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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 08/14/18 through 08/17/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 8/14/18 through 8/17/18. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 240 certified bed facility was 214 at the time of the survey. The survey sample consisted of 35 current Resident reviews and 4 closed record reviews. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of | F 580 | | 9/25/18 |

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

Electronically Signed | 09/13/2018

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| F 580 | Continued From page 1<br>treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on family interview, staff interview, facility document review and clinical record review, the facility staff failed to inform the responsible party of a change in condition for 1 of 39 residents (Resident #14). | F 580 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and | |

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| F 580 | Continued From page 2<br><br>The findings included:<br><br>The facility staff failed to inform the RP (responsible party) of a speech therapy consult for Resident #14.<br><br>The clinical record of Resident #14 was reviewed 8/14/18 through 8/17/18. Resident #14 was admitted to the facility 12/22/14 and readmitted 2/8/18 with diagnoses that included but not limited to motor vehicle accident with traumatic brain injury, decubitus ulcer of right hip, stage 3, spasticity, sepsis, unspecified organism, dysphagia, intracranial injury, allergic rhinitis, seizures, left hand and wrist contractures, major depressive disorder, quadriplegia, idiopathic scoliosis, and hypertension.<br><br>Resident #14's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/16/18 coded the resident with short-term memory problems, long-term memory problems, and severely impaired cognitive skills for daily decision-making.<br><br>Resident #14's current comprehensive care plan created on 12/26/2014 and revised on 2/13/18 identified the focus area of impaired cognitive function r/t (related to) head injury. Interventions: Communicate with the resident/family/caregivers regarding residents capabilities and needs.<br><br>The surveyor met with the ombudsman and Resident #14's mother on 8/15/18 at 11:03 a.m. Resident #14's mother had numerous concerns one of which was she was not notified of a speech therapy consult in October 2017. Resident #14's mother stated she had some | F 580 | federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.<br><br>F 580<br>Resident #14□s RP has been notified of the speech therapy consult order 10/24/2017.<br>Long term care residents with orders for speech therapy in the last 30 days were reviewed to ensure RP notification. Issues were corrected at the time of identification.<br>Current licensed nurses and therapy staff were educated regarding notification of RP when orders are received for speech therapy. Order listing report will be reviewed by nursing leadership 4X weekly X 8 weeks to ensure notification of RP for new speech therapy orders. Any issues will be addressed immediately at the time of identification.<br>Process will be reviewed in quarterly QA meeting. | |

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| F 580 | Continued From page 3 | F 580 | | |

issues with the speech therapist that occurred in October 2017. The mother stated the facility did not inform her of the speech therapy assessment.

The surveyor reviewed the clinical record of Resident #14. An order dated 10/24/17 read "ST (speech therapy) to evaluate for communication." The October 2017 progress notes were reviewed. The surveyor was unable to locate any evidence Resident #14's mother/responsible party was informed of the order.

The surveyor interviewed the unit manager licensed practical nurse #1 on 8/17/18 at 9:17 AM L.P.N. #1 stated there was an order for a ST evaluation dated 10/24/17. L.P.N. #1 stated usually therapy talks to the RP of a consult involving therapy.

The surveyor interviewed the rehab manager 8/17/18 at 9:32 a.m. The rehab manager stated she didn't see anything charted about notification. The rehab manager stated the ST talks with the mother often. "She was on caseload." The rehab manager stated "You won't find anything written."

The surveyor informed the director of nursing of the above issue 8/17/18 and requested the facility policy on notification.

The policy titled "Documentation and Notification" was reviewed 8/17/18. The policy read, "The Unit Manager is responsible for ensuring that notifications by the Charge Nurses to physicians and responsible parties regarding a change in the care of the patient have properly occurred."

The DON stated to the surveyor 8/17/18 at 11:41 a.m. that she would expect nurses to call the RP

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| F 580 | Continued From page 4<br>and document about the physician order.<br><br>No further information was provided prior to the exit conference on 8/17/18. | F 580 | | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas; | F 584 | | 9/25/18 |

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| F 584 | Continued From page 5<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, Resident interview, and clinical record review, the facility staff failed to ensure a clean, comfortable, homelike environment for one of 39 Residents (Resident #39) and on 3 of 4 units (units 2, 3, and 4).<br><br>The Findings included:<br><br>1. For Resident #39, the surveyor observed two tiles on the Residents ceiling that were stained brown, a brown substance on the Residents walls, a brown substance on the Residents privacy curtain, and urine in the commode in the bathroom.<br><br>The clinical record review revealed that Resident #39 had been admitted to the facility 10/29/15. Diagnoses included, but were not limited to, dysphasia, chronic pain, aphasia, and gastro-esophageal reflux disease with esophagitis.<br><br>Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/30/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section H (bladder and bowel) was coded to indicate the Resident was always | F 584 | F584<br>Urine odors on Units 2, 3, and 4 have been removed. Stained privacy curtain for Resident #311 has been replaced. Baseboard has been replaced in room 117. Stained tiles, stained wall, stained privacy curtain, and urine in commode has been corrected for Resident #39.<br>Facility wide rounds were completed to observe tiles, privacy curtains, urine odors, walls, baseboards, commodes. Issues were corrected at the time of identification.<br>Current facility staff were educated regarding clean, homelike environment.<br>Facility rounds will be completed weekly X 8 weeks to ensure rooms and environment are free of urine odors, and tiles, walls, baseboards, curtains, and toilets are clean. Ongoing renovations for center rooms will occur while repairs are made as needed. Any issues will be addressed immediately at the time of identification.<br>Process will be reviewed in quarterly QA meeting. | |

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| F 584 | Continued From page 6 | F 584 | | |

incontinent in both of these areas.

During an interview with Resident #39 on 08/15/18 at 12:31 p.m., the surveyor observed two brown stained ceiling tiles above the Residents bed, brown streaks on the wall, and the bathroom was noted to have urine in the commode, at the top of this urine the surveyor was able to observe a brown ring that went around the bowl of the commode. The surveyor observed two wheelchairs in this bathroom. Resident #39 stated the brown tiles had been that way for a while.

The surveyor rechecked the Residents room on 08/16/18 at 8:15 a.m., the surveyor was able to observe two brown stained ceiling tiles, brown streaks on the Residents walls, and urine in the commode in the bathroom. During this observation, the surveyor also noted the privacy curtain was stained with a brown substance.

After this observation, the surveyor spoke with the unit manager. The unit manager verbalized that neither Resident in this room used the commode/bathroom.

On 08/16/18 at 10:11 a.m., maintenance personnel #2 was shown the brown stained tiles. The surveyor was still able to observe the stains on the Residents wall and curtain. Urine remained in the bathroom and the bathroom now had a strong urine smell.

The administrative staff were notified of the issues in the Residents room on 08/16/18 at 4:40 p.m.

No further information regarding these issues

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| F 584 | Continued From page 7 | F 584 | | |

were shared with the surveyor prior to the exit conference.
2. The facility staff failed to ensure a clean, comfortable and homelike environment on 2 of 4 units in the facility, Unit 2 and Unit 3.

For Unit 2 of the facility, the facility staff failed to ensure a clean environment.

During initial tour of the facility on 08/14//18 at approximately 1130, the surveyor noted a pervasive odor of urine on Unit 3 of the facility, in the area of rooms 73-89. Surveyor also noted a pervasive odor of urine on Unit 2 of the facility, in the area of rooms 37-38, at approximately 1140 on 08/14/18. The surveyor again noticed a pervasive odor of urine on Unit 3 of the facility on 08/14/18 at approximately 1240, in the area of rooms 73-89.

On 08/15/18 at approximately 1005, the surveyor noted a strong odor of urine on Unit 2 of the facility, in area of rooms 37-38.

On 08/16/18 at approximately 0915, the surveyor noted an underlying odor of urine odor on Unit 2 of the facility, in area of rooms 35-38.

The concern of the urine odor was discussed with the administrative team during a meeting on 08/16/18 at approximately 1630.

No further information was provided prior to exit.
3. The facility staff failed to ensure a clean, comfortable and sanitary environment on unit 4.

During the initial tour on 8/14/18 on unit 4 around 11:30 a.m., the surveyor noted a strong odor of urine on the far end of unit 4 in the corridor

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| F 584 | Continued From page 8 | F 584 | | |

between rooms 114-117 but more noticeable in rooms 116 and 117. Room 116 had two residents currently residing there and Room 117 was a four-bed ward with four residents.

The surveyor informed the unit manager licensed practical nurse #1 of the odor especially in Room 116 and Room 117 on 8/14/18. She stated the resident in Room 116 tends to hoard urinals.

During the initial tour on 8/14/18, the residents in the four bed ward in Room 117 each had their privacy curtain pulled. As you entered the room, the surveyor observed many darkened dried areas on the privacy curtain between A and B beds and between C and D beds.

The surveyor interviewed Resident #311 on 8/14/18 at 3:10 p.m. Resident #311 was in bed D in the four-bed ward. A pervasive odor of urine was noted in the room. Resident #311's room was also observed to be cluttered.

The surveyor and the unit manager licensed practical nurse #1 observed Room 117 on 08/16/18 11:58 a.m. The surveyor shared her concerns about the baseboards and odor in the room. The baseboards had numerous "black marks" from the door to the bathroom.

The surveyor observed wound care on 8/16/18 at 11:59 a.m. with registered nurse #1.

The surveyor showed the wound care nurse as both were exiting the room, the privacy curtain separating Bed A and B and the privacy curtain separating bed c and Bed D. She agreed that the privacy curtains were soiled and stated she would get someone to replace them.

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| F 584 | Continued From page 9<br><br>The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the administrator-in-training of the above concern during the end of the day meeting on 8/16/18 at 4:41 p.m.<br><br>The administrator stated that the maintenance department was replacing the baseboards one room at a time. Room 102 was completed in May 2018, Room 113 was completed in June 2018, and Room 114 was completed in July 2018.<br><br>No further information was provided prior to the exit conference on 8/17/18. | F 584 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to follow physician orders for two of 39 Residents, Residents #39 and #129.<br><br>The findings included:<br><br>1. For Resident #39, the facility failed to follow physician orders in regards to the Residents | F 684 | F684<br>Protonix medication has been discontinued for Resident #39. Resident #129 is no longer being weighed.<br>Current residents receiving Protonix medication will be reviewed to ensure medication is available for administration.<br>Current residents with orders for no weights will be reviewed to ensure weights | 9/25/18 |

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| F 684 | Continued From page 10<br>protonix medication. Resident #39 did not have any protonix to administer.<br><br>The clinical record review revealed that Resident #39 had been admitted to the facility 10/29/15. Diagnoses included, but were not limited to, dysphasia, chronic pain, aphasia, and gastro-esophageal reflux disease with esophagitis.<br><br>Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/30/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.<br><br>A review of the Residents eMARs (electronic medication administration records) for August 2018 revealed that the facility nursing staff had documented a "9" on 08/05/18 and 08/06/18 and a "5" on 08/08-08/15/18. For 08/07/18 the facility staff had documented they had administered the medication.<br><br>Per the preprinted "Chart Codes" on the eMARs a 5 meant "Hold/See Progress Notes" and 9 meant "Other/See Progress Notes."<br><br>A review of the progress notes indicated that the facility nursing staff had documented the following in regards to the protonix.<br>08/05/18-"Protonix solution 20 mg via peg tube in the morning for gerd Rsd is out. Meds have been ordered."<br>08/06/18-"Protonix solution 20 mg...Rsd does not have meds. Have reordered but has not come yet."<br>08/08/18-"Protonix solution...Rsd still has not | F 684 | are not being obtained. Issues were corrected at the time of identification. Current licensed nursing staff were educated regarding processing of new orders and process for acquiring medications from the pharmacy. Order listing report and clinical dashboard for meds not administered will be reviewed 4X week X 8 weeks to identify medication availability and to ensure weights have been discontinued for any new orders for no weights. Any issues will be addressed immediately at the time of identification. Process will be reviewed in quarterly QA meeting. | |

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received meds. Will follow up with day shift to get it ordered."
08/10/18 at 1:14 a.m.-"Protonix solution...Rsd does not have any meds at this time."
08/10/18 at 5:32 a.m.-"Protonix...Rsd does not have meds. Sent MD communication to see what to do about meds. tried to order from pharmacy."
08/11/18-"Protonix...does not have any meds at this time."
08/12/18-"Protonix solution via peg tube in the morning for gerd."
08/13/18-"Protonix...not in stock."
08/14/18-"Protonix...Meds are not in stock."
08/15/18-"Protonix Packet...Rsd does not have any meds at this time."
08/16/18-"Protonix...Meds not covered by pharmacy."

A review of the stat box list indicated that this medication would not have been available in the stat box for administration.

The administrative staff were made aware of the issue regarding the Residents protonix during a meeting with the survey team on 08/15/18 at 4:48 p.m.

On 08/16/18 at 9:07 a.m., the surveyor interviewed the unit manager regarding the Residents protonix. The unit manager verbalized to the surveyor that the Residents insurance would not pay for the protonix. The unit manager stated that "after so long" she would call and see if they could get the medication and stated she had spoken with the PA (physician assistant) this am and received an order to discontinue the medication.

On 08/16/18 at 9:20 a.m., the surveyor

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| F 684 | Continued From page 12 | F 684 | | |

interviewed pharmacist #1 via phone. Pharmacist #1 stated that the insurance would not pay for the liquid protonix, as it was a compound. Pharmacist#1 stated the protonix was last sent to the facility May 4, 2018.

On 08/16/18, the facility provided the surveyor with the following progress note from the family nurse practitioner. "...Pt (patient) currently ordered protonix but insurance will not provide. Will change to ranitidine solution 150 mg via PEG BID (twice a day)."

No further information regarding the protonix was provided to the survey team prior to the exit conference.

2. For Resident #129, the facility obtained the Residents weights after they had been discontinued by the physician. The Resident was on comfort care.

The clinical record review revealed that Resident #129 had been admitted to the facility 04/10/2001. Diagnoses included, but were not limited to, anoxic brain damage, muscle weakness, constipation, and quadriplegia.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/22/18 included a BIMS (brief interview for mental status) summary score of 9 out of a possible 15 points.

Attempts to interview the Resident were unsuccessful.

The clinical record included a physician order

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| F 684 | Continued From page 13<br>dated 02/03/17 "Comfort care orders...D/C (discontinue) all weights..."<br><br>However, the clinical record included weights obtained after 02/03/17 with the last weight being documented on 05/28/18 (102.9 pounds). Since the last standard survey (05/23/17-05/25/17), the facility staff had documented 19 weights for this Resident.<br><br>The comprehensive care plan included the intervention "...no weights..."<br><br>The administrative team were notified of the above during a meeting with the survey team on 08/15/18 at 4:48 p.m.<br><br>During an interview with the unit manager on 08/15/18 at 11:02 a.m., the unit manager verbalized to the surveyor that the order had been discontinued. However, it was still showing as active in the CNA (certified nursing assistant) task screen. The unit manager stated she had resolved it today.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference. | F 684 | | |
| F 689 SS=E | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent | F 689 | | 9/25/18 |

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| F 689 | Continued From page 14<br>accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility staff failed to ensure an accident free environment on four of four units and for one of 39 residents #149.<br><br>The findings included.<br><br>1. The facility failed to ensure a hazard free environment on unit's 1, 2, 3, and 4. The surveyor was able to observe jagged/splintered edges on doors on all four units of the facility.<br><br>On 08/16/18 at 3:15 p.m., while doing environmental rounds the surveyor observed the following doors with jagged/splintered edges-Rooms 1, 16, 24 , 29, 47, 50, 59, 88, 103, 105, 106, 109, 113, 117, 118, corridor doors between rooms 20-23 and 18-21.<br><br>The surveyor also observed a loose wall socket outside room 23.<br><br>The DON (director of nursing) was notified of the jagged/splintered door to room #1 on 08/16/18 at 3:20 p.m. and stated she would work put a work order in.<br><br>The administrative staff were notified of the above during a meeting with the survey team on 08/16/18 at 4:40 p.m.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference on 08/17/18.<br>2. For Resident #149, facility staff failed to ensure that the bathroom doorway was free of | F 689 | F689<br>Splintered doors and jagged edges for rooms 1, 16, 24, 29, 47, 50, 59, 88, 103, 105, 106, 109, 113, 117, 118, and corridor doors between rooms 20-23 and 18-21 have been repaired. Rust and sharp edge on Resident #149□s door has been repaired.<br>Facility wide rounds, including common areas, were completed to observe any further doors for jagged, sharp edges and/or rust. Issues were corrected at the time of identification.<br>Current facility staff were educated regarding an accident free environment.<br>Facility rounds will be completed monthly X 2 to ensure doors remain free of sharp, jagged edges and rust. Any issues will be addressed immediately at the time of identification.<br>Process will be reviewed in quarterly QA meeting. | |

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| F 689 | Continued From page 15<br>rust and sharp edges.<br><br>Resident #149 was admitted to the facility on 4/14/18. Diagnoses included heart failure, diabetes mellitus, non-Alzheimer's dementia, congestive heart failure, muscle weakness, neuropathy, gout, collapsed vertebra, osteoarthritis, and cardiac arrhythmia. The on the quarterly minimum data set assessment with assessment reference date 4/17/2018, the resident scored 14/15 on the brief interview for mental status (BIMS) and was assessed as without symptoms of delirium, psychosis, or behaviors affecting care (including refusal of care).<br><br>During an interview on 8/16/18, the surveyor noted that the door frame to the resident's bathroom showed several spots where rust showed through the paint. On the lower left side of the door frame, approximately 3 inches had expanded outward enough that the door did not close flush to the frame. The edges of that part of the frame exhibited sharp edges which could snag clothing or cut skin.<br><br>The surveyor reported the concern with the door frame to the administrator and director of nursing during a summary meeting on 8/17/18. | F 689 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must | F 692 | | 9/25/18 |

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| F 692 | Continued From page 16<br>ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review and resident interview, failed to provide therapeutic diet that takes into account the resident's preferences and desirable weight for 1 of 39 residents in the survey sample (#149).<br><br>Resident #149 was admitted to the facility on 4/14/18. Diagnoses included heart failure, diabetes mellitus, non-Alzheimer's dementia, congestive heart failure, muscle weakness, neuropathy, gout, collapsed vertebra, osteoarthritis, and cardiac arrhythmia. On the quarterly minimum data set assessment with assessment reference date 4/17/2018, the resident scored 14/15 on the brief interview for mental status (BIMS) and was assessed as without symptoms of delirium, psychosis, or behaviors affecting care (including refusal of care).<br><br>The surveyor interviewed the resident on 8/15/18. During the interview, the resident expressed | F 692 | F692<br>Resident #149 is currently being provided a therapeutic diet that has taken into account her preferences and desirable weight.<br>Current residents were reviewed to ensure that resident preference and choices regarding supplements are being honored. Issues were corrected at the time of identification.<br>Dietary manager, Registered Dietician, and nursing leadership were educated regarding select menus that honor choice and preference. During weight meetings, residents receiving supplements for weight loss will be reviewed to ensure continued need based on desirable weight and current nutritional status. Registered Dietician, or designee, will discuss nutrition interventions and weights with residents and/or responsible parties during care plan meetings. Registered | |

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| F 692 | Continued From page 17<br>frustration with her efforts at weight management. She stated that she had been diagnosed with heart failure and told that she should lose weight to help control fluid levels and make it easier to breathe. The resident said she had tried really hard, given up desserts and most snacks, and had lost some weight, but that the weight had come back. The resident also said the aids did not like to take her to the bathroom, saying she went too often and that she was too heavy to transfer and that staff had started using a lift the night before.<br><br>The resident has an order dated 8/6/18 for med plus 2.0 40 cc per day to maintain body weight and prevent weight loss. The weight resident's dietary note said there had been undesirable weight gain and new orders were written.<br><br>8/16/18 Interviewed the facility dietician about the resident's weight gain, BMI of 29.3, and receiving Med Plus while gaining weight and falling within the parameters for obesity. The dietician stated that the supplement was for protein because the resident's gout prevented her from eating beef and pork. She stated that staff could not feed her chicken every day. The surveyor asked if the resident had any clinical indicators of protein deficiency and the dietician stated that she had none. On 8/17, the surveyor asked the dietary manger for a printout of the resident's dietary preferences. The dietician was in the office when the report was printed. At that time, the dietician stated that the resident needed the extra supplement for the calories. The surveyor stated the resident's BMI (body mass index) was 29.3, which is borderline obese. The dietician stated that desirable BMI for a resident of Resident # 149's age is 25-30. The surveyor asked for the | F 692 | Dietician, or designee, will audit supplements monthly x2 to review for appropriateness.<br>Process will be reviewed in quarterly QA meeting. | |

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| F 692 | Continued From page 18<br>treatment standard suggesting that the BMI should be that high. During an interview on 8/17/18, the facility dietician and the corporate dietician offered an article titled Desirable body weight in the older adult:What does the current research indicate? by Phyllis Famularo published in Dietetics in Healthcare Communities Connections Volume 40 Issue 1 Summer 2014. A sentence was highlighted indicating the mortality risk for community dwelling older adults was a bell curve with the lowest point between 27.0 and 27.9 and increasing with BMI less than 20 or greater than 33.5. There was no indication that an increase above the resident's lowest BMI in 6/1/2018 of 27.0 (height 65 inches and weight 162.5) was desirable if the article is the basis for a standard of practice. On 8/6/18 when the supplement was ordered "to maintain body weight and prevent weight loss", the resident's BMI had increased to 29.3, which is above the most desirable range of 27-27.9.<br><br>During a meeting on 8/16/18, the administrator and director of nursing were notified with the concerns with the resident's diet, weight management, and rationale for providing a high calorie dietary supplement to a resident who desired weight loss. | F 692 | | |
| F 697 SS=D | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br>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.<br>This REQUIREMENT is not met as evidenced | F 697 | | 9/25/18 |

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| F 697 | Continued From page 19<br>by:<br>Based on Resident interview, staff interview, clinical record review and facility document review failed to follow physician orders for pain management for 2 of 39 Residents, Resident #22 and #18.<br><br>The findings included:<br><br>1. For Resident #22 the facility staff failed to ensure the pain medication Tramadol was administered per physician's orders.<br><br>Resident #22 was admitted to the facility on 04/26/16. Diagnoses included but not limited to hypertension, diabetes mellitus, hyperlipidemia, hemiplegia, depression, atrial fibrillation, angina, insomnia and glaucoma.<br><br>The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/23/18 coded the Resident as 15 of 15 in section C, cognitive patterns. Section J of the MDS, health conditions, indicated that Resident #22 received scheduled pain medication and rated her pain as frequently being a 6 on a scale of 1-10. This is a quarterly MDS.<br><br>The Resident's CCP (comprehensive care plan) was reviewed and contained a care plan for pain. The goal for this plan read "Resident will have no/decreased complaints of pain through next review". The interventions for this plan read in part "Medicate as ordered".<br><br>The surveyor spoke with Resident #22 on 08/14/18 at approximately 1450. Resident stated that she receives scheduled pain medication, but there have been occasions when she did not | F 697 | F697<br>Resident #22 is currently receiving Tramadol as ordered. Resident #18 is currently receiving Hydrocodone as ordered.<br>Current residents receiving Tramadol and Hydrocodone will be reviewed to ensure medications are available for administration. Issues were corrected at the time of identification.<br>Current licensed nursing staff were educated regarding processing of new orders and process for acquiring medications from the pharmacy. Order listing report and clinical dashboard for meds not administered will be reviewed 4X week X 8 weeks to identify medication availability. Any issues will be addressed immediately at the time of identification. Process will be reviewed in quarterly QA meeting. | |

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receive her medication. She stated the reason as the facility had ran out of her medications and it had not arrived from the pharmacy. Resident #22 stated that she takes Tramadol for pain and that she waited all night one night and never received her pain medication.

Resident #22's clinical record was reviewed on 08/14/18. It contained a POS (physician's order summary) for the month of August which read in part, "Tramadol HCl tablet-Dispersible (sic) 50 mg. give 1 tablet by mouth every 6 hours for pain", with an order date of 05/25/17.

Resident #22's eMAR (electronic medication administration record) for the months of July and August were reviewed. For the month of July, the eMAR had been coded "H" for 07/19/19 at 0600, 1200 and 1800, and for 07/20/18 at 0000 and 0600. The eMAR for July was coded "9" on 07/27/18 at 1200, which is the equivalent of "other/see progress notes" and coded "5" on 07/27/18 at 1800, which is the equivalent of "hold/see progress notes". The eMAR was coded "H" on 07/28/18 at 0600 and 1200. The surveyor reviewed Resident #22's progress notes for the days indicated, but could not locate any notes related to medication.

The surveyor reviewed Resident #22's narcotics sheet for the month of July. The narcotics sheet indicates that the last tablet of a 30-tablet card was signed for on 07/19/18 at 0000. The next tablet was signed out on 07/20/18 at 0035. The narcotic sheet for 07/27/18 indicated the last tablet was signed out on 07/27/18 at 0600, and the next tablet was signed out on 07/28/18 at 1800.

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Surveyor requested and was provided with a copy of facility policy entitled "Medication Shortages/Unavailable Medications", which read in part "Procedure: 1. Upon discovery that Facility has an inadequate supply of a medication to administer to a Resident, Facility staff should immediately initiate action to obtain the medication form pharmacy. If the medication shortage is discovered at the time of medication administration, facility staff should immediately take the action specified in Section 2 or 3 of this policy, as applicable. 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available causes delay or a missed dose in the Resident's medication schedule, facility nurse should obtain the medication form the Emergency Medication Supply to administer the dose. 3. If a medication shortage is discovered after normal pharmacy hours: 3.1 A licensed facility nurse should obtain the ordered medication form the Emergency Medication Supply. 8. When a missed dosed is unavoidable, facility nurse should document the missed dose and the explanation for such missed dose on the MAR or TAR (treatment administration record) and in the nurse's notes per facility policy".

Surveyor requested and was provided with a list of medications located in the facility stat on 08/15/18 at approximately 0900. The medication Tramadol 50 mg was observed to be available in the stat box.

Surveyor spoke with the administrative team on

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08/15/18 at approximately 1650 regarding Resident #22's medications not being administered. Surveyor asked the RNC (regional nurse consultant) to clarify the coding on the eMAR, and RNC stated that the codes indicate that the medication had not been administered. Surveyor asked the administrative team what the procedure was for reordering medications and they never gave a definitive answer.

The concern of the pain medications not being administered per the physician's orders was discussed with the administrative team during a meeting on 08/16/18 at approximately 1630.

No further information was provided prior to exit.

2. For Resident #18 the facility staff failed to ensure the pain medication hydrocodone was administered per physician's orders.

Resident #18 was admitted to the facility on 06/30/17 and readmitted on 04/08/18. Diagnoses included but not limited to congestive heart failure, hypertension, diabetes mellitus, hyperlipidemia, depression, chronic obstructive pulmonary disease, fibromyalgia, and atrial fibrillation.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/18/18 coded the Resident as 9 of 15 in section C, cognitive patterns. Section J of the MDS, health conditions, indicated the Resident received scheduled pain medication and rated her pain as being almost constantly a 6 on a scale of 1-10. This is a quarterly MDS.

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Resident #18's CCP (comprehensive care plan) was reviewed and contained a care plan for pain. The goal for this plan read "Resident will have no/decreased complaints of pain through next review". The interventions for this plan read in part "Medicate as ordered".

Surveyor spoke with Resident #18 on 08/15/18 at approximately 1410. Resident stated to surveyor "one day last week they let my pain meds run out, told me they had to wait for the pharmacy to deliver it".

Resident #18's clinical record was reviewed on 08/16/18. It contained as POS (physician's order summary) for the month of August which read in part, "Hydrocodone-Acetaminophen Tablet 5-325 mg-Give 1 tablet by mouth every 6 hours for pain while awake". Resident #18's eMAR (electronic medication administration record) for the month of July was reviewed and contained an entry, which read in part, "Hydrocodone-acetaminophen tablet 5-325 mg-Give 1 tablet by mouth every 6 hours for pain while awake -order date-06/27/2018". This entry had been coded with "9" on 07/10/18 at 1200, 1800 and 07/11/18 at 0000. On 07/10/18 at 0600, there was no entry nor initials. Chart code for "9" is the equivalent of "other/see progress notes". The surveyor reviewed Resident #18's progress notes for these dates, but could not locate any notes related to medication.

Surveyor requested and was provided with a copy of facility policy entitled "Medication Shortages/Unavailable Medications", which read in part "Procedure: 1. Upon discovery that Facility has an inadequate supply of a medication to administer to a Resident, Facility staff should

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immediately initiate action to obtain the medication form pharmacy. If the medication shortage is discovered at the time of medication administration, facility staff should immediately take the action specified in Section 2 or 3 of this policy, as applicable. 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available causes delay or a missed dose in the Resident's medication schedule, facility nurse should obtain the medication form the Emergency Medication Supply to administer the dose. 3. If a medication shortage is discovered after normal pharmacy hours: 3.1 A licensed facility nurse should obtain the ordered medication form the Emergency Medication Supply. 8. When a missed dosed is unavoidable, facility nurse should document the missed dose and the explanation for such missed dose on the MAR or TAR (treatment administration record) and in the nurse's notes per facility policy".

Surveyor requested and was provided with a list of medications located in the facility stat on 08/15/18 at approximately 0900. The medication hydrocodone-acetaminophen 5-325 mg was not available in the stat box.

Surveyor spoke with the administrative team on 08/15/18 at approximately 1650 regarding Resident #18's medications not being administered. Surveyor asked the RNC (regional nurse consultant) to clarify the coding on the eMAR, and RNC stated that the codes indicate that the medication had not been administered.

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| F 697 | Continued From page 25<br>Surveyor asked the administrative team what the procedure was for reordering medications and they never gave a definitive answer.<br><br>The concern of the pain medications not being administered per the physician's orders was discussed with the administrative team during a meeting on 08/16/18 at approximately 1630.<br><br>No further information was provided prior to exit. | F 697 | | |
| F 755 SS=E | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in | F 755 | | 9/25/18 |

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| F 755 | Continued From page 26<br>sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on Resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure medications were available for administration for 4 of 39 Residents, Resident #78, #64, #309 and #87.<br><br>The findings included:<br><br>1. For Resident #78 the facility staff failed to ensure the medication ropinirole (generic for Requip) was available for administration. According to Davis Drug Guide, ropinirole is a medication used to treat restless leg syndrome.<br><br>Resident #78 was admitted to the facility on 04/17/18. Diagnoses included but not limited hypertension, diabetes mellitus, Parkinson's disease, macular degeneration, and restless leg syndrome.<br><br>The most recent MDS (minimum data set) with an ARD (assessment reference date) of 06/21/18 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a significant change MDS.<br><br>Resident #78's clinical record was reviewed on 08/15/18. It contained a POS (physician's order summary) for the month of August which read in part, "Ropinrole HCl Tablet 3 mg-give 1 tablet by | F 755 | F755<br>Resident #78 is currently receiving Ropinirole as ordered. Resident #64 no longer resides in the center. Resident #309 no longer resides in the center. Resident #87 is currently receiving Aldactone as ordered.<br>Current residents receiving Ropinirole, Coumadin, Vancomycin, Aldactone will be reviewed to ensure medications are available for administration. Issues were corrected at the time of identification.<br>Current licensed nursing staff were educated regarding processing of new orders and process for acquiring medications from the pharmacy. Order listing report and clinical dashboard for meds not administered will be reviewed 4X week X 8 weeks to identify medication availability. Any issues will be addressed immediately at the time of identification.<br>Process will be reviewed in quarterly QA meeting. | |

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mouth every 8 hours for Restless leg syndrome". The Resident's eMAR (electronic medication administration record) for the month of July was reviewed and contained an entry, which read in part, "Ropinirole HCl tablet 1 mg-Give 3 tablet by mouth every 8 hours for Restless leg syndrome -order date- 07/05/2018". This entry had been coded with "9" on 07/2518 at 1600, which is the equivalent of "other/see progress notes". Resident #78's progress notes were reviewed and the surveyor could not locate any notes related to medication.

Surveyor requested and was provided with a copy of facility policy entitled "Medication Shortages/Unavailable Medications", which read in part "Procedure: 1. Upon discovery that Facility has an inadequate supply of a medication to administer to a Resident, Facility staff should immediately initiate action to obtain the medication form pharmacy. If the medication shortage is discovered at the time of medication administration, facility staff should immediately take the action specified in Section 2 or 3 of this policy, as applicable. 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available causes delay or a missed dose in the Resident's medication schedule, facility nurse should obtain the medication form the Emergency Medication Supply to administer the dose. 3. If a medication shortage is discovered after normal pharmacy hours: 3.1 A licensed facility nurse should obtain the ordered medication form the Emergency Medication Supply. 8. When a missed dosed is

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unavoidable, facility nurse should document the missed dose and the explanation for such missed dose on the MAR or TAR (treatment administration record) and in the nurse's notes per facility policy".

Surveyor requested and was provided with a list of medications located in the facility stat on 08/15/18 at approximately 0900. The medication ropinirole was not available in the stat box.

Surveyor spoke with the administrative team on 08/15/18 at approximately 1650 regarding Resident #78's medications not being available for administration. Surveyor asked the RNC (regional nurse consultant) to clarify the coding on the eMAR, and RNC stated that the codes indicate that the medication had not been administered. Surveyor asked the administrative team what the procedure was for reordering medications and they never gave a definitive answer.

The concern of the pain medications not being administered per the physician's orders was discussed with the administrative team during a meeting on 08/16/18 at approximately 1630.

No further information was provided prior to exit.

2. For Resident #64 the facility staff failed to ensure the medication Coumadin was available for administration.

Resident #64 was admitted to the facility on 01/18/16 and readmitted on 06/06/18. Diagnoses included but not limited to hypertension, peripheral vascular disease, diabetes mellitus,

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hyperlipidemia, hemiplegia, seizure disorder, depression, atrial fibrillation and benign prostatic hyperplasia.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 06/11/18 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS.

Resident #64's CCP (comprehensive care plan) was reviewed and contained a care plan for alteration in hematological status r/t (related to) Anticoagulant medication side effect. Interventions for this care plan were give medication as ordered.

Resident #64's clinical record was reviewed on 08/15/18. It contained a POS (physician's order summary) for the month of July which read in part "Coumadin Tablet-give 5 mg by mouth one time a day for DVT (deep venous thrombosis)". The Resident's eMAR (electronic medication administration record) for the month of July was reviewed and contained an entry which read in part, "Coumadin Tablet-give 5 mg by mouth one time a day for DVT". This entry was coded "9" on 07/12/18 at 1700, which is the equivalent of "other/see progress notes". Resident #78's progress notes were reviewed and the surveyor could not locate a note related to this medication.

Surveyor requested and was provided with a copy of facility policy entitled "Medication Shortages/Unavailable Medications", which read in part "Procedure: 1. Upon discovery that Facility has an inadequate supply of a medication to administer to a Resident, Facility staff should immediately initiate action to obtain the medication form pharmacy. If the medication

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shortage is discovered at the time of medication administration, facility staff should immediately take the action specified in Section 2 or 3 of this policy, as applicable. 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available causes delay or a missed dose in the Resident's medication schedule, facility nurse should obtain the medication form the Emergency Medication Supply to administer the dose. 3. If a medication shortage is discovered after normal pharmacy hours: 3.1 A licensed facility nurse should obtain the ordered medication form the Emergency Medication Supply. 8. When a missed dosed is unavoidable, facility nurse should document the missed dose and the explanation for such missed dose on the MAR or TAR (treatment administration record) and in the nurse's notes per facility policy".

Surveyor requested and was provided with a list of medications located in the facility stat on 08/15/18 at approximately 0900. The medication Coumadin was available in the stat box in 1 mg, 2 mg and 5 mg.

Surveyor spoke with the administrative team on 08/15/18 at approximately 1650 regarding Resident #64's medications not being available for administration. Surveyor asked the RNC (regional nurse consultant) to clarify the coding on the eMAR, and RNC stated that the codes indicate that the medication had not been administered. Surveyor asked the administrative team what the procedure was for reordering

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medications and they never gave a definitive answer.

The concern of the medications not being available for administration was discussed with the administrative team during a meeting on 08/16/18 at approximately 1630.

No further information was provided prior to exit.
3. The facility staff failed to ensure Resident #309's Vancomycin was available for administration.

The clinical record of Resident #309 was reviewed 8/14/18 through 8/17/18. Resident #309 was admitted to the facility 7/27/18 with diagnoses, that included but not limited to sacral pressure ulcer, rhabdomyolysis, type 2 diabetes mellitus, obstructive sleep apnea, gastroesophageal reflux disease, enteorcolitis due to Clostridium difficile (cdiff), peripheral vascular disease, major depressive disorder, hypertension, diverticulitis of large intestine and hypercholesterolemia.

Resident #309's 14-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/10/18 assessed the resident with a BIMS (brief interview of mental status) Summary Score of 13/15.

Resident #309's current comprehensive care plan created 8/9/18 and revised on 8/9/18 had the focus area that read, "The resident has C. difficile. Interventions: Educate resident/family/staff regarding preventive measures to contain the infection, encourage good nutrition and hydration, monitor for symptoms of weakness, dehydration, fever,

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nausea and vomiting and character of stool."

Resident #309's August 2018 electronic medication administration record was reviewed. The entry for Vancomycin read "Vancomycin Hcl Capsule Give 250 mg (milligrams) by mouth every 6 hours for cdiff for 14 days-Order date-08/03/18 1303." The first entry on the August 2018 eMAR for vancomycin was 8/3/18 at 1800 (6:00 p.m.) In the box was a "9" and the initials lkc. The legend for "9" read-"Other/See Progress Notes."

The surveyor reviewed the 8/3/18 progress notes. The progress note timed 22:35 (10:35 p.m.) read "Hold per md (medical doctor) order." The note did not specify what was to be held.

The surveyor interviewed licensed practical nurse #3 on 8/15/18 at 4:09 p.m. L.P.N. #3 stated the medication had not arrived from the pharmacy. "I passed that on to the next nurse. We have to put a reason why the medication was not given." The surveyor asked L.P.N. #3 if the med was in the stat box and she stated she didn't think it was.

The physician order for Vancomycin read "Vancomycin Hcl Capsule Give 250 mg every 6 hours for cdiff for 14 days. Order date: 8/3/18 Start date: 8/3/18."

The surveyor informed the administrator, the director of nursing, the administrator-in-training and the corporate registered nurse of the above concern on 8/15/18 at 4:47 p.m. and requested the pharmacy manifest for the Vancomycin ordered on 8/3/18 and the contents of the stat box.

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The surveyor reviewed the pharmacy manifest on 8/16/18. Fifty-six (56) Vancomycin Hcl 250 mg capsules were delivered on 8/3/18 at 11:12 p.m. The surveyor interviewed the unit manager licensed practical nurse on 8/16/18 at 8:01 a.m. The unit manager L.P.N. #1 stated we do not know if the medication was given or just not documented but the medication was not available for the 6:00 p.m. dose on 8/3/18.

The surveyor reviewed the contents of both the stat box and the emergency box. Neither one contained Vancomycin 250 mg.

No further information was available prior to the exit conference on 8/17/18.
4. The facility staff failed to ensure that a physician prescribed medication, Aldactone, was available for administration to Resident #87.

Resident #87 was readmitted to the facility on 9/27/14 with the following diagnoses of, but not limited to high blood pressure, peripheral vascular disease, cirrhosis, dementia and Traumatic Brain Injury. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/18/18 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #87 was also coded as requiring extensive assistance with dressing, personal hygiene and bathing.

The surveyor performed a review of Resident #87's clinical record on 8/16/18 at 2 pm. During this review, it was noted by the surveyor that the resident did not receive a physician ordered medication, Aldactone, on 7/27/18. This was noted on the July 2018 MAR (Medication Administration Record). The MAR reflected the

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| F 755 | Continued From page 34<br>documentation for 7/27/18, which in the box for that date was the following: "9 along with the nurses' initials." According to the code to be used on the MAR a "9" stood for "Other/See Progress Notes." The order stated, "Aldactone Tablet 100 mg (milligram) Give 0.5 tablet by mouth in the morning for edema." In the Progress Notes dated for 7/27/18 and timed for 9:49 am the documentation stated, "Aldactone Tablet 100 mg Give 0.5 tablet by mouth in the morning for edema Awaiting Pharmacy."<br><br>The surveyor notified the administrative team on 8/16/18 at 3:45 pm in the director of nurses' office of the above documented findings.<br><br>No further information was provided to the surveyor prior to the exit conference on 8/17/18. | F 755 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a | F 756 | | 9/25/18 |

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| F 756 | Continued From page 35<br>separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to follow up on pharmacy recommendations for one of 39 Residents, Resident #19.<br><br>The findings included.<br><br>The facility staff failed to follow up on two pharmacy recommendations.<br><br>The record review revealed that Resident #19 had been admitted to the facility 02/13/17. Diagnoses included, but were not limited to, syncope and collapse, essential hypertension, chronic obstructive pulmonary disease, hemiplegia, and benign prostatic hyperplasia. | F 756 | F756<br>Pharmacy recommendations on 10/31/17 and 1/31/18 for Resident #19 have been completed.<br>Current residents with pharmacy recommendations in the last 30 days were reviewed to ensure completion. Issues were corrected at the time of identification.<br>Current nursing leadership will be educated regarding process for completion of pharmacy recommendations. Recommendations will be received from pharmacy consultant and acted upon by DON.<br>Recommendations will be reviewed monthly X 2 to ensure completion. Any | |

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| F 756 | Continued From page 36<br>Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/21/18 included a BIMS (brief interview for mental status) summary score of three out of a possible 15 points.<br><br>The clinical record included progress notes made by the pharmacist dated 10/31/17 and 01/31/18 indicating that the pharmacist had completed medication regimen review's. The pharmacist had written, "See report for any noted irregularities and/or recommendations."<br><br>During the clinical record review the surveyor was unable to find any medication regimen reviews that matched these dates.<br><br>On 08/17/18 at 8:23 a.m., the DON (director of nursing) was made aware of the missing pharmacy recommendations.<br><br>On 08/17/18 at 10:18 a.m., the DON stated she was unable to find the pharmacy recommendations for 10/31/17 and 01/31/18.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference. | F 756 | issues will be addressed immediately at the time of identification.<br>Process will be reviewed in quarterly QA meeting. | |
| F 757 SS=D | Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including | F 757 | | 9/25/18 |

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| F 757 | Continued From page 37<br>duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, failed to ensure 1 of 39 residents was free of unnecessary medications, Resident #22.<br><br>The findings included:<br><br>For Resident #22 the facility staff administered sliding scale insulin outside of physician ordered parameters.<br><br>Resident #22 was admitted to the facility on 04/26/16. Diagnoses included but not limited to hypertension, diabetes mellitus, hyperlipidemia, hemiplegia, depression, atrial fibrillation, angina, insomnia and glaucoma.<br><br>The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/23/18 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS. | F 757 | F757<br>Resident #22 is currently receiving insulin as ordered.<br>Current residents receiving insulin were reviewed to ensure insulin is being administered as ordered. Issues were corrected at the time of identification.<br>Current licensed nursing staff will be educated regarding accurate administration of insulin based on parameters set forth by physician. Order listing report and clinical dashboard for meds not administered will be reviewed 4X week X 8 weeks to identify medication availability and accuracy of insulin order transcriptions. Any issues will be addressed immediately at the time of identification.<br>Process will be reviewed in quarterly QA meeting. | |

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| F 757 | Continued From page 38 | F 757 | | |

The Resident's CCP (comprehensive care plan) was reviewed and contained a care plan for diabetes mellitus. The goal for this plan read "Resident will have no complications related to diabetes through the review date". The interventions for this plan read in part "Diabetes medication as ordered by doctor".

Resident #22's clinical record was reviewed on 08/14/18. It contained a POS (physician's order summary) for the month of August which read in part, "Novolog Solution 100 unit/ml-Inject 4 unit subcutaneously two times a day for DM (diabetes mellitus). Accuchecks BID (twice daily) 0800-1600 (GIVE ONLY IF BLOOD SUGAR 200 OR GREATER)". The Resident's eMAR (electronic medication administration record) for the months of July and August 2018 were reviewed and contained an entry which read in part, "Novolog Solution 100 unit/ml-Inject 4 unit subcutaneously two times a day for DM (diabetes mellitus). Accuchecks BID (twice daily) 0800-1600 (GIVE ONLY IF BLOOD SUGAR 200 OR GREATER)". For the month of July, the eMAR had been initialed as having been administered on 07/04/18 at 0500 with a BS (blood sugar) of 100, 07/05/18 at 1600 with a BS of 187, 07/5/18 at 1600 with a BS of 140 and 07/27/18 at 0500 with no recorded BS. For the month of August, the eMAR had been initialed as having administered on 08/01/18 at 1600 with a BS of 185, 08/03/18 at 1600 with a BS of 156, 08/04/18 at 1600 with a BS of 179 and 08/05/18 at 0500 with a BS of 173.

Surveyor spoke with the administrative team on 08/15/18 at approximately 1650 regarding Resident #22's insulin being administered outside the physician ordered parameters. Surveyor

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| F 757 | Continued From page 39<br>asked the RNC (regional nurse consultant) to look over the eMAR's, and RNC stated that the insulin should not have been administered.<br><br>The concern of the insulin being administered outside the physician ordered parameters was discussed with the administrative team during a meeting on 08/16/18 at approximately 1630.<br><br>No further information was provided prior to exit. | F 757 | | |
| F 758 SS=E | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; | F 758 | | 9/25/18 |

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| F 758 | Continued From page 40<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to ensure 4 of 39 residents (Resident #309, Resident #308, Resident #162, and Resident #151) were free of an unnecessary medication.<br><br>The findings included:<br><br>1. The facility staff failed to ensure Resident #309 was free of an unnecessary medication. The facility staff failed to monitor the use of the antidepressant Celexa for Resident #309.<br><br>The clinical record of Resident #309 was reviewed 8/14/18 through 8/17/18. Resident #309 was admitted to the facility 7/27/18 with | F 758 | F758<br>The use of Celexa for Resident #309, Sertraline for Resident #308, Duloxetine for Resident #162, and Zoloft for Resident #151 are currently being monitored for behavioral interventions and side effects. Current residents receiving antidepressants were reviewed to ensure behavioral interventions and side effects are being monitored. Issues were corrected at the time of identification. Current licensed nurses will be educated regarding psychotropic drug use and the need for side effect and behavioral monitoring. Order listing report and clinical dashboard for psychotropic medications | |

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| F 758 | Continued From page 41<br>diagnoses, that included but not limited to sacral pressure ulcer, rhabdomyolysis, type 2 diabetes mellitus, obstructive sleep apnea, gastroesophageal reflux disease, colitis due to Clostridium difficile (cdiff), peripheral vascular disease, major depressive disorder, hypertension, diverticulitis of large intestine and hypercholesterolemia.<br><br>Resident #309's 14-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/10/18 assessed the resident with a BIMS (brief interview of mental status) Summary Score of 13/15.<br><br>The current comprehensive care plan was reviewed 8/14/18 and included a focus area that the resident has some interest in group activities, created on 7/31/18. Interventions: Monitor her leisure needs, resident likes religious music, religious programs, being outdoors, and watching religious programs on television.<br><br>The surveyor reviewed the August 2018 physician orders. Resident #309 had orders for Celexa tablet 10 mg (milligrams) Give 1 tablet at bedtime for depression. Start date 8/10/18.<br><br>The surveyor reviewed the August 2018 electronic medication administration record (eMAR). Celexa 10 mg had been administered from 8/10/18 through 8/14/18; however, upon further review of the clinical record including the medication administration record, nurse's notes, and progress notes, the surveyor could not locate monitoring of target behaviors, effectiveness of medication, side effects, or documentation of non-pharmacological interventions utilized associated with the use of Celexa. | F 758 | ordered in the last 7 days will be reviewed 4X week X 8 weeks to identify new orders and ensure monitoring is in place. Any issues will be addressed immediately at the time of identification.<br>Process will be reviewed in quarterly QA meeting. | |

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| F 758 | Continued From page 42 | F 758 | | |

The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the administrator-in-training of the above concern during the end of the day meeting on 8/15/18 at 4:47 p.m.

The surveyor interviewed the unit manager licensed practical nurse #1 on 8/16/18 at 10:26 a.m. L.P.N. #1 stated she had fixed the monitoring and then stated antidepressants are changed so much sometimes the monitoring doesn't get added.

No further information was provided prior to the exit conference on 8/17/18.

2. The facility staff failed to monitor the use of the psychotropic medication Sertraline for Resident #308.

The clinical record of Resident #308 was reviewed 8/14/18 through 8/17/18. Resident #308 was admitted to the facility 8/4/18 with diagnoses of but not limited to Wernicke's encephalopathy, muscle weakness, major depressive disorder, chronic obstructive pulmonary disease, unspecified dementia with behavioral disturbances, alcohol dependence, gastro-esophageal reflux disease, and dysphagia.

Resident #308's admission minimum data set (MDS) had not yet been completed. Interim care plan created on 8/6/18 and revised on 8/6/18 identified the focus area that read "The resident uses psychotropic medications r/t (related to) depression. Interventions: Monitor for side effects and effectiveness."

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Resident #308's August 2018 admission orders included the following order for Sertraline Hcl Give 50 mg (milligrams) by mouth one time a day for depression and then increased on 8/11/18 to Sertraline 75 mg one time a day.

The surveyor reviewed the August 2018 electronic medication administration record. The surveyor found no evidence the use of Sertraline had been monitored.

A review of the clinical record including the medication administration record, nurse's notes, and progress notes, the surveyor could not locate monitoring of target behaviors, effectiveness of medication, side effects, or documentation of non-pharmacological interventions utilized associated with the use of Sertraline.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the administrator-in-training of the above concern during the end of the day meeting on 8/15/18 at 4:47 p.m.

No further information was provided prior to the exit conference on 8/17/18.

3. The facility staff failed to ensure Resident #162 was free of an unnecessary drug. The facility staff failed to monitor the use of Duloxetine.

The clinical record of Resident #162 was reviewed 8/14/18 through 8/17/18. Resident #162 was admitted to the facility 12/20/17 and readmitted 4/19/18 with diagnoses that included but not limited to encephalopathy, type 2 diabetes mellitus, chronic obstructive pulmonary disease,

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peripheral vascular disease, hyperlipidemia, anemia, insomnia, gastro-esophageal reflux disease, end stage renal disease, hypertension, paroxysmal atrial fibrillation, major depressive disorder, Vitamin B12 deficiency, anxiety disorder, gout, and atherosclerotic heart disease.

Resident #162's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 7/27/18 assessed the resident with a BIMS (brief interview of mental status) of 15/15.

Resident #162's current comprehensive care plan created on 12/29/17 and revised 4/20/18 had the focus area: Resident uses psychotropic medications r/t (related to) anxiety. Interventions: Interventions to be utilized before psychotropic med: remind resident about smoke times, one on one interaction, redirect patient as appropriate. Monitor of side effects and effectiveness.

The July 2018 physician orders and the August 2018 physician orders were reviewed. Resident #162 had orders for Duloxetine Hcl delayed release capsule 30 mg (milligrams) Give 1 capsule by mouth one time a day for depression-order date 4/23/18, start date 4/23/18 and then orders to decrease the dose on 8/9/18 and to start on 8/10/18 to 20 mg every day.

The surveyor was unable to locate any monitoring of the effects, side effects, or use of non-pharmacological interventions prior to the use of Duloxetine.

Duloxetine accessed at www.drugs.com Duloxetine is a selective serotonin and norepinephrine reuptake inhibitor antidepressant (SSNRI). Duloxetine affects chemicals in the

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brain that may be unbalanced in people with depression. Duloxetine is used to treat major depressive disorder in adults.
Brand names: Irenka, Cymbalta

The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the administrator-in-training of the above concern during the end of the day meeting on 8/15/18 at 4:47 p.m.

No further information was provided prior to the exit conference on 8/17/18.
4. The facility staff failed to monitor the use of a psychotropic medication, Zoloft, for Resident #151.

Resident #151 was readmitted to the facility on 7/11/18 with the following diagnoses of, but not limited to high blood pressure, renal failure, dementia and depression. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/17/17 coded the resident was having a BIMS (Brief interview for Mental Status) score of 5 out of a possible score of 15. Resident #151 also was coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and bathing.

The surveyor performed a review of Resident #151's clinical record on 8/16/18 at 3 pm. During this review, the surveyor noted that the resident had a physician order for Zoloft. The physician order for this medication was as follows: "Sertraline (Zoloft) ...tablet 25 mg (milligram) Give 25 mg one time a day for depression. The physician ordered this medication on 7/11/18. The surveyor did not note any documentation for behavior monitoring for Zoloft from 7/11/18

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| F 758 | Continued From page 46<br>through 8/8/18. The behavior monitoring was begun on 8/9/18 on the evening shift as documentation was noted on the resident's MAR (Medication Administration Record).<br><br>The surveyor notified RN (Registered Nurse) #1 of the above documented findings at 3:30 pm. RN #1 stated to the surveyor that she found this not being done when the medicine was ordered in July so she started the monitoring of the behaviors for the Zoloft when she found this on 8/9/18 during the chart audit review.<br><br>The surveyor notified the administrative team of the above documented findings on 8/16/18 at 3:45 pm in the director of nurses' office.<br><br>No further information was provided to the surveyor prior to the exit conference on 8/17/18. | F 758 | | |
| F 760 SS=D | Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review the facility staff failed to ensure 2 of 39 residents were free of significant medication errors, Resident #22 and #64.<br><br>The findings included:<br><br>1. For Resident #22 the facility staff administered sliding scale insulin outside of physician ordered parameters. | F 760 | F760<br>Resident #22 is currently receiving insulin as ordered. Resident #64 is currently receiving Coumadin as ordered.<br>Current residents receiving insulin and Coumadin will be reviewed to ensure medications are available for administration. Issues were corrected at the time of identification.<br>Current licensed nursing staff were educated regarding processing of new | 9/25/18 |

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| SALEM HEALTH & REHABILITATION | 1945 ROANOKE BLVD SALEM, VA 24153 |

| (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 |
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| F 760 | Continued From page 47<br>Resident #22 was admitted to the facility on 04/26/16. Diagnoses included but not limited to hypertension, diabetes mellitus, hyperlipidemia, hemiplegia, depression, atrial fibrillation, angina, insomnia and glaucoma.<br><br>The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/23/18 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS.<br><br>The Resident's CCP (comprehensive care plan) was reviewed and contained a care plan for diabetes mellitus. The goal for this plan read "Resident will have no complications related to diabetes through the review date". The interventions for this plan read in part "Diabetes medication as ordered by doctor".<br><br>Resident #22's clinical record was reviewed on 08/14/18. It contained a POS (physician's order summary) for the month of August which read in part, "Novolog Solution 100 unit/ml-Inject 4 unit subcutaneously two times a day for DM (diabetes mellitus). Accuchecks BID (twice daily) 0800-1600 (GIVE ONLY IF BLOOD SUGAR 200 OR GREATER)". The Resident's eMAR (electronic medication administration record) for the months of July and August 2018 were reviewed and contained an entry which read in part, "Novolog Solution 100 unit/ml-Inject 4 unit subcutaneously two times a day for DM (diabetes mellitus). Accuchecks BID (twice daily) 0800-1600 (GIVE ONLY IF BLOOD SUGAR 200 OR GREATER)". For the month of July, the eMAR had been initialed as having been administered on 07/04/18 at 0500 with a BS (blood sugar) of 100, 07/05/18 at 1600 with a BS of 187, 07/5/18 at 1600 with a BS of 140 and | F 760 | orders and process for acquiring medications from the pharmacy. Order listing report and clinical dashboard for meds not administered will be reviewed 4X week X 8 weeks to identify medication availability and accuracy of order transcription. Any issues will be addressed immediately at the time of identification.<br>Process will be reviewed in quarterly QA meeting. | |

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| F 760 | Continued From page 48 | F 760 | | |

07/27/18 at 0500 with no recorded BS. For the month of August, the eMAR had been initialed as having administered on 08/01/18 at 1600 with a BS of 185, 08/03/18 at 1600 with a BS of 156, 08/04/18 at 1600 with a BS of 179 and 08/05/18 at 0500 with a BS of 173.

Surveyor spoke with the administrative team on 08/15/18 at approximately 1650 regarding Resident #22's insulin being administered outside the physician ordered parameters. Surveyor asked the RNC (regional nurse consultant) to look over the eMAR's, and RNC stated that the insulin should not have been administered.

The concern of the insulin being administered outside the physician ordered parameters was discussed with the administrative team during a meeting on 08/16/18 at approximately 1630.

No further information was provided prior to exit.

2. For Resident #64 the facility staff failed to administer the medication Coumadin as ordered by the physician.

Resident #64 was admitted to the facility on 01/18/16 and readmitted on 06/06/18. Diagnoses included but not limited to hypertension, peripheral vascular disease, diabetes mellitus, hyperlipidemia, hemiplegia, seizure disorder, depression, atrial fibrillation and benign prostatic hyperplasia.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 06/11/18 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS.

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| F 760 | Continued From page 49<br>Resident #64's CCP (comprehensive care plan) was reviewed and contained a care plan for alteration in hematological status r/t (related to) Anticoagulant medication side effect. Interventions for this care plan were give medication as ordered.<br><br>Resident #64's clinical record was reviewed on 08/15/18. It contained a POS (physician's order summary) for the month of July which read in part "Coumadin Tablet-give 5 mg by mouth one time a day for DVT (deep venous thrombosis)". The Resident's eMAR (electronic medication administration record) for the month of July was reviewed and contained an entry which read in part, "Coumadin Tablet-give 5 mg by mouth one time a day for DVT". This entry was coded "9" on 07/12/18 at 1700, which is the equivalent of "other/see progress notes". Resident #64's progress notes were reviewed and the surveyor could not locate a note related to this medication.<br><br>Surveyor spoke with the administrative team on 08/15/18 at approximately 1650 regarding Resident #64's medications not being administered per physician's orders. Surveyor asked the RNC (regional nurse consultant) to clarify the coding on the eMAR, and RNC stated that the codes indicate that the medication had not been administered.<br><br>The concern of the medications not being administered was discussed with the administrative team during a meeting on 08/16/18 at approximately 1630.<br><br>No further information was provided prior to exit. | F 760 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals | F 761 | | 9/25/18 |

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| F 761 | Continued From page 50<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and facility document review, the facility staff failed to safely store and label medications on 2 of the 4 nursing units in the facility (Units 2 and 3).<br><br>The findings included:<br><br>The surveyor was performing an observation of the medication carts on Unit 2 on 8/14/18 at 1:18 pm in which the following was noted: | F 761 | F761<br>Unlabeled open Ativan liquid was discarded and new bottle was received. Medication carts on Units 2 and 3 were cleaned and any loose pills were destroyed.<br>Center medication carts were cleaned and any loose pills were destroyed. Medication refrigerators on all 4 units were inspected to ensure open Ativan bottles had been | |

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| F 761 | Continued From page 51<br><br>On Pod 2 and Pod 3, the medication carts were noted to have whole pills of different colors and shapes laying free in the back of the second drawer on the left hand side of both of the medication carts. These pills were observed to not be present in pill containers. The medication cart on Pod 2 had 3 pills and the medication cart on Pod 3 had 2 pills observed by the surveyor.<br><br>RN (Registered Nurse) #1 was present with the surveyor during the above documented observations. The surveyor asked RN #1 who was responsible for cleaning the medication carts and making sure there were no loose pills that were out of packs and in the drawers of the medication carts. RN #1 stated, "Every nurse is responsible for cleaning these drawers after every shift and making sure there is nothing in the drawers that do not need to be in there, like these loose pills."<br><br>At 1:35 pm, the surveyor observed the following on Unit 3:<br><br>In the medication room refrigerator, the surveyor observed a 10 ml (milliliter) multi use bottle of Lorazepam was opened and there was no documentation on the bottle of an opened date on it.<br><br>On medication cart #1, it was noted by the surveyor that (8) whole pills of different shapes and colors along with (5) ½ pills of different shapes and colors were laying loose in the back of the first drawer on the left hand side of the medication cart.<br><br>On medication cart #2, it was noted by the | F 761 | labeled with date opened. Issues were corrected at the time of identification. Current licensed nurses will be educated regarding storage of medications and general dose preparation to include labeling of opened liquid medications. Medication room refrigerators and medication carts will be inspected weekly X 8 weeks to ensure no evidence of loose pills in drawers and to validate dating of opened liquid medications. Any issues will be addressed immediately at the time of identification.<br>Process will be reviewed in quarterly QA meeting. | |

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| F 761 | Continued From page 52 | F 761 | | |

surveyor that (2) whole pills of different shapes and colors were laying loose in the back of the first drawer on the left hand side of the medication cart.

RN #3 was present with the surveyor at the time the above observations were made by the surveyor. The surveyor asked RN #3 about the multi-use bottle of Lorazepam that was in the medication refrigerator in the medication storage room. RN #3 stated, "The nurses are to write the date the bottle was opened on the bottle."

The surveyor requested a copy of the facility's policy on storage of medications and dating bottle of medications when first opened from RN #1 at 2:00 pm.

The surveyor received the facility's policy titled "Storage and Expiration of Medications, Biologicals, Syringes, and Needles" from the director of nursing at 2:30 pm. The policy read in part, " ...Facility should ensure that resident medication and biologicals for each resident are stored in the containers in which they were originally received ..."

The surveyor also received the facility's policy titled "General Dose Preparation and Medication Administration" from the director of nursing at 2:30 pm. The policy read in part, " ...Facility staff should enter the date opened on the label of medications ..."

The surveyor notified the administrative team of the above documented findings on 8/15/18 at 4:48 pm in the conference room.

No further information was provided to the

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| F 761 | Continued From page 53<br>surveyor prior to the exit conference on 8/17/18. | F 761 | | |
| F 803 SS=D | Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)<br><br>§483.60(c) Menus and nutritional adequacy. Menus must-<br><br>§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;<br><br>§483.60(c)(2) Be prepared in advance;<br><br>§483.60(c)(3) Be followed;<br><br>§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;<br><br>§483.60(c)(5) Be updated periodically;<br><br>§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and<br><br>§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, document review and clinical record, the facility staff failed to ensure menus acknowledged her choices for 1 of 39 residents (#149).<br><br>Resident #149 was admitted to the facility on | F 803 | F803<br>Resident #149 is currently being provided a therapeutic diet that has taken into account her preferences and desirable weight.<br>Current residents were reviewed to | 9/25/18 |

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| F 803 | Continued From page 54<br>4/14/18. Diagnoses included heart failure, diabetes mellitus, non-Alzheimer's dementia, congestive heart failure, muscle weakness, neuropathy, gout, collapsed vertebra, osteoarthritis, and cardiac arrhythmia. On the quarterly minimum data set assessment with assessment reference date 4/17/2018, the resident scored 14/15 on the brief interview for mental status (BIMS) and was assessed as without symptoms of delirium, psychosis, or behaviors affecting care (including refusal of care).<br><br>The surveyor interviewed the resident on 8/15/18. During the interview, the resident expressed frustration with her efforts at weight management. She stated that she had been diagnosed with heart failure and told that she should lose weight to help control fluid levels and make it easier to breathe. The resident said she had tried really hard, given up desserts and most snacks, and had lost some weight, but that the weight had come back. She stated "the food is cold; the meat is hard to chew and dry". The resident reported not being able to eat beef and pork because of her gout. She reported her preferred protein foods are beans, chicken, and peanut butter. The resident's profile detail list in the dietary computer system did not list any of these foods. The registered dietician told the surveyor that the resident needed to receive a high calorie supplement daily because "we can't give her chicken every day". The surveyor asked if she had clinical signs of protein deficiency but did not receive an answer.<br><br>The resident had an order dated 8/6/18 for med plus 2.0 40 cc per day to maintain body weight and prevent weight loss. The weight resident's | F 803 | ensure that resident preference and choices regarding supplements are being honored. Issues were corrected at the time of identification.<br>Dietary manager, Registered Dietician, and nursing leadership were educated regarding select menus that honor choice and preference. During weight meetings, residents receiving supplements for weight loss will be reviewed to ensure continued need based on desirable weight and current nutritional status. Registered Dietician, or designee, will discuss nutrition interventions and weights with residents and/or responsible parties during care plan meetings. Registered Dietician, or designee, will audit supplements monthly x2 to review for appropriateness.<br>Process will be reviewed in quarterly QA meeting. | |

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| F 803 | Continued From page 55 | F 803 | | |

dietary note said there had been undesirable weight gain and new orders were written.

8/16/18 Interviewed the facility dietician about the resident's weight gain, BMI of 29.3, and receiving Med Plus while gaining weight and falling within the parameters for obesity. The dietician stated that the supplement was for protein because the resident's gout prevented her from eating beef and pork. She stated that staff could not feed her chicken every day. The surveyor asked if the resident had any clinical indicators of protein deficiency and the dietician stated that she had none. On 8/17, the surveyor asked the dietary manger fro a printout of the resident's dietary preferences. The dietician was in the office when the report was printed. At that time, the dietician stated that the resident needed the extra supplement for the calories. The surveyor stated the resident's BMI (body mass index) was 29.3, which is borderline obese. The dietician stated that desirable BMI for a resident of Resident # 149's age is 25-30. The surveyor asked for the treatment standard suggesting that the BMI should be that high. During an interview on 8/17/18, the facility dietician and the corporate dietician offered an article titled Desirable body weight in the older adult:What does the current research indicate? by Phyllis Famularo published in Dietetics in Healthcare Communities Connections Volume 40 Issue 1 Summer 2014. A sentence was highlighted indicating the morality risk for community dwelling older adults was a bell curve with the lowest point between 27.0 and 27.9 and increasing with BMI less than 20 or greater than 33.5. There was no indication that in increase above the resident's lowest BMI in 6/1/2018 of 27.0 (height 65 inches and weight 162.5) was desirable if the article is the basis for

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| F 803 | Continued From page 56<br>a standard of practice. On 8/6/18 when the supplement was ordered "to maintain body weight and prevent weight loss", the resident's BMI had increased to 29.3, which is above the most desirable range of 27-27.9.<br><br>During a meeting on 8/16/18, the administrator and director of nursing were notified with the concerns with the resident's dietary preferences, desire for weight management, and rationale for providing a high calorie dietary supplement to a resident who desired weight loss. | F 803 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility staff failed to store and prepare foods | F 812 | F812<br>Nesting cups with condensation, debris on | 9/25/18 |

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| F 812 | Continued From page 57<br>under sanitary conditions.<br><br>The findings included.<br><br>The kitchen area included, nesting of cups, debris on the lids of storage bins, sugar that had been contaminated, hair not secured by a hairnet, and live flies.<br><br>During initial tour of the facility on 08/14/18 at 10:44 a.m., two surveyors entered the facility kitchen and completed a brief tour with the dining service manager.<br><br>During this observation, the surveyors were able to observe several trays of clear plastic cups. These cups were stacked on top of each other. The surveyors were able to observe condensation and water droplets on the inside of the cups. The dining service manager stated she would rewash the cups.<br><br>The outside of the storage bins that contained sugar, thickener, and flour were observed to have debris present and the sugar bin was observed to have dark clumps inside.<br><br>The surveyors observed live flies in the kitchen during this brief tour.<br><br>On 08/14/18 at 4:29 p.m., the surveyors entered the kitchen area to check the tray line temperatures during the observation the dining service managers hair was not completely secured by her hairnet. When asked about her hair she stated sometimes my hairnet moves.<br><br>Again, the surveyors were able to observe live flies in the kitchen area. | F 812 | storage bin lids, contaminated sugar, and hairnet out of place in the kitchen was corrected during the survey.<br>A kitchen inspection was completed to identify any further evidence of nesting cups with condensation, contaminated sugar, debris on storage bin lids, and hair nets not in place. Issues were corrected at the time of identification. Drying equipment updated.<br>Current dietary staff were educated regarding food safety requirements to include sanitary storage and preparation.<br>Kitchen audits will be conducted by dietary consultant weekly X8 weeks to ensure compliance.<br>Any issues will be addressed immediately at the time of identification.<br>Process will be reviewed in quarterly QA meeting. | |

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| F 812 | Continued From page 58<br><br>The surveyor entered the kitchen area again on 08/15/18 at 8:01 a.m., the dietary manager was observed washing the lids to the bins and stated she was dumping the sugar because, "Obviously something has gotten into it."<br><br>The administrative staff were notified of the kitchen issues during meetings with the survey team on 08/15/18 at 4:48 p.m. and again on 08/16/18 at 4:40 p.m.<br><br>No further information regarding these issues were provided to the survey team prior to the exit conference. | F 812 | | |
| F 842 SS=E | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized | F 842 | | 9/25/18 |

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

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

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and

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| F 842 | Continued From page 60<br>determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on family interview, staff interview, resident interview, and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 5 of 39 residents (Resident #14, Resident #149, Resident #156, Resident #73, and Resident #123).<br><br>The findings included:<br><br>1. The facility staff failed to document Resident #14's outpatient surgical procedure on 8/13/18.<br><br>The clinical record of Resident #14 was reviewed 8/14/18 through 8/17/18. Resident #14 was admitted to the facility 12/22/14 and readmitted 2/8/18 with diagnoses that included but not limited to motor vehicle accident with traumatic brain injury, decubitus ulcer of right hip, stage 3, spasticity, sepsis, unspecified organism, dysphagia, intracranial injury, allergic rhinitis, seizures, left hand and wrist contractures, major depressive disorder, quadriplegia, idiopathic scoliosis, and hypertension.<br><br>Resident #14's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/16/18 coded the resident with short-term memory problems, long-term memory problems, and severely impaired cognitive skills for daily decision-making.<br><br>Resident #14's current comprehensive care plan | F 842 | F842<br>The outpatient procedure for Resident #14 has now been accurately documented in the clinical record. The physician progress notes for Resident #156 were corrected to indicate full code status. The physician has been notified for withholding medication for Resident #149 and the administration times have been adjusted. Progress notes were generated for Residents #73 and #123 to indicate dates of hospitalization that resulted in incomplete medication administration record for days out of facility.<br>Current residents with DNR status were reviewed to ensure physician progress notes accurately reflect status. Current residents with outpatient consults during the last 30 days were reviewed to ensure documentation in clinical record. Current residents with medications withheld due to being out of facility were reviewed to ensure doses were provided. Current residents that have been sent to hospital and admitted within last 7 days were reviewed to ensure medication orders have been discontinued. Issues were corrected at the time of identification.<br>Current licensed nurses were educated regarding accuracy of medical record documentation to include DNR status, omissions in medication administration | |

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| F 842 | Continued From page 61<br>created on 12/26/2014 and revised on 2/13/18 identified the focus area of chronic pain r/t (related to) trauma MVA (motor vehicle accident). Interventions: Document non-pharmacological interventions prior to administration: turn and reposition, incontinence care, check for abd (abdominal) distention, make sure resident is cool, follow-up MD (medical doctor) as needed.<br><br>The surveyor met with the ombudsman and Resident #14's mother on 8/15/18 at 11:03 a.m. Resident #14's mother informed the surveyor that the resident had an outpatient procedure on Monday 8/13/18 for a new Baclofen pump at a local hospital.<br><br>The surveyor reviewed the progress notes for 8/13/18 on 8/15/18 at 3:40 p.m. and did not find any documentation about an outpatient procedure on 8/13/18, any post-op orders about the procedure or any documentation of the procedure itself in the clinical record. The surveyor informed the unit manager of the lack of documentation of Resident #14's outpatient procedure for a larger baclofen pump in the progress notes.<br><br>The surveyor reviewed the electronic clinical record again on 8/15/18. A progress note read "Late Entry 8/13/18 07:12 and read Patient came back from doctor's appt. (appointment). Patient received a bigger baclofen internal pump dressing intact over right abd (abdominal) quadrant. Some blood drainage showed through dressing. Patient's mother did not want dressing removed. Patient was put back in bed. Meds (medications) given through peg tube. No residual. Flushed peg tube with water per orders. TF (tube feeding) turned back on. Patient resting in bed at this time." The progress note was | F 842 | record, withholding medications when out of facility, and outpatient consultations. Physician progress notes and consultation reports will be reviewed weekly X 8 weeks to ensure documentation present in clinical record. Nursing leadership will review discharged residents 4 X week X 8 weeks to ensure medication orders have been discontinued. Clinical dashboard for meds not administered will be reviewed 5X week X 8 weeks to identify medications withheld when a resident is out of facility. Any issues will be addressed immediately at the time of identification.<br>Process will be reviewed in quarterly QA meeting. | |

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written before the resident went to the outpatient procedure.

The surveyor requested the outpatient procedure summary and the physician orders for care of the new Baclofen pump from the unit manager L.P.N. #1 on 8/16/17 at 10:27 a.m.

The surveyor interviewed licensed practical nurse #2 on 8/16/18 at 9:25 a.m. regarding the lack of documentation when Resident #14 was out of the facility on 8/13/18 for a larger baclofen pump and the lack of documentation completed. L.P.N. #2 stated and showed the surveyor on the computer screen how she can change the date and time of her documentation. L.P.N. #2 did state she incorrectly entered a progress note in Resident #14's clinical record.

The surveyor received Resident #14's procedure completed on 8/13/18 from the unit manager L.P.N. #1 on 8/17/18 at 8:59 a.m. L.P.N. #1 stated, "They don't usually send us anything. I had to call to get it. The dressing is to be changed every day for 10 days." The surveyor requested the post-op orders for the care of the surgical site from the unit manager L.P.N. #1 on 8/16/18; however, the surveyor did not receive post-op orders for the care of Resident #14's surgical site.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the administrator in training of the above concern during the end of the day meeting on 8/16/18 at 4:41 p.m. and requested the facility policy on documentation.

The policy titled "Documentation Summary" read

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in part "10. Errors are corrected by marking through the error with a single line, initialing, and dating the error. Enter the correct information. Electronic record corrected errors require a late entry note. 12. Document all of the facts and pertient information related to an event, course of treatment, patient condition, response to care, and deviations from standard treatment along with the reason for the deviation."

No further information was provided prior to the exit conference on 8/17/18.
2. For Resident #149, Facility staff failed to accurately document the reason for with holding medications.

Resident #149 was admitted to the facility on 4/14/18. Diagnoses included heart failure, diabetes mellitus, non-Alzheimer's dementia, congestive heart failure, muscle weakness, neuropathy, gout, collapsed vertebra, osteoarthritis, and cardiac arrhythmia. The on the quarterly minimum data set assessment with assessment reference date 4/17/2018, the resident scored 14/15 on the brief interview for mental status (BIMS) and was assessed as without symptoms of delirium, psychosis, or behaviors affecting care (including refusal of care).

During an interview on 08/17/18 10:06 AM the resident said staff won't give her medication before or after doctor appointments because scheduled time is while out of the building.

Clinical record review revealed the nurse documented on 8/9/18 '3' ( not given for out of facility). There were no nursing notes for that date in the clinical record. The surveyor asked the

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resident's nurse how to determine when the resident left and returned. The nurse pulled a binder with sign-out sheets but the resident was not signed out of the facility on that date. The unit manager, when asked if there was a policy allowing the resident to take medications before leaving the facility for physician appointments, stated she had been on the unit on that day and the resident refused to take the medications.

The surveyor reported the concern that the resident reported staff would not allow her to take the medication while the medication administration record documented the resident was absent from the facility, a witness stated the resident refused to take them, and nursing notes failed to document the resident leaving the facility and returning.

3. For Resident #156, the facility failed to ensure accurate code status on physician's progress notes. The Resident was a fullcode and it stated she was DNR (Do Not Resuscitate).

Per clinical record review Resident # 156 was admitted to the facility on 12/16/2016. Diagnosis included, but were not limited to, Generalized Muscle Weakness, Unspecified Kidney Failure, Unspecified Sequelae of Unspecified Cerebrovascular Disease, and Sleep Apnea.

Section C (cognitive patterns) of the Residents quarterly MDS (Minimum Data Set) assessment with an ARD (assessment reference date) of 07/26/2018 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

The clinical record included Physician progress

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notes dated 08/08/2018, 06/25/2018, that indicated resident # 156 code status was DNR and a DNR dated 09/16/2015.

However it also included an Order Summary Report that indicated the Resident was a full code and the current comprehensive care plan indicated the Resident was a full code.

DON (Director of Nursing) was requested to provide last two Physician Progress Notes, DNR, current Physician orders.

On 08/16/18 at 11:04 am during an interview with DON the requested documents were provided and stated Resident#156 was a fullcode.

On 08/16/18 at 12:05pm DON provided amended Physician progress notes to indicate the Resident #156 had been a fullcode as of 06/19/17.

No further information was provided to the surveyor prior to the exit conference.
4. The facility staff failed to ensure a complete and accurate clinical record for Resident #73.

Resident #73 was readmitted to the facility on 6/13/18 with the following diagnoses of, but not limited to high blood pressure, dementia, depression and Psychotic Disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/18/18 coded the resident as having BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident # 73 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and bathing.

The surveyor performed a review of Resident

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#73's clinical record on 8/16/18. During this review, the surveyor also reviewed the MAR (Medication Administration Record) for the month of June 2018. For the dates of 6/6/18 through 6/13/18, the medications that were ordered by the physician to be administered to the resident was left blank. There was no documentation in the clinical record that stated why the resident had not been administrated these medications.

The surveyor notified RN (registered nurse) #1 of the above documented findings at 2:30 pm. RN #1 reviewed the clinical record of Resident #73. RN #1 stated, "I have found a progress note that stated the resident was readmitted to the facility on 6/13/18 late in the afternoon. The way the nurse and the admission office takes the resident out of the computer system shows blanks when the resident had been discharged and then readmitted. The dates in between will show blanks on the MAR."

The surveyor notified the administrative team of the above documented findings on 8/16/18 at 3:45 pm in the director of nurses' office. The corporate nurse stated, "She is right and it is a computer system issue. We can look into this and fix so this won't be happening."

No further information was provided to the surveyor prior to the exit conference on 8/17/18.

5. The facility staff failed to ensure a complete and accurate clinical record for Resident #123.

Resident #123 was readmitted to the facility on 7/6/18 with the following diagnoses of, but not limited to anemia, peripheral vascular disease, and depression. On the quarterly MDS (Minimum

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Data Set) with an ARD (Assessment Reference Date) of 7/11/18 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident # 123 was also coded as requiring supervision of 1 staff member for dressing, limited assistance of 1 staff member for personal hygiene and was independent for bathing.

The surveyor performed a review of Resident #123's clinical record on 8/16/18. During this review, the surveyor noted that on the July 2018 MAR (Medication Administration Record) for the dates of 7/5 and 7/6/18, there were blanks for the physician ordered medications that were to be administrated on these dates. The surveyor also reviewed the progress notes for these dates. It was noted that there was documentation for these dates that stated the resident was in the hospital.

The surveyor notified RN (registered nurse) #2 at 11:30 am of the above documented findings. RN #2 stated, "Let me show you what I am talking about. When a resident is discharged to the hospital and the nurses don't go into each medication to discontinue them, they continue to show up and have blanks until the resident is readmitted to the facility." The surveyor did observe these occurrences as RN #2 performed these procedures in the computer.

The surveyor notified the administrative team of the above documented findings on 8/16/18 at 3:45 pm in the director of nurses' office. The corporate nurse stated, "She is right and it is a computer system issue. We can look into this and fix so this won't be happening."

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| F 842 | Continued From page 68<br>No further information was provided to the surveyor prior to the exit conference on 8/17/18. | F 842 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported; | F 880 | | 9/25/18 |

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| F 880 | Continued From page 69<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow infection control guidelines for 2 of 39 residents (Resident #309 and Resident #98).<br><br>The findings included: | F 880 | F880<br>Isolation carts for residents #309 and #98 had hand sanitizer placed.<br>Other isolations carts were audited to ensure placement of hand sanitizer.<br>Issues were corrected at the time of the audit. | |

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| F 880 | Continued From page 70<br><br>1. The facility staff failed to ensure the three (3)-drawer cart contained hand sanitizer for Resident #309.<br><br>The clinical record of Resident #309 was reviewed 8/14/18 through 8/17/18. Resident #309 was admitted to the facility 7/27/18 with diagnoses, that included but not limited to sacral pressure ulcer, rhabdomyolysis, type 2 diabetes mellitus, obstructive sleep apnea, gastroesophageal reflux disease, colitis due to Clostridium difficile (cdiff), peripheral vascular disease, major depressive disorder, hypertension, diverticulitis of large intestine and hypercholesterolemia.<br><br>Resident #309's 14-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/10/18 assessed the resident with a BIMS (brief interview of mental status) Summary Score of 13/15.<br><br>Resident #309's current comprehensive care plan created 8/9/18 and revised on 8/9/18 had the focus area that read, "The resident has C. difficile. Interventions: Educate resident/family/staff regarding preventive measures to contain the infection, encourage good nutrition and hydration, monitor for symptoms of weakness, dehydration, fever, nausea and vomiting and character of stool."<br><br>During the initial tour on 8/14/18 at 11:30 a.m., Resident #309's door was closed. On the door was a sign that read "STOP Contact Precautions Visitors must report to Nursing Station before entering.<br>" Perform hand hygiene using soap and water | F 880 | Nursing staff educated to ensure placement of hand sanitizer in isolations carts.<br>Unit Manager or designee will audit carts once a day, 4x per week, for 8 weeks to ensure hand sanitizers are in place and report to Administrator or designee. Any issues will be immediately addressed at the time of identification. Process will be reviewed in quarterly QA meeting. | |

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| | 495087 | A. BUILDING _____ B. WING _____ | C 08/17/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SALEM HEALTH & REHABILITATION | 1945 ROANOKE BLVD SALEM, VA 24153 |

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| F 880 | Continued From page 71 | F 880 | | |

and/or alcohol based rub before entering and before leaving room.
" Wear gown and gloves when entering room or cubicle.
" Bag linen to prevent contamination of self, environment or outside bag.
" Discard infectious trash to prevent contamination of self, environment or outside bag."

The surveyor checked the three (3)-drawer cart but was unable to locate any hand sanitizer or alcohol based rub in the cart. The 3-drawer cart did contain gloves, gowns, and masks.

The surveyor observed staff enter and exit Resident #309's room to deliver her lunch tray 8/14/18 around 12:30 p.m. and to pick the lunch tray up after she had eaten on 8/14/18. The surveyor did not observe staff use hand sanitizer prior to entering the room or wash their hands in the resident's sink.

The surveyor interviewed Resident #309 on 8/14/18 at 4:50 p.m. The 3-drawer cart was checked and there was no hand sanitizer in the cart.

The surveyor checked the 3-drawer cart on 8/15/18 at 4:09 p.m. No hand sanitizer in cart.

The surveyor checked the 3-drawer cart on 8/16/18 10:09 a.m. No hand sanitizer was in the cart. Contact precautions sign say "Soap and water or hand sanitizer before entering room" Informed the unit manager licensed practical nurse #1 of the above concern. L.P.N. #1 stated she would take care of the issue.

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| F 880 | Continued From page 72 | F 880 | | |

The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the administrator-in-training of the above concern during the end of the day meeting on 8/16/18 at 4:41 p.m. and requested the facility policy on contact precautions.

The surveyor reviewed the facility policy titled "Transmission Based Precautions" on 8/16/18. The policy read in part "Contact Precautions 2. Gloves and Handwashing a. Perform hand hygiene before entering room and after removing PPE (personnel protective equipment) upon room exit."

No further information was provided prior to the exit conference on 8/17/18.
2. For Resident #98, facility staff failed to stock antiseptic hand gel on the isolation cart outside the door.

Resident #98 was admitted to the facility on 3/18/18 with diagnoses including coronary artery disease, cirrhosis, encephalopathy, and history of falls. On the significant change assessment with assessment reference date 6/27/18, the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, and behaviors affecting care.

Resident was placed on droplet precautions on 5/8/18 to protect the resident (diagnosed with low white blood cell count) from exposure to infectious agents.

Per facility policy and door signage, droplet precautions required staff to wash hands with soap and water or use hand sanitizer prior to donning protective equipment.

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| F 880 | Continued From page 73<br><br>On 8/14/18 and 8/15/18, during initial pool observations, there was no alcohol-based hand gel on the isolation cart. On 8/16/18 12:08 PM the hand gel was present in the isolation cart.<br><br>The administrator and director of nursing were notified of the concern during a summary meeting on 8/15/18. | F 880 | | |
| F 925 SS=E | Maintains Effective Pest Control Program<br>CFR(s): 483.90(i)(4)<br><br>§483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, Resident interview, staff interview, and facility document review, the facility failed to ensure an effective pest control program.<br><br>The findings included.<br><br>1. The surveyors were able to observe live flies and gnats throughout the survey process and Residents of the facility complained of live flies and gnats.<br><br>The surveyors were able to observe live flies in the kitchen area during initial tour of the facility on 08/14/18 and at again at 4:29 p.m. while obtaining tray line temperatures.<br><br>The surveyors were able to observe live flies in the main dining room on 8/14/18 at 12:15 p.m. and live gnats in the hallway near room 59 at 08/16/18 at 3:26 p.m. and again on unit 1 at 3:45 p.m. | F 925 | F925<br>Rooms of residents #92, 182, 39, 64, and 8 were deep cleaned.<br>Resident care areas audited for signs of pests and treated accordingly.<br>Staff educated to properly dispose of residual food after meals and to ensure that food kept in resident rooms is stored appropriately.<br>Director of Housekeeping, or designee, will audit care areas 4x per week, for 8 weeks and report findings to Administrator or designee, immediately addressing any issues identified. Process will be reviewed in quarterly QA meeting. | 9/25/18 |

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Resident interviews-

Resident #92-08/14/18 at 1:49 p.m. The Resident was asked if there was ever a problem with live flies and/or gnats. Resident #92 stated, Yes, when I am eating. I do not see them much in the dining room see them more in here (room).

Resident #182-08/15/18 at 8:47 a.m., Problems with gnats or flies? In this room, there is a couple of gnats when there is food in here. In the dining room, there was some flies last week they left when we swished them off.

Resident #39-08/15/18 at 12:30 p.m., Resident #39 complained of live flies and gnats being in his room.

The surveyor completed an interview with the maintenance director on 08/26/18 at 11:25 a.m., during this interview the maintenance director verbalized to the surveyor that he was aware there was a problems with live flies at the facility and identified the flies as phorid flies.

The maintenance director stated they had not sprayed facility wide and only take care of the flies that they see. The maintenance director was able to show the surveyor where they had placed fly lights in the long hallways on the units. He also stated they had placed these in the trash room, kitchen, and breakdown area in the kitchen, the front hall, and near the loading dock doors. He stated they had not placed these on the short halls on the units.

The facility had a pest control contract with a local exterminating company that had been in effect

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| F 925 | Continued From page 75<br>since July 7, 1999.<br><br>The administrative staff were notified of the issues regarding the flies/gnats during a meeting with the survey team on 08/16/18 at 4:40 p.m.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference.<br><br>2. For Resident #64 the facility staff failed to maintain an effective pest control program.<br><br>Resident #64 was admitted to the facility on 01/18/16 and readmitted on 06/06/18. Diagnoses included but not limited to hypertension, peripheral vascular disease, diabetes mellitus, hyperlipidemia, hemiplegia, seizure disorder, depression, atrial fibrillation and benign prostatic hyperplasia.<br><br>The most recent MDS (minimum data set) with an ARD (assessment reference date) of 06/11/18 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS.<br><br>Surveyor observed Resident #64 on 08/15/18 at 1000. Resident was alert and oriented, resting on his bed. Resident spoke pleasantly with the surveyor. While the Resident was speaking, the surveyor observed a gnat flying around the Resident's face. Resident was swatting at gnat when it came around his face. Surveyor asked the Resident if this bothered him and he stated that it did. | F 925 | | |

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| F 925 | Continued From page 76<br><br>Surveyor informed the administrative team of observations during a meeting on 08/16/18 at approximately 1630.<br><br>No further information was provided prior to exit.<br><br>3. For Resident #8 the facility staff failed to maintain an effective pest control program.<br><br>Resident #8 was admitted to the facility on 09/07/17 and readmitted on 10/04/17. Diagnoses included but not limited to chronic obstructive pulmonary disease, dysphagia, and pneumonia.<br><br>The most recent MDS (minimum data set) with an ARD (assessment reference date) of coded the Resdient as of 15 in section C, cognitive patterns. This is a quarterly MDS.<br><br>Surveyor observed Resident #8 after the lunch meal on 08/14/18 at approximately 1400. Resident's lunch tray was on her overbed table. Resident showed the surveyor what she had eaten. Surveyor observed a piece of pie on Resident's tray that had not been eaten. Resident stated to the surveyor "I was going to eat that pie, but a fly landed on it". Suveyor observed several flies in the Resident's room.<br><br>Surveyor informed the administrative team of observations during a meeting on 08/16/18 at approximately 1630.<br><br>No further information was provided prior to exit. | F 925 | | |