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	345296	A. BUILDING _____ B. WING _____	06/16/2017

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F 166 SS=C	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166		7/14/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/06/2017

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conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 166	Continued From page 2 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's grievance policy failed to include resident's rights: to notify resident individually or through postings in prominent locations throughout the facility of the right to file grievances, the right to obtain a written decision regarding his or her grievances and the contact information of independent entities with whom grievances may be filed such as pertinent State agency, State Long Term Care Ombudsman program or Quality Improvement Organization, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated and take appropriate corrective action in accordance with State law if the alleged violation the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility. Findings included: A review of a facility policy titled Grievances which was not dated included a policy statement which revealed the reporting, investigation and resolution of grievances is a vital function to	F 166	1. Administrator updated the grievance policy to include all 7 elements of the grievance regulation. Completed 7/7/17. Corporate reviewed and agreed with changes. 2. Updated Policy will be redistributed to residents and families by 7/14/17. Policy will be re posted in facility as well. IDT training completed by Administrator on 7/11/17. 3. QA to monitor grievances x 2 months to ensure new addition of policy has been followed. Administrator to oversee training of new policy by 7/12/17 for IDT staff. 4. Administrator to oversee plan of correction.	

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protect the health, safety and welfare of the facility community as well as the integrity of facility staff and facility operations.

During an interview on 06/16/17 at 11:42 AM with the Social Services Director she explained she got the grievance information together and did initial interviews and called the person who had filed the grievance. She explained she followed up with families after the grievance was resolved and typically she met one on one with the individual to discuss it but sometimes she made a phone call. She further explained they gave a copy of the grievance to the individual who filed the grievance once it was resolved so they could see what had been done and she did follow up after that. She stated she distributed grievances to the appropriate parties during morning meetings and to the Director of Nursing and Administrator. After review of the policy titled Grievances she stated she thought it was an updated policy but stated there was no date on the policy. She explained the Administrator was in charge of grievances. She stated when residents or families came to tell them about an issue they reviewed the grievance process with them. She further stated they distributed grievance forms as needed and staff usually wrote the grievance on the form for them.

During an interview on 06/16/17 at 1:49 PM with the Administrator he verified he had attended training on the new regulations for grievances. He confirmed the policy titled Grievances is the most current one and it had been provided by the corporate office. He stated he did not write the policy but they could make recommendations. He further stated some of the new language in the regulation was updated but he was not sure if

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F 166	Continued From page 4 it included all of the required elements of the new regulation effective November 2016.	F 166		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family and staff interviews, the facility failed to transcribe an anti-rejection medication (prednisone) according to physician orders and failed to administer 58 out of 58 doses of the anti-rejection medication to a resident from March 13, 2017 through May 10, 2017 for 1 of 6 resident's medication orders reviewed (Resident #8). The findings included: Resident #8 was admitted to the facility on 03/25/15 and readmitted on 03/12/17. His diagnoses included status post heart transplant and heart failure. A review of his hospital discharge orders dated 03/12/17 revealed that prednisone 2.5 milligrams (mg) daily by mouth had been ordered to continue at the facility. Additionally, the orders indicated the next dose was to be given on 03/13/17 in the morning. A review of the 03/13/17 through 03/31/17	F 281	1. Complete audit conducted of chart and orders to ensure accuracy by Nursing Admin team, DON, SDC, MDS nurses. Audit completed 6/2/17. Nurses involved in admission received individual in-service on 5/26/17 in regards to proper transcription of admission orders. 2. All admission/readmission orders have been audited by DON and designees from 5/30/17 back until 1/1/17 to ensure no other admissions were affected. Nursing staff was retrained on 5/30 and 5/31/17 on the changes to admission verification. All admissions must have 3 sets of orders reconciled to come up with readmission/admission orders. Home or previous meds, hospital meds and D/C orders must be in hand as well as a 2nd nurse signature verifying receipt. 3. All admission/readmission charts will be brought daily to morning meeting for review by DON and nursing administration	7/14/17

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F 281	Continued From page 5 medication administration record (MAR) for Resident #8 revealed prednisone 2.5 mg daily by mouth had not been transcribed on the orders. A review of his quarterly Minimum Data Set (MDS) dated 04/08/17 revealed that Resident #8 was cognitively intact. The MDS also revealed Resident #8 required extensive assistance of 1 to 2 persons with most activities of daily living. A review of the care plan for Resident #8 dated 04/12/17 revealed that he was care planned for being at risk for complications related to immunosuppressive therapy secondary to his heart transplant. The goal was the resident would have no complications requiring hospitalization through the next review period. The interventions were to administer medications per the physician orders. A review of Resident #8's medical record revealed the pharmacist had reviewed his medications on 04/11/17 and there had been no recommendations for change. Continued review of the 04/01/17 through 04/30/17 MAR and 05/01/17 through 05/10/17 MAR revealed no prednisone 2.5 mg daily had been transcribed on the orders. Additional medical record review revealed Resident #8 was hospitalized again from 05/10/17 to 05/18/17 related to diagnoses of congestive heart failure and swelling in his legs. A review of the hospital's Cardiology Admission History and Physical dated 05/10/17 revealed that Resident #8 had been admitted to the hospital with decompensated heart failure and concerns	F 281	to ensure compliance x 3 months. Charts reviewed by 2 nurses after initial admission prior day to ensure orders are verified per the hospital D/C or home med list. QA to monitor x 3 months to ensure compliance with admission/readmission audits. Will be monitored monthly to ensure compliance with plan of correction and has not missed any orders for admissions/readmits. 4. DON or designee to monitor.	

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for rejection. Resident #8 had reported progressive leg swelling with increased tiredness and fatigue for 1 month with symptoms gradually getting worse. He had been walking in the past in the skilled facility with a walker but stated for the past couple of weeks he could hardly walk 5 feet before getting dyspneic (short of breath).

Observation of Resident #8 on 06/13/17 at 11:53 AM revealed him in a hospital gown, lying in bed with the head of the bed elevated 45 degrees, watching TV and visiting with a family member who was at his bedside. He was alert and oriented to person but not answering questions appropriately and his family member stated he had some increased confusion since returning to the facility after his last hospitalization. An interview was conducted with his family member at this time. The family member revealed Resident #8 had had 2 recent hospitalizations. The first hospitalization was 03/08/17 to 03/12/17 related to urinary infection and pneumonia. The family member stated that he returned to the facility on 03/12/17. The second hospitalization was 05/10/17 to 05/18/17 and he was admitted to the hospital with congestive heart failure and edema of his legs. The family member stated it was during his May hospitalization that the hospital Cardiologist discovered Resident #8 had not been receiving his prednisone 2.5 mg as prescribed following his hospitalization of 03/08/17 to 03/12/17.

A phone interview on 06/15/17 at 08:36 AM with the Nurse Coordinator for the Cardiologist for Resident #8 revealed the Cardiologist could not say with a certainty that the omission of the prednisone led to his heart failure and hospitalization in May of this year. The

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Cardiologist could only say that Resident #8 was not in rejection as a result of his biopsy.

A phone interview with the facility pharmacist on 06/15/17 at 10:47 AM revealed that his usual procedure for readmissions was to look at any new orders and compare them to previous orders to see what had changed and why the orders may have changed. He stated that he could not remember any specifics regarding Resident #8 and was not aware that he had missed 58 doses of prednisone.

A phone interview was conducted on 06/15/17 at 11:19 AM with Nurse #7 who had transcribed the physician orders from the 03/12/17 readmission of Resident #8. Nurse #7 stated that she could not remember if the Medical Director told her to take the prednisone off the orders or if it was an oversight. She stated their process was to copy the orders from the hospital discharge orders if the Medical Director wanted to continue the orders. Nurse #7 stated that if the Medical Director did not want the order continued in the facility, the nurse would mark the order off with an "X" and leave the orders in the resident's chart. Nurse #7 stated that it was so long ago that she could not remember much about the readmission or the orders and was not sure what had happened with the order.

An interview was conducted on 06/15/17 at 3:15 PM with Nurse #8 who checked the physician orders transcribed from the 03/12/17 readmission of Resident #8. Nurse #8 stated she usually went line by line checking the orders and talked with the Medical Director to make sure he wanted to continue the orders at the facility. Nurse #8 stated she could not remember if the Medical

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Director did not want the prednisone ordered but stated if not it should have been marked with an "X" on the order sheet. Nurse #8 verified the prednisone was not marked with an "X" but stated she could not remember specifically what had happened with Resident #8's orders. She stated they usually only continue the orders the Medical Director approved.

An interview was conducted on 06/15/17 at 4:18 PM with the facility's Medical Director. The Medical Director stated it was significant any time a medication error was made but that it was also dependent on the medication. The Medical Director stated it was unfortunate that Resident #8 had missed 58 doses of prednisone but it was doubtful the omitted medication led to his hospitalization for congestive heart failure. He stated Resident #8 was a complicated resident and he took full responsibility for the medication being missed and stated he should have caught the error. The Medical Director stated he did not tell the nurse who transcribed the orders to take Resident #8 off the prednisone. He stated Resident #8 cycles between doing well and being sick and it was a constant effort to take care of him and stated he felt they had done a good job at the facility with Resident #8's care.

An interview was conducted on 06/16/17 at 1:11 PM with the Director of Nursing (DON) regarding the process of transcribing admission and readmission physician orders. She stated their process was to get the orders and go over them with the Medical Director or personal physician. The DON stated that most of the time the orders on admission or readmission were utilized but sometimes there could be changes or additions. She stated they usually will check (?) the orders

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F 281	Continued From page 9 the physician wishes to continue and "X" the orders that he does not want to continue and then transcribe the orders onto the carbon medication administration record (MAR). The DON stated she did not know how the medication had been missed, especially 58 doses by 2 of her nurses, the pharmacist and the Medical Director. She stated her expectation would have been the medication be transcribed as ordered by the physician or there be an indication on the orders the Medical Director did not want the medication given to the resident.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is	F 309		7/14/17

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F 309	Continued From page 10 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. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to assess bowel sounds or lung sounds for a resident with abdominal pain and shortness of breath prior to transport to the hospital (Resident #64) and the facility failed to complete an assessment of a peripherally inserted central catheter (PICC line) upon admission, failed to complete weekly wound assessments of the PICC line insertion site and failed to measure the external PICC catheter length or arm circumference (Resident #225) for 2 of 3 sampled residents reviewed for assessments. Findings included: 1. Resident #64 was re-admitted to the facility on 07/04/16 with diagnoses which included pneumonia, diverticulitis of the intestine (small pouches in the intestine which become inflamed and cause pain), chronic lung disease, type 2 diabetes, chronic kidney disease, heart disease with atrial fibrillation (rapid heartbeat), muscle weakness, lack of coordination and dementia. A review of the most recent quarterly Minimum	F 309	1.Facility will re-educate staff involved on need to document before discharge a full assessment of the resident when clinically possible. As well as re-educate nurses on PICC line procedures to ensure that they are followed per protocol. ER discharged patients have been reviewed through QA since ... to monitor for assessments and proper methods followed. All other PICC line patients in building to be reviewed by DON for compliance with policy. 2. Each ER discharge will be reviewed in morning meeting by the nursing administration team to evaluate the corresponding assessment. DON expects PICC line placement and site will be checked upon admission and weekly with dressing change by charge nurse and documented on MAR. In addition charge nurse will monitor PICC site each time medication or flush administered. DON or designee to ensure compliance with stated documentation through daily MAR checks.	

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F 309	Continued From page 11 Data Set (MDS) dated 05/12/17 revealed Resident #64 was cognitively intact for daily decision making. The MDS further indicated Resident #64 required extensive assistance with bed mobility, transfers, toileting, hygiene and bathing and had range of motion impairment on both sides of upper and lower extremities. The MDS also indicated Resident #64 was continent of bladder and bowel. A review of a physician's order dated 06/29/16 indicated may go to hospital emergency room for evaluation and treatment and family may transport. A review of nurse's progress notes dated 06/29/16 at 1:06 PM by the Staff Development Coordinator/Infection Prevention Nurse revealed Resident #64 had refused to eat breakfast and stated he did not feel good. The notes indicated Resident #64 stated his ear, head and belly hurt and he felt bad all over. The notes further indicated breath sounds were clear but apical pulse was slightly irregular and abdomen was large with diminished bowel sounds and vital signs were blood pressure 126/80, pulse 72, respirations 18 and temperature was 98 degrees Fahrenheit (F). A review of nurse's progress notes titled Late Entry for 06/29/16 at 7:45 PM by Nurse #10 revealed family had contacted her and reported Resident #64 had complained to them because he felt terrible and needed to go to the hospital. The notes indicated Nurse #10 had Nurse Aides obtain vital signs and they were blood pressure 130/66, pulse 76, respirations 20 and temperature was 96.5 degrees F. The notes further indicated Resident #64 complained of pain	F 309	3. DON or designee will monitor 10% of discharges and PICC lines x 4 weeks and then 10% monthly x 3 months thereafter to ensure compliance with proper discharge assessments. Results will be brought before QA. QA to review results quarterly thereafter to ensure assessments completed per ER discharge. 4. DON or designee will be responsible for implementing this POC.	

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upon urination and nausea however, there was no assessment of resident #64's abdomen or bowel sounds. The notes also revealed Resident #64's oxygen saturation percentage was 82 on room air and oxygen was placed on Resident #64 at 2 liters per minute however, there was no assessment regarding lung sounds. The notes further revealed family stated they were going to take Resident #64 to the hospital if the physician would allow. The notes indicated Nurse #10 called the physician and reported the complaints and Resident #64 was transported to the hospital by family.

A review of a hospital Physician Emergency Department Report dated 06/29/16 indicated Resident #64 presented to the emergency room due to increased shortness of breath today with decreased oxygen saturation percentage of 82 on room air and complaints of left lower abdominal pain. The report further indicated the findings were compatible with diverticulitis, pulmonary infiltrate (substance in the lung associated with pneumonia) and congestive heart failure.

A review of a nurse's progress notes dated 06/30/16 at 8:00 AM titled Addendum by Nurse #10 revealed family had reported Resident #64 told them he had been sick all day on 06/29/16 and wanted to go to the hospital but nobody would send him. The notes indicated Nurse #10 asked them for clarification because no one had reported to her Resident #64 had been sick and family stated they would transport Resident #64 to the hospital if the physician was okay with it.

A review of a hospital History and Physical dated 06/30/16 revealed Resident #64 had presented to the hospital with abdominal pain and shortness of

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breath. The report further revealed Resident #64 stated he had been short of breath for a couple of days and had developed abdominal pain on 06/29/16 that was at times quite severe. The report also indicated Resident #64 had reported he just couldn't catch his breath and he had some cough but no wheezing and the abdominal pain was now more in the middle of his belly. A section labeled plan revealed Resident #64 was placed on Zosyn (antibiotic) for diverticulitis and Gentamycin (antibiotic) for pneumonia as well as supplemental oxygen and nebulizer treatments.

A review of a hospital Discharge Summary dated 07/04/16 indicated Resident #64 had been treated for sigmoid (lower intestine) diverticulitis and possible right apical pneumonia and his condition had improved and he was discharged.

During an interview on 06/15/17 at 4:18 PM with the facility Medical Director he explained he made rounds in the facility usually 5 days a week and was on call for 24 hours a day 7 days a week and expected nursing staff to assess residents and report when they had a change in condition. He stated if a resident had diminished bowel sounds he would want to know if they had a distended abdomen and if pain was present. He explained more information was important because it was his job to know what was going on. He stated if a resident had abdominal pain, distention and staff didn't hear bowel sounds he would expect a nursing supervisor to assess the resident and report findings to the physician.

During an interview on 06/16/17 at 11:00 AM with the Staff Development Coordinator/Infection Prevention Nurse she explained she provided orientation and training to nursing staff. She

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stated she had put together a packet of information for nurses regarding nursing assessments and gave them information to determine when to call the physician or when to send a resident to the hospital. She confirmed she had written the nurse's progress note on 06/29/16 for Resident #64 and had documented Resident #64 had a distended abdomen and diminished bowel sounds but did not recall any other details since it had been so long ago. After review of nurse's progress notes for 06/29/16 and 06/30/16 she verified there was no further assessments of Resident #64's bowel sounds or lung sounds. She explained vital signs and pulse oximetry was not a thorough assessment and she would have expected to have seen monitoring and further assessments of Resident #64's abdomen and lung sounds by nurses before he was sent to the hospital.

An attempt was made on 06/16/17 at 11:27 AM to contact Nurse #10 by phone but there was no answer and Nurse #10 did not return a phone call after messages were left for her.

During an interview on 06/16/17 at 1:36 PM with the Director of Nursing she stated it was her expectation for nurses to thoroughly assess residents when they complained of abdominal pain or had any change in their condition. She stated after review of the nurse's notes for 06/29/16 and 06/30/16 she would have expected for the nurse to have assessed Resident #64's abdomen and lung sounds and she should have talked to him herself in order to report to the physician. She stated it did not appear a thorough assessment had been done of Resident #64's condition prior to his transport to the hospital.

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2. Review of the Nurses' Infusion Manual for Long Term Care protocol for Central Vascular Access Device Dressing change included instructions for peripherally inserted central (PICC) line devices. The protocol stipulated that assessment of the PICC line insertion site was to be performed upon admission and during dressing changes. The protocol also included instructions for assessment of the arm for signs of infection, measurement of length of external catheter, and upper arm circumference upon admission.

Resident #225 was admitted to the facility 06/05/17 with diagnosis which included cellulitis in right hand, dementia, heart failure, and diabetes.

The Nursing admission assessment dated 06/05/17 revealed that the resident was oriented to self, required assistance by one person for transferring and help with activities of daily living. The admission assessment indicated that the resident had a peripherally inserted central catheter (PICC) line in place on the right upper arm with a dressing over PICC site.

A physician's order dated 06/05/17 was in place for Resident #225 to receive Vancomycin 1250 milligrams every twenty-four hours infused through a peripherally inserted central catheter line (PICC). The Vancomycin was to be given through 06/12/17 for diagnosis of cellulitis on the right hand.

An admission note dated 06/05/17 completed by nurse #5 indicated Resident #225 had a PICC line but did not include assessment of the PICC

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site.

A review of Resident #225's medical record wound assessment area revealed there were no weekly wound assessments documented for PICC line site for dates 06/05/17 through 06/14/17.

A form entitled "Visual Body Map" dated 06/06/17 provided by Nurse #4 who was the Treatment Nurse did not include assessment of the PICC line insertion site.

A review of the care plan dated 06/12/17 revealed Resident #225 required care for PICC line related to intravenous antibiotic therapy for cellulitis on the right hand. The goal was for Resident #225 to have no signs of infection of the PICC site over next 90 days. The interventions on the care plan included observation of the PICC site each shift and dressing changes as ordered.

On 06/14/17 at 9:44 AM an interview was conducted with Nurse # 4 (Treatment Nurse) who stated wound documentation would be entered in the electronic medical record using the weekly skin assessment forms.

On 06/14/17 at 5:04 PM Resident #225 was observed as he sat in his room. The PICC line remained in place on right upper arm. The dressing included a piece of gauze over the PICC insertion site held in place with transparent dressing. The dressing was dry and intact. The dressing was dated 06/14/17.

On 06/15/17 at 1:00 PM a follow up interview was conducted with Nurse #4 who stated the PICC line dressing would only be removed at the time

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of admission if the dressing was loosened or had large amount of drainage. Nurse #4 explained the Protocol from the Nurses' Infusion Manual for Long Term Care Facilities from the facility's Pharmacy was used as guidance for assessment of and care for PICC lines. Nurse #4 confirmed the dressing had not been removed at time of admission for assessment of PICC line site, and measurements for the external catheter length and upper arm had not been done.

An interview was conducted on 06/16/17 at 9:22 AM with Nurse #3 who also served as Staff Development Nurse. She stated it was her expectation the PICC line dressing be removed at time of admission, the site assessed, and measurements of external catheter length and arm circumference be taken. She also stated the expectation was the condition of the PICC line insertion site, and measurements of the catheter and arm be recorded in the medical record. Nurse #3 also stated that it was her expectation that the guidelines in the facility's Pharmacy protocol from Nurses' Infusion Manual for Long Term Care Facilities protocol would be followed.

On 6/16/17 at 10:35 AM an observation of Nurse # 3 as assessment was completed of PICC insertion site, measurements made of external catheter length and arm circumference. At that time a new sterile transparent dressing was applied.

On 06/19/17 at 9:35 AM an interview was conducted with the Director of Nursing. She stated during the interview it was her expectation that nurses make assessment of the condition the PICC line insertion site and obtained catheter length and arm circumference measurements at

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F 309	Continued From page 18 the time of admission per the facility's Pharmacy protocol. She also stated it was her expectation the assessments be documented in the resident's medical record.	F 309		
F 333 SS=E	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family and staff interviews, the facility failed to administer 58 out of 58 doses of an anti-rejection medication to a resident from March 13, 2017 through May 10, 2017 for 1 of 6 resident's medication orders reviewed (Resident #8). The findings included: Resident #8 was admitted to the facility on 03/25/15 and readmitted on 03/12/17. His diagnoses included status post heart transplant and heart failure. A review of his hospital discharge orders dated 03/12/17 revealed that prednisone 2.5 milligrams (mg) daily by mouth had been ordered to continue at the facility. (Prednisone can be used as an anti-rejection medication after a transplant.) Additionally, the orders indicated the next dose was to be given on 03/13/17 in the morning. A review of the 03/13/17 through 03/31/17	F 333	1. Complete audit conducted of chart and orders to ensure accuracy by DON and nursing admin team on 6/2/17. Nurses involved in admission received individual in-service on 5/26/17 in regards to proper transcription of admission orders by DON/SDC 2. All admission/readmission orders have been audited by DON and designees from 5/30/17 back until 1/1/17 to ensure no other admissions were affected. Nursing staff was retrained on 5/30 and 5/31/17 on the changes to admission verification by DON/SDC. All admissions must have 3 sets of orders reconciled to come up with readmission/admission orders. Home or previous meds, hospital meds and D/C orders must be in hand as well as a 2nd nurse signature verifying receipt. Med errors reported to DON/MD on a case by case basis. When identified corrective action implemented based on specific	7/14/17

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F 333	Continued From page 19 medication administration record (MAR) for Resident #8 revealed prednisone 2.5 mg daily by mouth had not been transcribed from the hospital orders onto the MAR. A review of his quarterly Minimum Data Set (MDS) dated 04/08/17 revealed that Resident #8 was cognitively intact. The MDS also revealed Resident #8 required extensive assistance of 1 to 2 persons with most activities of daily living. A review of the care plan for Resident #8 dated 04/12/17 revealed that he was care planned for being at risk for complications related to immunosuppressive therapy secondary to his heart transplant. The goal was the resident would have no complications requiring hospitalization through the next review period. The interventions were to administer medications per the physician orders. A review of Resident #8's medical record revealed the pharmacist had reviewed his medications on 04/11/17 and there had been no recommendations for change. Continued review of the 04/01/17 through 04/30/17 MAR and 05/01/17 through 05/10/17 MAR revealed no prednisone 2.5 mg daily had been transcribed from the orders onto the MAR. Additional medical record review revealed Resident #8 was hospitalized again from 05/10/17 to 05/18/17 related to diagnoses of congestive heart failure and swelling in his legs. Observation of Resident #8 on 06/13/17 at 11:53 AM revealed him in a facility gown, lying in bed with the head of the bed elevated 45 degrees,	F 333	issue. Errors will be measured per 1000 resident calendar days to gain percentage. 3. All admission/readmission charts will be brought to daily morning meeting for review by DON or designee to ensure compliance. This will be continued indefinitely. QA to monitor this indefinitely moving forward. 4. Plan will be implemented by DON and designees.	

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watching TV and visiting with a family member who was at his bedside. He was alert and oriented to person but not answering questions appropriately. The family member stated the resident was hospitalized from 05/10/17 to 05/18/17 and he was admitted to the hospital with congestive heart failure and edema of his legs. The family member stated it was during his May hospitalization that the hospital Cardiologist discovered Resident #8 had not been receiving his prednisone 2.5 mg as prescribed following his hospitalization of 03/08/17 to 03/12/17.

A phone interview with the facility pharmacist on 06/15/17 at 10:47 AM revealed that his usual procedure for readmissions was to look at any new orders and compare them to previous orders to see what had changed and why the orders may have changed. He stated that he could not remember any specifics regarding Resident #8 and was not aware that he had missed 58 doses of prednisone.

A phone interview was conducted on 06/15/17 at 11:19 AM with Nurse #7 who had transcribed the physician orders from the 03/12/17 readmission of Resident #8. Nurse #7 stated that she could not remember if the Medical Director told her to take the prednisone off the orders or if it was an oversight. Nurse #7 stated that it was so long ago that she could not remember much about the readmission or the orders and was not sure what had happened with the order.

An interview was conducted on 06/15/17 at 3:15 PM with Nurse #8 who checked the physician orders transcribed from the 03/12/17 readmission of Resident #8. Nurse #8 stated she could not remember if the Medical Director did not want the

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F 333	Continued From page 21 prednisone ordered but stated if not it should have been marked with an "X" on the order sheet. Nurse #8 verified the prednisone was not marked with an "X" but stated she could not remember specifically what had happened with Resident #8's orders. She stated they usually only continued the orders the Medical Director or personal physician approved. An interview was conducted on 06/15/17 at 4:18 PM with the facility's Medical Director. The Medical Director stated it was significant any time a medication error was made but that it was also dependent on the medication. The Medical Director stated it was unfortunate that Resident #8 had missed 58 doses of prednisone but it was doubtful the omitted medication led to his hospitalization for congestive heart failure. He stated Resident #8 was a complicated resident and he took full responsibility for the medication being missed and stated he should have caught the error. The Medical Director stated he did not tell the nurse who transcribed the orders to take Resident #8 off the prednisone. An interview was conducted on 06/16/17 at 1:11 PM with the Director of Nursing (DON) regarding the process of medication administration. She stated their process was to get the orders and go over them with the Medical Director or personal physician. The DON stated she did not know how the medication had been missed, especially 58 doses by 2 of her nurses, the pharmacist and the Medical Director. She stated her expectation would have been the medication be administered to the resident as written by the physician.	F 333		
F 428 SS=E	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		7/14/17

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c) Drug Regimen Review

(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic.

(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.

(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.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a 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.

(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

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F 428	Continued From page 23 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (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. This REQUIREMENT is not met as evidenced by: Based on record reviews, family, pharmacy and staff interviews, during a medication review on 04/12/17 the consultant pharmacist failed to identify 1 of 6 residents had not received an anti-rejection medication as ordered when readmitted to the facility on 03/12/17 resulting in 58 missed doses of the medication (Resident #8). The findings included: Resident #8 was admitted to the facility on 03/25/15 and readmitted on 03/12/17. His diagnoses included status post heart transplant and pneumonia. A review of his hospital discharge orders from 03/12/17 revealed that prednisone (an anti-rejection medication) 2.5 milligrams (mg) daily by mouth had been ordered to continue at the facility. Additionally, the orders indicated the next dose was to be given on 03/13/17 in the morning. A review of the 03/13/17 through 03/31/17 medication administration record (MAR) for Resident #8 revealed Prednisone 2.5 mg daily by	F 428	1. All admission/readmission orders have been checked back to 1/1/17 to ensure no other missing medications. This was completed by Nursing Admin team. Pharmacist to review chart week of 7/14 to ensure no other items missed. Audit to be finished 7/14 of current residents to ensure pharmacist review was done monthly, DON or designee to complete. 2. Consultant pharmacist will audit all current residents monthly going forward. As well as get a list of all admits/re-admits from facility since last review upon the monthly visit to ensure all medications are restarted appropriately per the hospital discharge. This will occur each monthly visit. Nurse Supervisor to provide a list of current residents and admits/readmits. 3. DON or designee to audit 10% of medical records monthly x 3 months. And then 10% quarterly thereafter to ensure compliance. QA to monitor monthly x 12 months to ensure compliance thereafter.	

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F 428	Continued From page 24 mouth had not been transcribed on the orders. A review of the medical record of Resident #8 revealed the pharmacist had reviewed his medications on 04/11/17 and there had been no recommendations for change. Continued review of the 04/01/17 through 04/30/17 MAR and 05/01/17 through 05/10/17 MAR revealed no prednisone 2.5 mg daily had been transcribed on the orders. Additional medical record review revealed Resident #8 was hospitalized again from 05/10/17 to 05/18/17 related to diagnoses of congestive heart failure and swelling in his legs. Observation of Resident #8 on 06/13/17 at 11:53 AM revealed him in a hospital gown, lying in bed with the head of the bed elevated 45 degrees, watching TV and visiting with a family member who was at his bedside. He was alert and oriented to person but not answering questions appropriately and his family member stated he had some increased confusion since returning to the facility after his last hospitalization. An interview was conducted with his family member at this time. The family member revealed Resident #8 had had 2 recent hospitalizations. The first hospitalization was 03/08/17 to 03/12/17 related to urinary infection and pneumonia. The family member stated that he returned to the facility on 03/12/17. The second hospitalization was 05/10/17 to 05/18/17 and he was admitted to the hospital with congestive heart failure and edema of his legs. The family member stated it was during his May hospitalization that the hospital Cardiologist discovered Resident #8 had not been receiving his prednisone 2.5 mg as	F 428	4.DON or designee and Pharmacist will be responsible for implementation and plan of correction.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 25 prescribed following his hospitalization of 03/08/17 to 03/12/17. A phone interview on 06/15/17 at 08:36 AM with the Nurse Coordinator for the Cardiologist for Resident #8 revealed the Cardiologist could not say with a certainty that the omission of the prednisone led to his heart failure and hospitalization in May of this year. The Cardiologist could only say that Resident #8 was not in rejection as a result of his biopsy. A phone interview with the facility pharmacist on 06/15/17 at 10:47 AM revealed that his usual procedure for readmissions was to look at any new orders and compare them to previous orders to see what had changed and why the orders may have changed. He stated that he could not remember any specifics regarding Resident #8 and was not aware that he had missed 58 doses of prednisone. An interview was conducted on 06/16/17 at 1:11 PM with the Director of Nursing (DON) regarding the process of transcribing admission and readmission physician orders. The DON stated she did not know how the medication had been missed, especially 58 doses by 2 of her nurses, the pharmacist and the Medical Director. She stated her expectation would have been the medication be transcribed as ordered by the physician or there be an indication on the orders the Medical Director did not want the medication given to the resident.	F 428		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		7/14/17

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	345296	A. BUILDING _____ B. WING _____	06/16/2017

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F 514	Continued From page 26 (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to document assessments for bowel sounds or lung sounds for a resident with abdominal pain and shortness of breath prior to transport to the hospital	F 514	1. Plan to correct specific deficiency: - Facility will re-educate staff involved on need to document before discharge a full assessment of the resident when clinically possible. PICC line assessed for infection	

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F 514	Continued From page 27 (Resident #64) and the facility failed to document an assessment of a peripherally inserted central catheter (PICC line) upon admission, failed to document weekly wound assessments of the PICC line insertion site and failed to document measurements of the external PICC catheter length or arm circumference (Resident #225) for 2 of 3 sampled residents reviewed for complete and accurate documentation. Findings included: 1. Resident #64 was re-admitted to the facility on 07/04/16 with diagnoses which included pneumonia, diverticulitis of the intestine (small pouches in the intestine which become inflamed and cause pain), chronic lung disease, type 2 diabetes, chronic kidney disease, heart disease with atrial fibrillation (rapid heartbeat), muscle weakness, lack of coordination and dementia. A review of the most recent quarterly Minimum Data Set (MDS) dated 05/12/17 revealed Resident #64 was cognitively intact for daily decision making. The MDS further indicated Resident #64 required extensive assistance with bed mobility, transfers, toileting, hygiene and bathing and had range of motion impairment on both sides of upper and lower extremities. The MDS also indicated Resident #64 was continent of bladder and bowel. A review of nurse's progress notes dated 06/29/16 at 1:06 PM by the Staff Development Coordinator/Infection Prevention Nurse revealed Resident #64 had refused to eat breakfast and stated he did not feel good and his ear, head and belly hurt and he felt bad all over. The notes further indicated breath sounds were clear but	F 514	and line measured 6/16 with no issues noted. Dressing applied per policy. PICC lines checked weekly since survey to ensure compliance. Residents who are not sent out to ER but have acute change or concern will be discussed each morning by the clinical team to ensure proper follow up. 2. Each ER discharge medical record will be reviewed in daily morning meeting by the clinical team to evaluate the corresponding assessment. DON expects PICC lines to be checked upon admission and weekly by charge nurse and with all medication and flush administrations. DON or designee to ensure compliance through daily MAR checks. Currently no PICC lines in facility to audit. Weekly documentation of PICC site includes condition of site, arm circumference, length of catheter and dressing change/cap change. 3. DON or designee to monitor 25% of PICC line documentation and discharge assessments x 4 weeks and 10% monthly thereafter x 11 months. Results forwarded to QA committee for review and further recommendation. 4. DON or designee will be responsible for implementing this POC.	

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apical pulse was slightly irregular and abdomen was large with diminished bowel sounds and vital signs were blood pressure 126/80, pulse 72, respirations 18 and temperature was 98 degrees Fahrenheit (F).

A review of nurse's progress notes titled Late Entry for 06/29/16 at 7:45 PM by Nurse #10 indicated Resident #64 complained of pain upon urination and nausea however, there was no documentation of assessments of resident #64's abdomen or bowel sounds. The notes revealed Resident #64's oxygen saturation percentage was 82 on room air and oxygen was placed on Resident #64 at 2 liters per minute however, there was no documentation regarding lung sounds. The notes indicated Nurse #10 had Nurse Aides obtain vital signs and they were blood pressure 130/66, pulse 76, respirations 20 and temperature was 96.5 degrees F but there was no documentation as to whether Resident #64's pulse was regular or irregular. The notes further indicated Nurse #10 called the physician and reported the complaints and Resident #64 was transported to the hospital by family.

A review of a hospital Physician Emergency Department Report dated 06/29/16 indicated Resident #64 presented to the emergency room due to increased shortness of breath and left lower abdominal pain and the findings were compatible with diverticulitis, pulmonary infiltrate (substance in the lung associated with pneumonia) and congestive heart failure.

During an interview on 06/16/17 at 11:00 AM with the Staff Development Coordinator/Infection Prevention Nurse she confirmed she had written the nurse's progress note on 06/29/16 for

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Resident #64 and had documented Resident #64 had a distended abdomen and diminished bowel sounds but did not recall any other details since it had been so long ago. After review of nurse's progress notes for 06/29/16 and 06/30/16 she verified there was no further assessments documented of Resident #64's bowel sounds or lung sounds before Resident #64 was sent to the hospital.

An attempt was made on 06/16/17 at 11:27 AM to contact Nurse #10 by phone but there was no answer and Nurse #10 did not return a phone call after messages were left for her.

During an interview on 06/16/17 at 1:36 PM with the Director of Nursing she stated it was her expectation for nurses to thoroughly assess residents when they complained of abdominal pain or had any change in their condition. She stated after review of the nurse's notes for 06/29/16 and 06/30/16 she would have expected for the nurse to have documented assessments in the resident's medical record.

During an interview on 06/16/17 at 1:49 PM with the Administrator he stated it was his expectation for nursing assessments to be documented in the resident's medical record.

2. Resident #225 was admitted to the facility on 06/05/17 with diagnosis which included cellulitis of right (R) hand, dementia, diabetes, and heart failure. A review of the admission nursing assessment dated 06/05/17 indicated Resident #225 was oriented to self, required assistance by one person for transfers and help with activities of daily living. The admission skin assessment dated 06/05/17 indicated Resident #225 had a wound with dressing dry and intact on R hand

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and a peripherally inserted central catheter (PICC) line in R upper arm with dressing dry and intact.

Record review revealed physician's order dated 06/05/17 to change PICC dressing every week and as needed per protocol.

Admission note dated 06/05/17 by Nurse #5 indicated resident had PICC line and wound on R hand but there was no documentation of an assessment of the PICC line site or the surgical wound on the R hand.

A review of Resident #225's medical record revealed there were no weekly wound assessments documented for PICC line site or R hand surgical wound/cellulitis from dated 06/05/17 through 06/14/17.

A paper form entitled Visual Body Map dated 06/06/17 provided by Nurse #4 who was also the Treatment Nurse did not include documentation of an assessment of the PICC line insertion site or the condition of the surgical wound on R hand.

On 06/14/17 at 9:44 AM an interview was conducted with Nurse #4 who stated wound documentation would be entered in the electronic record using the weekly skin assessment forms.

On 06/15/17 a follow up interview was conducted with Nurse #4 who stated the PICC line dressing would only be removed at the time of admission if the dressing was loosened or had large amount of drainage. Nurse #4 confirmed there was no documentation for assessment of PICC line site, and measurements of the external catheter length and upper arm circumference had not

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F 514	Continued From page 31 been documented at time of the initial assessment. An interview was conducted on 06/15/17 at 9:22 AM with Nurse #3 who was also the Staff Development Nurse. She stated it was her expectation the condition of the PICC line insertion site, measurements of the catheter length and arm circumference be recorded in the medical record. On 06/16/17 at 9:35 AM an interview was conducted with the Director of Nursing. She stated during the interview it was her expectation nurses documented the condition of the PICC line insertion site and obtained catheter length and arm circumference measurements at time of admission. She also stated it was her expectation the assessments be documented in the resident's medical record.	F 514		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and	F 520		7/14/17

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F 520	Continued From page 32 (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in June of 2016. This was for one recited deficiency which was originally cited in May of 2016 on a Recertification survey and subsequently recited on the current Recertification survey. The deficiency was in the area to maintain complete and accurate resident records. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to	F 520	1.All unplanned discharges will be reviewed the next morning to ensure appropriate assessment completed. PICC lines to be monitored weekly per policy. 2.Nurses educated on need to properly assess and note any changes of condition and document accordingly. This will be accomplished by 7/14/17. Any documentation pertinent to change of condition will be monitored daily by Nurse Admin team and acted upon accordingly. PICC line policy training to be completed	

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F 520	Continued From page 33 sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 514: Based on observations, record reviews and staff interviews the facility failed to document assessments for bowel sounds or lung sounds for a resident with abdominal pain and shortness of breath prior to transport to the hospital (Resident #64) and the facility failed to document an assessment of a peripherally inserted central catheter (PICC line) upon admission, failed to document weekly wound assessments of the PICC line insertion site and failed to document measurements of the external PICC catheter length or arm circumference (Resident #225) for 2 of 3 sampled residents reviewed for accuracy of documentation. The facility was recited for F 514 for failing to document assessments for bowel sounds or lung sounds for a resident with shortness of breath and abdominal pain and for failing to document assessments of a peripherally inserted central catheter (PICC line) upon admission, on weekly wound assessments and for failing to document the external catheter length or arm circumference. F 514 was originally cited during the May 12, 2016 recertification survey for failing to complete medical record documentation for intensity of pain according to a pain scale from 0 for no pain to 10 for worst pain to determine effectiveness of pain medications given to 2 of 6 residents sampled for pain (Resident #136 and #77). During an interview on 06/16/17 at 1:49 PM with	F 520	by 7/14/17 to ensure all nurses are aware of steps in process. 3. DON or designee will audit 25 % of PICC line and discharge documentation weekly x 4 weeks and 10% monthly thereafter x 11 months to ensure compliance. Results will be monitored by QA with recommendations discussed monthly. QA to focus monthly on assessment documentation and change of condition charting to ensure residents with acute issues are properly assessed and treated. This will continue x 12 months. 4.Administrator and DON to be responsible for this plan of action and ensuring QA committee follows up on each audit.	

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F 520	Continued From page 34 the Administrator he acknowledged last year F 514 was cited due to a lack of documentation of pain and they had followed their plan of correction and worked hard and audited it to make sure that was not a problem on the current survey. He stated he realized during this survey documentation of assessments was a problem and they would have to broaden their scope when looking at complete and accurate documentation. He further stated the documentation of the assessments should have been done and audits would have to be done to ensure the problem was resolved.	F 520		