STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 07/13/2018

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F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		8/10/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/31/2018

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F 578	Continued From page 1 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to document an advanced directive (code status) for 1 of 26 residents reviewed (Resident #396) to indicate what the resident's desires were in an emergent situation. Findings included: Resident #396 was admitted to the facility on 07/06/18. Diagnoses included in part, high blood pressure, coronary artery disease, diabetes, dependence on oxygen, nonspecific abnormal finding in lung field, and pulmonary fibrosis. There was no Minimum Data Set (MDS) information at this time. A review of the physician's order from 07/06/18 through 07/09/18 revealed there was no order for a code status. A review of a Social Service note written on 07/09/18 indicated the resident's code status would continue to be a DNR (Do Not Resuscitate) while in the facility. A review of the resident's chart revealed Resident #396 had no admission orders indicating a code status (DNR/Full Code). Upon continued review of the chart there was a hospital note indicating the resident was a full code. An interview was conducted with Nursing Assistant (NA) #1 on 07/11/18 at 11:10 AM. NA #1 stated to determine what a resident ' s code status was quickly and in an emergent situation,	F 578	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F578 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to document an advanced directives for 1 of 26 residents reviewed to indicate what the resident's desires were in an emergent situation. The Health Information Manager will audit all current residents' orders to ensure each residents advanced directives were present in the physician orders. If any resident was identified without an advanced directive order in place, the physician will be immediately notified to obtain the advance directive order. This will be completed by August 3, 2018. 2. Procedure for implementing the acceptable plan of correction. On 07/25/2018, the Nurse Consultant provided an in-service education to all full time, part time, and as needed nurses. Topics included: • Advance Directives documentation	

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F 578	Continued From page 2 we looked in the computer in the resident's profile. An interview with Nurse #8 on 07/11/18 at 11:30 am was conducted. Nurse #8 explained the admission process that when a resident was being admitted, the nurse would be notified of name, date and time of arrival. Nurse #8 stated as soon as she got the chart she reviewed the history and physical, discharge orders, pertinent labs, and diagnoses from the hospital records. The nurse stated she would then go through the orders, fax the orders to the pharmacy and put in other orders such dietary needs, labs if needed, code status, and medications. Nurse #8 added there was a checklist that the nurses used called the admission and readmission check list and we go over each one to make sure we completed everything we needed to complete. At this time, this list was reviewed for this resident, however, nothing was checked off as completed. Nurse #8 stated it should have been completed and signed. Nurse #8 reported when a resident was admitted, we determine if they are full code or DNR and put the order in the computer. If they were a DNR, we are to have the "Goldenrod" paper to indicate the resident was a DNR in front of the chart. Nurse #8 reported if she needed to know what a resident's code status was in an emergent situation, she would go to the computer. When reviewing the records with the nurse she saw that the resident did not have a Goldenrod which indicated he was not a DNR. She found documents from the hospital that the resident was a full code, but there was no actual order. When Nurse #8 was reviewing the orders in the computer she noted an order that Resident #396 was a DNR as of 07/10/18. The nurse stated she did not know why there was no Goldenrod in the	F 578	• How to enter an order for Advance Directives • Honoring residents and families wishes regarding Advanced Directives The NHA provided an in-service education to the Social Worker and Admissions Director. Topics included: • Notification of the hall nurse and Nurse Managers when advance directive decisions are made on admission to the facility This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses, Social Worker, and Admission Director and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor the documentation of advance directives. The Quality Assurance tool will be completed weekly for 4 weeks then monthly for 2 months. Monitoring will include auditing 100% of all new admissions for advance directive documentation in physician orders. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the	

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F 578	Continued From page 3 resident's chart. Nurse #8 confirmed there were no orders available in the computer to note the resident was a full code or DNR from 07/06/18 through later in the day 07/10/18. Nurse #8 provided a form called Advance Directive and Self Administration of Medication which indicated the resident's desire was to be a "no code" also known as DNR and Resident #396 signed the form on 07/06/18. Nurse #8 stated Resident #396 was a DNR since admission. Nurse #8 reported she spoke to a family member to confirm the code status and she confirmed Resident #396 should have been a DNR since first day of admission but there was no documentation or order to support Resident #396's request. An interview with Nurse #1 on 07/11/18 at 2:30 PM revealed she would go to the computer to determine what the resident's code status was if a resident was in an emergent situation. She indicated this would be the fastest way. Nurse #1 stated she would also check the chart and look for the goldenrod paper which would indicate if the resident was a DNR. An interview with the Assistant Director of Nursing (ADON) on 07/12/18 at 3:32 PM regarding the process from an administrative standpoint, we have the Advance Directive and Self-Administration of Medication form filled out and signed by the resident and/or family. We review this form and check with the resident if they are alert and oriented, if not, with the family to clarify the code status was accurate. If the form was not accurate, we get an order from the doctor. When we find out what the resident's desires were, we would make sure the face sheet (profile) was updated as well as the orders and	F 578	Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Social Services Coordinator and Health Information Manager. 4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	

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F 578	Continued From page 4 the Social Services Coordinator would get the goldenrod paper signed. The ADON stated if the resident chooses to be a DNR, we have to have two nurses call the physician and the family and get a verbal order for the DNR status until we have the goldenrod in hand. The process was to continue calling the doctor every 48 hours until we get the goldenrod signed. The ADON reported her expectation for documenting the code status was for the nurses to follow the process by reviewing the admission orders to determine what the code status was, following the admission check list and implementing standing orders to ensure the advance directive orders are in the system as well as getting the "Goldenrod - Do Not Resuscitate" form in the front of the chart if the resident was a DNR.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment regarding pressure wounds in Sections I and M for 1 of 26 MDS assessments reviewed, Resident #90. Findings included: Resident #90 was admitted to the facility on 04/12/18 with diagnoses that included hypertensive heart and chronic kidney disease stage 3, Diabetes Mellitus, presence of aortocoronary bypass graft, paroxysmal atrial	F 641	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	8/10/18

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F 641	Continued From page 5 fibrillation and dementia. Additional diagnoses added after admission included (5) pressure wounds that were facility acquired involving the right and left buttock, both heels, and the sacral region. Review of the plan of care in progress with a completion date of 07/27/18 included, in part, that the resident had a pressure wound on his left and right buttocks and heels, and sacrum. Goals included for the pressure wounds to show signs of healing and remain free from infection for a period of 90 days. Some interventions included the administration of treatments, weekly wound assessments, education for the resident and family, and a pressure reducing wheelchair pad and mattress. It was documented that the resident refused to wear bilateral bunny boots. A quarterly MDS assessment completed on 06/20/18 was reviewed. Section I of the assessment documented that the resident had a wound infection, (2) stage 4 buttock pressure wounds, (1) stage 3 heel pressure wound and (1) stage 2 sacral pressure wound. Section M of the same assessment documented that the resident had (1) stage 4 pressure wound, (2) stage 2 pressure wounds, and (1) unstageable pressure wound. Review of the weekly wound assessments for 06/20/18 documented that the resident had (2) stage 4 pressure wounds (right and left buttock), (2) stage 2 pressure wounds (right heel and sacrum), and (1) unstageable pressure wound on the left heel. In an interview with the MDS Nurse on 07/12/18 at 12:20 PM she revealed that the MDS	F 641	F 641 Plan for correcting the specific deficiency and including what processes that lead to deficiency cited. The specific deficiency was corrected on 7/12/18 by modifying the Quarterly Minimum Data Set with an ARD of 6/20/18 so that Section I would include the diagnoses of: unstageable pressure ulcer, stage II pressure ulcer, and stage IV pressure ulcer and to remove the diagnosis of stage III pressure ulcer. Section M of that same Minimum Data Set was also corrected so that it would reflect that resident had: 1 unstageable pressure ulcer, 2 stage II pressure ulcers and 2 stage IV pressure ulcers. This was completed by the MDS Nurse. Corrected Minimum Data Set was re-submitted to State Database on 7/12/18 in Batch #1180. The process identified that lead to these areas of concern is that the facility staff failed to include the diagnosis of unstageable pressure ulcer, stage II and stage IV pressure ulcers in Section I, and accurate coding of these pressure ulcers in Section M on the Minimum Data Set. The facility process is the Health Information Manager enters the active diagnosis into the electronic medical record. The diagnosis then populate into the Minimum Data Set assessments and the MDS Coordinator validate that the	

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F 641	Continued From page 6 assessment dated 06/20/18 had been coded incorrectly in Sections I and M. She said Section I should have included a diagnosis of an unstageable pressure wound and not a diagnosis for a stage 3 pressure wound. She also revealed that Section M was missing one stage 4 pressure wound. She said that she would submit a modification to correct the assessment to reflect that the resident had (2) stage 4 pressure wounds, (2) stage 2 pressure wounds and (1) unstageable pressure wound on 06/20/18 in both Sections I and M. In an interview with the Assistant Director of Nursing on 07/13/18 at 12:01 PM she stated that she expected MDS assessments to contain accurate information.	F 641	diagnosis is accurate. The wound nurse assesses and completes Weekly Pressure Ulcer review assessments in the electronic health record for each individual pressure ulcer. The MDS Coordinator then reviews these assessments prior to completing the Minimum Data Set. Procedure for implementing the acceptable plan of correction for specific deficiency The MDS Consultant provided education to the MDS Coordinators on 7/25/18. Information Provided on Education included: • Explanation of the intent of Section I on the Minimum Data Set. Items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the Minimum Data Set assessment is to generate an updated, accurate picture of the resident's current health status. • It also included steps for accurately assessing and coding Section I. • Section M is key in documenting the risk for, presence, appearance and change in pressure ulcers that a resident may have. • Steps for Assessment: 1. Review the medical record, including wound documentation in Weekly Pressure Ulcer	

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F 641	Continued From page 7	F 641	Review User Defined Assessments, Treatment Administration Record, Weekly Skin Checks, Wound Physician Reports, Physician Consults/Progress Notes or other skin tracking forms, Nurses' Notes, and Risk Assessments. • 2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident. • 3. Examine the resident and determine whether any ulcers, scars, or non-removable dressings/devices are present. Assess key areas for pressure ulcer development (e.g., sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also assess bony prominences (e.g., elbows and ankles) and skin that is under braces or subjected to pressure (e.g., ears from oxygen tubing). • It also included steps for accurately coding Section M of the Minimum Data Set. This information has been integrated into the standard orientation training for MDS Nurses. Monitoring procedure to ensure the plan of correction is effective and specific deficiency remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will perform Quality Assurance Audits by using the tool entitled "Accurate Diagnosis Coding on Minimum Data Set Assessments Audit Tool." This audit will	

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F 641	Continued From page 8	F 641	be completed weekly for 4 weeks and then monthly for 2 months. This audit will monitor a sample of 5 residents who have had an Minimum Data Set completed in the past 30 days to ensure compliance in accurately coding current active diagnoses in Section I. The quality assurance audit will start on 7/26/18. The Director of Nursing or designee will also complete Quality Assurance Audits by using the tool entitled “Accurate Coding of Section M on Minimum Data Set Audit Tool.” This audit will be completed weekly for 4 weeks and then monthly for 2 months. This audit will monitor a sample of up to 5 residents who have or have had a pressure ulcer in the past 90 days to ensure that their Minimum Data Set Assessment reflects accurate coding of Section M. The Administrator will monitor completion of the Quality Assurance audit to ensure regulatory compliance. Any negative findings will immediately be addressed. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Social Services Coordinator and Health Information Manager. Title of person responsible for implementing the acceptable plan of	

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F 641	Continued From page 9	F 641	correction The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on Nurse Practitioner (NP) interview, pharmacist interview, staff interview, observations, and record review the facility failed to administer medications on order through the pharmacy which were available in the facility's stock medications or emergency medication kit for 2 of 6 residents (Resident #35 and #147) whose medications were reviewed. For 1 of these 6 residents (Resident #147) the facility also failed to obtain a hard script for anti-anxiety medication which resulted in the resident missing two scheduled morning doses and experiencing elevated anxiety levels. Findings included: 1. Resident #147 was admitted to the facility on 06/01/18 and discharged home on 06/30/18. The resident's documented diagnoses included anxiety, atrial fibrillation, chronic kidney disease stage III, atherosclerotic heart disease, diverticulosis, gastritis, osteoporosis, and vitamin D deficiency. The resident's 06/01/18 hospital Discharge	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to administer medications on order through the pharmacy which were available in the facility's stock medications or emergency medication kit for 2 of 6 residents whose medications were reviewed. For 1 of these 6 residents the facility also failed to obtain a hard script for anti-anxiety	8/10/18

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F 658	Continued From page 10 Summary documented she was to continue: taking Xanax (anti-anxiety medication) 0.5 milligrams (mg) every morning at 8:00 AM for control of her anxiety. Review of Resident #147's electronic medication administration record (MAR) documented on 06/02/18 she did not receive her morning doses of Xanax 0.5 mg, Metamucil fiber packet, Hydrochlorothiazide (diuretic) 25 mg (even though it was in the facility's emergency medication kit), Protonix (peptic ulcer medication) 40 mg, Metoprolol Succinate (blood pressure medication) extended release 25 mg (even though it was in the facility's emergency medication kit), Miralax (medication to maintain bowel regularity) 17 grams (even though it was a stock medication kept in the facility), and Calcium/vitamin D 600/800 mg (even though it was a stock medication kept in the facility). The MAR review also revealed Resident #147 did not receive her 8:00 AM dose of Xanax on 06/03/18. A 06/03/18 10:20 PM progress note documented, "Resident family was upset about her medications." A 06/04/18 facility fax to Resident #147's primary physician documented, "Resident has order for Xanax 0.5 mg in the AM for anxiety-Pharmacy needs hard script for this med." On 06/05/18 "I use anti-anxiety medications with risk for adverse side effects" was identified as a problem in the resident's care plan. Interventions to this problem included "Give anti-anxiety medications ordered by physician." The resident's 06/08/18 admission minimum data	F 658	medication which resulted in the resident missing two scheduled morning doses and experiencing elevated anxiety levels. The Director of Nursing will audit the July Medication Administration Records (MAR) for any blank spaces or documentation indicating the medication was not given due to unavailability. If any medication is identified as not given due to unavailable, the medication was obtained from the back up pharmacy for administration prior to the next dose due. This will completed by the DON by August 10, 2018. 2. Procedure for implementing the acceptable plan of correction. On July 25, 2018, the Nurse Consultant provided an in-service education to all full time, part time, and as needed nurses, Medication Aides and Medication Tech's. Topics included: • Documenting medication administration on the electronic medication administration record • Medications that are available in the emergency medication box • How to obtain medications when they are unavailable in the facility or emergency box • Obtaining hard scripts for narcotic medications and how to ensure the narcotics are received timely • How to obtain medications from the back up pharmacy This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses, medication aides, and medication tech's and will be reviewed by the Quality Assurance process to verify	

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F 658	Continued From page 11 set (MDS) documented her cognition was intact, she exhibited no behaviors including rejection of care, she required anywhere from minimal to extensive assistance with her activities of daily living (ADLs), and during the 7-day look back period received an antidepressant on 7 days, an anti-anxiety medication on 2 days, and a diuretic medication on 3 days. On 07/12/18 at 4:02 PM the Assistant Director of Nursing (ADON) stated Resident #147 was admitted between 12:30 and 3:30 PM on 06/01/18. She reported hospitals were supposed to be sending hard scripts with residents when they discharged them on psychotropic medications and narcotics, but the nursing home was having problems getting them to do so. She commented that the two nurses who failed to administer some of Resident #147's medications on 06/02/18 and 06/03/18 were both agency nurses. On 07/12/18 at 11:38 AM, during a telephone interview, Pharmacist #1 stated the pharmacy she worked for was the facility's regular and back-up pharmacy. She explained since the pharmacy was so close to the facility physically that it was able to deliver medications to the facility at all hours. She reported the quickest way for the facility to obtain a hard script was to notify a pharmacy technician (who worked until 6:00 PM - 6:30 PM) that they needed a hard script as soon as possible (STAT). She explained pharmacy technicians were frequently able to get up with and obtain hard scripts from primary physicians faster than facility staff could. According to Pharmacist #1, once a hard script was obtained the medication could have been delivered to the facility STAT.	F 658	that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor the documentation of medication on the electronic medication administration record. The Quality Assurance tool will be completed weekly for 4 weeks then monthly for 2 months. Monitoring will include auditing 100% of all medication administration documentation on the MAR for missed medications due to unavailable. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Social Services Coordinator and Health Information Manager. 4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	

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On 07/12/18 at 4:08 PM Nurse #2 stated on the afternoon of 06/03/18 she encountered a situation where a family member of Resident #147 was very upset because the resident had gone two mornings without her scheduled Xanax. She reported the family member stated, and she overheard a couple of staff members talking about, Resident #147 trembling because she was so scared and anxious. Nurse #2 commented she had not observed this on 06/03/18, but had witnessed Resident #147's anxiety on another morning. According to this nurse, in the past the staff used to ask the pharmacy technicians to make contact with primary physicians to obtain hard scripts, but she remarked the facility had kind of gotten away from doing that. Nurse #2 stated there were several doctors that preferred contact by the pharmacy versus nursing before writing hard scripts. She reported that she always checked stock medications and the emergency medicine kit if medications had not been delivered by the pharmacy yet so that residents would not miss doses and there was a consistent flow of the medications in resident bloodstreams.

On 07/12/18 at 4:37 PM Nurse Practitioner (NP) #1 stated she was in the facility starting 04/23/18 Monday through Friday until 7:00 - 9:00 PM. She reported residents should not miss doses of medication, especially heart medications and diuretics. She commented hospitals were supposed to send the hard script for psychotropics and narcotics if they discharged residents on them. She stated the facility could utilize her to make contact with doctors in the community with whom she had built a good rapport to obtain hard scripts more quickly.

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On 07/13/18 at 9:21 AM the ADON stated the facility received orders for medications electronically from the hospital before residents were discharged from there, but sometimes this might be five minutes before the resident left the hospital. She reported Friday afternoons were rough when the hospital did not send hard scripts. She explained the facility had to try to get up with the primary physicians, but usually they had to talk to on-call doctors, many of whom did not want to write the hard scripts because they did not know the residents well enough. She remarked when the facility tried to call back to the hospital, the doctors there were all gone home. The ADON stated she had not heard that the facility could call the pharmacy technicians who might be able to make quicker contact and assistance in obtaining hard scripts from a doctor. She reported agency nurses were put through orientation and some of that orientation was on the floor with facility nursing so they could learn where things could be found and how to access resident information in a hands-on environment. According to the ADON, the expectation was for nurses to check the emergency medication kit and stock medications before documenting that medication administration was not possible due to the medications being on order from the pharmacy.

Nurse #3, who failed to administer morning medications to Resident #147 on 06/02/18, some of which were stock medications or in the emergency medication kit, did not return phone messages requesting an interview with her.

2. Resident #35 was admitted to the facility on

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02/16/16 and had diagnoses of heart failure, anemia and hypertension.

Review of the quarterly Minimum Data Set (MDS) dated 05/06/18 revealed Resident #35 was cognitively intact.

Review of Resident #9's July 2018 Medication Administration Record (MAR) revealed a 100mg (milligram) dose of atenolol was to be administered every day by mouth. Instead of a checkmark signifying the medication had been provided on 07/05/18 and 07/06/18 there was a number 9 signifying a nurse's note had been written.

Review of the Medication Administration Note dated 07/05/18 revealed Resident #35's atenolol was not administered because the medication was not available.

Review of the Medication Administration Note dated 07/06/18 revealed Resident #35's atenolol was not administered because the medication was unavailable.

The July 2018 MAR also revealed that lasix 70mg by mouth was to be administered daily. On 07/06/18 instead of a check mark signifying the medication had been provided there was a number 9 signifying a nurse's note had been written.

Review of the Medication Administration Note dated 07/06/18 revealed Resident #35's lasix was not administered because the medication was on order.

In an interview on 07/12/18 at 10:50 AM Nurse #1

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stated medications should be reordered when the bubble pack containing the individual medications showed the blue column. She indicated residents should not run out of medications but if they did an E-kit (emergency drug box) was available. She stated if a resident's medication was missing the pharmacy should be notified so the medication could be delivered.

On 07/12/18 at 10:55 AM a review of the undated Emergency Drug Box (E-kit) contents list and an observation of the E-kit contents was conducted. The E-kit list revealed the box should contain five 25mg tablets of atenolol and five 20mg tablets of Lasix. The atenolol and lasix at the dosages shown were in the E-kit.

In an interview on 07/12/18 at 11:20 AM Pharmacist #1 indicated that atenolol and lasix at the doses shown on the E-kit contents list would have been available in the E-kit for administration to residents on 07/05/18 and 07/06/18. She indicated that the pharmacy delivered to the facility at all times during the day because they were also the back-up pharmacy. She stated the facility could either fax or call for medications that the residents needed and they would be delivered the same day.

In a telephone interview on 07/12/18 at 1:03 PM Nurse #11, who worked with Resident #35, confirmed she did not administer Lasix to Resident #35 on 07/06/18. She indicated she did not think to check the E-kit for the medication.

In an interview on 07/12/18 at 2:25 PM the Nurse Practitioner (NP) stated a resident should never miss any doses of ordered medications and especially not cardiac medications.

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F 658	Continued From page 16 In a telephone interview on 07/12/18 at 11:32 PM Nurse #12, who worked with Resident #35 on 07/05/18, confirmed she did not administer Resident #35's atenolol that morning. She indicated she did not think to check the E-kit for the medication and she did not call or fax the pharmacy to re-order the medication. She indicated she had monitored Resident #9's blood pressure throughout the day and had no concerns with the readings. In an interview on 07/13/18 at 12:20 PM the Assistant Director of Nursing (ADON) stated medications should be re-ordered when the blue column on the bubble pack was accessed using the order function in the electronic record. If a medication was unavailable in the medication cart the nurse should check the E-kit and provide the medication if it was available. The pharmacy should be called to re-order the missing medications. The ADON stated it was her expectation that all medications be provided to the residents and that no doses were missed. The ADON indicated she expected nurses to check the E-kit if medications were missing. Nurse #3, who failed to administer atenolol which was available in the E-kit on 07/06/18 to Resident #35, did not return phone messages requesting an interview with her.	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to	F 690		8/10/18

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F 690	Continued From page 17 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to obtain and include physician orders in the medical records for 2 of 3 sampled residents (Resident #88 and #93) with indwelling catheters. The facility also failed to facilitate the removal of an indwelling catheter for 1 of these 3 sampled residents (Resident #93) who had a	F 690	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this	

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F 690	Continued From page 18 justifying diagnosis that required consultation with a primary physician or urologist. Findings included: 1. Resident #93 was admitted to the facility on 06/02/18, was hospitalized from 06/16/18 until 06/21/18, and was discharged home from the facility on 07/12/18. The resident's documented diagnoses included urinary retention and congestive heart failure. The resident's 06/9/18 admission minimum data set (MDS) documented Resident #93's cognition was intact, he exhibited no behaviors including rejection of care, he required extensive assistance from staff with all his activities of daily living (ADLs) except for eating, he had an indwelling catheter, and he was frequently incontinent of bowel. A 06/21/18 hospital discharge summary documented, "He (Resident #93) had urinary retention, Foley catheter was inserted on 6/18. He still has the Foley catheter in place. He needs to follow up with PCP (primary care physician) or urology for removing the Foley." On 06/26/18 the resident's care plan identified, "I have an Indwelling Catheter r/t (in regard to) urinary retention" as a problem. Interventions to this problem included "I will be/remain free from catheter-related trauma through review date, I will show no s/sx (signs and symptoms) of urinary infection through review date, and Urology consult as needed/ordered." On 07/12/18 at 10:43 AM Nurse #1 stated it was important to have a physician order for a catheter so that the facility knew the size of catheter and balloon to be used, the justifying diagnosis for the catheter, and the frequency for changing out or replacing the catheter. She reported Resident #93 had urinary retention, and usually residents with such a diagnosis had follow-up appointments	F 690	plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F690 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to obtain and include physician orders in the medical records for 2 of 3 sampled residents with indwelling catheters. The facility also failed to facilitate the removal of an indwelling catheter for 1 of these 3 sampled residents who had a justifying diagnosis that required consultation with a primary physician or urologist. The Director of Nursing will assess all current residents for the presence of an indwelling foley catheter. Residents identified with an indwelling foley catheter will have their orders reviewed by the DON for the presence of an MD order for the foley catheter and for the appropriate diagnosis to justify the use of the foley catheter. Any residents with a foley catheter identified without a current physicians order or appropriate diagnosis had their physician called for orders to complete a voiding trial if applicable or orders to keep the foley catheter with an appropriate diagnosis. This was will be completed by August 3, 2018. 2. Procedure for implementing the acceptable plan of correction. On July 25, 2018 the Nurse Consultant provided an in-service education to all full time, part time, and as needed nurses. Topics included:	

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F 690	Continued From page 19 with their urologists who provided orders for voiding trials to see if the catheters could be removed. However, she commented she was not aware of any urology consultations or voiding trials for Resident #93. On 07/12/18 at 11:25 AM Resident #93 stated he would like to have his catheter removed because it was irritating him, and was cumbersome when he was trying to maneuver through the facility. He reported he had not seen a urologist since his hospital discharge. The resident commented he was supposed to be discharged home on 07/12/18, but he sure would like to have the catheter removed prior to leaving the facility. On 07/12/18 at 12:23 PM the Assistant Director of Nursing (ADON) stated when she reviewed Resident #93's paper and electronic medical records there was no physician order present for his indwelling catheter. She reported there were standing orders for indwelling catheters. She commented a physician order provided information such as catheter and balloon size, justifying diagnosis, and details about catheter care and maintenance. Record review revealed the standing orders for Resident #93 provided spaces to document indwelling catheter size, balloon size, and diagnosis, but they had been left blank. Record review also revealed there were no physician progress notes documenting correspondence with the facility about the possible or potential removal of the resident's catheter. On 07/13/18 at 1:26 PM the ADON stated from a regulatory standpoint urinary retention was not an acceptable diagnosis for continued use of an indwelling catheter. However, she reported if a resident was admitted with an order for a catheter, and retention was the justifying diagnosis, then facility honored the order, but	F 690	• Assessing residents on admission for the presence of an indwelling foley catheter • Obtaining physician orders for the indwelling foley catheter and appropriate diagnosis as applicable • Requesting a voiding trial if the diagnosis urinary retention is used for the indwelling foley catheter. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor indwelling foley catheters. The Quality Assurance tool will be completed weekly for 4 weeks then monthly for 2 months. Monitoring will include auditing 100% of all new admissions for the presence of an indwelling foley catheter, MD orders for the catheter, and appropriate diagnosis or need for a voiding trial. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Assistant Director of Nursing,	

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F 690	Continued From page 20 worked with the urologist or primary physician to get orders for voiding trials. She explained if voiding trials were successful then the indwelling catheter was removed immediately. 2. Resident #88 was admitted to the facility on 06/13/18. Diagnoses included, in part, urinary retention. The MDS 14-day assessment dated 06/20/18 revealed the resident was moderately impaired, had an indwelling urinary catheter and was occasionally incontinent of bowel. A review of the physician's orders revealed there was no order for Resident #88 to have an indwelling urinary catheter. An interview with Nurse #8 on 07/11/18 at 11:25 AM was conducted. Nurse #8 confirmed Resident #88 had an indwelling urinary catheter, but she did not know what size it was. Nurse #8 attempted to check the order and determined there was no order by the physician for the indwelling urinary catheter. Nurse #8 stated there should have been order for the indwelling urinary catheter. An interview with Assistant Director of Nursing (ADON) on 07/12/18 at 3:15 PM was conducted. The ADON reported if a resident was admitted with an indwelling urinary catheter, she would have expected the nursing staff to obtain orders for the catheter. The ADON stated there were batch orders that were put into the system for any resident with a urinary catheter.	F 690	Dietary Manager, Social Services Coordinator and Health Information Manager. 4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to clean the back wall of the ice machine and the walls and ceiling of the walk-in refrigerator to prevent the build-up of black/brown/gray matter on these surfaces. The facility also failed to monitor dish machine gauges to ensure the wash temperature was maintained at 150 degrees Fahrenheit or above and failed to discard plastic soup and cereal bowls which had abraded interior surfaces. Findings included: 1. During initial tour of the kitchen, beginning on 07/09/18 at 12:15 PM, there were black/brown spots on the back wall of the ice machine. Ice was making contact with this wall. In addition, the walls and ceiling of the walk-in refrigerator	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 An in-service covering anticipated deficiencies on the Annual Re-certification	8/10/18

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F 812	Continued From page 22 had gray/white spots and build-up on them. On 07/11/18 at 9:48 AM there were still black/brown spots on the back wall of the ice machine, and ice was making contact with this wall. A damp, warm, white cloth was used to wipe the back wall of the ice machine. There was black/brown residue on the cloth after wiping the wall. At this time the Dietary Manager (DM) stated the Maintenance Manager (MM) was responsible for cleaning the ice machine. She provided a cleaning schedule which documented the MM last cleaned the ice machine on 06/28/18. On 07/11/18 at 9:53 AM the walls and ceiling of the walk-in refrigerator still had gray/white spots and build-up on them. A damp, warm, white cloth was used to wipe a wall and the ceiling of the walk-in refrigerator. There was gray/black residue on the cloth after wiping these surfaces, and crumbling residue fell from the ceiling. At this time the DM stated shelving was removed and the whole walk-in refrigerator was power washed not long ago. On 07/13/18 at 10:04 AM the DM stated she knew the MM emptied the ice machine when he cleaned it, and ice contaminated by possible bacteria or mold could cause cross-contamination problems with the potential for making residents sick. She reported she was not sure what was causing the formation of the build-up on the walls of the walk-in refrigerator unless it was related to the heavy levels of condensation in the unit. She commented they had to place a pan in the unit to catch the overflow of moisture. She stated that if food items were to be left uncovered in the walk-in refrigerator there could also be problems with cross-contamination.	F 812	Survey was conducted for all Dietary staff on 7/17/18 by the Liberty Healthcare Corporate Dietitian. Topics covered included discussion of the potential findings during the Surveyor's initial and subsequent tour of the kitchen, proper ware washing and ongoing monitoring as well as documentation of temperatures during the ware washing process, cleaning and sanitizing of the ice machine and thorough cleaning of the Walk-in refrigerator. The Dietary Services Manager conducted an inservice for all Dietary staff on July 26, 2018. Topics covered included proper ware washing, monitoring of dish machine temperature during wash, discarding of abraded dishware and cleaning of the ice machine. The Ecolab Representative plans to conduct an inservice for dietary staff in August. Topics will include checking the dish machine gauges and deliming the dish machine. An audit tool was put into place to monitor compliance on July 26, 2018. Documentation was provided by Ecolab regarding appropriate ware washing and sanitizing temperatures for the Facility's Dish machine. The Dietary Services Director or designee will monitor sanitary practices of the kitchen to include proper cleaning and sanitizing of the ice machine, proper mechanical ware washing, discarding of abraded serviceware and proper cleaning of the walk-in refrigerator using the Dietary QA Audit Tool. This will be done 5 days per week, including weekend days,	

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F 812	Continued From page 23 On 07/13/18 at 10:17 AM the AM Cook stated she thought a dietary aide was responsible for cleaning the ice machine and had to periodically empty the ice machine to thoroughly clean all interior surfaces. She reported that if the inside of the ice machine was not cleaned well then bacteria and mold could form. The cook commented she thought the walls of the walk-in refrigerator were wiped down every couple of weeks, but within a couple of days build-up began to form on the walls once again. On 07/13/18 at 10:36 AM the MM stated in January or February 2018 all shelving was pulled out of the walk-in refrigerator, painted, and the dietary staff cleaned the ceiling, floors, and walls. He reported he had not been informed of any problems with the walk-in refrigerator since then. According to the MM, he was responsible for breaking down and emptying the ice machine once a month, and dietary was responsible for keeping the outside of the ice machine clean. He reported he wiped the inside of the ice machine down using bleach. 2. During observation of the dish machine on 07/11/18 between 9:15 AM and 10:00 AM 14 racks of kitchenware were run through the dish machine, and the wash gauge registered between 133 and 138 degrees Fahrenheit. The two employees working at the dish machine, one feeding the dirty kitchenware into the machine and the other removing sanitized kitchenware from the machine, were not watching the temperature gauges. On 07/13/18 at 10:04 AM the Dietary Manager (DM) stated dietary staff operating the dish	F 812	for two months and then weekly for one additional month. Reports will be presented to the weekly Quality Assurance meeting by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Committee. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Social Services Coordinator and Health Information Manager. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	

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F 812	Continued From page 24	F 812		

machine had been taught to monitor temperature gauges as the first couple of racks were run through the dish machine, and record those temperatures on the dish machine temperature log. However, she reported she did not think the importance of continuing to watch the gauges as the dish machine process progressed had been discussed. She commented her expectation was that the facility's high-temperature dish machine maintained wash temperatures of at least 140 degrees Fahrenheit. (However, the Centers for Medicare and Medicaid Service's State Operations Manual suggests wash temperatures be maintained at 150- 165 degrees Fahrenheit for high-temperature dish machines).

On 07/13/18 at 10:17 AM the AM Cook stated it was important to watch the temperature gauges on the dish machine all the time because the facility had problems in the past with the accuracy of the gauges and the functionality of the machine due to its age. She reported the wash and rinse temperatures had to be hot enough to kill bacteria and germs on the kitchenware that was being run through the dish machine.

3. At 10:07 AM on 07/11/18 15 of 28 plastic soup and cereal bowls had abraded interior surfaces. At this time the Dietary Manager (DM) stated she thought the abrasions were caused by microwaving soup in the bowls.

On 07/13/18 at 10:04 AM the DM reported dietary staff had been trained to count kitchenware that was abraded, chipped, or cracked, and then dispose of it. She commented staff were supposed to provide her with the count so she could order enough replacement kitchenware to keep stock levels adequate to serve all the

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F 812	Continued From page 25 residents. According to the DM, the abrasions in the soup and cereal bowls increased the chance of the kitchenware harboring dried food particles and bacteria. On 07/13/18 at 10:17 AM the AM Cook stated the dietary staff was supposed to dispose of any damaged kitchenware, including items with abraded interior surfaces. She reported it was much more difficult to clean kitchenware that was chipped, cracked, or abraded. She commented if bacteria or dried food gathered in abrasions the possibility of making residents sick was increased.	F 812		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(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. §483.75(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 staff interview and record review the	F 865	The statements made on this plan of	8/10/18

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F 865	Continued From page 26 facility's quality assurance (QA) process failed to prevent the reoccurrence of deficient practice related to kitchen sanitation in a repeat deficiency at F371/F812. The re-citing of F371/F812 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to: F812: Kitchen Sanitation: Based on observation and staff interview the facility failed to clean the back wall of the ice machine and the walls and ceiling of the walk-in refrigerator to prevent the build-up of black/brown/gray matter on these surfaces. The facility also failed to monitor dish machine gauges to ensure the wash temperature was maintained at 150 degrees Fahrenheit or above and failed to discard plastic soup and cereal bowls which had abraded interior surfaces. Review of the facility's survey history revealed F371/F812 was cited during the facility's 06/15/17 annual recertification/complaint investigation survey, and was re-cited during the current 07/13/18 annual recertification/complaint investigation survey. At 2:05 PM on 07/13/18 the Administrator stated the facility had been cited for deficient practice with kitchen sanitation in both 2017 and 2018, but the specific issues were different on the two surveys. She explained in 2017 there was a problem with the overall cleanliness of the kitchen, but in 2018 cleanliness issues were confined to the ice machine and walk-in refrigerator. She also commented that in 2018 only there were problems with the dish machine process and the disposal of damaged	F 865	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F865 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility's quality assurance (QA) process failed to prevent the reoccurrence of deficient practice related to kitchen sanitation in a repeat deficiency at F371/F812. The re-citing of F371/F812 during the last year of federal survey history showed a pattern of the facility's in ability to sustain an effective QA program. On July 26, 2018 the dietary manager audited the entire kitchen using the kitchen inspection form. The administrator audited the kitchen on July 27, 2018 using the kitchen inspection form. 2. Procedure for implementing the acceptable plan of correction. An in-service covering anticipated deficiencies on the Annual Re-certification Survey was conducted for all Dietary staff on 7/17/18 by the Liberty Healthcare Corporate Dietitian. Topics covered included discussion of the potential	

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F 865	Continued From page 27 kitchenware. The Administrator reported that although all these issues fell into the regulatory category of kitchen sanitation they were not the same identical problems in both years.	F 865	findings during the Surveyor's initial and subsequent tour of the kitchen, proper ware washing and ongoing monitoring as well as documentation of temperatures during the ware washing process, cleaning and sanitizing of the ice machine and thorough cleaning of the Walk-in refrigerator. The Dietary Services Manager conducted an inservice for all Dietary staff on July 26, 2018. Topics covered included proper ware washing, monitoring of dish machine temperature during wash, discarding of abraded dishware and cleaning of the ice machine. The Ecolab Representative plans to conduct an inservice for dietary staff in August. Topics will include checking the dish machine gauges and deliming the dish machine. An audit tool was put into place to monitor compliance on July 26, 2018. Documentation was provided by Ecolab regarding appropriate ware washing and sanitizing temperatures for the Facility's Dish machine. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Dietary employees and Administrator and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator will monitor completion of the dietary audits and in addition will	

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F 865	Continued From page 28	F 865	complete a full kitchen inspection weekly for 4 weeks then monthly for 2 months of any negative findings will immediately be addressed. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Social Services Coordinator and Health Information Manager. 4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	