STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 08/26/2019 through 08/29/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 08/26/2019 through 08/29/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 7 complaints were investigated during the survey. The census in this 124 certified bed facility was 106 at the time of the survey. The survey sample consisted of 62 resident reviews, which included 11 closed record reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure the MDS (minimum data set) assessment accurately reflected the status of one resident (Resident #107), out of 62 sampled residents. The facility staff failed to code accurately Resident #107's destination upon discharge on the residents discharge assessment, with an assessment reference date (ARD) of 7/18/19.	F 641	The Laurels of Bon Air wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is September 20, 2019. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or	9/20/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 09/18/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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The findings include:

Resident #107 was admitted to the facility on 6/18/19 with diagnoses that included but were not limited to: cancer of the colon and rectum, high blood pressure, and multiple sclerosis (a progressive disease in which nerve fibers of the brain and spinal cord lose their myelin cover). (1)

The most recent MDS, a discharge assessment, with an assessment reference date (ARD) of 7/18/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily decisions.

The "Interdisciplinary Discharge Summary" dated, 7/18/19, documented the resident was discharged on 7/18/19. A check mark was documented next to "Home."

The discharge MDS assessment with an ARD of 7/18/19, coded in Section A - Identification Information - Discharge Status, "03" indicating the resident was discharged to the acute hospital.

An interview was conducted with RN (registered nurse) #5, the MDS coordinator, on 8/28/19. RN #5 was shown the "Interdisciplinary Discharge Summary" sheet dated, 7/18/19. The MDS above was reviewed with RN #5. When asked if the MDS was correct, RN #5 stated, "I must have hit the wrong button. It should have been discharged to the community."

The facility presented the RAI (resident assessment instrument) manual documenting the instructions for completing of Section A2100

F 641

conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.

1. MDS section A for resident #107 was corrected on 8-28-19 and resubmitted.
2. All residents have the potential to be affected by this practice. The MDS Coordinator will audit the MDS for all discharges in the last 30 days, with corrections submitted as needed.
3. Regional Clinical Resource Specialist will provide education to MDS staff on accurate coding of section A.
4. MDS Coordinator will audit MDS section A for accuracy 5 pts daily x 5 days, 5 pts weekly x 2 weeks, 5 pts monthly x 3 months. Will review monthly x 3 months during QA to ensure compliance. Corrections will be made as needed with additional education and/or corrective actions provided.

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F 641	Continued From page 2 Discharge Status on 8/29/19 at approximately 1:30 p.m. The RAI manual documented in part, "Select the 2-digit code that corresponds to the resident's discharge status: Code 01 - community (private home/apt [apartment], board and care, assisted living facility or group home...Code 03, acute hospital." Administrative staff member (ASM) #1, the administrator, and ASM #2, the director or nursing, were made aware of the above concern on 8/29/19 at 8:12 a.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 380.	F 641		
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	F 656		9/20/19

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F 656	Continued From page 3 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to implement the comprehensive care plan for two of 62 residents in the survey sample, Residents #112 and #157. The findings include: 1. The facility staff failed to implement Resident #112's comprehensive care plan for her surgical wound by not changing her dressing per	F 656	1. A. Resident # 112 was discharged from facility on 5-30-2018. No negative outcomes occurred as a result of this practice. All other residents with wound care have been audited to ensure following MD orders and documentation reflected on the TAR. B. Pain medication orders for resident #157 have been updated to reflect non pharmacological interventions and interventions are being attempted and documented prior to administration of pain	

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physician's orders on multiple dates in May 2018.

Resident # 112 was admitted to the facility on 4/27/18, and was discharged from the facility 5/30/18. Her diagnoses included, but were not limited to: left below knee amputation and peripheral vascular disease (1). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/4/18, Resident #112 was coded as being cognitively intact, having scored 14 out of 15 on the BIMS (brief interview for mental status). In Section M, Skin Conditions, Resident #112 was coded as having a surgical wound and as receiving surgical wound care.

A review of Resident #112's EMR (electronic medical record) revealed the following order, written 4/27/18: "Dry dressing to LBKA (left below knee amputation) one time every other day for wound care." Further review of the April and May 2018 TARs (treatment administration records) revealed blanks for this dressing change on the following dates: 5/4/18, 5/16/18, and 5/22/18. All other dates were signed off, indicating the dressing change had been done.

A review of Resident #112's comprehensive care plan dated 5/9/18 revealed, in part, the following: "Amputation: Left lower leg BKA (below knee amputation). Wound treatments per order."

On 8/28/19 at 7:11 a.m., CNA (certified nursing assistant) #5, who cared for Resident #112 on the 11-7 shift, was interviewed. She stated that she did remember Resident #112. CNA #5 stated she remembered nurses changing Resident #112's surgical wound dressing. CNA #5 stated, "I remember seeing [the wound] one time. It looked

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medications. No negative outcomes occurred as a result of this practice.
2. A. All residents with ordered wound care are at risk.
B. All Residents with orders for PRN pain medication are at risk. All orders for guests receiving PRN pain medications will be audited and non-pharmacological interventions will be updated as needed.
3. A. ADON or designee will provide education to licensed nurses on following MD orders and documentation for wound care.
B. ADON or designee will provide education to licensed nurses on providing and documenting on pharmacological interventions prior to pain medication administration.
4. ADON or designee will audit 10 pts daily x 5 days, 10 pts weekly x 2 weeks, 10 pts monthly x 3 months to ensure proper protocol is followed. Will review monthly x 3 months during QA to ensure compliance. Additional staff education and/or corrective action will be provided as needed.

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F 656	Continued From page 5 really good." On 8/28/19 at 10:34 a.m., LPN (licensed practical nurse) #3 was interviewed regarding Resident #112's surgical wound. LPN #3 stated, "I vaguely remember [Resident #112]. She had an amputation; her wound had staples." When asked if she ever provided wound care for Resident #112, LPN #3 stated, "I don't remember whether I did or not." She stated that wound care for surgical wounds is usually done either by her or by the wound care nurse. When shown her initials on some of the dates of the April and May 2018 TARs, indicating that she had performed the wound care, LPN #3 stated, "Oh yes. I guess I did." When asked if she signs the TAR each time she completes a resident's wound care, LPN #3 stated, "Yes I do." When shown the blanks on the TAR for the three dates in May referenced above, LPN #3 stated, "It does not look like it was done. If it has not been signed off, it has not been done." When asked the meaning of resident's care plan, LPN #3 stated, "It tells us what the resident needs. It should be the guide for our care." When shown Resident #112's care plan for wound care, LPN #3 stated, "I guess we didn't follow it like we should. We should have done the wound care like the doctor ordered." On 8/29/19 at 7:40 a.m., LPN #7 was interviewed. When asked about the purpose of the care plan, LPN #7 stated, "You look at it and know what the person needs. It helps us meet their needs." On 8/29/19 at 9:40 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. The surveyor requested a facility policy for following a resident's plan of care.	F 656		

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On 8/29/19 at 12:35 p.m., ASM #2 informed the surveyor that the facility does not have a policy on following a resident's plan of care.

No further information was provided prior to exit.

(1) "PERIPHERAL VASCULAR DISEASE is any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447.

COMPLAINT DEFICIENCY

2. The facility staff failed to implement the comprehensive care plan for pain by failing to provide non-pharmacological interventions for pain for Resident #157.

Resident #157 was admitted to the facility on 8/23/19 with diagnoses that included but were not limited to: status post pneumothorax (a collection of air or gas in the pleural cavity, causing the lung to collapse. It may occur spontaneously but usually results from injury to the chest that allows the entrance of air. Treatment involves aspiration of the air form the pleural cavity and the administration of pain relievers.) (1).

A MDS (minimum data set) assessment was not yet completed at the time of the survey. The "Nursing Comprehensive Evaluation" dated 8/23/19, documented the resident was alert and oriented to time, person and place...Skin - incision on right flank, chest tube present draining to gravity."

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The comprehensive care plan dated, 8/23/19, documented in part, "Need - (Resident #157) is at risk for pain and/or has acute pain r/t (related to) chest tube incision." The "Interventions" documented in part, "Encourage/provide non-pharmacological interventions to prevent/manage pain as needed such as positioning devices, relaxation techniques such as deep breathing, meditation, prayer, shower. Distraction such as music, television, activities of choice. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Observe for side effects of pain medication. Observe for constipation, new onset or increased agitation, restless ness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls. Report occurrences to the physician."

An interview was conducted with Resident #157 on 8/28/19 at 11:41 a.m. When asked if the staff offer anything prior to giving him pain medications, such a repositioning or back rub, Resident #157 stated he doesn't complain of pain that often but when he does, he takes some Tylenol and that helps and he can reposition himself so he doesn't need help with that.

The physician order dated, 8/26/19, documented, "Acetaminophen (Tylenol) [used to treat mild to moderate pain. (2)] Tablet - give 325 mg (milligrams) by mouth every 8 hours as needed for pain 1-3 (pain level of 1-3 on a scale of 0-10, ten being the worse pain ever in)."

The physician order dated, 8/23/19, documented, "Tramadol Tablet [used to treat moderate to

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moderately severe pain. (3)] 50 mg - give 50 mg by mouth every 4 hours as needed for moderate pain (Scale 4-7)."

The physician order dated, 8/26/19, documented, "Percocet 5-325 (oxycodone - acetaminophen) [used to treat moderate to severe pain. (4)] give 1 tablet by mouth every 6 hours as needed for pain. Percocet 5-325 - give 2 tablet by mouth every 6 hours as needed for pain."

The August 2019 MAR (medication administration record) documented the above medication ordered from the physician.
The August MAR documented the Acetaminophen was administered for the following pain levels on the following dates and times:
8/24/19 at 2:02 a.m. for a pain level of "10."
8/26/19 at 12:31 a.m. for a pain level of "4."
8/26/19 at 10:12 a.m. for a pain level of "7."
The August 2019 MAR documented the Tramadol was administered on: 8/24/19 at 3:01 a.m. for a pain level of "10."
The August 2019 MAR documented the Percocet as one tablet was administered on 8/26/19 at 10:14 p.m. for a pain level of "3."

An interview was conducted with LPN (licensed practical nurse) #3 on 8/28/19 at 5:19 p.m., regarding what the nurse does if a resident complains of pain. LPN #3 stated the nurse should assess the resident, determine the location of the pain, what it is on the pain scale, then go to the physician orders, and mediate as indicated. When asked if anything else should be tried prior to the administration of medication, LPN #3 stated, "Yes, we should try non-pharmacological interventions; lie down,

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move their position, offer a drink, apply hot or cold, turn the lights down, get involved in an activity such as a puzzle, or adjust the temperature of the room." When asked where the attempted non-pharmacological interventions are documented, LPN #3 stated, "It should be on the MAR if the order was put into the computer correctly or the nurse can write a progress note." LPN #3 reviewed the above MAR and stated the orders were not set up correctly in the computer.

Review of the nurse's notes and the skilled care notes failed to evidence documentation of non-pharmacological interventions attempted prior to the administration of the above as needed pain medications.

An interview was conducted with LPN #7 on 8/29/19 at 7:58 a.m. When asked the purpose of the care plan, LPN #7 stated, "It's for us to look at and helps up meet the needs of the resident. It's what we need to do for the resident such as, diet, continence status, mood, behavior, pain, and transfer status." When asked if it should be followed, LPN #7 stated, "Yes."

A request was made on 8/29/19 at approximately 12:32 p.m. of ASM (administrative staff member) #2, (the director of nursing), for a policy on implementing care plan, ASM #2 informed the survey team that she did not have a policy on following the care plan.

Administrative staff member (ASM) #1, the administrator, and ASM #2, the director or nursing, were made aware of the above concern on 8/29/19 at 8:12 a.m.

No further information was provided prior to exit.

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F 656	Continued From page 10 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 464. (2) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=tylenol (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a695011.html (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682132.html	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, and review of facility documentation the facility staff failed to meet professional standards for one of 62 residents in the survey sample, Residents #157; and failed to handle and store medications in a professional manner during a medication pass observation on 8/27/19. The facility staffed clarify physician's orders for Resident #157's as needed pain medication Percocet (4) to determine at what pain level parameters the medication should be	F 658	1. Pain medication parameters were clarified for Resident #157 and there were no negative outcomes as a result of this. The nurse was provided with 1 to 1 education on 8-30-19. Med pass observation was completed with Nurse on 8.30.19 with 0 percent error rate and following all professional standards regarding medication administration. 2. All Residents are at risk. 3. ADON or designee will provide	9/20/19

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administered. Facility staff dispensed a pill in error, during a medication pass observation, and with a gloved hand pushed the pill back into the bubble pack, then placed it in the medication cart drawer without properly disposing of the dispensed medication.

The findings include:

1. The facility staffed clarify physician's orders for Resident #157's as needed pain medication Percocet (4) to determine at what pain level parameters the medication should be administered to the resident.

Resident #157 was admitted to the facility on 8/23/19 with diagnoses that included but were not limited to: status post pneumothorax [a collection of air or gas in the pleural cavity, causing the lung to collapse. It may occur spontaneously but usually results from injury to the chest that allows the entrance of air. Treatment involves aspiration of the air form the pleural cavity and the administration of pain relievers]. (1)

A MDS (minimum data set) assessment had not been completed yet at the time of the survey. The "Nursing Comprehensive Evaluation" dated 8/23/19, documented the resident was alert and oriented to time, person and place...Skin - incision on right flank, chest tube present draining to gravity."

A physician order dated, 8/26/19, documented, "Acetaminophen (Tylenol) [used to treat mild to moderate pain. (2)] Tablet - give 325 mg (milligrams) by mouth every 8 hours as needed for pain 1-3 [pain level of 1-3 on a scale of 0-10, ten being the worse pain ever in]."

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education to licensed nurses on following professional standards of care during medication administration, to include proper disposal of medications, documentation of waste as appropriate, and on clarification of orders for pain medication parameters.

4. ADON or designee will conduct Medication Pass observation for 2 residents daily x 5 days, weekly x 2 weeks, monthly x 3 months to ensure professional standard of practice is maintained. Will review monthly x 3 months during QA to ensure compliance.

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A physician order dated, 8/23/19, documented, "Tramadol Tablet [used to treat moderate to moderately severe pain. (3)] 50 mg - give 50 mg by mouth every 4 hours as needed for moderate pain (Scale 4-7)."

A third physician order dated, 8/26/19, documented, "Percocet 5-325 [oxycodone - acetaminophen- used to treat moderate to severe pain. (4)] give 1 tablet by mouth every 6 hours as needed for pain. Percocet 5-325 - give 2 tablet by mouth every 6 hours as needed for pain."

The August 2019 MAR (medication administration record), for Resident #157 documented the above physician medication orders. The Acetaminophen was documented as administered by staff to Resident #157 for pain levels, as follows on the following dates, and times:
8/24/19 at 2:02 a.m. for a pain level of "10."
8/26/19 at 12:31 a.m. for a pain level of "4."
8/26/19 at 10:12 a.m. for a pain level of "7."
The Tramadol was documented as administered on 8/24/19 at 3:01 a.m. for a pain level of "10."
The Percocet, one tablet was documented as administered on 8/26/19 at 10:14 p.m. for a pain level of "3."

The comprehensive care plan dated, 8/23/19, documented in part, "Need - (Resident #157) is at risk for pain and/or has acute pain r/t (related to) chest tube incision." The "Interventions" documented in part, "Encourage/provide non-pharmacological interventions to prevent/manage pain as needed such as positioning devices, relaxation techniques such as deep breathing, meditation, prayer, shower.

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Distraction such as music, television, activities of choice. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Observe for side effects of pain medication. Observe for constipation, new onset or increased agitation, restless ness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls. Report occurrences to the physician."

An interview was conducted with administrative staff member (ASM) #3, the nurse practitioner, on 8/28/19 at 1:14 p.m. When asked if there should be some guidance for the nurses on which medication to administer when a resident has three different pain medication orders, ASM #3 stated, "Yes, the orders should say for what pain level (parameters) the resident has, as to what medication they should get."

An interview was conducted with LPN (licensed practical nurse) #3 on 8/28/19 at 5:19 p.m. LPN #3 was shown the above orders for Tylenol, Tramadol and Percocet. When asked how the staff know which pain medication to administer for complaints of pain, LPN #3 stated, she would ask the nurse practitioner or doctor to clarify these orders.

A request was made on 8/29/19 at approximately 12:32 p.m. to administrative staff member (ASM) #2, the director of nursing, for a policy on clarifying physician orders. At 12:53 p.m., ASM #2 stated that the facility did not have a policy on clarifying physician orders.

On 8/29/19 at 1:15 p.m., ASM #2 was asked what standard of practice the facility follows; ASM #2

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stated they follow Lippincott.

According to Lippincott's "Fundamentals of Nursing, 5th edition, page 553 documents the following statement, "Always clarify with the prescriber any medication order that is unclear or seems in appropriate."

Administrative staff member (ASM) #1, the administrator, and ASM #2, the director or nursing, were made aware of the above concern on 8/29/19 at 8:12 a.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 464.
(2) This information was obtained from the following website:
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=tylenol
(3) This information was obtained from the following website:
https://medlineplus.gov/druginfo/meds/a695011.html
(4) This information was obtained from the following website:
https://medlineplus.gov/druginfo/meds/a682132.html
2. Facility staff failed to handle and store medications in a professional manner during the medication pass observation on 8/27/19.

On 08/27/2019 at 4:00p.m., an observation of the medication administration pass was conducted with RN #6. During the medication pass, with gloved hands RN #6 withdrew a blister pack of

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F 658	Continued From page 15 Methocarbamol (1) to administer to a Resident. After popping the tablet out of the blister pack and depositing it into a plastic medication cup, RN #6 reviewed the Resident's Medication Schedule and discovered that the Methocarbamol was not yet due for administration. Observation then revealed that RN #6 pushed the dispensed Methocarbamol tablet back into the opened space on the blister pack, and returned the blister pack to the medication drawer. RN #6 then continued with the medication administration without issue. At approximately 5:00 p.m., on 8/27/19, RN #6 was interviewed about the medication pass observation above. RN #6 was asked if he should have pushed the Methocarbamol tablet back into the opened blister pack when he discovered it was not yet due for administration. RN #6 stated he should have "maybe put tape behind it" [behind the pill on the bubble pack]. RN #6 was asked to open the medication cart and to remove the Methocarbamol blister pack for inspection. Upon removal of the blister pack from the drawer, the tablet of Methocarbamol was observed falling out of the opened space on the blister pack and into the medication cart drawer. RN #6 stated "I'll throw that away now" and proceeded to dispose of the tablet in the secured sharps container on the medication cart. A review of the facility policy on Medication Administration revealed no specific instructions for disposal of medications. At the end of day meeting on 08/28/2019, Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings. When asked what professional standard the facility	F 658		

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F 658	Continued From page 16 follows for medications or Pharmacy services, the Director of Nursing stated that they used Omnicare. A review of the Omnicare document entitled "Medication Pass Fundamentals 2" dated 04/2014(2) revealed the following on page 25 "Preparing Oral Medications" and documented the following: "If you accidentally pop an extra pill or one comes out of the blister pack, do not tape it back in, discard it properly and remember to document waste as appropriate." No further information was provided. References: 1. Methocarbamol is used with rest, physical therapy, and other measures to relax muscles and relieve pain and discomfort caused by strains, sprains, and other muscle injuries. Methocarbamol is in a class of medications called muscle relaxants. It works by slowing activity in the nervous system to allow the body to relax - https://medlineplus.gov/druginfo/meds/a682579.html 2. https://www.mmlearn.org/hubfs/docs/Med%20Pass%20Fundamentals%202.pdf	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		9/20/19

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practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide care and services in accordance with professional standards and the comprehensive care plan for one of 62 residents in the survey sample, Resident #112. The facility staff failed to follow the physician's orders for surgical wound care by failing to change Resident #112's dressing on multiple dates in May 2018.

The findings include:

Resident # 112 was admitted to the facility on 4/27/18, and was discharged from the facility 5/30/18. Her diagnoses included, but were not limited to: left below knee amputation and peripheral vascular disease (1). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/4/18, Resident #112 was coded as cognitively intact, having scored 14 out of 15 on the BIMS (brief interview for mental status). In Section M, Skin Conditions, Resident #112 was coded as having a surgical wound and as receiving surgical wound care.

A review of Resident #112's clinical record revealed the following order, written 4/27/18: "Dry dressing to LBKA (left below knee amputation) one time every other day for wound care." Review of the April and May 2018 TARs (treatment administration records) revealed blanks for this dressing change on the following

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Resident #112 was discharged from facility on 5-30-18, and no negative outcomes occurred as a result of this practice. All Residents with wounds were audited to ensure dressing changes were being completed per MD order and documented on 8/30/2019. No other anomalies observed.
2. All residents with wound care are at risk.
3. ADON or designee will provide education to licensed nurses on providing and documenting wound care per MD order.
4. ADON or designee will audit TAR for 10 residents daily x 5 days, 10 residents weekly x 2 weeks, 10 residents monthly x 3 months to ensure treatment is completed and documented. . Will review monthly x 3 months during QA to ensure compliance.

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dates: 5/4/18, 5/16/18, and 5/22/18. All other dates were signed with initials, indicating the dressing change had been done.

A review of Resident #112's Nursing Weekly (Head-To-Toe) Skin Assessments revealed, in part, the following:
- 5/4/18 "Skin Condition: Is the resident's skin intact with no problems? No.Skin Alteration: Left lower leg (front) BKA noted, no drainage or redness noted staples (sic) intact."
- 5/12/18 "Skin Condition: Is the resident's skin intact with no problems? No.Skin Alteration: Left lower leg (front) BKA noted, no drainage or redness, skin intact."
- 5/21/18 "Skin Condition: Is the resident's skin intact with no problems? No.Skin Alteration: Left lower leg (front) BKA-stump is pink and healthy skin."
- 5/28/18 "Skin Condition: Is the resident's skin intact with no problems? Yes."

Further review of Resident #112's clinical record revealed the following order, written 5/28/19: "Dry dressing to LBKA one time a day every other day for wound care Discontinue Reason: no longer needed."

Further review of Resident #112's progress notes revealed, in part, the following discharge note, written on 5/29/18 by ASM (administrative staff member) #3, the nurse practitioner: "Skin: no rash,..Warm, dry, no edema (swelling)."

A review of Resident #112's comprehensive care plan dated 5/9/18 revealed, in part, the following: "Amputation: Left lower leg BKA (below knee amputation). Wound treatments per order."

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On 8/28/19 at 7:11 a.m., CNA (certified nursing assistant) #5, who cared for Resident #112 on the 11-7 shift, was interviewed. She stated that she did remember Resident #112. CNA #5 stated she remembered nurses changing Resident #112's surgical wound dressing. CNA #5 stated, "I remember seeing [the wound] one time. It looked really good."

On 8/28/19 at 10:34 a.m., LPN (licensed practical nurse) #3 was interviewed regarding Resident #112's surgical wound. LPN #3 stated, "I vaguely remember [Resident #112]. She had an amputation; her wound had staples." When asked if she ever provided wound care for Resident #112, LPN #3 stated, "I don't remember whether I did or not." She stated that wound care for surgical wounds is usually done either by her or by the wound care nurse. When shown her initials on some of the dates of Resident #112's TAR (treatment administration record), indicating that she had performed the wound care, LPN #3 stated, "Oh yes. I guess I did." When asked if she signs the TAR each time she completes a resident's wound care, LPN #3 stated, "Yes I do." When shown the blanks on the TAR for the three dates in May referenced above, LPN #3 stated, "It does not look like it was done. If it has not been signed off, it has not been done." When asked if she had completed the Head-to-Toe skin assessments referenced above, she stated that she had. When asked if her documentation on 5/28/18 meant that the wound was completely healed, LPN #3 stated, "Yes. It was healed completely."

On 8/28/19 at 1:00 p.m., ASM (administrative staff member) #3, the nurse practitioner was interviewed. She stated Resident #112's

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attending physician is no longer employed by the facility. She reviewed her notes, and stated she did not remember ever seeing Resident #112's wound. However, she also stated that according to her discharge summary, Resident #112's wound had healed by discharge time. ASM #3 stated, "If the wound had not been healed, I would have noted that in my discharge note. But my note says nothing at all about a wound. It was healed."

On 8/29/19 at 9:30 a.m., ASM #2, the director of nursing was interviewed. When shown the blank entries on the May 2018 TAR for Resident #112's surgical wound care, ASM #2 stated, "That just means the nurse did not document what she did." When asked how she was certain that a nurse had indeed, performed the wound care on those days, ASM #2 stated, "We have been emphasizing that nurses need to take credit for the care they are giving." When ASM #2 was informed that a nurse on the staff had stated that if the wound care was not signed off, it had not been done, ASM #2 stated, "Okay."

On 8/29/19 at 9:40 a.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. The surveyor requested facility policies regarding following physicians' orders and following the care plan.

On 8/29/19 at 12:35 p.m., ASM #2 stated the facility did not have a policy on following physicians' orders or following the care plan. She stated she could not find a professional standard for following physicians' orders. ASM #2 stated, "It is just common sense."

A review of the facility policy "Clean Dressing

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Change" revealed, in part, the following: "Check Physician order for current, correct treatment...Document treatment given and wound appearance and changes in nurses' notes and elsewhere as indicated."

No further information was provided prior to exit.

(1) "PERIPHERAL VASCULAR DISEASE is any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447.

COMPLAINT DEFICIENCY

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F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		9/20/19

§483.25(c) Mobility.
§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.

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F 688	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to implement a restorative nursing program for one of 62 residents in the survey sample; Resident #28. The findings include: Resident #28 was admitted to the facility on 7/6/16 with the diagnoses of but not limited to diabetes, chronic obstructive pulmonary disease, hypothyroidism, pulmonary hypertension, heart failure, atrial fibrillation, insomnia, lumbar disc degeneration, chronic kidney disease, apnea, pathological fractures, high blood pressure, osteoporosis, and sciatica. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/26/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring limited assistance for bathing and eating; supervision for all other areas of activities of daily living, including ambulation and transfers. Resident #28 was coded as being unsteady but able to stabilize without staff assistance for walking (with an assuasive device if used), turning around and face the opposite direction, moving from seated to standing position, and surface-to-surface transfers. Section O, Special Treatments, Procedures, and Programs documented under "Restorative Nursing Programs" that the resident had received only 1 day of walking in the last 7 calendar days prior to the date of this assessment.	F 688	1. Resident #28 was evaluated by PT on 9-3-19 and picked up for part B services. A new restorative therapy program will be initiated when appropriate based on their recommendation. 2. All residents with Restorative Nursing orders are at risk. All residents with restorative therapy orders will be audited for proper implementation of programs. Corrections will be made as needed. 3. ADON or Designee will provide education to licensed nurses, CNAs and Restorative aide on the importance of following Physician orders and entering correct documentation that reflects restorative services. Restorative services will be provided by all CNAs as well as restorative aide. 4. ADON or designee will audit restorative programs and documentation on 5 patients daily x 5 days, 5 pts weekly x 2 weeks, and 5 pts monthly x 3 months. Will follow monthly x 3 months in QA to ensure compliance.	

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On 8/27/19 at 3:14 PM, an interview was conducted with Resident #28. Resident #28 stated that she was not getting Restorative Nursing Program (RNP) as she thought she was supposed to have. She stated that she is walked by the restorative aide "only once or twice a month."

A review of the clinical record revealed an order dated 1/9/18 for "May participate in restorative programs."

Further review revealed an order dated 12/13/18 for "Resident may participate in RNP [restorative nursing program] ...effective 12/13/19....for 90 days."

The above order dated 12/13/18 was in response to a referral by therapy, dated 12/13/18, which was documented on a "Restorative Program Therapy to Nursing Communication" form. Review of the form documented, "Please ambulate resident 1x/day 3-5x/wk (once a day for three to five times a week) (with) rw (rolling walker) and SBA (stand-by assist) (gait belt) for distances of up to 350 feet as tol (tolerated). Please (A) (assist) resident to complete functional transfers 1x/day 3-5x/wk (with) rw and sba (gait belt). (Check) for technique / safety." The restorative aide signed this form on 1/2/19.

Further review of the clinical record failed to reveal any evidence of documentation of the resident receiving the restorative nursing for the specifically ordered 90-day time frame; or any restorative nursing services since then as needed / per resident request.

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F 688	Continued From page 24 On 8/28/19 at 8:10 AM in an interview with CNA #2 (Certified Nursing Assistant) who was the Restorative Nursing Program aide, she stated that she does restorative nursing with Resident #28. CNA #2 stated that she walks with Resident #28 "once or twice a week." When asked how she evidences that this is being done, CNA #2 stated, "I chart it." When asked where and how this restorative nursing activity is charted, CNA #2 stated, "At one time it was on a log book. Now we do it in the computer." CNA #2 was asked the charting for restorative nursing activity was started in the computer. CNA #2 stated, "This year, January I think." When asked about the restorative nursing services provided to Resident #28, CNA #2 stated that she walked her about 15 to 20 minutes, and that the resident rests in between. When asked if the resident complained of not getting enough restorative assistance, CNA #2 stated, "She has commented about not getting RNP enough because sometimes they pull me to the floor." When asked how often she is pulled to the floor, CNA #2 stated, "At least 3 days a week I am pulled to the floor. When I am pulled to the floor, I can't do the restorative." At this time CNA #2 took this surveyor to the kiosk to show how she documented restorative nursing activities provided to residents, however, she was unable to show the documentation history to evidence that restorative nursing activity was provided. On 8/28/19 at 1:37 PM in an interview with LPN #1 (Licensed Practical Nurse), when asked if Resident #28 is getting restorative nursing, she stated, "I think she was but not sure about right now." When asked how the RNP works, LPN #1 stated, "RNP works by minutes every day and they document it." When asked how she ensures the residents are getting RNP, LPN #1 stated, "It	F 688		

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pops up on daily assignments. I was told we have an RNP and that person should be documenting." When asked if, as the nurse, she should follow up to see that the time is being documented, LPN #1 stated she does not. When asked what happens if residents still get their RNP that day, if the RNP aide is pulled to the floor, LPN #1 stated, "I'm not sure. I would think they would assign another RNP person to do that."

On 8/28/19 at 1:22 PM in an interview with OSM #1 (Other Staff Member, the Physical Therapist), when asked if Resident #28 has had a decline due to RNP not being provided regularly, he stated, "We (therapy) would not know if there has been a decline. The way the restorative works is that when a resident is done with therapy, whatever level they achieved, the intent of RNP is not going to increase their ability but to maintain where we got them. The nice part is if that they decline, nursing can then come, tell us, and make a referral. Once referred to RNP, therapy does not monitor progress any longer. Only way I would know if there was an issue is if nursing came and told me." When asked about the 12/13/18 order for RNP for 90 days, OSM #1 stated, "The 90 day concept would be that if there was an issue, we would know about it, and at 90 days is a prompt for nursing to reassess how the resident is doing. RNP is a nursing program and therapy would only get back involved if there was a significant change."

On 8/28/19 at 1:09 PM, an interview was conducted with ASM #3 (Administrative Staff Member, a Nurse Practitioner). When asked if Resident #28 had a decline in mobility status in recent months, ASM #3 stated, "Because of the

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sciatica pain. She doesn't want to take a lot of medicine so we have to do baby steps. We started Neurontin (1) on a low dose, 100 milligrams at bedtime because she didn't want to be groggy in the morning. Once we got to 3 times a day, she started having muscle spasms and we had to increase that because she was still having pain." When asked what was being done to maintain Resident #28's mobility, beyond medications, ASM #3 stated, "Sometimes I see her walking with restorative in the hallways." When asked if a physician's order is required to receive restorative nursing, ASM #3 stated, "The facility can initiate it. It does not require an order." When asked if Resident #28 needs restorative for mobility, ASM #3 stated, "Yes and no. I think with the pain she is not going to until the pain is controlled." When asked if the resident would benefit and improve with restorative, ASM #3 stated, "I think she could benefit and make improvements with restorative. She has had broken bones in her back. I have seen her in the halls walking but do not recall dates or how frequently."

On 8/28/19 at 7:30 AM, in an interview with ASM #2, the Director of Nursing, when asked about evidence that Resident #28 had received restorative nursing, ASM #2 stated that, "the restorative documentation was transitioned to computer from paper. On August 6, we realized they were not documenting the care in the computer the way they were supposed to. We started revising everything, how the plans were entered, and showed up on the task list, just about everything. Identified residents who were on restorative. We tried to revamp everything and all of the documentation is done in the computer. I Don't know where it was being

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F 688	Continued From page 27 documented before August 6. I'm not sure that it was." When asked how the facility ensure people are receiving RNP, ASM #2 stated, "That is in progress. I see the restorative walking them and doing exercises with them but, what I don't see is the documentation." When asked about restorative aides being pulled to the floor and residents not getting the restorative program several days a week, ASM #2 stated, "There are two people who work in restorative right now. We are in the midst of training all the CNAs to do restorative. She (Resident #28) was walking with (CNA #9 a restorative aide) the day before yesterday." When asked if Resident #28 had ever expressed concerns with not getting restorative nursing services, ASM #2 stated, "She has never shared any concerns about the restorative program that I am aware of." When asked about documented evidence that Resident #28 was getting restorative during the 90-day time frame ordered on 12/13/18, or since then, ASM #3 stated, "Getting them to do the documentation has been an ongoing project. When I went back to look, the paper logs could not be found, and when it is put in the computer, it has to be scheduled or it won't show up on the documentation. It was not entered correctly in the computer, so it was not showing up as scheduled, just PRN (as needed). I had to go in and revise all that. On 8/28/19 at 7:45 AM, in a follow up interview with ASM #2, she stated she followed up with, (CNA #2) and that CNA #2 says she has been documenting in the computer but I don't see it. I don't think she is documenting it right. ASM #2 stated CNA #2 said she walks her (Resident #28), a couple times a week and that she has not had a decline." When asked how staff evaluated that	F 688		

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Resident #28 has not had a decline, ASM #2 stated, "I ask (CNA #2). She has been walking with her."

A review of the comprehensive care plan revealed one dated 2/8/18 that documented, "ADL (Activities of Daily Living)...Requires assistance with ADL's completion...." This care plan included the intervention, dated 2/8/18 for, "Restorative as needed." Also the intervention, dated 5/16/18, "May participate in nursing restorative programs." This care plan also documented, under the same area, the intervention, dated 12/17/18 (in response to the 12/13/18 RNP order), "Resident may participate in RNP."

A review of the facility policy, "Restorative Nursing" documented, "....to assist and promote an individual to achieve or maintain his/her optimal physical, mental, and psychosocial functioning....Procedure: The restorative nursing programs are carried out under the direction of the nursing department, and are provided by licensed nurses and trained restorative aides. These programs employ measurable goals, and each guest is evaluated quarterly (or more often, if need be). Restorative programs are provided in groups of four guests or less. Nursing management will provide supervision for the restorative programs and is therefore responsible for program implementation, program utilization, documentation, review of progress, consultation with and evaluations, as needed, by therapists, and program evaluation. The nursing staff will be trained in restorative care through staff development inservice programs....Advantages of Restorative Programs:....1. Maintain, improve, or prevent decline in the guest's ability to function

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F 688	Continued From page 29 and to perform self-care activities as independently as possible. 2. Increase self-esteem....3. Enhance sense of satisfaction and relationship between guests and staff...4. Offer less risk of complications to functional guests..." No further information was provided by the end of the survey to evidence that the resident received restorative nursing for the ordered 90-day period dated 12/13/18, or any since then as needed / requested. (1) Neurontin is used to relieve post-herpetic neuralgia pain. Information obtained from https://medlineplus.gov/druginfo/meds/a694007.html	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation resident interview, staff interview and review of the clinical record the facility staff failed to ensure respiratory services were provided consistent with professional standards of practice for one sampled resident (Resident #89) in the survey sample of 62	F 695	1. Resident # 89 nebulizer equipment was changed and bagged immediately on 8/28/19. Resident had no negative outcome as a result of deficient practice. All other residents with Respiratory equipment were audited on 8/30 to ensure	9/20/19

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residents. The facility staff failed to store Resident #89's nebulizer mask in a sanitary manner after completing ordered nebulizer treatments on 8/26/19 and 8/27/19. Resident # 89's nebulizer mask was observed sitting on the nightstand uncovered and on 8/26/19 and was observed in the bed next to a pillow on 8/27/19.

The findings include:

Resident #89 was admitted to the facility on 8/7/19 with diagnoses that include but are not limited to: Congestive heart failure [characterized by circulatory congestion and retention of salt and water by the kidneys; it is usually caused by a heart disorder and most often develops chronically with shortness of breath due to fluid accumulation in the lungs, and edema of the extremities. Treatment includes diuretics, beta-blockers, digitalis, and oxygen. (1)], COPD [chronic, nonreversible lung disease is usually a combination of emphysema and chronic bronchitis. Treatment is with bronchodilators, corticosteroids, and antibiotics, when necessary. Oxygen may be helpful in advanced cases. (2)] and hypertension.

The most recently MDS (minimum data set) assessment, was a five-day assessment with an ARD (assessment reference date) of 8/14/19, and documented Resident's BIMS (brief interview for mental status) score was a 15 out of 15 (indicating intact cognition). Resident 89's functional status was coded as, one-person physical assist with bed mobility and partial or moderate assistance in rolling left to right in bed.

On 8/26/19 at 7:00 PM, observation of Resident #89 in the residents room revealed a nebulizer

F 695

equipment was properly stored. No other anomalies observed.
2. All residents receiving Oxygen or respiratory therapy are at risk.
3. ADON or designee will provide education to licensed nurses on the importance of bagging respiratory equipment per protocol.
4. ADON or designee will audit respiratory equipment storage on 10 patients daily x 5 days, 10 pts weekly x 2 weeks, and 10 pts monthly x 3 months to ensure proper storage. Will follow monthly x 3 months in QA to ensure compliance.

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mask on the over the bed table. On 8/27/19 at 10:45 AM, Resident #89 was observed with the nebulizer mask in the bed near the pillow.

The comprehensive care plan dated 8/7/19, documented in part; "Need": (Resident #89) "has a potential for difficulty breathing and risk for respiratory complications related to: COPD (chronic obstructive pulmonary disease) with chronic hypoxia, hypercapnic respiratory failure; is at risk for cardiac complications related to multiple cardiovascular diseases: CHF (congestive heart failure), COPD, CAD (coronary artery disease)". "Interventions": "Observe resident's respiratory status, report abnormal findings to physician. Administer medications per order. Observe for adverse reactions/side effects as indicated and report to physician as necessary".

The August MAR (medication administration record) for Resident #89 documented, "Tiotropium Bromide Monohydrate Aerosol Solution 2.5 MCG [microgram], 2 inhalation inhale orally one time a day for copd and Budenosonide Suspension 0.5 mg [milligram]/2ml [milliliter], 1 blister inhale orally two times a day for copd". Documentation indicated that Budesonide was administered at 5 PM on 8/26/19; Tiotropium and Budesonide were administered at 9AM on 8/27/19.

An interview was conducted with Resident #89 on 8/26/19 at 7:20 PM, regarding the time of her last nebulizer treatment. Resident #89 stated, "I had it around supper time".

A follow up interview was conducted with Resident #89 on 8/27/19 at 10:45 AM. When

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asked the time of her last nebulizer treatment, Resident #89 stated, "I had it with my morning medicines".

An interview was conducted with LPN (licensed practical nurse) #8, on 8/28/19 at 10:01 AM. When asked about the process staff follows for administration of ordered nebulizer treatments, LPN #8 stated, "I put medicine in nebulizer and give it to the patient and patient takes it". When asked if she stays with patient during treatment, LPN #8 stated, "No". LPN # 8 stated, "I usually try to go back in 15-20 minutes". When asked about the process staff follows when a nebulizer treatment has been completed, LPN #8 stated, "I put nebulizer in bag and cover it". When asked if it was standard of practice for the nebulizer mask to be left uncovered on the over the bed table or in bed, LPN # 8 stated, "No".

On 8/28/19 1:15 PM, when ASM (administrative staff member) #2, the director of nursing, was asked about the standard of practice the facility uses, ASM #2 stated they (facility) use Lippincott 2019 edition, as their standard of practice.

Administrative staff members (ASM) # 1, the administrator, (ASM) # 2, the director of nursing and (ASM) #3 the regional resident care coordinator, were made aware of the above concerns on 8/29/19 at 10:25 AM.

No further information was provided prior to exit.

References:
1. Barron's Dictionary of Medical Terms 7th edition, Kaplan2. Barron's Dictionary of Medical Terms 7th edition, Kaplan

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F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure that pain management was provided consistent with professional standards of practice, and the comprehensive person-centered care plan for two of 62 residents in the survey sample, Residents #157, and #4. The facility staff failed to offer / provide non-pharmacological interventions prior to the administration of as needed pain medications to Resident #157 and Resident #4. The findings include: 1. The facility staff failed to offer non-pharmacological interventions prior to the administration of as needed pain medications for Resident #157. Resident #157 was admitted to the facility on 8/23/19 with diagnoses that included but were not limited to: status post pneumothorax (a collection of air or gas in the pleural cavity, causing the lung to collapse. It may occur spontaneously but usually results from injury to the chest that allows the entrance of air. Treatment involves aspiration of the air form the pleural cavity and the	F 697	1. Resident # 157 was discharged from facility on 8.31.19. Resident # 4 was discharged from facility on 9.14.19. No negative outcomes occurred as a result of this practice. 100% audit on all patients with orders for PRN pain medication were reviewed and orders updated to reflect non-pharmacological interventions prior to administration of medication. 2. All residents receiving PRN pain medications are at risk. 3. ADON or designee will provide education to licensed nurses on the importance of providing and entering documentation for non-pharmacological interventions prior to administration of PRN pain medications 4. ADON or designee will audit Pain medication orders and documentation on 10 patients daily x 5 days, 10 pts weekly x 2 weeks, and 10 pts monthly x 3 months. Will follow monthly x 3 months in QA to ensure compliance.	9/20/19

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administration of pain relievers.) (1).

There MDs (minimum data set) assessment was not completed yet at the time of the survey. The "Nursing Comprehensive Evaluation" dated 8/23/19, documented the resident was alert and oriented to time, person and place...Skin - incision on right flank, chest tube present draining to gravity."

A physician order dated, 8/26/19, documented, "Acetaminophen (Tylenol) [used to treat mild to moderate pain. (2)] Tablet - give 325 mg (milligrams) by mouth every 8 hours as needed for pain 1-3 [pain level of 1-3 on a scale of 0-10, ten being the worse pain ever in]."

A physician order dated, 8/23/19, documented, "Tramadol Tablet [used to treat moderate to moderately severe pain. (3)] 50 mg - give 50 mg by mouth every 4 hours as needed for moderate pain (Scale 4-7)."

A third physician order dated, 8/26/19, documented, "Percocet 5-325 [oxycodone - acetaminophen- used to treat moderate to severe pain. (4)] give 1 tablet by mouth every 6 hours as needed for pain. Percocet 5-325 - give 2 tablet by mouth every 6 hours as needed for pain."

The comprehensive care plan dated, 8/23/19, documented in part, "Need - (Resident #157) is at risk for pain and/or has acute pain r/t (related to) chest tube incision."
The "Interventions" documented in part, "Encourage/provide non-pharmacological interventions to prevent/manage pain as needed such as positioning devices, relaxation techniques such as deep breathing, meditation,

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prayer, shower. Distraction such as music, television, activities of choice. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Observe for side effects of pain medication. Observe for constipation, new onset or increased agitation, restless ness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls. Report occurrences to the physician."

The August 2019 MAR (medication administration record), for Resident #157 documented the above physician medication orders. The Acetaminophen was documented as administered by staff to Resident #157 for pain levels, as follows on the following dates, and times:
8/24/19 at 2:02 a.m. for a pain level of "10."
8/26/19 at 12:31 a.m. for a pain level of "4."
8/26/19 at 10:12 a.m. for a pain level of "7."
The Tramadol was documented as administered on 8/24/19 at 3:01 a.m. for a pain level of "10."
The Percocet, one tablet was documented as administered on 8/26/19 at 10:14 p.m. for a pain level of "3."

An interview was conducted with Resident #157 on 8/28/19 at 11:41 a.m. When asked if the staff offer anything prior to giving him pain medications, such a repositioning or back rub, Resident #157 stated he doesn't complain of pain that often but when he does, he takes some Tylenol and that helps and he can reposition himself so he doesn't need help with that.

An interview was conducted with LPN (licensed practical nurse) #3 on 8/28/19 at 5:19 p.m. When

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asked about the process staff follows for resident complaints of pain, LPN #3 stated the nurse should assess the resident, determine the location of the pain, what it is on the pain scale, then go to the physician orders, and mediate as indicated. When asked if staff attempts other interventions prior to the administration of pain medication, LPN #3 stated, "Yes, we should try non-pharmacological interventions; lie down, move their position, offer a drink, apply hot or cold, turn the lights down, get involved in an activity such as a puzzle, or adjust the temperature of the room." When asked where the non-pharmacological interventions attempted/provided are documented, LPN #3 stated, "It should be on the MAR if the order was put into the computer correctly or the nurse can write a progress note." LPN #3 reviewed the above MAR for Resident #157 and stated the orders were not set up correctly in the computer.

Review of the nurse's notes and the skilled care notes failed to evidence documentation of non-pharmacological interventions attempted prior to the administration of as needed pain medications.

The facility policy, "Pain Management Program" documented in part, "Policy: The Pain Management Program will be used by nursing staff to evaluate, provide appropriate interventions, and monitor the effectiveness of the pain regimen for guest experiencing acute and/or chronic pain, in order to promote comfort and the ability to reach their highest functional level...."INTERVENTION: 1. The nurse will develop a written care plan for pain relief, considering medicinal and non-medicinal interventions (Non-medicinal interventions should

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be attempted before medicinal interventions are explored)."

Administrative staff member (ASM) #1, the administrator, and ASM #2, the director or nursing, were made aware of the above concern on 8/29/19 at 8:12 a.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 464.
(2) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=tylenol
(3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a695011.html
(4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682132.html

2. The facility staff failed to implement non-pharmacological interventions prior to the administration of as needed Oxycodone (1) to Resident #4.

Resident #4 was admitted to the facility on 04/11/2019 with a readmission on 08/21/2019, with diagnoses that included but were not limited to: fracture of unspecified part of neck of left femur (2), aftercare following joint replacement surgery, and gout (3).

Resident #4's most recent MDS (minimum data

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set), an admission assessment from a previous admission with an ARD (assessment reference date) of 04/18/19, coded Resident #4 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions. Section J coded Resident #4 as not having pain. There was no completed MDS assessment since readmission to the facility.

The nursing skilled care note dated 08/22/2019 03:25 (3:25 a.m.) documented "Alert, Verbal, Behavior: None, Pain: 2. Mild Pain. Left hip. Treatment of Pain: Effective. Pain Level: 2 (two) 08/22/2019 03:29 (3:29 a.m.) Pain Scale: Numerical."

On 08/27/19 at approximately 11:00 a.m., an interview was conducted with Resident #4. Resident #4 stated that she frequently has pain in her left leg. When asked if the staff assess her pain Resident #4 stated, "Sometimes, they ask me a number." When asked if the staff try other methods to alleviate the pain before administering the as needed pain medication Resident #4 stated, "No, they give me my pill when I hurt."

The POS (physicians order sheet) dated "08/21/2019" for Resident #4 documented, "Endocet Tablet 5-325 MG (milligrams) (oxycodone-Acetaminophen) Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain, pain scale 7-10."

The comprehensive care plan for Resident #4 dated 08/22/2019 documented, "[PREFERRED NAME of Resident #4] is at risk for pain and/or has (Specify: acute/chronic) pain r/t; Date Initiated: 08/22/2019 Revision on 08/22/2019."

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Under "Goals" it documented, "Will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. Date Initiated 08/22/2019."

The eMAR (electronic medication administration record) dated "Aug (August) 2019" documented the same orders as in the POS above, review of the eMAR revealed Oxycodone 5mg was administered to Resident #4 on the following dates and at the following times:
On "08/22/19 at 2220 (10:22 p.m.),
08/23/19 1952 (7:52 p.m.),
08/24/19 2018 (8:18 p.m.)."
Further review failed to evidence documentation of non-pharmacological interventions for the dates listed above on the eMAR.

Review of the nurse's progress notes and the eMAR notes dated 08/21/2019 through 08/28/19 failed to evidence documentation of non-pharmacological interventions for the dates listed above.

On 08/28/19 at 10:35 a.m., an interview was conducted with RN (registered nurse) #1, the unit manager. When asked about the process staff follows for pain management for residents, RN #1 stated that staff check the physician orders, compare the MAR (medication administration record) against the computer to verify accuracy and assess the level of pain the resident is having. RN #1 stated, "For example if the level of pain is 1-5 they give the medication ordered for that level, if it is 6-10 they give the medication that is ordered with that level." RN #1 stated that they also try non-pharmacological interventions before as needed pain medication administration. When asked if non-pharmacological interventions are

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attempted for all residents prior to as needed pain medication administration, RN #1 stated, "Yes, all prn (as needed) pain medications have non-pharmacological interventions with them." When asked where non-pharmacological interventions provided to residents are documented, RN #1 stated that they are documented on the eMAR (electronic medication administration record) prior to giving the medication. When asked if this documentation is visible after it is documented, RN #1 stated "Yes." RN #1 reviewed the eMAR record on her computer for Resident #4 and was unable to find documentation of non-pharmacological interventions provided prior to the staff administering the Oxycodone to Resident #4 on the dates referenced above.

On 8/28/19 at 1:15 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked if non-pharmacological interventions should be attempted for residents prior to the administration of as needed pain medications ASM #2 stated, "If it is appropriate." ASM #2 stated "For example prior to going to therapy for a post-surgical patient they would not do non-pharmacological interventions because they know the resident is going to be in pain." When asked if non-pharmacological interventions are documented ASM #1 stated "Yes." ASM #1 stated that it documented on the eMAR or in a progress note."

On 08/29/19 at approximately 8:00 a.m., an interview was conducted with LPN (licensed practical nurse) #7 regarding as needed pain medication administration. When asked if all residents should be offered non-pharmacological

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interventions prior to the administration of as needed pain medication, LPN #7 stated, "Yes." When asked if non-pharmacological interventions provided are documented, LPN #7 stated that they were documented on the eMAR or in a progress note. LPN #7 stated that when giving as needed pain medications the computer prompts them to enter two non-pharmacological interventions prior to giving the medication. LPN #7 reviewed the eMAR dated Aug 2019 and the progress notes dated 8/21/19 through 8/28/19, and agreed that they failed to evidence documentation of non-pharmacological interventions prior to the administration of as needed pain medication for Resident #4 on the dates listed above.

On 08/29/19 at 8:40 a.m., ASM # 1 (administrator) and ASM # 2 (director of nursing) were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Oxycodone-
Oxycodone-acetaminophen is used to relieve moderate to severe pain. Oxycodone extended-release tablets and extended-release capsules are used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

2. Femur fracture-
You had a fracture (break) in the femur in your

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F 697	Continued From page 42 leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm. 3. Gout- A type of arthritis. It occurs when uric acid builds up in blood and causes inflammation in the joints. This information was obtained from the website: https://medlineplus.gov/ency/article/000422.htm.	F 697		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing	F 700		9/20/19

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and maintaining bed rails.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, the facility staff failed to complete assessment for risk of entrapment, failed to ensure the risks and benefits of bed rails were reviewed, and consent obtained, prior to the use of, side rails for eleven, of 62 residents, (Residents #58, #87, #83, #89, #62, #17, #78, #28, #8, #51 and #88), in the survey sample.

The findings include:

1. The facility staff failed to assess, failed to review the risks and benefits and obtain consent prior to the use of side rails for Resident #58.

Resident #58 was admitted to the facility on 10/22/17, with a recent readmission on 8/6/19, with diagnoses that included, but were not limited to: dementia, diabetes, recent pathological hip fracture, depression and muscle weakness.

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 8/13/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of two staff members for moving in the bed.

Resident #58 was observed in bed on 8/27/19 at 1:12 p.m., with two side rails on the bed in up position. The resident was again observed in bed

F 700

1. Resident #89, #62, #88, have been discharged from facility. Residents #58, #87, #83, #17, #28, #8, and #51 assessment of entrapment evaluation was completed, risk of entrapment was completed on 9/12 and the RPS were informed of the risk of entrapment and injury associated with bed rail use. Consents were obtained. 100% of current residents with bed rails were evaluated for bed rail use by Interdisciplinary team, rails removed where applicable. Residents for whom bed rails were required, received an assessment of entrapment evaluation, were assessed for entrapment risk and consents were obtained. MD orders obtained.
2. All residents with bed rails of any size are at risk.
3. ADON or designee will provide education to licensed nurses on assessing need for bed rails as well as assessing entrapment risk, completing entrapment evaluation, obtaining MD order and educating resident and RP and obtaining signed consent when using rails.
4. ADON or designee will audit bed rail use on new admissions daily x 5 days, weekly x 4 weeks, and monthly x 3 months to ensure above process is followed. Will follow monthly x 3 months in QA to ensure compliance.

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on 8/28/19 at 11:49 a.m. with both rails in the up position.

The physician order dated, 8/27/19, documented, "Bilateral enabler bars."

The comprehensive care plan dated, 4/15/19, documented in part, "Need: (Name of Resident #58) is at risk for potential complications r/t (related to) functional ability to safely perform ADLs (activities of daily living) r/t dementia." The "Interventions" documented in part, "BED MOBILITY: Resident uses assistive device enabler bars to reposition and turn in bed...Provide assistive devices as needed...Bilateral enabler bars to assist with bed mobility."

A "Physical Device Evaluation" dated, 7/2/19, "2. Bed/Side Rails and Assist Bars." A check mark was documented next to, "Assist Bar." Further review of the form failed to evidence documentation related to an assessment for the risk of entrapment, explanation of the risk versus benefits and signed consent for the use of the side rails for Resident #58.

A list was provided to ASM (administrative staff member) #2, the director of nursing, on 8/27/19 at 6:00 p.m. The list consisted of a request for the documentation of the assessment for the use of bed rails, the documentation of where the risks of entrapment and a consent for the use of the bed rails for residents listed including Resident #58.

An interview was conducted with administrative staff member (ASM) #2, [the director of nursing], on 8/28/19 at 9:09 a.m. ASM #2 stated the facility evaluated every resident for the risk of

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entrapment. When asked where the assessment was documented in the clinical record, ASM #2 stated, "We don't have a form for this. We have where we reviewed them, on a form, but it's not part of the clinical record. We are in the process of implementing it to be included in the computer." ASM #2 was asked to explain their assessment for the use of side rails. ASM #2 stated, "We have a physical device evaluation. It's our understanding the form is being revised to include the entrapment piece but we don't have that yet." When asked where the discussion regarding the risks versus benefits for the use of side rails with the resident and/or responsible party is documented, ASM #2 sated, "That was done on the date the consents were signed." The form presented was a restraint consent. The form did not reveal any documentation addressing the use of, risks versus benefits and the risks of entrapment with the use of side rails. When asked for the consents that were obtained for the use of the side rails, ASM #2 stated, "There will be no consents for the use of the enabler bars. We are awaiting different forms that have the entrapment risk and the new consent form that addresses the risks and benefits of the use of the side rails/enabler rails. We tried to do the best we could with the resources we had."

On 8/28/19 at 2:30 p.m., ASM #2 returned with a list of resident who did not have consents obtained. Resident #58 was on the list as having no consent for the use of side rails.

A request was made on 8/29/19 at approximately 12:30 p.m. of ASM #2 for the policy for the use of side rails, indications for use, risks and benefits and process for obtaining a consent for the use of the side rails. At 12:59 p.m., ASM #2 returned

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and stated they did not have a policy on bed rail assessment; the only policy they had to address side rails was the "Bed/Mattress/Siderail [Sic.]/ Spacing" policy that does not address the assessment, discussion and consent for the use of the side rails and the risk of entrapment.

Administrative staff member (ASM) #1, the administrator, and ASM #2, the director or nursing, were made aware of the above concern on 8/29/19 at 8:12 a.m.

No further information was provided prior to exit.

2. The facility staff failed to assess Resident #87 for the use of side rails and failed to review the risks and benefits and obtain consent for the use of side rails.

Resident #87 was admitted to the facility on 8/7/19 with diagnoses that included but were not limited to: dementia, difficulty walking, muscle weakness, heart disease, and high blood pressure.

The most recent MDS (minimum data set) assessment, a Medicare admission assessment, with an assessment reference date of 8/14/19, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded in Section G - Functional Status, as requiring extensive assistance of two staff members for moving in the bed.

The physician orders dated, 8/9/19, documented, "Bilateral 1/2 side rails for positioning. Monitor every shift for safety, every shift for positioning

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and safety."

The comprehensive care plan dated, 8/9/19, documented in part, "Need - (Resident #87) is at risk for complications related to use of 1/2 side rails as an enabler, does not restrict movement, guest has impaired mobility related to generalized weakness and fall history." The "Interventions" documented in part, "Discuss and record with resident/family/RP (responsible party), the risks and benefits of 1/2 side rails use. Utilize device as ordered. Device: 1/2 side rails."

A "Physical Device Evaluation" dated, 8/11/19, "2. Bed/Side Rails and Assist Bars." A check mark was documented next to, "1/2 side rail." Further review of the form failed to evidence documentation related to the risk of entrapment and consent for the use of the enabler bars (side rails).

A list was provided to ASM (administrative staff member) #2, the director of nursing, on 8/27/19 at 6:00 p.m. The list consisted of a request for the documentation of the assessment for the use of bed rails, the documentation of where the risks of entrapment and a consent for the use of the bed rails for residents listed including Resident #87.

On 8/28/19 at 2:30 p.m., ASM #2 returned with a list of resident who did not have consents obtained. Resident #87 was on the list evidencing no consent was obtained prior to the use of side rails.

Administrative staff member (ASM) #1, the administrator, and ASM #2, the director or nursing, were made aware of the above concern on 8/29/19 at 8:12 a.m.

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No further information was provided prior to exit.

3. The facility staff failed to evidence that an assessment for the risk of entrapment, review of the risks / benefits and informed consent was obtained for Resident # 83, prior to the use of side rails.

Resident #83 was admitted to the facility on 7/30/19 with diagnoses that include but are not limited to: Cellulitis (inflammation of tissue especially that below the skin, characterize by redness, pain, and swelling. Treatment is by antibiotics) (1), atherosclerotic heart disease of native coronary artery with unspecified angina pectoris (disorder of the arteries in which plaques consisting mostly of cholesterol and lipids form on the inner arterial wall. Treatment may include surgical bypass or stenting of the vessel). (2), and lymphedema (accumulation of lymph in tissues, leading to swelling; it occurs most often in the legs. It can be a result from lymph vessel obstruction or inflammation). (3)

The most recent MDS (minimum data set) assessment, was a 14 day admission assessment with an ARD (assessment reference date) of 8/13/19, coded Resident #83's BIMS (brief interview for mental status) score as a 14 out of 15 indicating intact cognition. Resident #83's functional status was coded as, one-person physical assist with bed mobility.

On 8/26/19 at 7:40 PM, Resident #83's bed was observed with bilateral half upper rails in place. Resident #83 was seated in a wheelchair during this observation. On 8/27/19 at 11:30 AM, Resident #83 was observed in a wheelchair and

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the resident's bed was observed with bilateral half upper rails in place on bed.

On 8/27/19 at 11:30 AM, An interview was conducted with Resident #83. When Resident #83 was asked if the side rails were used when in the bed, Resident # 83 stated, "Sometimes". When asked if the staff had discussed the risks/benefits for the use of side rails, Resident # 83 stated, "No, I don't think so". When asked if she had signed a consent for the side rails, Resident # 83 stated, "I believe so, I think when I came in".

A Physician's order on 8/9/19 at 10:34 AM, documented, "Bilateral half side rails to aide in positioning'.

A physical device evaluation form dated 8/9/19, for Resident #83 documented in part, "One half side rail, assessment of device as enabler for use in repositioning, increase bed mobility, and enhance mobility".

A list was provided to ASM (administrative staff member) #2, the director of nursing, on 8/27/19 at 6:00 p.m. The list consisted of a request for the documentation of the assessment for the use of bed rails, the documentation of where the risks of entrapment, risks versus benefits and a consent for the use of the bed rails was located for each resident listed, including Resident #83.

Review of the clinical record revealed a consent for the use of restraints was signed by Resident #83 on 8/8/19, but failed to reveal a consent for the use of side rails.

On 8/28/19 at 2:30 p.m., ASM #2 returned with a

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list of resident who did not have consents obtained. Resident #83 was on the list with a consent, however, the form did not address the use and the risks of entrapment with side rails nor was there a consent for the use of side rails.

On 8/29/19 at approximately 12:30 PM, ASM #2 was asked to provide the policy on side rails, their use, their risks and benefits and obtaining a consent for the use of them. At 12:59 p.m., ASM #2 returned and stated they did not have a policy on bed rail assessment; the only policy they had to address side rails was the "Bed/Mattress/Siderail [Sic.]/ Spacing" policy which did not address the assessment, discussion and consent for the use of the side rails and the risk of entrapment.

Administrative staff members (ASM) # 1, the administrator, (ASM) # 2, the director of nursing and (ASM) #3 the regional resident care coordinator, were made aware of the above concerns on 8/29/19 at 10:25 AM.

No further information was provided prior to exit.
References:
1. Barron's Dictionary of Medical Terms 7th edition, Kaplan
2. Barron's Dictionary of Medical Terms 7th edition, Kaplan
3. Barron's Dictionary of Medical Terms 7th edition, Kaplan

3. The facility staff failed to evidence that an assessment for the risk of entrapment, review of the risks / benefits and informed consent was obtained for Resident # 89, prior to the use of side rails.

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Resident #89 was admitted to the facility on 8/7/19 with diagnoses that include but are not limited to: Congestive heart failure [characterized by circulatory congestion and retention of salt and water by the kidneys; it is usually caused by a heart disorder and most often develops chronically with shortness of breath due to fluid accumulation in the lungs, and edema of the extremities. Treatment includes diuretics, beta-blockers, digitalis, and oxygen. (1)], COPD [chronic, nonreversible lung disease the is usually a combination of emphysema and chronic bronchitis. Treatment is with bronchodilators, corticosteroids, and antibiotics, when necessary. Oxygen may be helpful in advanced cases. (2)] and hypertension.

The most recent MDS (minimum data set) assessment, was a five-day assessment with an ARD (assessment reference date) of 8/14/19, coded Resident 89 with a BIMS (brief interview for mental status) score was 15 out of 15, indicating intact cognition. Resident 89's functional status was coded as one-person physical assist required with bed mobility and partial or moderate assistance in rolling left to right in bed.

On 8/26/19 at 7:20 PM, Resident #89 was observed in a wheelchair in their room. Observation of the resident's bed revealed bilateral half-upper rails in place on bed. On 8/27/19 at 8:15 AM, Resident #89 was observed sitting on side of bed, bilateral half-upper rails were observed in place on bed. On 8/28/19 at 10:40 AM, Resident #89 was observed in a wheelchair, the bilateral half-upper rails remained in place on the bed.

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On 8/26/19 at 7:20 PM, an interview was conducted with Resident #89. When asked, if side rails were used while in the bed, Resident # 89 stated, "Yes". When asked, if the staff had reviewed the risks/benefits for the use of side rails, Resident # 89 stated, "No". When asked if she had signed a consent for the use of side rails, Resident # 89 stated, "I don't believe so".

A Physician's order dated 8/9/19 at 10:56 AM, documented, "Bilateral enabler bars for positioning".

A list was provided to ASM (administrative staff member) #2, the director of nursing, on 8/27/19 at 6:00 p.m. The list consisted of a request for the documentation of the assessment for the use of bed rails, the documentation of the risks of entrapment and a consent for the use of the bed rails was located for each resident listed. Resident #89 was included on this list.

The physical device evaluation for Resident #89 dated 8/27/19, documented in part, "One half side rail, assessment of device as enabler for use in repositioning, increase bed mobility, and enhance mobility".

Review of the clinical record revealed a consent for the use of restraints was signed by Resident #89 on 8/27/19, but failed to reveal a consent for the use of side rails.

On 8/28/19 at 2:30 p.m., ASM #2 returned with a list of resident who did not have consents obtained. Resident #83 was on the list with a

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consent, however, the form did not address the use and the risks of entrapment with side rails nor was there a consent for the use of enabler bars.

On 8/28/19 1:15 PM, ASM #2 stated they use Lippincott 2019 edition, as their standard of practice.

Administrative staff members (ASM) # 1, the administrator, (ASM) # 2, the director of nursing and (ASM) #3 the regional resident care coordinator, were made aware of the above concerns on 8/29/19 at 10:25 AM.

No further information was provided prior to exit.

References:
1. Barron's Dictionary of Medical Terms 7th edition, Kaplan
2. Barron's Dictionary of Medical Terms 7th edition, Kaplan

5. The facility staff failed to evidence an assessment for the risk of entrapment with the use of side rails, risk versus benefits were discussed and consent obtain prior to the use of side rails for Resident #62.

Resident #62 was readmitted to the facility on 6/29/19 with the diagnoses of but not limited to chronic kidney disease, high blood pressure, dementia, psychosis, heart failure, encephalopathy, dysphagia, bradycardia, chronic obstructive pulmonary disease, anxiety disorder, and cataracts. The quarterly/5-day MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 7/6/19 coded the resident as being severely impaired in ability

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to make daily life decisions. The resident was coded as requiring total care for bathing and dressing; extensive assistance for bed mobility, transfers, toileting and hygiene; and supervision for eating.

On 8/26/19 at approximately 6:45 PM and on 8/27/19 at 2:05 PM an observation was made of Resident #62's bed. Her bed was noted to have bilateral side rails in place.

A review of the clinical record revealed an order dated 8/27/19, which documented, "left enabler bar [side rail]."

A review of the clinical record revealed a "Physical Device Evaluation" form dated 7/2/19 which documented under "Bed/Side Rails and Assist Bars" that the resident had an "Assist Bar."

A review of the comprehensive care plan revealed one dated 3/30/19 for "...at risk for potential complications related to her functional ability to perform ADLs (Activities of Daily Living) independently and safely..." This care plan included the intervention dated 3/13/19 for "Provide assistive devices as needed (specify)....Right enabler bar to assist with bed mobility...."

Further review of the clinical record failed to reveal any evidence of an entrapment evaluation, risk vs benefits were provided to the resident and/or responsible party, and informed consent was obtained prior to use of the side rail / assist bar.

On 8/27/19 at 6:00 PM, a list was provided to ASM #2 (Administrative Staff Member) the

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Director of Nursing. The list consisted of a request for the documentation of the assessment for the use of bed rails, the documentation of where the risks of entrapment and a consent for the use of the bed rails was located for each resident listed, including Resident # 62.

On 8/28/19 at 2:30 PM, ASM #2 returned with a list of resident who did not have consents obtained. Resident #62 was on the list. ASM #2 stated that since the resident had an assist bar and not what the facility deemed was an actual side rail, that the required assessments and consent were not completed.

No further information was provided prior to exit.

6. The facility staff failed to evidence an assessment for the risk of entrapment with the use of side rails, risk versus benefits were discussed and consent obtain prior to the use of side rails for Resident #17.

Resident #17 was readmitted to the facility on 5/15/19 with the diagnoses of but not limited to compression fracture, depression, dementia, hypothyroidism, psychosis, insomnia, high blood pressure, delusions, gastrointestinal hemorrhage, osteoarthritis, and adult failure to thrive. The annual MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 6/7/19 coded the resident as moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and toileting; extensive assistance for bed mobility, dressing, and hygiene; limited assistance for transfers; and supervision for eating.

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F 700	Continued From page 56 On 8/26/19 at approximately 6:45 PM and on 8/27/19 at 2:30 PM an observation was made of Resident #17's bed. Her bed was noted to have bilateral side rails in place. A review of the clinical record revealed an order dated 8/4/19, which documented, "bilateral enabler bars to assist with bed mobility." A review of Resident #17's clinical record revealed a "Physical Device Evaluation" form dated 7/2/19 which documented under "Bed/Side Rails and Assist Bars" that the resident had an "Assist Bar." A review of the comprehensive care plan revealed one dated 5/16/19 for "...has an ADL Self Care Performance Deficit and requires assistance with ADL's (Activities of Daily Living) and mobility.....Guest prefers to remain in bed...." This care plan included the intervention dated 6/11/19 for "Provide appropriate assistive devices as needed:....bilateral enabler bars to assist with mobility...." Further review of the clinical record failed to reveal any evidence of an entrapment evaluation, risk vs benefits were provided to the resident and/or responsible party, and informed consent was obtained prior to use of the side rail / assist bar. On 8/27/19 at 6:00 PM, a list was provided to ASM #2 (Administrative Staff Member) the Director of Nursing. The list consisted of a request for the documentation of the assessment for the use of bed rails, the documentation of where the risks of entrapment and a consent for the use of the bed rails was located for each	F 700		

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resident listed, including Resident #17.

On 8/28/19 at 2:30 PM, ASM #2 returned with a list of resident who did not have consents obtained. Resident #17 was on the list. ASM #2 stated that since the resident had an assist bar and not what the facility deemed was an actual side rail, that the required assessments and consent were not completed.

No further information was provided prior to exit.

7. The facility staff failed to evidence an assessment for the risk of entrapment with the use of side rails, risk versus benefits were discussed and consent obtain prior to the use of side rails for Resident #78.

Resident #78 was readmitted to the facility on 8/3/19 with the diagnoses of but not limited to respiratory failure, chronic obstructive pulmonary disease, heart failure, anxiety disorder, pulmonary hypertension, macular degeneration, dementia, chronic kidney disease, atrial fibrillation, high blood pressure, diabetes, sleep apnea, cataracts, emphysema, and stroke. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 6/12/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for hygiene, toileting, dressing, transfers, and bed mobility; and limited assistance for eating.

On 8/26/19 at approximately 6:45 PM and on 8/27/19 at 2:05 PM an observation was made of Resident #78's bed. Her bed was noted to have

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bilateral side rails in place.

A review of the clinical record revealed an order dated 8/4/19, which documented, "bilateral enabler bars to assist with bed mobility."

A review of Resident #78's clinical record revealed a "Physical Device Evaluation" form dated 8/4/19 which documented under "Bed/Side Rails and Assist Bars" that the resident had an "Assist Bar."

A review of the comprehensive care plan revealed one dated 5/13/19 for "...requires assistance with ADL's (Activities of Daily Living) r/t (related to): impaired mobility...." This care plan included the intervention dated 8/5/19 for "Provide assistive devices as needed (specify)....bilateral enabler bar...."

Further review of the clinical record failed to reveal any evidence of an entrapment evaluation, risk vs benefits were provided to the resident and/or responsible party, and informed consent was obtained prior to use of the side rail / assist bar.

On 8/27/19 at 6:00 PM, a list was provided to ASM #2 (Administrative Staff Member) the Director of Nursing. The list consisted of a request for the documentation of the assessment for the use of bed rails, the documentation of where the risks of entrapment and a consent for the use of the bed rails was located for each resident listed, including Resident #78.

On 8/28/19 at 2:30 PM, ASM #2 returned with a list of resident who did not have consents obtained. Resident #78 was on the list. ASM #2

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stated that since the resident had an assist bar and not what the facility deemed was an actual side rail, that the required assessments and consent were not completed.

No further information was provided prior to exit.

8. The facility staff failed to evidence an assessment for the risk of entrapment with the use of side rails, risk versus benefits were discussed and consent obtain prior to the use of side rails for Resident #28.

Resident #28 was admitted to the facility on 7/6/16 with the diagnoses of but not limited to diabetes, chronic obstructive pulmonary disease, hypothyroidism, pulmonary hypertension, heart failure, atrial fibrillation, insomnia, lumbar disc degeneration, chronic kidney disease, apnea, pathological fractures, high blood pressure, osteoporosis, and sciatica. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/26/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring limited assistance for bathing and eating; supervision for all other areas of activities of daily living.

On 8/26/19 at approximately 6:45 PM and on 8/27/19 at 12:57 PM an observation was made of Resident #28's bed. Her bed was noted to have assist bars in place.

A review of Resident #28's clinical record revealed an order dated 3/17/19, which documented, "bilateral enabler bars to assist with bed mobility."

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A review of the clinical record revealed a "Physical Device Evaluation" form for Resident #28 dated 6/28/19 which documented under "Bed/Side Rails and Assist Bars" that the resident had an "Assist Bar."

A review of the comprehensive care plan revealed one dated 2/8/18 for "...requires assistance with ADL's (Activities of Daily Living)...." This care plan included the intervention dated 3/18/19 for "Provide appropriate assistive devices as needed (specify)....bilateral enabler bars to assist with bed mobility...."

Further review of the clinical record failed to reveal any evidence of an entrapment evaluation, risk vs benefits were provided to the resident and/or responsible party, and informed consent was obtained prior to use of the side rail / assist bar.

On 8/27/19 at 6:00 PM, a list was provided to ASM #2 (Administrative Staff Member) the Director of Nursing. The list consisted of a request for the documentation of the assessment for the use of bed rails, the documentation of where the risks of entrapment and a consent for the use of the bed rails was located for each resident listed, including Resident #28.

On 8/28/19 at 2:30 PM, ASM #2 returned with a list of resident who did not have consents obtained. Resident #28 was on the list. ASM #2 stated that since the resident had an assist bar and not what the facility deemed was an actual side rail, that the required assessments and consent were not completed.

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No further information was provided prior to exit.

9. The facility staff failed to evidence an assessment for the risk of entrapment with the use of side rails, risk versus benefits were discussed and consent obtain prior to the use of side rails for Resident #8.

Resident #8 was admitted to the facility on 11/9/18 with the diagnoses of but not limited to brain cancer, left femur fracture, overactive bladder, macular degeneration, high blood pressure, psychotic disorder, and an eating disorder. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/16/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, bed mobility, dressing, toileting, and hygiene; and supervision for eating.

On 8/26/19 at approximately 6:45 PM and on 8/27/19 at 2:15 PM an observation was made of Resident #8's bed. Her bed was noted to have bilateral side rails in place.

A review of the clinical record revealed an order dated 3/15/19, which documented, "bilateral enabler bars to assist with bed mobility."

A review of Resident #8's clinical record revealed a "Physical Device Evaluation" form dated 7/2/19 which documented under "Bed/Side Rails and Assist Bars" that the resident had an "Assist Bar."

A review of the comprehensive care plan

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revealed one dated 5/29/19 for "...risk for falls...." This care plan included the intervention dated 5/29/19 for "Provide appropriate assistive devices as needed (specify)....bilateral enabler bar...."

Further review of the clinical record failed to reveal any evidence of an entrapment evaluation, risk vs benefits were provided to the resident and/or responsible party, and informed consent was obtained prior to use of the side rail / assist bar.

On 8/27/19 at 6:00 PM, a list was provided to ASM #2 (Administrative Staff Member) the Director of Nursing. The list consisted of a request for the documentation of the assessment for the use of bed rails, the documentation of where the risks of entrapment and a consent for the use of the bed rails was located for each resident listed, including Resident #8.

On 8/28/19 at 2:30 PM, ASM #2 returned with a list of resident who did not have consents obtained. Resident #8 was on the list. ASM #2 stated that since the resident had an assist bar and not what the facility deemed was an actual side rail, that the required assessments and consent were not completed.

No further information was provided prior to exit.

10. The facility staff failed to evidence an assessment for the risk of entrapment with the use of side rails, risk versus benefits were discussed and consent obtain prior to the use of side rails for Resident #51.

Resident #51 was admitted to the facility on

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03//29/19, with the diagnoses of but not limited to chronic obstructive pulmonary disease, diabetes, high blood pressure, heart failure, insomnia, depression, anxiety, and glaucoma. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/12/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; limited assistance for bed mobility, transfers, toileting, and hygiene; and supervision for dressing and eating.

On 8/26/19 at approximately 6:45 PM and on 8/27/19 at 12:502 PM an observation was made of Resident #51's bed. Her bed was noted to have bilateral side rails in place.

A review of the clinical record revealed an order dated 8/9/19 which documented, "bilateral 1/2 (half) side rails to assist with bed mobility. Monitor q (every) shift for safety..."

A review of Resident #51's clinical record revealed a "Physical Device Evaluation" form dated 6/28/19 which documented under "Bed/Side Rails and Assist Bars" that the resident had an "1/2 Side Rail."

A review of the comprehensive care plan revealed one dated 8/9/19 for "...is at risk for complications related to use of 1/2 side rails as an enabler, and does not restrict guest movement, r/t (related to) impaired mobility." This care plan included the intervention dated 8/9/19 for "Utilize device as ordered."

Further review of the clinical record failed to reveal any evidence of an entrapment evaluation,

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risk vs benefits were provided to the resident and/or responsible party, and informed consent was obtained prior to use of the side rail / assist bar.

On 8/27/19 at 6:00 PM, a list was provided to ASM #2 (Administrative Staff Member) the Director of Nursing. The list consisted of a request for the documentation of the assessment for the use of bed rails, the documentation of where the risks of entrapment and a consent for the use of the bed rails was located for each resident listed, including Resident #51.

On 8/28/19 at 2:30 PM, ASM #2 provided a "Restraint Consent Statement" form, signed by Resident #51's responsible party. The form documented, "Based upon my understanding of the risks and benefits associated with the use of restraints, I agree to utilize the following restraint(s): 1/2 side rails (which was hand written on the line provided)." ASM #2 stated this was for the use of the side rails. However, the form did not address an assessment for the risk of entrapment or define the specific risks vs benefits for the use of side rails. The form was a very generic "restraint" use form without providing specific information for specific devices and did not document what specific information was provided to Resident #51 regarding the use of side rails. The side rails were not a restraint for Resident #51, but were documented as enablers.

No further information was provided prior to exit.

11. The facility staff failed to evidence an assessment for the risk of entrapment with the use of side rails, risk versus benefits were

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discussed and consent obtain prior to the use of side rails for Resident #88.

Resident #88 was admitted to the facility on 7/31/19 with the diagnoses of but not limited to sepsis, dysphagia, diabetes, thyroid disorder, depression, anxiety, and psychosis with paranoia. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/26/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring limited assistance for bathing and eating; sepsis, dysphagia, diabetes, thyroid disorder, depression, and anxiety. The admission/5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/7/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for all areas of activities of daily living, except for eating, which required supervision only.

On 8/26/19 at approximately 6:45 PM and on 8/27/19 at 2:51 PM an observation was made of Resident #88's bed. Her bed was noted to have 1/2 (half-length) side rails in place.

A review of Resident #88's clinical record revealed an order dated 8/9/19 which documented, "1/2 side rails for positioning. Monitor every shift for safety."

A review of the clinical record revealed a "Physical Device Evaluation" form dated 8/9/19 which documented under "Bed/Side Rails and Assist Bars" that the resident had an "1/2 Side Rail."

A review of the comprehensive care plan

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revealed one dated 8/12/19 for "...is at risk for complications related to use of 1/2 side rails as an enabler, does not restrict movement, guest has impaired mobility." This care plan included the intervention dated 8/12/19 for "Utilize device as ordered. Device: 1/2 side rails."

Further review of the clinical record failed to reveal any evidence of an entrapment evaluation, risk vs benefits were provided to the resident and/or responsible party, and informed consent was obtained prior to use of the side rails.

On 8/27/19 at 6:00 PM, a list was provided to ASM #2 (Administrative Staff Member) the Director of Nursing. The list consisted of a request for the documentation of the assessment for the use of bed rails, the documentation of where the risks of entrapment and a consent for the use of the bed rails was located for each resident listed.

On 8/28/19 at 2:30 PM, ASM #2 provided a "Restraint Consent Statement" form, signed by Resident #88. The form documented, "Based upon my understanding of the risks and benefits associated with the use of restraints, I agree to utilize the following restraint(s): 1/2 side rails (which was hand written on the line provided)." ASM #2 stated this was for the use of the side rails. However, the form did not address an assessment for the risk of entrapment or define the specific risks vs benefits for the use of side rails. The form was a very generic "restraint" use form without providing specific information for specific devices and did not document what specific information was provided to Resident #88 regarding the use of side rails. The side rails were not a restraint for Resident #88, but were

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F 700	Continued From page 67 documented as being used as enablers. No further information was provided prior to exit.	F 700		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure one of 62 residents in the survey sample, was free of unnecessary medications, Resident #157. The facility staff administered Tylenol and Tramadol pain medication to Resident #157 when	F 757	1. Resident # 157 was discharged from facility on 8.31.19. No negative outcomes occurred as a result of this practice. 100% audit on all patients with orders for PRN pain medication were reviewed and orders updated to reflect physician ordered parameters where appropriate.	9/20/19

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the resident pain scale was outside the parameters ordered by the physician.

The findings include:

Resident #157 was admitted to the facility on 8/23/19 with diagnoses that included but were not limited to: status post pneumothorax (a collection of air or gas in the pleural cavity, causing the lung to collapse. It may occur spontaneously but usually results from injury to the chest that allows the entrance of air. Treatment involves aspiration of the air form the pleural cavity and the administration of pain relievers.) (1).

A MDS (minimum data set) assessment was not yet completed at the time of the survey. The "Nursing Comprehensive Evaluation" dated 8/23/19, documented the resident was alert and oriented to time, person and place...Skin - incision on right flank, chest tube present draining to gravity."

A physician order dated, 8/26/19, documented, "Acetaminophen (Tylenol) [used to treat mild to moderate pain. (2)] Tablet - give 325 mg (milligrams) by mouth every 8 hours as needed for pain 1-3 [pain level of 1-3 on a scale of 0-10, ten being the worse pain ever in]."

A physician order dated, 8/23/19, documented, "Tramadol Tablet [used to treat moderate to moderately severe pain. (3)] 50 mg - give 50 mg by mouth every 4 hours as needed for moderate pain (Scale 4-7)."

A physician order dated, 8/26/19, documented, "Percocet 5-325 [oxycodone - acetaminophen used to treat moderate to severe pain. (4)] give 1

F 757

2. All residents receiving PRN pain medications with parameters are at risk.
3. ADON or designee will provide education to licensed nurses on the importance of administering pain medications within physician ordered parameters and obtaining parameters when multiple prn pain medications are ordered.
4. ADON or designee will audit Pain medication orders and documentation on 10 patients daily x 5 days, 10 pts weekly x 2 weeks, and 10 pts monthly x 3 months to ensure parameters are followed per MD order. Will follow monthly x 3 months in QA to ensure compliance.

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tablet by mouth every 6 hours as needed for pain. Percocet 5-325 - give 2 tablet by mouth every 6 hours as needed for pain."

The August 2019 MAR (medication administration record), for Resident #157 documented the above physician medication orders. The Acetaminophen was documented as administered by staff to Resident #157 for pain levels, as follows on the following dates, and times:
8/24/19 at 2:02 a.m. for a pain level of "10."
8/26/19 at 12:31 a.m. for a pain level of "4."
8/26/19 at 10:12 a.m. for a pain level of "7."
The Tramadol was documented as administered on 8/24/19 at 3:01 a.m. for a pain level of "10."
The Percocet, one tablet was documented as administered on 8/26/19 at 10:14 p.m. for a pain level of "3."

The comprehensive care plan dated, 8/23/19, documented in part, "Need - (Resident #157) is at risk for pain and/or has acute pain r/t (related to) chest tube incision."
The "Interventions" documented in part, "Encourage/provide non-pharmacological interventions to prevent/manage pain as needed such as positioning devices, relaxation techniques such as deep breathing, meditation, prayer, shower. Distraction such as music, television, activities of choice. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Observe for side effects of pain medication. Observe for constipation, new onset or increased agitation, restless ness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls. Report occurrences to the physician."

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An interview was conducted with administrative staff member (ASM) #3, the nurse practitioner, on 8/28/19 at 1:14 p.m. When asked if there should be some guidance for the nurses on which medication to administer when a resident has three different pain medication orders, ASM #3 stated, "Yes, the orders should say for what pain level (parameters) the resident has, as to what medication they should get." When asked if the nurse should give a medication when the pain level rating is outside the ordered parameters for that medication, ASM #3 stated, "No not usually but sometimes we have resident that's specify which one they want."

An interview was conducted with LPN (licensed practical nurse) #3 on 8/28/19 at 5:19 p.m. regarding the process staff follows for resident complaints of pain. LPN #3 stated the nurse should assess the resident for pain, the location, the intensity, use the pain scale. Determine if any non-pharmacological interventions help the resident. Then you give the pain medication according to the physician's orders. LPN #3 was asked to review Resident #157's August 2019 MAR for the pain medications that were administered. When asked if the Tylenol and Tramadol medications were given per the physician ordered pain scale parameters prescribed, LPN #3 stated, "No, they should have given them per the physician's order."

On 8/29/19 at approximately 11:30 a.m., a policy on following physician orders was requested of administrative staff member (ASM) #2, the director of nursing.

On 8/29/19 at 12:32 p.m., ASM #2 informed the

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F 757	Continued From page 71 survey team the facility had no policy on following physician orders. Administrative staff member (ASM) #1, the administrator, and ASM #2, the director or nursing, were made aware of the above concern on 8/29/19 at 8:12 a.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 464. (2) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=tylenol (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a695011.html (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682132.html	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		9/20/19

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§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview it was determined facility staff failed to properly store syringes (1) used for sublingual (under the tongue) medication administration in a sanitary manner on one of three medication carts observed.

The findings include:

On 8/28/19 at 12:25 p.m., an observation was made of the medication cart identified as #3 (three) on the Grand Summit Unit of the facility with LPN (licensed practical nurse) #4. Observation of the medication cart revealed two 30ml (milliliter) bottles labeled "Flavrd Morph sul [flavored morphine solution] (2) 20mg/ml (milligrams/milliliter)" with a rubber band around the white screw cap of each bottle holding an uncovered and uncapped 1 (one) ml syringe in the rubber bands on each of the bottles. Both syringes were observed to have a bluish colored

F 761

1.Medication cart #3s medication syringe was replaced and new one stored in plastic sleeve to prevent contamination. Resident did not have any negative outcome as a result of the practice. 100% audit on all patients with syringes used for oral medication administration were reviewed to ensure proper storage, no other anomalies observed.
2. All residents receiving medications administered with an oral syringe are at risk.
3. SDC or designee will provide education on the importance of storing syringes used for oral medication administration in protective sleeves or plastic bag to provide a barrier for infection control.
4. SDC or designee will audit storage of syringes used for oral medication administration for 5 patients daily x 5

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liquid residue in the tips and were observed uncovered without a cap on the ends. When asked what the syringes are used for LPN #4 stated that they are used to pull up and administer the medication in the bottle that they were attached to. When asked how staff administer the medication, LPN #4 stated, "We give it under the tongue." When asked what the purpose of the rubber band is, LPN #4 stated that it was to keep the syringe with the bottle, so staff know whose medication it is. When asked how often the syringes are changed or cleaned, LPN #4 stated that she did not know, she would have to ask someone. When asked if the syringes are kept covered or capped, LPN #4 stated, "I don't know, I guess we could cover them." When asked what the bluish liquid was in the tips of the syringes, LPN #4 stated that she was not sure that it was probably medicine residue. When asked why the syringes should be covered, LPN #4 stated to keep them clean.

On 8/28/19 at 1:15 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked about the nursing process for storage of syringes used for oral medication administration on the medication cart. ASM #2 stated that she was not sure if there was a specific policy regarding it. ASM #2 stated that most of the syringes have a cap on them and they are changed with each new bottle. When asked if syringes that are being reused and stored on medication carts for residents should be covered, ASM #2 stated that she wasn't sure.

The facility policy "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" did not document guidance on the storage of

Provider's Plan of Correction (F 761):

days, 5 pts weekly x 4 weeks, and 5 pts monthly x 3 months to ensure proper storage. Will follow monthly x 3 months in QA to ensure compliance.

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syringes used for oral medication administration.

The Institute for Safe Medication Practices documented in "Tips for measuring liquid medicines safely" under the section titled "Other liquid medication safety tips:" the following:
- After administering the medicine, always be sure to wash the dosing device. If you fail to do so, bacteria can grow and cause contamination with any future use.
- If you wash a dosing device immediately before administration, be sure to dry it well. Leaving liquid residue on the device can interfere with dosing accuracy. (3)

On 8/28/19 at approximately 8:30 a.m., ASM #2 stated that she had checked and the facility did not have a policy on storage of syringes used for sublingual medication administration. ASM #2 stated that the medication normally comes in a box that it is kept in but the pharmacy did not send it this way this time.

On 08/29/19 at 8:40 a.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were notified of the findings.

No further information was provided prior to exit.

References:

1. Syringe - a device used to inject fluids into or withdraw them from something (such as the body or its cavities): such as
b : an instrument (as for the injection of medicine or the withdrawal of bodily fluids) that consists of a hollow barrel fitted with a plunger and a hollow needle. This information was obtained from the

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F 761	Continued From page 75 website: https://www.merriam-webster.com/dictionary/syringe 2. Morphine is used to relieve moderate to severe pain. Morphine extended-release tablets and capsules are only used to relieve severe (around-the-clock) pain that cannot be controlled by the use of other pain medications. Morphine extended-release tablets and capsules should not be used to treat pain that can be controlled by medication that is taken as needed. Morphine is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682133.html 3. This information was retrieved from the website: https://www.consumermedsafety.org/tools-and-resources/medication-safety-tools-and-resources/taking-your-medicine-safely/measure-liquid-medications	F 761		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced	F 770		9/20/19

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F 770	Continued From page 76 by: Based on observation, staff interview, and facility document review it was determined facility staff failed to properly dispose of laboratory supplies past their expiration date located in 1 of 2 medication rooms observed. The findings include: On 8/28/19 at 9:00 a.m., an observation was made of the medication room on the Westham unit with LPN (licensed practical nurse) #1, the unit manager. Observation of the medication room revealed a package of fifty 3.5ml (milliliter) coagulation sodium citrate sandwich tube containers (blood collection tubes) located on the second shelf of the supply cart with other laboratory supplies available for use . The package was labeled showing an hourglass symbol (expiration date) with a date of 2019-05-10. When asked if the blood containers were expired LPN #1 stated that she would need to check to make sure that was the expiration date. LPN #1 stated that the blood containers are used to draw blood for coagulation (blood clotting) studies to send out to the lab [laboratory] but the facility performs the test there and they do not use them anymore. LPN #1 agreed that they were on the shelf available for use with other lab supplies. LPN #1 removed the tube containers with the date 2019-05-10 from the room. On 8/28/19 at 1:25 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked about the observation in the Westham medication room and the blood collection tubes with the expiration date of 2019-05-10. ASM #2 stated that LPN #1 had given them to her. ASM	F 770	1. Expired lab tubes were immediately removed from medication room and discarded on 8/28/19. Residents did not have any negative outcome as a result of the practice. 100% audit on all areas to check dates on lab tubes was completed, no other anomalies observed. 2. All residents are at risk. 3. SDC or designee will provide education on the importance of discarding expired lab tubes on the expiration date. 4. SDC or designee will audit lab tubes to ensure all expired tubes are discarded daily x 5 days, weekly x 4 weeks, and monthly x 3 months. Will follow monthly x 3 months in QA to ensure compliance.	

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F 770	Continued From page 77 #2 stated that the medication rooms are checked frequently and she did not know how they got in there. ASM #2 stated that they were expired and the blood collection tubes had been discarded. The facility policy "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" documented, "4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier." On 08/29/2019 at 8:40 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit.	F 770		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		9/20/19

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F 812	Continued From page 78 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined that the facility staff failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The staff failed store plates used to serve resident meals in a sanitary manner in the kitchen. The findings include: On 8/27/19 at approximately 8:30 a.m., an observation of the facility's kitchen was conducted with OSM (other staff member) # 2, the director of food and nutrition. Observation of the kitchen area revealed five white divided three section plates stacked on top of each other located on the second shelf of a three shelf metal rack with baking sheets and steam tray pans. OSM #2 stated that these were all washed, dried and available for use. Further observation of the plates revealed the top plate had several areas of brown colored debris stuck on the inside of the plates divided sections. OSM #2 stated that nothing should be on the plate and moved the plate to the dishwasher area. Further observation revealed the third plate in the stack had brown colored debris stuck on the two sections of the divided plate and the fourth plate had water droplets inside of two of the divided sections of the plate. OSM #2 stated they should not be there and returned them to the dishwasher area.	F 812	1. Dirty/wet plates were immediately removed from storage area and returned to the dishwasher. All other dishes and utensils were checked at that time to ensure proper cleaning and storage. Residents had no negative outcomes as a result of this practice. 2. All Residents are at risk. 3. Dietary Manager will provide education to Kitchen staff on proper storage of dishes. 4. Kitchen dish storage will be audited 5x weekly x 1, weekly x 4 weeks, then monthly x 3 months to ensure compliance. Will follow monthly x 3 months in QA to ensure compliance.	

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On 8/28/19 at 8:30 a.m., an interview was conducted with OSM #2. When asked about the facilities process for drying cookware and dishes, OSM #2 stated that dishes are air dried in the drying area prior to being put in use. When asked why they are air dried, OSM #2 stated this is done to avoid any type of infection and cross contamination. OSM #2 was asked what stacking dishes while still wet could cause. OSM #2 stated bacteria can grow (2). When asked if dishes are inspected prior to being put into service for use, OSM #2 stated, "Yes, they should be." When asked about the observation made in the kitchen of the brown debris stuck on the divided plates in the kitchen on 08/27/2019, OSM #2 stated that she could not confirm that it was food, but it was debris and it was stuck on the plates and that the plates were available for use. When asked if plates with stuck on debris should be available for use by residents, OSM #2 stated, "No" (2).

The facility policy "Storage of Dishes" documented, "Policy: Dishes shall be appropriately stored to prevent contamination and breakage." Under the section titled "Procedure" it documented, "Plates, cereal bowls, vegetable dishes, saucers, and bread & butter plates shall be stored in covered dish carts ..."

The facility policy, "Storage of Foodservice utensils" documented under "Procedure: 3. All food preparation and serving utensils shall be thoroughly washed and sanitized after each use. All utensils shall be air dried. 4. Clean utensils shall be stored in a clean, dry location where they are not exposed to splashes, dust, or other contamination ..."

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Food Code 2009 Recommendations of the United States Public Health Service Food and Drug Administration
4-901.11 Equipment and Utensils, Air-Drying Required.
Federal food code: 4-901.11 Equipment and Utensils, Air-Drying Required.
- Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils.

Food Code 2009 Recommendations of the United States Public Health Service Food and Drug Administration
4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.
- (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. Pf
- (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.
- (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.

On 08/29/2019 at 8:40 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing were made aware of the findings.

No further information was provided prior to exit.