive section was blank.

An interview was conducted with the facility Administrator on 3/11/2020 at approximately 11:20 a.m. regarding the advance directive and was asked, where, within the medical record, is it documented that this resident was offered an opportunity to formulate an advanced directive? The Administrator responded, "There are problems with the system. Normally it would be captured on the business contract but we are having some problems with the system and the only thing that is captured is the signature."

These findings were reviewed with the facility Administrator, Director of Nursing and Corporate Staff during a briefing held on 3/12/2020 at approximately 5:00 p.m. There was no additional information provided.

4. For Resident #37, the facility staff failed to ensure that a copy of the residents advance directive was in the clinical record. Resident #37 was originally admitted to the facility on 08/27/2013. Diagnoses included but were not limited to, Dementia and Anxiety Disorder. Resident #37's Minimum Data Set (MDS-an assessment protocol) with an Assessment

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Reference Date of 01/18/2020 was coded with short-term memory problems and long-term memory problems and severely impaired cognitive skills for daily decision making.

On 03/12/2020 at approximately 3:00 p.m., review of Resident #37's clinical record revealed that the resident's Responsible Party signed the "Advance Directives Acknowledgement" form on 09/25/2009. Review of the form revealed that the following was elected on the form by the Responsible Party: "I have executed Advance Medical Directive: "Living Will"." Review of the form also revealed that the Responsible Party indicated that they had not provided the Healthcare Center with the original directive and had not provided the Healthcare Center with a copy verified by the Healthcare Center.

On 03/12/2020 at approximately 3:50 p.m., an interview was conducted with the Administrator. When asked if the facility had a copy of Resident #37's "Living Will", the Administrator stated, "No." When asked what process does the facility have in place to follow up with residents and responsible parties when they state that they have an advance directive but have not brought it in, Administrator stated, "We give them the option to bring it in or not. We have no follow up, they are choosing to bring it in or not."

The facility policy titled Patient Self Determination Act (PSDA) dated 02/05/15 was reviewed and included: "4. If the patient indicates that he/she has an Advanced Directive, but does not have it present, the patient must be informed of the urgency to deliver the Advance Directive to the Admissions Director so that a verified copy can be placed in the patient's chart. In the interim

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F 578	Continued From page 8 notify the Director of Nursing that an Advance Directive according to the patient's description (Living Will, Medical Power of Attorney and/or Appointment of Anatomical gift) exists and the location of the original document according to the patient and the contents therein as described by the patient, so that a notation can be made in the patient record." The Administrator and Corporate staff were informed of the finding on 03/12/2020 at approximately 5:20 p.m. The facility did not present any further information about the finding.	F 578		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to implement abuse policies and thoroughly investigate a skin injury of unknown source on two occasions for one of 44 residents in the survey sample, Resident #44.	F 607	F607 1-Resident #44 is free of skin impairments. 2-Current residents were reviewed to ensure that any skin injuries of unknown source are investigated to determine to source of injury and the abuse policy is followed appropriately.	4/27/20

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F 607	Continued From page 9 The findings include: 1. Resident #44 was admitted to the facility on 11/7/2012 and readmitted on 5/30/14 with diagnoses that included but were not limited to unspecified dementia without behavioral disturbance and chronic obstructive pulmonary disease. Resident #44's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 1/23/20. Resident #44 was coded as being severely impaired in cognitive function scoring 04 out of possible 15 on the BIMS (Brief Interview for Mental Status Exam). Resident #44 was coded as being totally dependent on two plus persons with bed mobility and transfers; and totally dependent on one person with dressing, toileting, personal hygiene, and bathing. Review of Resident #44's clinical record revealed that she obtained a skin tear to her right outer thigh on 11/17/19. The following nursing note was documented: "Resident noted to have skin tear on right thigh...Quarter size skin tear...Cleansed skin tear, applied dressing." The following was documented on an incident report: "Nursing Description: resident has a skin tear to right thigh. Patient Description: Patient unable to give Description. Immediate Action Taken: treatment order in place. clean (sic) with NS (normal saline), pat dry, apply foam dressing...Injury Type: Skin Tear...Injury Location: Right thigh (rear)... Mobility: Bedridden...Mental Status: Oriented to Person; Oriented to Place...Predisposing Environmental Factors: None...Predisposing Physiological Factors: None...Witnesses: No Witnesses found."	F 607	3-The DON or designee will educate Nurses on Investigation of skin injuries of unknown source and the timely notification of injuries of unknown source to Administrative staff. 4-The DON will review residents with skin injuries of unknown source on a weekly basis to ensure that the injuries are investigated to determine to the source of injury and that the abuse policy is followed appropriately. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation. 5-Completion date 4/27/20.	

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Further review of the incident report revealed that under category "Predisposing Situation Factors," nothing was documented.

There was no evidence that an investigation was conducted determining the cause of her skin tear on 11/17/19.

Review of Resident #44's November 2019 MAR (Medication Administration Record) revealed that a treatment was put into place for the skin tear on 11/18/19 until the area was resolved on 12/14/19.

Further review of Resident #44's clinical record revealed that she obtained an abrasion to the same area (right outer thigh) on 1/29/20. The following was documented on the "Skin and Wound Evaluation" form: "Describe: Abrasion Location: Right thigh (rear) Acquired: In -House Acquired. How long has the Wound been present? New Exact Date: 1/29/20. Wound Measurements: 1. Area 1.4 cm 2 (centimeters squared) 2. Length: 1.5 cm 3. Width: 1.4 cm...Wound Bed: Epithelial...Exudate: None...Primary Dressing: Foam."

There was no evidence that an investigation was conducted determining the cause of her skin abrasion on 1/29/20.

Review of Resident #44's March 2020 POS (physician order summary) revealed the following active order: "Clean abrasion to right thigh with DWC, pat dry, apply border dressing until healed. every (sic) morning shift every 2 day (s) for abrasion."

Review of Resident #44's ADL (Activities of Daily Living) care plan dated 9/28/14 and revised on

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3/8/19 documented the following: "Bed mobility: The resident uses assist bars to maximize independence with turning and repositioning...Transfer: The resident is able to transfer stand up lift and 2 people."

On 3/12/20 an observation was made of Resident #44's skin alteration with LPN (Licensed Practical Nurse) #3 and LPN #2, the unit supervisor. A healing abrasion was observed to Resident #44's outer right thigh. The area had light pink tissue. The area did not appear to be pressure related. When asked when the abrasion had originally started, LPN #3 stated that it was back in November of 2019 and that she was not sure how it happened. LPN #2 stated that the DON (Director of Nursing) had found that the abrasion the second time about one month ago. LPN #2 stated that the DON had found the abrasion during skin sweeps on 3-11 shift. LPN #2 stated that they were putting a protective bandage in place at this point. Both nurses could not recall an investigation being initiated to determine the cause of her skin alterations on both occasions (11/1/19 and 1/29/20). When asked how Resident #44 transferred in and out of bed; LPN #2 stated that Resident #44 used the sit to stand lift with two staff members. LPN #2 stated that Resident #44 could not get herself in and out of bed or turn in bed by herself.

On 3/12/20 at 1:50 p.m., an interview was conducted with ASM (Administrative Staff Member) #2, the DON (Director of Nursing). When asked when she first found Resident #44's skin tear or abrasion, ASM #2 stated that she was not sure, that she would have to look back at the resident's notes. ASM #2 stated that she found the area during a skin sweep (the second time

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around) but could not recall the date. ASM #2 stated that when she asked the nurse manager (LPN #1) about the skin area, LPN #1 had told her that Resident #44 always had that area. ASM #2 stated that she only recalled notifying the medical doctor and obtaining a physician's order. When asked the description of the skin area when found, ASM #2 stated that it looked like a place of shearing, not really a skin tear. When asked the process to determine the cause of a new skin alteration, ASM #2 stated that she would investigate the cause of any new skin areas by interviewing staff who had last worked with the resident and interview the resident to determine how it occurred. When asked if she conducted an investigation to determine the cause of the skin abrasion to Resident #44, ASM #2 stated that she didn't remember. ASM #2 stated that she was not sure how it occurred. When asked if the location (right outer thigh) was an unusual location for an abrasion or skin tear, ASM #2 stated that in her opinion it was not. ASM #2 stated that Resident #44 was totally dependent on staff for all transfers, bed mobility etc.

On 3/12/20 at 2:27 p.m., further interview was conducted with LPN (Licensed Practical Nurse) #2, the unit supervisor. When asked the process when a new skin alteration is found on a resident, LPN #2 stated that an assessment would be completed, the medical doctor and family would be notified and then the skin area would be rounded on weekly. LPN #2 stated that the same process would be followed if a previous skin area was re-opened. LPN #2 stated that an investigation would also be conducted to determine the cause of the skin alteration. LPN #2 stated that the investigation was usually initiated by the DON (Director of Nursing). LPN

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#2 stated that it was important to determine the cause of a skin alteration so that the same skin area did not keep opening up or reoccurring. LPN #2 stated, "We don't want the same thing happening again and again." LPN #2 stated that she did not think the right outer thigh was an unusual place for a skin tear or abrasion. LPN #2 stated that an investigation should have been conducted for Resident #44 so that staff knew what was causing the skin tear/abrasion. LPN #2 stated, "That is something we have to look into." LPN #2 then stated that she was not sure if it was from the sit to stand lift.

On 3/12/20 at 3:00 p.m., an interview was conducted with LPN #1, the unit manager and the nurse who found the skin tear on 11/1/19. When asked the process if she were to find a new skin alteration on a resident, LPN #1 stated that she would fill out an incident report, notify the medical doctor/family, revise the care plan and implement a treatment. LPN #1 then stated that she would investigate to determine how the skin alteration had occurred. LPN #1 stated that if the resident could not tell staff how the skin alteration had occurred, she would interview staff. When asked if this investigation would be documented anywhere, LPN #1 stated on a "Risk Management Sheet" that was in the electronic record. When asked if she was able to determine how Resident #44 obtained her skin tear on 11/1/19, LPN #1 stated that she didn't remember. LPN #1 stated that she did not recall interviewing any staff regarding her skin tear and that the resident could not tell her how it had occurred. When asked if a skin tear to the right outer thigh was an unusual place for a skin alteration, LPN #1 stated that it was not for her because she used the lift and was totally dependent on staff

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F 607	Continued From page 14 with ADLs (Activities of Daily Living). On 3/12/20 at 5:11 p.m., ASM #1, the Administrator and ASM #3 the Corporate Nurse Consultant were made aware of the above concerns. Facility policy titled, "Abuse/Investigate/Reporting," documents in part, the following: "Policy: Injuries of unknown origin (injuries not witnessed or patient cannot state what happened) will be handled the same as an allegation of mistreatment, neglect, or abuse...Any injuries of unknown origin to a patient are to be reported to a licensed nurse...A licensed nurse is responsible for completing an incident record...Investigative protocols will be immediately initiated."	F 607		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 610		4/27/20

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F 610	Continued From page 15 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to thoroughly investigate a skin injury of unknown source on two occasions for one of 44 residents in the survey sample, Resident #44. The findings include: Resident #44 was admitted to the facility on 11/7/2012 and readmitted on 5/30/14 with diagnoses that included but were not limited to unspecified dementia without behavioral disturbance and chronic obstructive pulmonary disease. Resident #44's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 1/23/20. Resident #44 was coded as being severely impaired in cognitive function scoring 04 out of possible 15 on the BIMS (Brief Interview for Mental Status Exam). Resident #44 was coded as being totally dependent on two plus persons with bed mobility and transfers; and totally dependent on one person with dressing, toileting, personal hygiene, and bathing. Review of Resident #44's clinical record revealed that she obtained a skin tear to her right outer thigh on 11/17/19. The following nursing note was documented: "Resident noted to have skin tear on right thigh...Quarter size skin tear...Cleansed skin tear, applied dressing." The following was documented on an incident report: "Nursing Description: resident has a skin tear to right thigh. Patient	F 610	F610 1-Resident #44 is free of skin impairments. 2-Current residents were reviewed to ensure that any skin injuries of unknown source are investigated to determine to source of injury appropriately. 3-The DON or designee will educate Nurses on investigation of skin injuries of unknown source and the timely Administrative notification of injuries of unknown source. 4-The DON will review residents with skin injuries of unknown source on a weekly basis to ensure that the injuries are investigated to determine to the source of injury appropriately. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation. 5-Completion date 4/27/20.	

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unable to give Description. Immediate Action Taken: treatment order in place. clean (sic) with NS (normal saline), pat dry, apply foam dressing...Injury Type: Skin Tear...Injury Location: Right thigh (rear)... Mobility: Bedridden...Mental Status: Oriented to Person; Oriented to Place...Predisposing Environmental Factors: None...Predisposing Physiological Factors: None...Witnesses: No Witnesses found."

Further review of the incident report revealed that under category "Predisposing Situation Factors," nothing was documented.

There was no evidence that an investigation was conducted determining the cause of her skin tear on 11/17/19.

Review of Resident #44's November 2019 MAR (Medication Administration Record) revealed that a treatment was put into place for the skin tear on 11/18/19 until the area was resolved on 12/14/19.

Further review of Resident #44's clinical record revealed that she obtained an abrasion to the same area (right outer thigh) on 1/29/20. The following was documented on the "Skin and Wound Evaluation" form: "Describe: Abrasion Location: Right thigh (rear) Acquired: In -House Acquired. How long has the Wound been present? New Exact Date: 1/29/20. Wound Measurements: 1. Area 1.4 cm 2 (centimeters squared) 2. Length: 1.5 cm 3. Width: 1.4 cm...Wound Bed: Epithelial...Exudate: None...Primary Dressing: Foam."

There was no evidence that an investigation was conducted determining the cause of her skin abrasion on 1/29/20.

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Review of Resident #44's March 2020 POS (physician order summary) revealed the following active order: "Clean abrasion to right thigh with DWC, pat dry, apply border dressing until healed. every (sic) morning shift every 2 day (s) for abrasion."

Review of Resident #44's ADL (Activities of Daily Living) care plan dated 9/28/14 and revised on 3/8/19 documented the following: "Bed mobility: The resident uses assist bars to maximize independence with turning and repositioning...Transfer: The resident is able to transfer stand up lift and 2 people."

On 3/12/20 an observation was made of Resident #44's skin alteration with LPN (Licensed Practical Nurse) #3 and LPN #2, the unit supervisor. A healing abrasion was observed to Resident #44's outer right thigh. The area had light pink tissue. The area did not appear to be pressure related. When asked when the abrasion had originally started, LPN #3 stated that it was back in November of 2019 and that she was not sure how it happened. LPN #2 stated that the DON (Director of Nursing) had found that the abrasion the second time about one month ago. LPN #2 stated that the DON had found the abrasion during skin sweeps on 3-11 shift. LPN #2 stated that they were putting a protective bandage in place at this point. Both nurses could not recall an investigation being initiated to determine the cause of her skin alterations on both occasions (11/1/19 and 1/29/20). When asked how Resident #44 transferred in and out of bed; LPN #2 stated that Resident #44 used the sit to stand lift with two staff members. LPN #2 stated that Resident #44 could not get herself in and out of bed or turn

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in bed by herself.

On 3/12/20 at 1:50 p.m., an interview was conducted with ASM (Administrative Staff Member) #2, the DON (Director of Nursing). When asked when she first found Resident #44's skin tear or abrasion, ASM #2 stated that she was not sure, that she would have to look back at the resident's notes. ASM #2 stated that she found the area during a skin sweep (the second time around) but could not recall the date. ASM #2 stated that when she asked the nurse manager (LPN #1) about the skin area, LPN #1 had told her that Resident #44 always had that area. ASM #2 stated that she only recalled notifying the medical doctor and obtaining a physician's order. When asked the description of the skin area when found, ASM #2 stated that it looked like a place of shearing, not really a skin tear. When asked the process to determine the cause of a new skin alteration, ASM #2 stated that she would investigate the cause of any new skin areas by interviewing staff who had last worked with the resident and interview the resident to determine how it occurred. When asked if she conducted an investigation to determine the cause of the skin abrasion to Resident #44, ASM #2 stated that she didn't remember. ASM #2 stated that she was not sure how it occurred. When asked if the location (right outer thigh) was an unusual location for an abrasion or skin tear, ASM #2 stated that in her opinion it was not. ASM #2 stated that Resident #44 was totally dependent on staff for all transfers, bed mobility etc.

On 3/12/20 at 2:27 p.m., further interview was conducted with LPN (Licensed Practical Nurse) #2, the unit supervisor. When asked the process when a new skin alteration is found on a resident,

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LPN #2 stated that an assessment would be completed, the medical doctor and family would be notified and then the skin area would be rounded on weekly. LPN #2 stated that the same process would be followed if a previous skin area was re-opened. LPN #2 stated that an investigation would also be conducted to determine the cause of the skin alteration. LPN #2 stated that the investigation was usually initiated by the DON (Director of Nursing). LPN #2 stated that it was important to determine the cause of a skin alteration so that the same skin area did not keep opening up or reoccurring. LPN #2 stated, "We don't want the same thing happening again and again." LPN #2 stated that she did not think the right outer thigh was an unusual place for a skin tear or abrasion. LPN #2 stated that an investigation should have been conducted for Resident #44 so that staff knew what was causing the skin tear/abrasion. LPN #2 stated, "That is something we have to look into." LPN #2 then stated that she was not sure if it was from the sit to stand lift.

On 3/12/20 at 3:00 p.m., an interview was conducted with LPN #1, the unit manager and the nurse who found the skin tear on 11/1/19. When asked the process if she were to find a new skin alteration on a resident, LPN #1 stated that she would fill out an incident report, notify the medical doctor/family, revise the care plan and implement a treatment. LPN #1 then stated that she would investigate to determine how the skin alteration had occurred. LPN #1 stated that if the resident could not tell staff how the skin alteration had occurred, she would interview staff. When asked if this investigation would be documented anywhere, LPN #1 stated on a "Risk Management Sheet" that was in the electronic

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F 610	Continued From page 20 record. When asked if she was able to determine how Resident #44 obtained her skin tear on 11/1/19, LPN #1 stated that she didn't remember. LPN #1 stated that she did not recall interviewing any staff regarding her skin tear and that the resident could not tell her how it had occurred. When asked if a skin tear to the right outer thigh was an unusual place for a skin alteration, LPN #1 stated that it was not for her because she used the lift and was totally dependent on staff with ADLs (Activities of Daily Living). On 3/12/20 at 5:11 p.m., ASM #1, the Administrator and ASM #3 the Corporate Nurse Consultant were made aware of the above concerns. Facility policy titled, "Abuse/Investigate/Reporting," documents in part, the following: "Policy: Injuries of unknown origin (injuries not witnessed or patient cannot state what happened) will be handled the same as an allegation of mistreatment, neglect, or abuse...Any injuries of unknown origin to a patient are to be reported to a licensed nurse...A licensed nurse is responsible for completing an incident record...Investigative protocols will be immediately initiated."	F 610		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		4/27/20

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F 658	Continued From page 21 Based on observation, staff interview, clinical record review and facility documentation review the facility staff failed to adhere to accepted standards of quality for medication administration for 1 of 44 residents in the survey sample, Resident #66. The facility staff failed to ensure medications were administered as ordered and failed to observe Resident #66 ingest the ordered medications. The findings included: Resident #66 was originally admitted to the facility on 01/31/2016. Diagnoses included but were not limited to, Bipolar Disorder, Depression and Parkinson's Disease. Resident #66's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 02/27/2020 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #66 as independent with personal hygiene, independent with setup help only for eating, requiring supervision of 1 for toilet use, bed mobility and transfer and total dependence of 1 for bathing. On 03/10/2020 at 11:15 a.m., Resident #66 was heard saying, "I didn't get all my pills and eye drops." Resident #66 was observed holding a medication cup in her hand with pills in it. 5 pills were observed in the cup and one was red in color. The resident stated, "I didn't get all my pills and eye drops because I had to go to the bathroom when the nurse came." Resident #66 stated, "I will just wait for her because she has other people to give medications to." Resident #66 put her call light on.	F 658	F658 1-Residents #66 is receiving medications as ordered. 2-The DON or designee will complete Medication Pass Observations on Charge Nurses to ensure that the Medications are administered as ordered and that residents are observed taking their medications appropriately. 3- The DON or designee will educate Nurses on Observation of residents taking their medications as ordered and the Administration and documentation of medications as ordered. 4-The DON or designee will complete a random weekly Medication Pass Observation of Charge Nurses during medication administration to ensure that they are receiving their medications as ordered and that the nurse is observing them ingest the medications as ordered. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation. 5-Completion date 4/27/20.	

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On 03/10/2020 at 11:19 a.m., Licensed Practical Nurse (LPN) #1 entered Resident #66's room. Resident #66 was heard telling LPN #1 that she was missing medications. LPN #66 walked out of the resident's room. The Surveyor walked into the room and did not see the cup of pills. The Surveyor asked Resident #66 where the cup of pills were at and she stated, "(LPN #1) took them with her."

On 03/10/2020 at 12:30 p.m., an interview was conducted with Resident #66, when asked if the nurses usually leave her medications with her to take, Resident #66 stated, "Yes and then I take them. Most of the nurses leave my medications with me to take and some stay and watch me take them. When I finish taking them I always let them know."

On 03/10/2020 at approximately 1:00 p.m., review of Resident #66's clinical record did not evidence a physician order for the resident to self administer medications. Review of Resident #66's care plan did not evidence a care plan for the resident to self administer medications.

An interview was conducted with LPN #1 on 03/10/2020 at approximately 1:00 p.m., when asked what did Resident #66 say to her when she answered her call light, LPN #1 stated, "(Resident #66) told me that she was missing a pill." LPN #1 stated, "I took the cup of pills from Resident #66 and gave them to the nurse." LPN #1 stated, "I told the nurse that the pills were in Resident #66's room." LPN #1 stated, "The nurse is an agency nurse." When asked do the nurses usually leave medications with the resident, LPN #1 stated, "I don't leave pills with the resident."

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An interview was conducted with LPN #4, the agency nurse, on 03/10/2020 at approximately 1:30 p.m. When asked what Unit did she pass medications on today, LPN #4 stated, "Unit C." When asked what times did she pass medications on the Unit today, LPN #4 stated, "9 A.M. and Noon meds (Medications)." When asked if she administered medications to Resident #66 today, LPN #4 stated, "Yes." When asked if she observed Resident #66 take all of her medications, LPN #4 stated, "Yes." LPN #4 stated, "She had to come back and get a vitamin and a Fentanyl patch." When asked if LPN #1 give her a cup of pills that belonged to Resident #66, LPN #4 stated, "Not sure which patient they belonged to, they were not Resident #66's. I think they were Resident #38's. I don't remember." LPN #4 stated, "I passed pills for thirty people. Resident #66 came up to the med cart and said she was missing a pill and I think it was the multivitamin."

The facility policy titled "General Dose Preparation and Medication Administration" dated with a Revision Date of 01/01/13 was reviewed and included: "5. During medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 5.9 Observe the resident's consumption of the medication(s)."

The Administrator and Corporate Staff were informed of the finding on 03/12/2020 at approximately 5:20 p.m. When asked should the nurses observe residents take their medications, Administrator and Corporate Staff stated, "Yes." The facility did not present any further information

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 24 about the finding.	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interviews, family interview, staff interviews, and clinical record review, the facility's staff failed to provide necessary care and services to 1 of 41 residents (Resident #132), in the survey sample to manage diabetes by obtaining blood sugars, and administering blood sugar medications. This failure resulted in more than minimal consequence for the resident, with blood sugar readings ranging 450 - 577 mg/dl, accompanied by chest pain which required an emergency room visit and 24 hour observation for stabilization at an acute care hospital. The findings included: Resident #132 was originally admitted to the facility 3/9/20, was sent to the hospital on 3/10/20 and returned on 3/11/20. The current diagnoses included but not limited to, long term use of insulin secondary to diabetes and diabetic ketoacidosis, vancomycin resistant urinary tract infection, heart disease including a heart attack.	F 684	F684 1 -Resident #132 was discharged on 3/20/20. 2- The DON or designee will review current residents receiving Diabetic medication and Blood sugar checks to ensure that they are receiving the Diabetic medication and blood sugar checks as ordered. 3- The DON or designee will educate Nurses on obtaining blood sugars as ordered by the physician and administering Diabetic Medications as ordered by the physician. 4- The DON or designee will review residents who receive Diabetic medications and blood sugar checks on a random weekly basis to ensure that that they are receiving the Diabetic medication as ordered and that the blood sugar checks are obtained as ordered by the physician. Issues noted during the random weekly review will be presented to	4/27/20

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F 684	Continued From page 25 The admission nursing assessment dated 3/9/20, coded the resident as alert and oriented to person, place, time and situation, with the ability to express ideas and wants verbally and to understand what was spoken. The admission Nursing assessment also coded the resident as having intact cognition. During the initial tour on 3/10/20 at approximately 3:30 p.m., Resident #132 was observed in an isolation room, seated in a chair at the foot of the bed. The resident stated the admission to the nursing facility was to help regain strength loss during a lengthy hospital stay for cardiac complications and to (diabetic ketoacidosis) with a need to achieve better glucose control. Resident #132 further stated the facility's nurses hadn't administered any of the scheduled insulin (U-500), which is administered with breakfast and supper. The resident further stated no blood sugar checks, cardiac drugs or insulin had been administered since admission to the facility. The resident further stated Licensed Practical Nurse (LPN) #6 stated the on-call physician wasn't comfortable with the hospital's discharge summary sliding scale coverage insulin therefore; it was deferred to the primary physician to review the the next day. The resident also stated the last dose of scheduled U-500 insulin received was at the local hospital with breakfast on 3/9/20 and the last dose of sliding scale insulin was local hospital with lunch 3/9/20, then transportation to the nursing facility arrived at approximately 4:00 p.m. The resident further stated no blood glucose check was performed at the nursing facility and no scheduled or sliding scale insulin was administered the evening of 3/9/20. Resident	F 684	the Quality Assurance Committee for review and recommendation. 5-Completion date 4/27/20	

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#132 stated multiple calls were made to the nurse's station the morning of 3/10/20, to inform the nurse that no scheduled breakfast insulin was administered, no glucose check was performed that morning and no cardiac drugs had been administered and this was upsetting.

Resident #132 stated on 3/10/20, at approximately 1:00 p.m., Licensed Practical Nurse (LPN) #5 stated the medication orders were not correct therefore; only the "as needed" sliding scale coverage insulin could be administered because that order was just received and all other admission orders were still subject to clarification before administration.

Review of Resident #132's endocrinologist discharge summary dated 3/9/20 at 6:10 a.m., revealed the following orders for Insulin Regular U-500 concentrated subcutaneous insulin pen:
Inject 100 units with Breakfast.
Insulin Regular U-500 concentrated subcutaneous insulin pen. Inject 50 with Dinner.
Trulicity 1.5 mg subcutaneous injection weekly, and;
one unit of Novolog for every 10mg/dl of blood sugar greater than 150 mg/dl while in rehabilitation.
For blood sugars less than 150 mg/dl, no correction.
Please check your blood sugars a minimum of 3-4 times daily and as needed.
Call your physician if blood sugars are consistently less than 100 or greater than 200 mg/dl.
For low blood sugars less than 70mg/dl take 15 grams of sugar (4 glucose tablets of 1/2 glass of orange juice or soda) check sugars 15 minutes later or every 15 minutes until sugars are above

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70mg/dl.
For blood sugars greater than 400 please call your endocrinologist or the Diabetes Institute, Call 911, or go to the emergency department.
On 3/13/20 at approximately 3:15 p.m., the assistant admission coordinator provided this document. She stated the above orders were not included with the admission orders for the admitting nurse.

Review of the admission orders by the on-call physician from 3/9/20, revealed the two above Insulin Regular U-500 concentrated orders were approved for administration in the nursing facility and the Humalog order was left for further verification by the physician the next day.

An interview was conducted with LPN #5 on 3/11/20 at approximately 6:50 p.m. LPN #5 stated on 3/10/20, she was assigned to care for Resident #132. LPN #5 stated the pharmacist had telephoned the facility twice the morning of 3/10/20, attempting to clarify the admission orders they had received and that she was afraid to administer any of the ordered medications until clarifications were made. LPN #5 also stated the morning of 3/10/20 at approximately 9:00 a.m., the Unit Manager was on the phone with the Nurse Practitioner working on clarifying the resident's orders and at approximately 12:30 p.m., she was on the phone with the physician's nurse and was able to obtain orders for blood glucose finger sticks and sliding scale coverage associated with the blood glucose readings. LPN #5 stated the Unit Manager continued to clarify all other orders with the Nurse Practitioner and at approximately 1:30 p.m., they were made available to her. LPN #5 stated she obtained the resident's blood glucose finger stick around 1:15

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p.m., the reading was 505. LPN #5 stated a one time order for 10 units of sliding scale coverage was obtained and administered. LPN #5 stated this information was passed on to the 3:00 p.m. through 11:00 p.m. nurse because another blood sugar check was due one hour after the sliding scale coverage was administered. (The physician's call system had no record of LPN #5's call).

The Medication Administration Record (MAR) revealed on 3/10/20, LPN #5 administered Humalog Kwikpen 100/units/milliliter 10 units to the resident at 4:26 p.m., based on the 1:15 p.m., blood sugar reading. As a result of the 4:26 p.m., sliding scale coverage another blood glucose check was ordered in one hour.

The clinical record revealed LPN #6 obtained the residents blood sugar reading at 5:40 p.m., and the reading was 450. Another 10 units of Humalog Kwikpen 100/units/milliliter was administered with a blood glucose recheck ordered within one hour and the scheduled U-500 insulin was administered for the first time. The clinical record further revealed at 6:11 p.m., the resident's blood sugar reading was 567, another check was performed with another meter and the reading was 578 and the physician was notified. At 8:30 p.m., the on call physician ordered 5 units of Humalog Kwikpen 100/units/milliliter.

The clinical record further revealed on 3/10/20 at 9:42 p.m., the resident complained of chest pain and that the blood sugar readings were too high. The resident and family member requested the resident be transferred to a local emergency room because the resident's endocrinologist had given them a written document which stated if

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blood sugars are greater than 400 mg/dl to call the diabetes institute, 911 or go to the emergency room.

The discharge summary from the local hospital dated 3/11/20 stated the EMS blood glucose check reading was 325 mg/dl and the ER blood glucose check was 309 upon the initial assessment.

An interview was conducted with the Nurse Practitioner (NP) assigned to Resident #132 while in the nursing facility on 3/13/20, at approximately 11:00 a.m. The NP stated she has been assigned to the nursing facility for two weeks and she is scheduled in the nursing facility on Mondays, Wednesdays and Fridays and the physician is in the facility on Wednesdays as well. The NP stated Resident #132 arrived on a Monday night therefore she didn't see the resident until after the return from the 24 observation at a local hospital. The NP stated Registered Nurse (RN) #2 contacted her at approximately 10:00 a.m., on 3/10/20, about clarifying orders. The NP read directly from her phone the following orders were discussed; no stop date for the antibiotics, Rocephin last day 3/10/20, continue Zyvox 4 more days, 2 statins, instructed RN to keep Zetia and Lipitor and discontinue Crestor and discontinue the Heparin. The NP stated no insulin orders were not discussed. She further stated she wasn't familiar with the U-500 insulin for it wasn't a common type but she was aware it is usually prescribed and adjusted by an endocrinologist. The NP further stated on 3/11/20 (time not specified) she was informed that Resident #132 was transferred to the hospital the night before. The NP stated the protocol is to call the office and the nurse in the

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office will notify the practitioner responsible to respond and that is what she prefers would occur.

On 3/13/20 at approximately 11:30 a.m., a call was placed to the primary physician for information of the facility staff calls regarding Resident #132. The physician stated the call system in place is very costly but it was instituted to prevent practitioners from having to try to recall information relayed by direct calls. The physician also stated they have found this call system very effective. On 3/19/20 at 10:50 a.m., the physician provided the following information for calls coming from the nursing facility regarding Resident #132, 3/9/20 through 3/10/20; 3/9/20 at 8:00 p.m., a call from LPN #6 notifying the on-call of the arrival of Resident #132's admission to the facility and the name of the physician who returned the call, 3/10/20, a call from RN #2 to clarify medication orders they had issues with as well as the pharmacy concerning Resident #132 and again on 3/10/20 at 3:25 p.m., from a nurse about use of Nystatin.

An interview was conducted with LPN #7 on 3/13/20 at, approximately 11:40 p.m. LPN #7 stated the procedure for admission is as follows; when report is called to the facility, determine if there are prescriptions for pain medications, the need for a prescription to accompany the resident and if any medications are ordered which are not in the stat box. Upon arrival of the resident call the practitioner, read the discharge summary to the practitioner, once the practitioner approves the orders, enter the orders into the electronic system and ensure the pharmacy received them. If it is after 5:00 PM., call the on-call pharmacist and they will make suggestions if necessary for immediate needed medications. The next two

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shifts reviews the new orders and verify as indicated.

An interview was conducted with LPN #6 at approximately 3/13/20, at approximately 1:20 p.m. LPN #6 stated she was the nurse who admitted Resident #132 on 3/9/20. LPN #6 stated an admission could take 2-4 hours and the resident arrived approximately 5:30 p.m., the physical assessment was completed with assistance of another nurse, the resident was asked if supper had been eaten, a diet was established, food provided and the assessments were completed in the computer system. LPN #6 stated a call was received from the on-call physician at 9:30 p.m., and verification based on the hospital's discharge summary was obtained for all medications except the sliding scale insulin (Humalog) for which the on-call physician asked to have it clarified the following day. LPN #6 also stated the resident stated she should be receiving Novolog and not Humalog. LPN #6 stated the resident had 3 insulin pens in possession at the time of admission and they were given to the staff to keep. LPN #6 stated she entered the scheduled insulin prescriptions in the computer system but she was very slow entering them therefore; all other medications were entered by LPN #8 who stated she could enter them quicker.

An interview was conducted with LPN #8 on 3/13/20 at approximately 3:40 p.m., LPN #8 stated all medication orders except the insulin orders were entered by her and she was unaware of any concerns with the others other than the sliding scale insulin order. LPN #8 also stated she was aware the resident had brought 3-4 insulin pens into the facility at the time of admission and they were bagged and put away.

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LPN #8 stated she assumed they would be used until the pharmacy medications were delivered.

On 3/13/20 at approximately 1:35 p.m., the pharmacist provide the following document as orders which needed to be clarified on 3/10/20 and LPN #6 was spoken to concerning them; Acetaminophen 200 mg, Aspirin (an allergy to), Bumex (no strength), Cyclobenzaprine Hcl 5 mg (interaction seventy level 1 to Linezoid and level 3 to Tramadol), Isosorbide Dinitrate 30 mg (how often), Insulin Regular (no strength), Nitroglycerin tablets (no strength), Humalog Kwikpen 100mg/dl (before meals and bedtime) at 1:28 p.m., on 3/20/20.

An interview was conducted with Resident #132's spouse on 3/13/20 at approximately 2:15 p.m., the spouse stated the rehabilitation and activity departments are superb but the nursing department is not proficient. The spouse stated the resident had called multiple times each day because the staff didn't provide explanations why finger sticks weren't performed and medications were administered. The spouse also stated on 3/10/20, at approximately 8:10 p.m., the same hospital discharge document provided the facility was provided to them and it was necessary to bring their document to the facility and give it to the staff before the resident could be transferred to the hospital for not receiving scheduled insulin from time of arrival to the facility until after 5:00 p.m., the afternoon of 3/10/20. The spouse stated since the residents admission to the nursing facility only administered the sliding scale insulin and it wasn't as prescribed by the resident's endocrinologist.

On 3/13/20 at approximately 4:50 p.m., the above

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F 684	Continued From page 33 findings were shared with the Administrator and two Corporate Nurses. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 684		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		4/27/20

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F 758	Continued From page 34 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility staff failed to ensure 1 of 44 residents (Resident #39), in the survey sample, did not receive "as needed (PRN)" Ativan for greater than 14 days without the physician and/or prescribing practitioner evaluating the resident for the appropriateness of continuous PRN use. The findings included: Resident #39 was originally admitted to the facility 2/25/14 and had never been discharged from the facility. The resident's diagnoses included; depression and hypertension. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/17/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #39's cognitive abilities for	F 758	F758 1-Resident #39 was evaluated by the Physician for the appropriateness of the Ativan and is still receiving the medication on an as needed basis. 2-The DON or designee will review current residents receiving PRN Ativan medication to ensure that the medication use is not greater than 14 days without the Practitioner evaluating the appropriateness of PRN Ativan use. 3-The DON or designee educated Nurses on the guidelines for PRN psychotropic medications and the need for Practitioner or Physician evaluation of PRN psychotropic medications appropriateness and continued use for greater than 14 days. 4-The DON or designee will review residents receiving PRN psychotropic medications on a random weekly basis to	

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F 758	Continued From page 35 daily decision making were moderately impaired. The 1/17/20, MDS assessment also revealed Resident #39 exhibited mood problems (feeling tired 7-11 days and appetite changes 2-6 days over two weeks). Review of the physician's order summary revealed an order dated 2/3/20, which read *Ativan Solution 2 milligrams/milliliter(ml); Give 0.25 ml sublingually every four hours as needed for anxiety. The 2/3/20 physician's order had no stop use date. The medication administration record revealed the Ativan 0.25 ml was administered to Resident #39 on, 3/5/20, 3/7/20, and 3/9/20, with effective results. The above findings were shared with the Administrator and two Corporate Nurse consultants. Corporate Nurse Consultant #1 stated the 2/3/20 Ativan order should have been discontinued after day 14 since the physician didn't re-evaluate its use and document to continue use. *Ativan is used to relieve anxiety. Ativan is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation. https://medlineplus.gov/druginfo/meds/a682053.html)	F 758	ensure that the PRN medication is ordered appropriately and evaluated for the appropriateness of PRN use by the Physician or Practitioner. Issues noted during the random weekly review will be presented to the Quality Assurance Committee for review and recommendation. 5-Completion date 4/27/20.	
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program.	F 881		4/27/20

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F 881	Continued From page 36 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interviews the facility staff failed to ensure implementation of an ongoing antibiotic stewardship program. The findings included: On 03/12/20 at 03:29 P.M. the infection control program and antibiotic stewardship program was reviewed from January 2019 through February 2020 with the Staff Development Coordinator. Infection Control monitoring, tracking and trending was in place however, there was no antibiotic stewardship program in place for the months of March, April, May, and June of 2019. The Staff Development Coordinator was asked where the antibiotic use monitoring protocols were for those missing months. The Staff Development Coordinator stated, "I'm not sure, I only started in December 2019 and this is all I have." On 3/12/20 at 3:45 P.M. an interview was conducted with the Nurse Consultant regarding the expectations for antibiotic stewardship for the 4 missing months. The Nurse Consultant stated, "I would expect for who ever is doing the tracking and trending for our infection control program to also follow through with the antibiotic stewardship program to track the organisms and proper labs	F 881	F881 1-The facility has a current antibiotic stewardship program in place that includes protocols and a system to monitor antibiotic use. 2-The Staff Development Coordinator has reviewed current antibiotic use for residents to ensure that the organisms, proper labs and prescribed antibiotics are being tracked and trended. 3-The DON or designee will educate Nurses on Appropriate use of antibiotics, Identification of signs and symptom of possible infection and Communication of resident assessment findings to the Physician to help determine infections and treatment. 4-The DON or designee will ensure that there is an antibiotic stewardship program in place on a monthly basis. Issues noted during the monthly review will be presented to the Quality Assurance Committee for review and recommendation. 5-Completion date 4/27/20.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 881	Continued From page 37 and prescribed antibiotics." The facility policy titled "Antibiotic Stewardship" dated 6/6/2020 was reviewed and is documented in part, as follows: Policy: The Center is committed to providing quality of care through the implementation of an Antibiotic Stewardship Program (APS). The APS is designed to promote the appropriate use of antibiotics, monitoring and management of clinical antimicrobial outcomes and reduce antibiotic resistance, to the extent possible. A team of clinicians will facilitate and oversee components of the ASP. On 3/12/20 at 5:00 P.M. during a pre-exit debriefing with the Administrator, and two facility Nurse Consultants the above information was reviewed. Prior to exit no further information was provided by the facility.	F 881		