STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to provide access to the call system for 1 of 1 residents (Resident #59) whose records were reviewed. Findings included: Resident #59 was admitted to the facility on 04/02/18 and had diagnoses of cerebrovascular accident (CVA), aphasia, and seizure disorder. Review of the admission Minimum Data Set (MDS) revealed Resident #59 was severely cognitively impaired. Resident #59 exhibited no behaviors and did not reject care. Resident #59 was totally dependent on two people for bed mobility, transfers, and dressing and needed the extensive assistance of one person for eating. In an observation on 07/27/18 at 12:40 PM during a tour of the facility, a voice was heard calling "help" from behind the closed door of Resident #59's room. No staff was seen in the hallway. On entry into the room Resident #59 was seen positioned onto her right side with her head elevated on a pillow. A hand splint was on her right hand. She was lying in an electronic hospital bed. Resident #59 did not have a hand held call bell she could press for assistance. Instead, the electronic hospital bed had a flat orange button on the side rail with a picture of a	F 558	1. The call light was changed at the time of the survey. The root cause of the deficiency is that The facility was unaware that there was difficulty with the Resident being able to successfully use the call bell. Since the survey, all residents have been looked at to ensure there is no difficulty with them being able to utilize the call light. 2. All Residents in the facility have been assessed for the need for a special call light. The staff have been educated on assessing the call light daily to ensure the call light is appropriate for that Resident and they can easily use it. Education was started on 7-24-18. 3.We will add this to our Quality Assurance Program to be monitored monthly times 12 months to ensure compliance. This will be discussed in the monthly QAPI meeting on 8-21-18. The data that will be collected monthly will be the assessments of Residents in the facility to ensure they all are able to successfully utilize the call system to obtain assistance if needed. 4. Barbara Collins, DON will be responsible for implementing the acceptable plan of correction.	8/24/18

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

Electronically Signed | 08/13/2018

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nurse that could be pressed if assistance was needed. Resident #59 was unable to activate the call light on the side rail to call for assistance. Assistance was requested for Resident #59 and Nursing Assistant (NA) #8 came to the room.

In an interview and observation on 07/27/18 at 12:43 PM NA #8, who was not Resident #59's aide that day, came to Resident #59's room. When NA #8 asked if Resident #59 needed assistance Resident #59 responded "yes." NA #8 looked for Resident #59's call light. She indicated she could not find a hand held device and tracked the wall insertion site of the call light cord to the bed. She indicated she thought Resident #59 had an accessible call light because she would "mash" it all the time. Resident #59 was unable to activate the call light on the bed when NA #8 requested her to.

In an interview and observation on 07/27/18 at 12:46 PM the Staff Development Coordinator (SDC) came to Resident #59's room. He checked for the call light and verified the button was on the hospital bed side rail and there was no hand held call light. He requested several times for Resident #59 to reach out to push the call light button on the rail but Resident #59 was unable to stretch far enough to reach it. The SDC verified that Resident #59 had been unable to use the call light system to call for assistance and that he would notify the maintenance department that a different call light was needed for Resident #59.

In an interview on 07/27/18 at 2:24 PM NA #9, who worked with Resident #59 on the 7-3 shift that day, stated Resident #59 was able to verbalize when she needed something. She indicated Resident #59 "hollered" out 24-7 for

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help or for her spouse and was able to use the call light. She indicated she did not close Resident #59's door after providing care for her. NA #9 indicated that all residents should have access to call lights.

In an interview and observation on 07/27/18 at 3:45 PM the SDC accompanied the surveyor to Resident #59's room. Resident #59 was lying in the hospital bed with the covers tucked around her. A flat hand activated call bell was lying on top of the covers of the bed not in reach of Resident #59. The SDC pulled back Resident #59's covers and placed the call light within reach of Resident #59 and she was able to push it to call for assistance. The SDC requested several times that Resident #59 press the orange button on the side rail to call for the nurse. Although Resident #59 attempted to do this, she was never able to hit the nurse call button.

In an interview and observation on 07/27/18 at approximately 3:55 PM Nurse #7 accompanied the surveyor to Resident #59's room after stating Resident #59 was able to use the call light on the bed to call for assistance. She indicated Resident #59 "mashed" the button all the time. Nurse #7 pointed out that Resident #59's call light was activated as the light was on outside the door. On entry into the room Resident #59 was seen holding and pressing on the hand held call light. Resident #59 was requested to push the hand held call light several more times and was able to activate the call system each time. Nurse #7 then requested Resident #59 to push the orange call button on the bed side rail. Resident #59 was able to reach out and push the button to raise the head of the bed, but was never able to connect with the call system on the hospital bed.

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F 558	Continued From page 3 In an interview on 07/27/18 at 5:41 PM NA #10, who worked with Resident #59 on the 3-11 shift that day, stated Resident #59 was able to use the call light. She indicated a resident's call light should be within fingertip reach so residents could use them. She indicated she did not realize Resident #59's hand held call light had not been within reach after she provided care and left the room. In an interview on 07/27/18 at 6:25 PM the Director of Nursing (DON) indicated she expected residents to have individualized access to a call system they could use to call for assistance.	F 558		
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	F 578		8/24/18

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F 578	Continued From page 4 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to resolve discrepancy regarding code status for 1 of 5 sampled residents (Resident #79) whose code statuses were reviewed. Findings included: Record review revealed Resident #79 was admitted to the facility on 09/27/16, and most recently readmitted to the facility on 03/17/17 and 02/26/18 following hospitalizations. The resident's documented diagnoses included history of leukemia and prostate cancer, atherosclerotic heart disease, atrial fibrillation, and hypertension. The code status most recently documented in the resident's paper medical record was a physician order for "do not resuscitate" (DNR), dated 03/20/17.	F 578	1. At the time of the survey, we had a new computer system that was causing some issues with code statuses being removed when the Residents went out of the building. The code status was corrected during the survey. The root cause of this problem was that the new system required a completely new order to be entered each time the Resident went out on leave of absence and the facility was unaware this was occurring. Also the facility failed to ensure the Resident completely understood his code status if he did not sign the paperwork. 2. The EPIC team have corrected the issue with the EPIC system. At the time of the survey we were only getting orders for a no code. We are now doing orders for	

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F 578	Continued From page 5 Record review revealed the last code status documented in Resident #79's electronic medical record was "full code" which was effective from 02/26/18 through 03/13/18. Resident #79's 06/21/18 quarterly minimum data set (MDS) documented the resident's cognition was intact, he experienced depression, he exhibited no behaviors including rejection of care, he ranged from being independent to being completely dependent on staff for his activities of daily living, and there was no active discharge plan in place for returning to the community. Record review revealed there was not a current physician order regarding code status in Resident #79's electronic medical record. His code status was documented as "prior". On 07/27/18 at 4:19 PM Nurse #5 stated the quickest way to determine a resident code status was in the electronic medical record. She also reported if the nurse was working on documentation at the nursing station, she could check the spine of the paper medical record. She explained if the resident was a DNR there was a blue dot on the spine of the chart. On 07/27/18 at 4:23 PM Resident #79's paper medical record was examined, and there was a blue dot designating a DNR status on the spine of his chart. On 07/27/18 at 5:23 PM Social Worker (SW) #1 stated Resident #79 reported he wanted to be a DNR after his most recent hospitalization, but he refused to sign the forms for making him a DNR. Therefore she explained, even though Resident	F 578	both full code and no code. We have reviewed all orders and code statuses again for accuracy. We are looking at each Resident on a daily basis. Education has been completed on making sure a code status is entered on the Resident and matches the physician order. 3.The facility will add this to the quality program to be monitored monthly times 12 months to ensure for 100% compliance. Monthly, the facility will audit the residents to ensure there is a clear order for code statuses and that each code status matches the existing code order. 4. Barbara Collins DON is responsible for implementing the acceptable plan of correction.	

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F 578	Continued From page 6 #79 thought he was a DNR and expressed a desire to be so, he was technically a full code because he refused to sign the paperwork necessary to make his code status DNR. According to SW #1, she was the only one who had talked to Resident #79 about his code status, and she had not reapproached the resident about his code status because the resident was so belligerent about signing the DNR paperwork after returning from the hospital in February 2018. On 07/27/18 at 5:40 PM Unit Manager #1 stated it was the responsibility of the SW to obtain an order for a code status each time the resident was admitted to or re-entered the facility. She reported the code status should be the same in the paper medical record and in the electronic medical record. She commented there should be no doubt about the resident's code status when glancing at the medical records because decisions needed to be made quickly when no respirations and heart beats could be obtained for residents.	F 578		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse,	F 604		8/24/18

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F 604	Continued From page 7 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to ensure that a resident was free from physical restraint for 1 of 1 residents (Resident #64) who had socks on both hands to restrict her hand movements. Findings included: Record review revealed that Resident #64 was admitted to the facility on 10/02/17 with diagnoses that included, in part: cerebral vascular accident, altered mental status, dementia, PEG tube placement, and seizures. Record review of the July 2018 physician orders revealed that Resident #64 did not have an order to restrain her hand movements by placing socks on both her hands.	F 604	1.It is the goal of the facility to always provide dignity and respect for our Residents. The sock was being used to protect the Residents skin due to scratching not as a means to restrain her. The sock was removed during the survey and the staff have been educated on restraints and not using socks on the hands. The root cause for this deficiency is the lack of understanding of some staff that although the staff felt they were helping the Resident with the scratching of her face, the sock was restricting movement of hand. Also, there was a lack of communication between the nursing staff and the MDS team that caused the sock not to be care planned. 2. The staff have been educated on the restraint policy and we will continue to	

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F 604	Continued From page 8 Record review of the care plan for Resident #64 dated 06/13/18 revealed that there was no plan of care to restrain her hand movements. Record review of the Minimum Data Set (MDS) quarterly assessment dated 06/09/18 revealed that Section P responses indicated that Resident #64 had no restraints in use. On 7/23/18 at 12:48 PM Resident #64 was observed laying in bed. She was not verbally responsive. She had a non-skid, yellow, hospital issue sock on her right hand and a black sock on her left hand. On 7/24/18 at 11:14 AM Resident #64 was observed again to have a non-skid, yellow, hospital issue sock on her right hand and a black sock on her left hand. In an interview conducted with Nurse #1 on 07/24/18 at 11:14 AM she stated that Resident #64 had socks on both hands to keep her from scratching herself. She said she was not sure how long the staff had been using socks to restrict the resident's hand movements. In an interview conducted with the MDS Nurse on 07/24/18 at 4:30 PM she stated she was not aware and had only found out this morning that staff were putting socks on the resident's hands. She said it has not been documented anywhere that restraints were in use. She said that she also generated the resident care plans along with the MDS and there was no documentation for Resident #64 to have socks on both her hands to restrict her hand movements. In an interview conducted with the Director of	F 604	educate on restraints during orientation and yearly and as needed to ensure this doesn't happen again. 3. We will add the monitoring of restraints to our Quality program to be monitored monthly times 12 months to ensure 100% compliance. The monthly audits will include monitoring for restraint use, proper care planning,MDS assessment, and family consent. This will be discussed during the QAPI meeting on 8-21-18. 4. Barbara Collins DON will be responsible for implementing the acceptable plan of correction.	

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Nursing (DON) on 07/24/18 at 4:55 PM she stated that the facility had a no restraint policy and that restraints of any kind were not to be used. She commented that she was not aware that staff were putting socks on Resident #64's hands to restrict her movements.

In an interview conducted with CNA #1 on 07/24/18 at 4:58 PM she said that the staff were putting socks on Resident #64's hand to keep her from scratching herself.

In an interview conducted on 07/25/18 at 8:30 AM Nurse #2 stated that she had worked at the facility for four years and cared for Resident #64. She said that she could not remember when staff began putting socks on the resident's hands. She said the socks were being used to keep the resident from pinching the nurses when they administered medications, to keep her from pulling out her PEG tube, and to keep her from scratching herself. She commented that she had not known that the socks were considered a restraint.

In an interview conducted on 07/26/18 at 8:10 AM with CNA #2 she stated that she always worked on the hallway where Resident #64 resided. She said the staff had been putting socks on the resident's hands as far back as she could remember. She stated that she had worked at the facility for two years. She reported that the resident had scratched her herself on her head several months ago and she knew for sure that staff had been putting socks on both her hands since then.

In an Interview conducted with the DON on 7/27/18 at 11:30 AM she stated that she

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F 604	Continued From page 10 expected all residents to be free from physical restraints.	F 604		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and family and staff interviews the facility failed to complete a thorough investigation for an allegation of misappropriation of resident property for 1 of 1 residents (Resident #156) who reported missing money. Findings included: Resident #156 was admitted to the facility on 07/03/18 with diagnoses of a fractured hip, diabetes and end stage renal disease (ESRD). Review of the admission Minimum Data Set (MDS) dated 07/10/18 revealed Resident #156	F 610	1. The facility did investigate the allegation and did not proceed per policy because the daughter asked us to let it go since she was not sure her mom had any money. This has been a learning experience for the facility. The facility has always followed state and federal guidelines on any type of allegation. The root cause of this deficiency is that the facility lacked a complete investigation of the allegation. There was an investigation completed but the facility failed to get written statements from everyone	8/24/18

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F 610	Continued From page 11 was cognitively intact and did not exhibit any behaviors. Review of the facility complaint form dated 07/11/18 revealed a family member reported to the facility that Resident #156 complained of missing money. Review of a typed statement dated 07/11/18 and signed by Unit Manager (UM) #2 revealed that an interview had been conducted with Resident #156. UM #2 documented Resident #156 stated there had been $120.00 wrapped in a towel on the bed and the money was missing. Staff (nonspecific to which staff) was interviewed and no money had been seen by staff. Cameras had been reviewed and there was no activity seen into or out of the room. The dialysis center had been called and no money was seen. The linen was checked and no money was found. In an interview on 07/24/17 at 9:17 AM a family member of Resident #156 stated the facility had been informed that money was missing from the resident's room. In an interview on 07/25/18 at 8:35 AM the Director of Nursing (DON) stated there had been no abuse investigations done since the last facility recertification and was unable to produce the investigation for Resident #156's allegation of money missing from her room. In an interview on 07/25/18 at 8:45 AM UM #2 stated Resident #156's family member called the facility on 07/11/18 and reported that the resident said her money had been taken. UM #2 indicated she started an immediate investigation. UM #2 stated she looked at video footage taken by	F 610	involved. 2. The facility will in the future report any allegations to the state as specified in the policy and state regulations regardless of the family's input and ensure a proper investigation is written up and completed. This was included in the abuse education that began on 7-24-2018. 3. This will be added to the facility's quality assurance program to be monitored monthly times 12 months to ensure all allegations are investigated and reported accurately and timely. The monthly audits will include the review of all investigations and to determine whether all components of the investigations were completed per state and federal regulations. 4. Barbara Collins DON will be responsible for implementing the acceptable plan of correction.	

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facility cameras and saw no activity in the room. She stated she called the dialysis center where the resident received dialysis and the transport company but they did not find the money. UM #2 stated she interviewed Resident #156 and the resident said she might have left the money at dialysis. UM #2 indicated the only documentation she had related to the investigation of Resident #156's missing money was the typed statement of 07/11/18 that was signed by herself.

In an interview on 07/25/18 at 11:49 AM Nurse #7, who was the charge nurse for Resident #156 on the 7-3 shift on 07/11/18, stated that UM #2 asked her if she had ever seen Resident #156 with money and she told her no. She indicated she had not been asked to provide a written statement about the missing money.

In an interview on 07/25/18 at 12:36 PM Nurse #10, who cared for Resident #156 on the 7-3 shift on 07/11/18, stated she did not know anything about any missing money. She indicated someone may have asked her about it but she was not sure and did not provide a written statement to the facility.

Nursing Assistant (NA) #7, who cared for Resident #156 on the 7-3 shift on 07/11/18 was unavailable for interview.

In an interview on 07/25/18 at 3:00 PM the Staff Development Coordinator (SDC) stated for allegations of any type of abuse the residents needed to be interviewed and the resident making the allegation should provide a written statement if possible. Staff should be interviewed and provide a written statement about the incident. The SDC indicated the allegation

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F 610	Continued From page 13 needed to be thoroughly investigated and documented. In an interview on 07/27/18 at 6:25 PM the DON indicated she expected any allegation of abuse to be investigated thoroughly.	F 610		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assess 2 of 29 residents (Resident #10 and Resident #59) using the quarterly review instrument no less frequently than once every three months. Findings included: 1. Resident #10 was readmitted to the facility on 02/15/18 and had diagnoses of hypertension, depression and a urinary tract infection (UTI). Review of the quarterly Minimum Data Set (MDS) dated 04/07/18 revealed Resident #10 was independent with most activities of daily living (ADLs). Review of the July 2018 MDS Schedule revealed 18 Resident names whose assessments were due between 07/01/18-07/07/18. 16 of the 18 resident names had a line going through them signifying they had been completed. Resident #10's name was not crossed off and the due date	F 638	1. The facility has always ensured that MDS assessments are completed in a timely manner. The root cause of this deficiency is that the Care Plan Nurse had completed the assessment but had failed to lock and submit it. There was a misconception by the MDS nurse that the assessment is not considered completed until locked and submitted to the state. In the future the MDS nurse will validate that the completed list and the sent list matches. 2. The assessments have been completed and transmitted to state. A report will be given to the DON weekly on Fridays to ensure the assessments are completed timely. Assessments on Resident #10 and #59 have been completed and transmitted to the state. The Care plans have been updated. Both had baseline care plans. The comprehensive plan of care has also	8/24/18

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F 638	Continued From page 14 for the quarterly review was 07/05/18. In an interview on 07/24/18 at 9:50 AM MDS Nurse #1 stated that for a quarterly assessment she had 14 days following the due date to submit the assessment. She indicated Resident #10's quarterly assessment had not yet been completed. She stated the quarterly review should have been completed by 07/19/18. MDS Nurse #1 indicated the reason the assessments were late was because the MDS department was short staffed. She indicated the facility had hired another nurse to assist with the MDSs. In an interview on 07/27/18 at 6:25 PM the Director of Nursing (DON) stated she expected all the assessments to be completed in a timely manner per the regulation. 2. Resident #59 was admitted to the facility on 04/02/18 and had diagnoses of heart failure, hypertension, and cerebrovascular accident (CVA). Review of the admission MDS dated 04/09/18 revealed Resident #59 was totally dependent on one to two people for most ADLs. Review of the July 2018 MDS Schedule revealed 18 Resident names whose assessments were due between 07/01/18-07/07/18. 16 of the 18 resident names had a line going through them signifying they had been completed. Resident #59's name was not crossed off and the due date for the quarterly review was 07/07/18. In an interview on 07/24/18 at 9:50 AM MDS Nurse #1 stated that for a quarterly assessment she had 14 days following the due date to submit	F 638	been completed on both residents. 3. This will be added to the facility's quality assurance program to be monitored monthly times 12 months to ensure 100% compliance. The audits will include monitoring to ensure quarterly assessments have been completed in a timely manner and submitted to state. 4. Barbara Collins, DON will be responsible for implementing an acceptable plan of correction.	

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F 638	Continued From page 15 the assessment. She indicated Resident #59's quarterly assessment had not yet been completed. She stated the quarterly review should have been completed by 07/21/18. MDS Nurse #1 indicated the reason the assessments were late was because the MDS department was short staffed. She indicated the facility had hired another nurse to assist with the MDSs. In an interview on 07/27/18 at 6:25 PM the DON stated she expected all the assessments to be completed in a timely manner per the regulation.	F 638		
F 641 SS=E	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 interviews and record review the facility failed to accurately complete comprehensive Minimum Data Set (MDS) assessments for 7 of 29 residents sampled in the survey, (Residents #2, #57, #67, #69, #72, #78 and #209). Findings included: 1. Resident #69 was admitted to the facility on 07/07/15 with diagnoses that included, in part, cerebral vascular accident, atrial fibrillation, diabetes mellitus, schizoaffective disorder and dementia. Review of the care plan for Resident #69 dated 04/19/18 addressed focus areas including activities of daily living, dementia, falls,	F 641	1.The facility has always ensured assessments are completed with accuracy. The facility has implemented a new electronic system that has led to challenges for the care plan nurses. The root cause analysis is the complexity of the new system and the inability to review past assessments while completing the new assessment for resident #69 and resident #2 without going out of the system into the old system. The root cause for resident # 67 not being on the MDS and not being care planned is due to the lack of communication and the lack of knowledge that the sock was in fact a restraint. The root cause for resident # 57 and #78 is the lack of the ability of the system to pull the diagnosis list back and	8/24/18

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F 641	Continued From page 16 psychotropic drug use, and respiratory care. Review of the annual Minimum Data Set (MDS) assessment dated 06/13/18 documented that she had oxygen therapy and tracheostomy care. The resident was observed on 07/24/18 at 10:37 AM. No tracheostomy was present. In an interview conducted with MDS Nurse #1 on 07/24/18 at 2:30 PM she stated that the MDS assessment for this resident had been coded incorrectly. She reported that the resident had never had a tracheostomy. She commented that she expected the MDS to be coded correctly and it was not. 2. Resident #2 was admitted to the facility on 09/07/17 with a most recent reentry on 06/18/18. Diagnoses included, in part, chronic respiratory failure, diabetes mellitus, PEG tube placement, hemiparesis, and MRSA (Methicillin-resistant Staphylococcus Aureus) of the left foot. Record review of the quarterly MDS assessment dated 06/02/18 documented that the resident had a pressure ulcer present on the prior OBRA assessment but coded zero for all types of pressure ulcers indicating that the wounds were not present. Review of the prior OBRA MDS assessment dated 03/12/18 revealed that the resident had one stage 2 pressure ulcer. In an interview with MDS Nurse #1 on 07/25/18 at 4:15 PM she stated that the MDS assessment had been coded incorrectly and should have read (1) stage 2 pressure ulcer was present on the	F 641	forth when the resident leaves the facility and this was not caught by the MDS nurse. The root cause for resident #72 is the inability of the systems to merge if the resident goes out and comes back in. The root cause for #209 is also due to the complexity of the system and the inability of the nurse to look at the wound assessment while completing the MDS assessment. 2. The assessments on residents #2, #57,#67,#69,#72, #78, and #209 have been corrected and transmitted to the state. Education for MDS accuracy was completed on 8-1-2018. Each area of inaccuracy was covered with the MDS nurses. 3. Assessment accuracy will be added to the facility quality assurance program to be monitored monthly times 12 months to ensure 100% compliance. These monthly audits will include accuracy of the MDS for all pertinent information and that there is a coded diagnosis for all medications the Resident is receiving. 4. Barbara Collins, DON will be responsible for implementing an acceptable plan of correction to the state.	

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prior OBRA assessment, not zero. She commented that she thinks the nurse who completed the assessment looked at the last MDS assessment which was a discharge assessment not the last OBRA assessment as instructed on the MDS assessment tool.

3. Resident #67 was admitted to the facility on 10/02/17 with diagnoses that included, in part, cerebral vascular accident, altered mental status, PEG tube placement, and seizures.

On initial tour on 07/23/18 at 12:48 PM, Resident #67 was observed to have a yellow sock on her right hand and a black sock on her left hand. Again on 07/24/18 at 11:14 AM she was observed to have the same two socks on each hand.

Review of the care plan for Resident #67 dated 06/13/18 did not include a focus area for physical restraints.

Review of the quarterly MDS assessment dated 06/09/18 documented that the resident had no restraints of any kind in use.

In an interview conducted with MDS Nurse #1 on 07/24/18 at 4:30 PM she stated that she had not been aware that staff were putting socks on the resident's hands. She commented that it had not been documented that restraints were in use.

In an interview with the DON on 07/24/18 at 4:55 PM she stated that the facility was a "no restraint" facility and restraints were not to be used. She stated that she had not been aware that staff were putting socks on the resident's hands to restrict her movements.

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In an interview with Nurse Aide #1 on 07/24/18 at 4:58 PM she stated that the socks had been placed on the resident's hands to keep her from scratching herself.

In an interview conducted with Nurse #3 on 07/25/18 at 8:30 AM she stated that she had worked at the facility for four years. She said she cared for Resident #67. She could not remember when staff had began putting socks on the resident's hands. She said the socks were used to keep the resident from pinching her while she was administering medications, from pulling out her PEG tube, and to keep her from scratching herself.

In an interview with Nurse Aide #2 on 07/26/18 at 8:10 AM she stated that she always worked on the 1100 hall where the resident resided. She commented that they had been putting socks on the resident's hands as far back as she could remember. She stated that she had worked at the facility for two years. She recalled that the resident had scratched her head several months ago and she knew for sure that staff had been putting socks on both the resident's hands ever since then.

In an interview conducted with the Director of Nursing (DON) on 7/27/18 at 11:30 AM she stated that she expected the MDS assessments to be complete and accurate for every resident.

4. Resident #57 was admitted on 3/25/15 with re-entry to the facility on 4/3/18. Her cumulative diagnoses included, in part, depression and atrial fibrillation (an irregular heartbeat that increases the risk of stroke and heart-related complications).

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A review of Resident #57 ' s Cumulative Diagnosis Sheet signed by her physician in April 2018 and May 2018 (no specific days/dates noted) revealed "major depressive disorder" and "afib" (atrial fibrillation) were listed among her diagnoses.

A review of Resident #57 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 5/29/18 was completed. Section I of the MDS assessment did not include a diagnosis of depression or atrial fibrillation.

An interview was conducted on 7/27/18 at 11:50 AM with the MDS Nurse #1 and MDS Nurse #2. During the interview, the nurses were asked to review Section I of the 5/29/18 quarterly MDS assessment for Resident #57. Upon review of the MDS, the nurses confirmed neither depression nor atrial fibrillation were checked as an active diagnosis for this resident. MDS Nurse #2 reported she had completed this MDS assessment. When asked if depression and atrial fibrillation should have been checked as active diagnoses, MDS Nurse #2 responded, "It looks to me like it should have been on there."

An interview was conducted on 7/27/18 at 5:30 PM with the facility ' s Director of Nursing (DON). During the interview, concerns regarding the missing diagnoses on Resident #57 ' s MDS were discussed. When the DON was asked what her expectations were for the MDS assessment, she stated, "It should be accurate."

5. Resident #72 was admitted on 1/8/15 with re-entry to the facility on 2/26/18. Her cumulative diagnoses included, in part, convulsions

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(seizures) and hyperlipidemia (high levels of cholesterol and/or lipids in the blood).

A review of Resident #72 ' s Cumulative Diagnosis Sheet signed by her physician in May 2018 and June 2018 (no specific days/dates noted) revealed "convulsions" and "hyperlipidemia" were listed among her diagnoses.

A review of Resident #72 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 6/17/18 was completed. Section I of the MDS assessment did not include a diagnosis of seizures or hyperlipidemia.

An interview was conducted on 7/27/18 at 11:50 AM with the MDS Nurse #1 and MDS Nurse #2. During the interview, the nurses were asked to review Section I of the 6/17/18 quarterly MDS assessment for Resident #72. Upon review of the MDS, the nurses confirmed neither seizures nor hyperlipidemia were checked as an active diagnosis for this resident. MDS Nurse #2 reported she had completed this MDS assessment. When asked if seizures and hyperlipidemia should have been checked as active diagnoses, MDS Nurse #2 responded, "Both should be on the diagnosis list."

An interview was conducted on 7/27/18 at 5:30 PM with the facility ' s Director of Nursing (DON). During the interview, concerns regarding the missing diagnoses on Resident #72 ' s MDS were discussed. When the DON was asked what her expectations were for the MDS assessment, she stated, "It should be accurate."

6. Resident #78 was admitted to the facility on

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1/9/17. Her cumulative diagnoses included, in part, gastroesophageal reflux disease (GERD) and renal (kidney) insufficiency.

A review of Resident #78 ' s Cumulative Diagnosis Sheet signed by her physician in May 2018 and June 2018 (no specific days/dates noted) revealed "GERD" was listed among her diagnoses.

A review of Resident #78 ' s medical record included faxed information dated 6/13/18 from a nephrologists ' office (physicians specializing in the treatment of kidney disease). The fax contained an office communication note requesting a change in one of the medications for Resident #78 "due to chronic kidney disease Stage 4 ..."

A review of Resident #78 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 6/20/18 was completed. Section I of the MDS assessment did not include a diagnosis of GERD or renal insufficiency.

An interview was conducted on 7/27/18 at 11:50 AM with the MDS Nurse #1 and MDS Nurse #2. During the interview, the nurses were asked to review Section I of the 6/20/18 quarterly MDS assessment for Resident #78. Upon review of the MDS, the nurses confirmed neither GERD nor renal insufficiency were checked as an active diagnosis for this resident. MDS Nurse #2 reported she had completed this MDS assessment. When asked if GERD and renal insufficiency should have been checked as active diagnoses, MDS Nurse #2 responded, "It (the diagnoses) should be." MDS #2 reported she was aware Resident #78 was being seen by a

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nephrologist.

An interview was conducted on 7/27/18 at 5:30 PM with the facility ' s Director of Nursing (DON). During the interview, concerns regarding the missing diagnoses on Resident #78 ' s MDS were discussed. When the DON was asked what her expectations were for the MDS assessment, she stated, "It should be accurate."

7. Resident #209 was admitted to the facility on 07/02/18 with diagnoses of diabetes, hypertension, and a fractured ankle.

Review of the admission Minimum Data Set (MDS) dated 07/19/18 revealed Resident #209 was moderately cognitively impaired and had two unstageable deep tissue injuries (a localized area of maroon or purplish discoloration of intact skin) and one unstageable pressure ulcer that was covered in slough (yellow or white tissue adhered to the ulcer bed) or eschar (black, brown, or tan tissue adhered to the ulcer bed).

Review of the Skin Integrity sheet dated 07/12/18 revealed Resident #209 had a deep tissue injury (DTI) to the left heel. No other DTIs or pressure injuries was noted on the sheet.

Review of the Flowsheet Data dated 07/15/18 revealed Resident #209 now had a suspected DTI to the left anterior foot, a suspected DTI to the left outer lower leg, and the DTI to the left heel. There was no documentation that any of the wounds was covered in slough or eschar.

In an interview on 07/27/18 at 3:25 PM MDS Nurse #1 examined the documentation and verified that Resident #209 had three DTIs and

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F 641	Continued From page 23 no pressure ulcer that was covered with slough or eschar. MDS Nurse #1 stated the incorrect pressure ulcer information had been entered for Resident #209 on the comprehensive assessment by mistake. In an interview on 07/27/18 at 6:25 PM the Director of Nursing (DON) indicated she expected the MDS assessments to accurately reflect the resident's status.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655		8/24/18

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	345054	A. BUILDING _____ B. WING _____	C 07/27/2018

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F 655	Continued From page 24 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission with measurable objectives and timetables to address the immediate needs of tube feeding for 1 of 1 residents (Resident #65) whose care plan was reviewed. Findings included: Resident #65 was admitted to the facility on 05/30/18 and was re-admitted to the facility on 07/20/18. Resident #65 had diagnoses of debility, anxiety, pneumonia, and Cerebrovascular Accident (CVA). Review of the admission Minimum Data Set (MDS) dated 06/06/18 revealed Resident #65 was moderately cognitively impaired and needed set-up help only for eating. Resident #65 had a gastric tube and received tube feedings 25% or less of the time during the look back period.	F 655	1. The facility is aware of the regulation for baseline care plans to be completed and accurate and will ensure this happens in the future. The resident's name was crossed out before the assessment was complete. 2.The baseline care plan has been completed for Resident #65. Education on completing base line care plans was done on 8-1-2018. The root cause of this deficiency is the lack of knowledge on the MDS nurse's part that if the resident goes out and comes back in the comprehensive care plan has to be updated within 48 hours. 3. This will be added to the facility's Quality Assurance Program to be monitored monthly times 12 months. The audit for this will include checking to make sure that everyone has a baseline care	

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F 655	Continued From page 25 Review of the re-admission physician orders dated 07/20/18 revealed Resident #65 was to receive gastric tube feedings only now and would receive no food by mouth. Review of the computerized care plan revealed no baseline care plan for tube feeding for Resident #65. In an interview on 07/24/18 at 4:40 PM MDS Nurse #1 stated the 48 hour baseline care plans were on paper and not in the computer. She indicated she would get a copy and return with it. MDS Nurse #1 was not able to produce the paper baseline care plan. In an interview on 07/24/18 at 5:27 PM MDS Nurse #2 stated it was the MDS Nurse's responsibility to make sure the 48 hour baseline care plan was completed. She stated Resident #65's baseline care plan was just missed and had not been completed. In an interview on 07/27/18 at 6:25 PM the Director of Nursing (DON) indicated she expected baseline care plans to accurately portray the residents and to be completed within the 48 hour time frame.	F 655	plan within 48 hours or their comprehensive care plan is updated within 48 hours. We will review this in the QAPI meeting on 8-21-2018. 4. Barbara Collins, DON is responsible for implementing an acceptable plan of correction.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		8/24/18

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F 656	Continued From page 26 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately complete comprehensive care plans for 3 of 29 surveyed	F 656	1. The facility has always ensured comprehensive care plans have been completed timely.	

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F 656	Continued From page 27 residents (Resident #4, #57, and #67). Findings included: 1. Resident #4 entered the facility on 02/16/18 with a most recent re-entry on 06/22/18. Diagnoses included, in part: Acute renal failure, cellulitis, hypotension, altered mental status, diabetes mellitus, urinary tract infection with Vancomycin Resistant Enterococci, Alzheimer's dementia, pleural effusion, morbid obesity, anemia, chronic pain syndrome, hypertension, atrial flutter, chronic anticoagulation on Xarelto, venous stasis dermatitis bilateral lower extremities, chronic diastolic heart failure, acute respiratory failure with hypercapnia, visual hallucinations, diabetic retinopathy, and pneumonia. Review of a quarterly Minimum Data Set dated 06/17/18 revealed that the resident had intact cognition, no moods or behaviors, required limited to no assistance with activities of daily living, had an indwelling foley catheter, and had received as need pain medication for frequent pain. She was on oxygen therapy. During the look back period of the assessment she had received insulin injections, antidepressants, diuretics, and Opioid on all seven days. She had also received 2 days of physical therapy and 2 days of respiratory therapy. Record review revealed that Resident #4 had no comprehensive care plan. In an interview with MDS Nurse #1 on 07/26/18 at 11:20 AM she revealed that she could not find a care plan for Resident #4. She said that the MDS nurses were responsible for creating resident	F 656	2. These deficient areas have been corrected and transmitted to the state. The assessments for residents #4, #57, and #64 have been corrected by the team. Education for this was completed on 8-1-2018. The root cause for resident # 64 is lack of communication between the MDS team and the nursing staff to include a sock on the hand and the addition of the sock to the MDS as a restraint. The root cause is also due to the lack of knowledge of the staff to understand that although the sock was to prevent scratching her face, it was a restraint. The root cause for # 57 was that the anticoagulant was not in the build of the care plan in the new system that required it to be free typed which led to an omission by the MDS nurse. The root cause for #4 is that the Residents assessment was completed and she was marked off the sheet as completed in error. In the future, the care plan nurse will ensure the MDS and the care plan is complete before moving on to the next assessment. 3. This will be added to the facility Quality Assurance Program to be monitored monthly times 12 months to ensure 100% compliance. These audits will include the development of the comprehensive care plan and appropriate updates as needed. 4. Barbara Collins, DON will be responsible for implementing an acceptable plan of correction.	

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care plans. She commented that the facility had changed electronic software to that of the governing hospital last November. She said that she checked the electronic records to determine if a care plan could be pulled from the system but could not find one. She concluded that a comprehensive care plan for Resident #4 had not been completed.

2. Record review revealed that Resident #64 was admitted to the facility on 10/02/17 with diagnoses that included, in part: cerebral vascular accident, altered mental status, dementia, PEG tube placement, and seizures.

Record review of the care plan for Resident #64 dated 06/13/18 revealed that there was no plan of care to restrain her hand movements.

Record review of the Minimum Data Set (MDS) quarterly assessment dated 06/09/18 revealed that Section P responses indicated that Resident #64 had no restraints in use.

On 7/23/18 at 12:48 PM Resident #64 was observed laying in bed. She was not verbally responsive. She had a non-skid, yellow, hospital issue sock on her right hand and a black sock on her left hand.

On 7/24/18 at 11:14 AM Resident #64 was observed again to have a non-skid, yellow, hospital issue sock on her right hand and a black sock on her left hand.

In an interview conducted on 07/25/18 at 8:30 AM Nurse #2 stated that she had worked at the facility for four years and cared for Resident #64. She said that she could not remember when staff

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began putting socks on the resident's hands. She said the socks were being used to keep the resident from pinching the nurses when they administered medications, to keep her from pulling out her PEG tube, and to keep her from scratching herself. She commented that she had not known that the socks were considered a restraint.

In an interview conducted on 07/26/18 at 8:10 AM with CNA #2 she stated that she always worked on the hallway where Resident #64 resided. She said the staff had been putting socks on the resident's hands as far back as she could remember. She stated that she had worked at the facility for two years. She reported that the resident had scratched her herself on her head several months ago and she knew for sure that staff had been putting socks on both her hands since then.

In an interview conducted with the MDS Nurse on 07/24/18 at 4:30 PM she stated she was not aware and had only found out that morning that staff were putting socks on the resident's hands. She said that she generated the resident care plan and it was not documented for Resident #64 to have socks on both her hands.

In an interview conducted with the Director of Nursing (DON) on 07/27/18 at 11:30 AM she stated that she expected all resident to have an accurate care plan that was available to staff as the care plan drove the care delivered. She also commented that she expected care plans to be updated whenever there was a significant change in a resident's condition.

3. Resident #57 was admitted on 3/25/15 with

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F 656	Continued From page 30	F 656		

re-entry to the facility on 4/3/18. The resident ' s cumulative diagnoses included atrial fibrillation (an irregular heartbeat that increases the risk of stroke and heart-related complications).

A review of Resident #57 ' s medical record revealed the resident ' s 4/3/18 re-admission medication orders included 5 milligrams (mg) apixaban (an oral anticoagulant medication) was to be given as one tablet by mouth twice daily.

A review of Resident #57 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 5/29/18 was completed. The MDS assessment indicated the resident had severely impaired cognitive skills for daily decision making. She required limited assistance for bed mobility, transfers, dressing, toileting and personal hygiene. The resident required supervision for walking in her room/corridor and for locomotion on the unit, and she was independent with eating. Section N of the MDS assessment indicated Resident #57 ' s medications included an anticoagulant on 7 out of the previous 7 days during the look back period.

A review of Resident #57 ' s current care plan (initiated on 3/1/18) revealed a problem area related to the use of an anticoagulant medication was not addressed.

An interview was conducted on 7/27/18 at 11:50 AM with the MDS Nurse #1 and MDS Nurse #2. During the interview, the MDS nurses were asked if the use of an anticoagulant medication should be included on a resident's care plan. MDS Nurse #1 stated she thought the use of an anticoagulant should be on a resident ' s care plan. MDS Nurse #2 responded by saying, "If we

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F 656	Continued From page 31 have a resident on an anticoagulant medication, it needs to be on the care plan." An interview was conducted on 7/27/18 at 12:05 PM with Nursing Assistant (NA) #4. NA #4 reported she was frequently assigned to care for Resident #57. During the interview, the NA was asked if any residents on her hall received an anticoagulant medication. NA #4 stated she was not aware of any residents that received one. An interview was conducted on 7/27/18 at 12:06 PM with NA #5. NA #5 reported she was frequently assigned to care for Resident #57. When the NA was asked if she was aware of any residents on her hall who received an anticoagulant medication, the NA stated, "No." An interview was conducted on 7/27/18 at 5:30 PM with the facility ' s Director of Nursing (DON). During the interview, concerns regarding the failure to care plan Resident #57 ' s use of an anticoagulant medication was discussed. When the DON was asked what her expectation was, she stated, "It should be care planned."	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		8/24/18

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F 657	Continued From page 32 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to revise and update a care plan for 1 of 29 residents (Resident #65) whose care plans were reviewed. Findings included: Resident #65 was admitted to the facility on 05/30/18 and was re-admitted to the facility on 07/20/18. Resident #65 had diagnoses of debility, anxiety, pneumonia, and Cerebrovascular Accident (CVA). Review of the admission Minimum Data Set (MDS) dated 06/06/18 revealed Resident #65 was moderately cognitively impaired and needed set-up help only for eating. Resident #65 had a gastric tube and received tube feedings 25% or less of the time during the look back period. Review of the re-admission physician orders dated 07/20/18 revealed Resident #65 was to	F 657	1. The facility has always ensured the care plans have been reviewed and updated appropriately. The Resident's plan of care should have been revised to reflect the change in the physician order to tube feedings. 2. The care plan for Resident #65 has been revised appropriately. Education on the timely revision of the plan of care was done on 8-1-2018. The root cause of this deficiency was the lack of understanding by the MDS nurse that if there was a hospital stay and the resident returned, there was no requirement for a new baseline care plan; therefore, the new order was not added to the comprehensive care plan within 48 hours. 3. This will be added to the facility's Quality assurance Program to be monitored monthly times 12 months to	

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F 657	Continued From page 33 receive gastric tube feedings only now and would receive no food by mouth. Review of the computerized care plan that was in place on 07/27/18 revealed Resident #65 was to receive a mechanical soft diet. The goal was to maintain nutritional status and weight by consuming 75% of 3 meals daily. There was no mention of any type of gastric feeding in the care plan. In an interview on 07/27/18 at 9:30 AM MDS Nurse #2 stated the care plan had not been revised to show the change in Resident #65's diet from mechanical soft to gastric feeding. She indicated the change to being totally fed through a gastric tube was an important change and that the care plan should have been revised and updated to reflect the new diet. In an interview on 07/27/18 at 6:25 PM the Director of Nursing (DON) indicated she would expect that a care plan for a resident who now received nutrition and hydration through a gastric tube would be updated right away.	F 657	ensure for 100% compliance. These audits will include monitoring to ensure the baseline care plan is completed on all residents within 48 hours or the comprehensive care plan is updated within 48 hours. 4. Barbara Collins, DON will be responsible for implementing an 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 observation, record review and family, staff, and surgeon interviews the facility failed to remove a staple from an incision for 1 of 1	F 658	1.The facility has always ensured that we provide services that meet professional standards. We have implemented an new	8/24/18

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F 658	Continued From page 34 residents (Resident #156) and failed to transcribe a change in a tube feeding order to the Medication Administration Record for 1 of 1 Residents (Resident #65) whose records were reviewed. Findings included: 1. Resident #156 was admitted to the facility on 07/03/18 with diagnoses of a fractured hip, diabetes and end stage renal disease (ESRD). Review of the admission Minimum Data Set (MDS) dated 07/10/18 revealed Resident #156 was cognitively intact and did not exhibit any behaviors. Resident #156 needed the limited assistance of one person for bed mobility, transfer, dressing, toilet use and personal hygiene. Review of the July 2018 Treatment Administration Record (TAR) revealed an order to remove Resident #156's staples on 07/10/18 and was initialed as completed. Review of the facility complaint form dated 07/17/18 revealed Resident #156 and a family member were upset because when they went to the surgeon for a follow-up appointment that day they were informed that a staple had been left in the incision by the nurse who removed the staples from the incision. In a telephone interview on 07/24/18 a family member stated Resident #156 was admitted to the facility following a hip replacement. The family member stated when Resident #156 went to the hip surgeon for a follow-up appointment on 07/17/18 a staple was found in the incision by the surgeon.	F 658	electronic medical record system that we are still working through some issues with ensuring the accuracy of orders. 2. The diet order has been corrected and the nurses have been educated on removing staples with another nurse verifying that all the staples are removed. Education has also been done on transcribing orders properly and verifying with another nurse the complete removal of staples. The policy has been revised to reflect verification with another nurse when staples are removed. The root cause of the deficiency for resident #156 was due to the nurse missing a staple with no other nurse to verify that all staples are removed. The root cause for the deficiency for #65 was there was a new order added in the electronic system that did not get transcribed to the paper MAR and therefore, the tube feeding was missed. The inability for the diet order to show up on the electronic MAR led to the deficiency. 3. This will be added to the facility's Quality assurance Program to be monitored monthly times 12 months to ensure 100% compliance. The audits will include monitoring proper verification of staples being completed and the proper transcription of new orders. 4. Barbara Collins, DON will be responsible for implementing the acceptable plan of correction.	

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In a telephone interview on 07/25/18 at 12:36 PM Nurse #10 stated she saw on the TAR that Resident #156's staples were to be removed so she removed them. She indicated she removed all the staples she saw and then applied steri-strips (small adhesive strips to hold the incision together) to the incision. Nurse #10 stated she just missed seeing the last staple and did not remove it.

In a telephone interview on 07/25/18 at 12:36 PM Resident #156's surgeon stated that not removing the staple was an oversight due to the nurse not paying attention. He stated no radiology examination was needed as he saw the staple when he examined Resident #156's incision and he removed it. The surgeon stated no complications occurred from leaving the staple in the incision longer than intended.

In an interview on 07/27/18 at 8:40 AM Unit Manager (UM) #1 stated a new policy had been put in place where a second nurse checked to make sure all staples had been removed.

In an interview on 07/27/18 at 6:25 PM the Director of Nursing (DON) stated she expected the nurses to remove all staples and sutures as ordered.

2. Resident #65 was admitted to the facility on 05/30/18 and was re-admitted to the facility on 07/20/18. Resident #65 had diagnoses of debility, anxiety, pneumonia, and Cerebrovascular Accident (CVA).

Review of the admission MDS dated 06/06/18 revealed Resident #65 was moderately cognitively impaired and needed set-up help only

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for eating. Resident #65 received tube feedings 25% or less of the time during the look back period.

Review of the Registered Dietician (RD) Assessment dated 07/24/18 revealed Resident #65 now received all nutrition and hydration needs through a gastric tube into the stomach and no longer received meal trays. A new order for Resident #65's tube feeding was made.

Review of the orders dated 07/24/18 revealed Resident #65 had the tube feeding amounts of the formula changed to 240 milliliters (ml) via the tube at 2:00 AM, 10:00 AM, 6:00 PM, and 10:00 pm. At 2:00 PM Resident #65 was to receive 360 ml of the tube feeding.

In an observation on 07/25/18 at 2:05 PM Nurse #6 and Nurse #11 entered Resident #65's room to provide the tube feeding formula. The can of formula contained 237ml and was administered to Resident #65 through the gastric tube.

In an interview on 07/25/18 at 2:13 PM immediately following the observation, Nurse #6 and Nurse #11 stated they knew how much tube feeding formula to provide because it was written on the Medication Administration Record (MAR). The nurses provided a paper MAR which showed an order for one can of the tube feeding formula to be provided every 4 hours 5 times each day. When questioned on the amount of formula to be given the nurses checked the computer and verified the order had been changed but had not been transcribed onto the paper MAR. Nurse #6 and Nurse #11 stated they did not realize a new order had been received for Resident #65's tube feeding formula because it had not been changed

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F 658	Continued From page 37 on the MAR. In an interview on 07/25/18 at 2:15 PM Unit Manager (UM) #2 stated when the RD wrote an order for a diet change a call was placed to the physician to verify that the change was okay. She stated the order had been verified with the physician but the order had not been transcribed onto the paper MAR which resulted in Resident #65 receiving the wrong amount of the formula. In an interview on 07/26/18 at 10:50 AM Nurse #9 stated she did not follow through with transcribing the change in Resident #65's tube feeding order. She indicated she should have transcribed the new order to the MAR and discontinued the other order for the formula. In an interview on 07/27/18 at 6:25 PM the DON indicated she expected the nursing staff to transcribe all orders accurately and properly to the paper MAR to prevent errors.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		8/24/18

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F 686	Continued From page 38 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to assess and document a stage 1 (area of intact skin) pressure ulcer which declined to an unstageable pressure ulcer covered in yellow slough for 1 of 6 residents (Resident #207) whose pressure ulcers were reviewed. Findings included: Resident #207 was admitted to the facility on 07/02/18 with diagnoses of Alzheimer's dementia, hypertension, and a hip fracture. Review of the admission Minimum Data Set (MDS) dated 07/09/18 revealed Resident #207 was severely cognitively impaired and was incontinent of bowel and bladder. Resident #207 needed the extensive assistance of two people for bed mobility and was dependent on two people for transfers and toilet use. Resident #207 was at risk for pressure ulcers and had one stage 1 pressure ulcer and one unstageable deep tissue injury (DTI) (a localized area of maroon or purplish discoloration of intact skin) present on admission. Review of the Care Plan with a start date of 07/02/18 revealed Resident #207 had a problem of compromised skin integrity. The goal was for Resident #207's skin integrity to be maintained or improved. Interventions included treatments as ordered, weekly assessment and documentation of any wounds, and reporting changes to the provider. Review of the Wound Assessment/Care Flowsheet revealed Resident #207's sacral	F 686	1. It is the expectation of the facility to ensure weekly assessments be completed in the facility. The nurse performed the assessment but did not document or do any further action. 2. An assessment was completed on Resident #207. The staff have been educated on weekly skin assessment completion and notifying the physician if the wound worsens. Education began immediately. The root cause of this deficiency is the lack of recording by the nurse although she stated she measured the wound and wrote her findings on a piece of paper. She did not transcribe the findings in the computer. The nurse also failed to ensure the treatment was changed when the wound worsened. The facility policy was not followed. 3. This will be added to the facility Quality Assurance Program to be monitored monthly times 12 months to ensure 100% compliance. The audits for this include monitoring to ensure weekly assessments are completed on wounds and followed up on if the wound has worsened. 4. Barbara Collins, DON will be responsible for implementing an acceptable plan of correction.	

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wound was first identified and assessed on 07/10/18 as a stage 1 pressure ulcer which was red in color. On 07/17/18 the sacral wound was re-assessed and documented as a deep tissue injury (DTI) that was light purple and maroon in color. There were no further assessments of the wound on the flowsheet.

Review of the July Treatment Administration Record (TAR) revealed weekly body audits had been initialed as completed on 07/02/18, 07/09/18, 07/16/18 and 07/23/18. On 07/17/18 a new order to cleanse the DTI to Resident #207's sacrum and to apply sensicare covered with a dry dressing everyday was noted.

In an observation on 07/26/18 at 10:15 AM Nurse #9 provided wound care to Resident #207. There was an open wound on Resident #207's sacrum that was covered in yellow slough. The wound was rimmed in red and the area around the wound was a dark color.

In an interview on 07/26/18 at 10:30 AM Nurse #9 stated she was going to notify Resident #207's physician regarding the change in the status of the wound from closed to now being open and covered with slough.

In an interview on 07/26/18 at 2:45 PM when asked about the weekly assessment of the sacral wound, Nurse #9 stated an assessment should have been completed on Resident #207's sacral wound on 07/23/18 but there was no documentation of the assessment.

In an interview on 07/26/18 at 3:42 PM Nurse #6 stated she had completed an assessment of Resident #207's wound on 07/17/18 because

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F 686	Continued From page 40 Nurse #13 had signed off the body audit on 07/16/18 but had not placed the assessment on the flowsheet as she should have. She indicated on 07/17/18 the sacral wound was not open. Nurse #6 stated she had performed the wound assessment on Resident #207's sacral wound on 07/23/18. She indicated she must have gotten distracted and had not recorded the assessment but remembered the wound had been open at that time and had been open for a few days prior to the assessment. In a telephone interview on 07/26/18 at 5:21 PM Nurse #13 stated she was a float nurse from the hospital. She indicated she had been told by staff that unless the wound presented differently there was no need to enter a wound assessment on the flowsheet. She indicated when she performed Resident #207's body audit on 07/16/18 there was no open area to Resident #207's sacrum. In an interview on 07/27/18 at 6:25 PM the Director of Nursing (DON) indicated she expected pressure ulcers to be assessed and documented weekly and accurately.	F 686		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756		8/24/18

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F 756	Continued From page 41 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 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff and pharmacists interviews, the pharmacist failed to identify the need to address a gradual dose reduction (GDR) of an antidepressant for the physician's consideration for 2 of 18 residents whose medications were reviewed (Resident #13 and Resident #57) and failed to identify and report medication irregularities to the Director of Nursing (DON) and the physician for 1 of 18 residents (Resident #65) whose medications were	F 756	1. The medications of the three Residents #13, #57, and #65 have been reviewed by the pharmacy. The facility has always ensured that drug regimen reviews were completed in the facility. 2. Pharmacy has reviewed the medications and discussed with the physician. Resident #57 and #65 have been tapered and the third resident #13 has a depression score that indicates	

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F 756	Continued From page 42 reviewed. Findings included: 1. Resident #13 was admitted to the facility on 8/14/12 with re-entry on 12/9/14. The resident's cumulative diagnoses included anxiety disorder and major depressive disorder. A review of Resident #13's medical record revealed her medication orders included an order last written on 11/5/17 for 100 milligrams (mg) sertraline (an antidepressant) to be given once daily. A review of Resident #13's most recent annual Minimum Data Set (MDS) assessment dated 7/11/18 was completed. The MDS assessment indicated the resident had moderately impaired cognitive skills for daily decision making. She was independent with most of her Activities of Daily Living (ADLs), with the exception of requiring limited assistance for personal hygiene. Section N of the MDS assessment indicated Resident #13's medications included an antidepressant on 6 out of the previous 7 days during the look back period. A review of the clinical pharmacist's paper and electronic monthly medication regimen reviews (MRRs) from August 2017 through July 2018 was conducted. There was no documentation in the MRRs to indicate the pharmacist identified the need to address a GDR of Resident #13's sertraline for the physician's consideration. No documentation was found in the resident's medical record to indicate this GDR was addressed within the past year. An interview was conducted on 7/27/18 at 4:40 PM with Pharmacist #1. Upon request,	F 756	continued use of the antidepressant is needed. Education about Drug regimen review and reporting irregularities has been completed. The root cause of this deficiency for Resident # 65 was he came in on Friday and had not been assessed by pharmacy by that Tuesday. The root cause for Deficiencies for residents # 13 and #57 was the lack of pharmacy review as mandated by regulations. Prior pharmacy assessments were on paper and due to the complexity of the computerized system, the assessments were missed being reviewed. 3. This will be added to the Facility's Quality Assurance Program to monitor monthly times 12 months to ensure 100% compliance. Monthly Audits will include monitoring psychotropic medications to ensure a GDR is addressed per CMS regulations. 4. Barbara Collins, Director will be responsible for implementing the acceptable plan of correction.	

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Pharmacist #1 reviewed Resident #13's past medication history and reported her records indicated the resident received 100 mg sertraline once daily since 11/11/16. The pharmacist reported most of the facility's clinical work was completed by Pharmacist #2.

A telephone interview was conducted on 7/27/18 at 5:09 PM with Pharmacist #2. During the interview, Pharmacist #2 reported a number of residents in the facility had been tapered off of their antidepressant medication. Upon further inquiry, the pharmacist reported if she had recommended a GDR be addressed, it would be documented in the resident ' s MRR notes.

An interview was conducted on 7/27/18 at 7:20 PM the facility's Director of Nursing (DON). During the interview, the DON was asked what her expectation would be for addressing a GDR for a psychotropic medication such as an antidepressant. The DON stated she would have expected them to be reviewed.

2. Resident #57 was admitted to the facility on 3/25/15 with re-entry on 4/3/18. The resident's cumulative diagnoses included depression.

A review of Resident #57's medical record revealed her medication orders included an order last written on 4/3/18 for 50 milligrams (mg) sertraline (an antidepressant) to be given once daily.

A review of Resident #57's most recent quarterly Minimum Data Set (MDS) assessment dated 5/29/18 was completed. The MDS assessment indicated the resident had severely impaired cognitive skills for daily decision making. She

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required limited assistance with most of her Activities of Daily Living (ADLs), with the exception of being independent with eating and requiring supervision only for walking in her room/corridor. Section N of the MDS assessment indicated Resident #57's medications included an antidepressant on 7 out of the previous 7 days during the look back period.

A review of the clinical pharmacist's paper and electronic monthly medication regimen reviews (MRRs) from August 2017 through July 2018 was conducted. There was no documentation in the MRRs to indicate the pharmacist identified the need to address a GDR of Resident #57's sertraline for the physician's consideration. No documentation was found in the resident's medical record to indicate this GDR was addressed within the past year.

An interview was conducted on 7/27/18 at 4:40 PM with Pharmacist #1. Upon request, Pharmacist #1 reviewed Resident #57's past medication history and reported her records indicated the resident received 50 mg sertraline once daily since 4/30/17. The pharmacist reported most of the facility's clinical work was completed by Pharmacist #2.

A telephone interview was conducted on 7/27/18 at 5:09 PM with Pharmacist #2. During the interview, Pharmacist #2 reported a number of residents in the facility had been tapered off of their antidepressant medication. Upon further inquiry, the pharmacist reported if she had recommended a GDR be addressed, it would be documented in the resident's MRR notes. The pharmacist reported she was not sure if she had addressed a GDR for Resident #57's

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antidepressant, then added, "But probably not."

An interview was conducted on 7/27/18 at 7:20 PM the facility's Director of Nursing (DON). During the interview, the DON was asked what her expectation would be for addressing a GDR for a psychotropic medication such as an antidepressant. The DON stated she would have expected them to be reviewed.

3. Resident #65 was admitted to the facility on 05/30/18 and was re-admitted to the facility on 07/20/18. Resident #65 had diagnoses of debility, anxiety, pneumonia, and Cerebrovascular Accident (CVA).

Review of the admission Minimum Data Set (MDS) dated 06/06/18 revealed Resident #65 was moderately cognitively impaired and needed set-up help only for eating. Resident #65 had a gastric tube and received tube feedings 25% or less of the time during the look back period.

Review of the re-admission physician orders dated 07/20/18 revealed Resident #65 was to receive gastric tube feedings only and would receive no food by mouth. Resident #65 was also ordered to receive mirtazapine 15mg (milligrams) via the gastric tube every night at bedtime. The order for the mirtazapine was reviewed by Pharmacist #1.

In an interview on 07/24/18 at 4:00 PM Pharmacist #1 stated she was unable to find a diagnosis for the use of the mirtazapine. She indicated the medication could be used for several purposes such as appetite stimulation, insomnia, or depression. Pharmacist #1 stated

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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 756	Continued From page 46 she should have written an irregularity report that there was no supporting diagnosis for the mirtazapine but did not remember doing so and could not produce documentation of the report. She indicated it was her responsibility to notify the Director of Nursing (DON) and the physician of any medication irregularities. In a follow-up interview on 07/25/18 at 3:35 PM Pharmacist #1 stated she had been able to discover that the diagnosis for the use of the mirtazapine was for dysphagia (difficulty swallowing) and to stimulate Resident #65's appetite. She indicated mirtazapine was not an appropriate medication for a resident who was unable to take food by mouth. She stated she would recommend to the physician that the medication be discontinued. In an interview on 07/27/18 at 6:25 PM the DON indicated she expected the pharmacist to report any irregularities with medications to her and to the physician so changes could be made if needed.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		8/24/18

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F 757	Continued From page 47 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to ensure that a resident's drug regimen was free from unnecessary drugs for 1 of 18 residents surveyed (Resident #4). Finding included: Resident #4 was readmitted to the facility on 06/22/18 with diagnoses that included a Urinary Tract Infection (UTI) with VRE (Vancomycin Resistant Enterococci). Review of the July 2018 physician orders revealed that Resident #4 received the antibiotic Bactrim DS 800-160 milligrams twice a day for three days to treat a UTI. This medication was started on 07/22/18 and the last dose was given on 07/24/18 at 10:14 PM. A urine culture and sensitivity (UA C&S) test was also ordered on 7/22/18. Review of the final results of the UA C&S on 07/25/18 revealed that the organisms in the resident's urine were not susceptible to the antibiotic Bactrim DS. Record review revealed that no comprehensive care plan had been developed for Resident #4.	F 757	1.Resident #4 was symptomatic with three symptoms of UTI and labs were done. While awaiting culture results the physician started a medication based on the antibiotic stewardship program. 2. The medication was discontinued once culture results were received. Education on the Antibiotic stewardship program has been done. The root cause for this deficiency was the facility followed the Antibiotic Stewardship program guidelines although the Resident was colonized. The facility did not know the resident was colonized. The resident had three symptoms at the time that warranted treatment. 3. This is part of the facility's Quality Assurance program and the infection control meeting each month. This will be monitored monthly times 12 months by the PI nurse to ensure 100% compliance with the antibiotic stewardship program for all treated infections. 4. Barbara Collins, Director is responsible for implementing an acceptable plan of correction.	

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In an interview with MDS Nurse #1 on 07/26/18 at 2:20 PM she stated that a comprehensive care plan for Resident #4 had not been completed. She said that she did look in the EPIC system (electronic records shared with the hospital) to determine if a care plan could be brought forward but she could not find one.

Review of the most recent Minimum Data Set quarterly assessment was completed on 06/17/18. It documented that the resident had an indwelling foley catheter.

Record review revealed that pharmacy medication reviews were completed monthly with additional addendums each month.
She was also assessed by a physician every two months.

An interview conducted with Nurse #2, Unit Manager, on 07/27/18 at 6:55 PM revealed that the results of the UA C&S for resident #4 were sent to the Infection Diseases doctor at the hospital (Physician #1) for evaluation as documented by Nurse #3 on 07/25/18 at 3:35 PM. Nurse #2 stated that Physician #1 determined that the VRE in the resident's urine was colonized and did not require treatment. Nurse #2 said that Resident #4 received a three day course of Bactrim DS unnecessarily because the VRE was colonized.

In an interview conducted with Nurse #4, Infection Control, on 07/27/18 at 7:00 PM he stated that Resident #4 received an antibiotic (Bactrim DS) that she did not need because the VRE in her urine was colonized and did not require treatment.

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F 758	Continued From page 49	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		8/24/18

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prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and pharmacist interviews, the facility failed to discontinue an unnecessary psychotropic medication (any drug that affects brain activities associated with mental processes and behavior) for 1 of 18 residents (Resident #65) and failed to consider a gradual dose reduction (GDR) of a psychotropic medication for 2 of 18 residents whose medications were reviewed (Resident #13 and Resident #57). Findings included:

1. Resident #65 was admitted to the facility on 05/30/18 and was re-admitted to the facility on 07/20/18. Resident #65 had diagnoses of debility, anxiety, pneumonia, and Cerebrovascular Accident (CVA).

Review of the admission Minimum Data Set (MDS) dated 06/06/18 revealed Resident #65 was moderately cognitively impaired and needed set-up help only for eating. Resident #65 had a gastric tube and received tube feedings 25% or less of the time during the look back period.

Review of the re-admission physician orders dated 07/20/18 revealed Resident #65 was to

1. The medications for resident #13, #57 and #65 have been reviewed by pharmacy and the physician.
2. The medications have been reviewed and two have been tapered (Residents #57 and #65) The other resident #13 was not due to the depression score and the need to continue the medication. Education with the pharmacists have been completed. The root cause for this deficiency was the oversight of the pharmacist to review the medications due to Resident # 65 coming in the facility on Friday and the assessment not being done by the following Tuesday. The root cause for the deficiency for Residents # 57 and # 13 was an oversight by the pharmacist due to the facility moving to a computerized medical record that made it difficult to track the GDR of the Residents.
3. This has been added to the quality assurance program to be monitored monthly times 12 months by the PI nurse to ensure 100% compliance. We will discuss the results in the QAPI meeting scheduled for 8/21/2018. The monthly

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F 758	Continued From page 51 receive gastric tube feedings only and would receive no food by mouth. Resident #65 was also ordered to receive mirtazapine 15mg (milligrams) via the gastric tube every night at bedtime. The order for the mirtazapine was reviewed by Pharmacist #1. In an interview on 07/24/18 at 4:00 PM Pharmacist #1 stated she was unable to find a diagnosis for the use of the mirtazapine. She indicated the medication could be used for several purposes such as appetite stimulation, insomnia, or depression. Pharmacist #1 stated it would be an unnecessary and inappropriate medication to give to a resident who only received tube feedings because the medication was an appetite stimulant and the resident could not eat more food if hungry. In a follow-up interview on 07/25/18 at 3:35 PM Pharmacist #1 stated she had been able to discover that the diagnosis for the use of the mirtazapine was for dysphagia (difficulty swallowing) and to stimulate Resident #65's appetite. She again indicated it was not an appropriate medication for a resident who was unable to take food by mouth. She stated she would recommend to the physician that the medication be discontinued. In an interview on 07/27/18 at 6:25 PM the Director of Nursing (DON) indicated she expected the pharmacist to report any irregularities with medications to her and to the physician. She indicated psychotropic medications should be followed closely and not given unnecessarily. 2. Resident #13 was admitted to the facility on 8/14/12 with re-entry on 12/9/14. The resident's cumulative diagnoses included anxiety disorder,	F 758	audits will include monitoring the residents that receive psychotropics for a GDR. 4. Barbara Collins, Director of nursing will be responsible for ensuring an acceptable plan of correction is obtained.	

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major depressive disorder, and Alzheimer's disease.

A review of Resident #13's medical record revealed her medication orders included an order last written on 11/5/17 for 100 milligrams (mg) sertraline (an antidepressant) to be given once daily.

A review of Resident #13's most recent annual Minimum Data Set (MDS) assessment dated 7/11/18 was completed. The MDS assessment indicated the resident had moderately impaired cognitive skills for daily decision making. She was independent with most of her Activities of Daily Living (ADLs), with the exception of requiring limited assistance for personal hygiene. Section N of the MDS assessment indicated Resident #13's medications included an antidepressant on 6 out of the previous 7 days during the look back period.

The resident's current care plan included the following area of focus:
--Psychotropic drug use (dated 4/13/18): Resident #13 has depression related to Alzheimer's disease. She is currently on sertraline and alprazolam (an antianxiety medication) for anxiety. Notes on the care plan indicated her alprazolam had been tapered, discontinued, and restarted on 5/3/18 related to anxiety attacks and complaints of feeling anxious and agitated.

A review of the clinical pharmacist's paper and electronic monthly medication regimen reviews (MRRs) from August 2017 through July 2018 revealed there was no documentation to indicate a gradual dose reduction (GDR) of the resident's

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antidepressant (sertraline) was addressed. There was no information in the Resident #13's medical record to indicate a GDR for the sertraline had been considered or that a GDR was determined to be clinically contraindicated within the past year.

An interview was conducted on 7/27/18 at 4:40 PM with Pharmacist #1. Upon request, Pharmacist #1 reviewed Resident #13's past medication history and reported her records indicated the resident received 100 mg sertraline once daily since 11/11/16. The pharmacist reported most of the facility's clinical work was completed by Pharmacist #2.

A telephone interview was conducted on 7/27/18 at 5:09 PM with Pharmacist #2. During the interview, Pharmacist #2 reported a number of residents in the facility had been tapered off of their antidepressant medication. Upon further inquiry, the pharmacist reported if she had recommended a GDR be addressed, it would be documented in the resident's MRR notes.

An interview was conducted on 7/27/18 at 7:20 PM the facility's Director of Nursing (DON). During the interview, the DON was asked what her expectation would be for addressing a GDR for a psychotropic medication such as an antidepressant. The DON stated she would have expected them to be reviewed.

3. Resident #57 was admitted to the facility on 3/25/15 with re-entry on 4/3/18. The resident's cumulative diagnoses included depression.

A review of Resident #57's medical record revealed her medication orders included an order

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last written on 4/3/18 for 50 milligrams (mg) sertraline (an antidepressant) to be given once daily.

A review of Resident #57's most recent quarterly Minimum Data Set (MDS) assessment dated 5/29/18 was completed. The MDS assessment indicated the resident had severely impaired cognitive skills for daily decision making. She required limited assistance with most of her Activities of Daily Living (ADLs), with the exception of being independent with eating and requiring supervision only for walking in her room/corridor. Section N of the MDS assessment indicated Resident #57's medications included an antidepressant on 7 out of the previous 7 days during the look back period.

The resident's current care plan included the following area of focus:
--Depression (dated 3/1/18): Resident #57 uses an antidepressant medication (sertraline) daily.

A review of the clinical pharmacist's paper and electronic monthly medication regimen reviews (MRRs) from August 2017 through July 2018 revealed there was no documentation to indicate a gradual dose reduction (GDR) of the resident's antidepressant (sertraline) was addressed. There was no information in the Resident #57's medical record to indicate a GDR for the sertraline had been considered or that a GDR was determined to be clinically contraindicated within the past year.

An interview was conducted on 7/27/18 at 4:40 PM with Pharmacist #1. Upon request, Pharmacist #1 reviewed Resident #57's past medication history and reported her records

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F 758	Continued From page 55 indicated the resident received 50 mg sertraline once daily since 4/30/17. The pharmacist reported most of the facility's clinical work was completed by Pharmacist #2. A telephone interview was conducted on 7/27/18 at 5:09 PM with Pharmacist #2. During the interview, Pharmacist #2 reported a number of residents in the facility had been tapered off of their antidepressant medication. Upon further inquiry, the pharmacist reported if she had recommended a GDR be addressed, it would be documented in the resident's MRR notes. The pharmacist reported she was not sure if she had addressed a GDR for Resident #57's antidepressant, then added, "But probably not." An interview was conducted on 7/27/18 at 7:20 PM the facility's Director of Nursing (DON). During the interview, the DON was asked what her expectation would be for addressing a GDR for a psychotropic medication such as an antidepressant. The DON stated she would have expected them to be reviewed.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		8/24/18

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F 761	Continued From page 56 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility: 1) Failed to include an expiration date on the labeling of medications stored in 5 of 5 medication (med) carts (1601-1610 med cart, 1611-1620 med cart, 1203-1207 med cart, 1708-1716 med cart, and the 1101-1102/1113-1115 med cart); and, 2) Failed to discard an expired medication stored in 1 of 2 medication rooms (1600 Hall Med Room). The findings included: 1.a. An observation was made on 7/26/18 at 12:03 PM of the 1601-1610 medication cart. The observation revealed the following medications stored on the med cart were not labeled with an expiration date: --One vial containing approximately 30 tablets of 25 milligrams (mg) mirabegron ER (a medication used to treat overactive bladder) dispensed for Resident #208. A review of Resident #208 ' s scheduled medications revealed the resident had a current order to receive 50 mg mirabegron ER	F 761	1. The facility has never had issues with expiration dates on medications. This error was due to the facility's new electronic health record system and the ability of the pharmacy to label medications correctly. This error was noted in 5 of 5 medication carts. The pharmacist immediately corrected the problem during the survey. The night cart had been checked during the survey and the expired medications had been overlooked by the pharmacist. 2. The root cause for this deficiency was due to the new computerized system lacking the ability to place expiration dates on the bottled medications. Pharmacy has put a process in place to correctly label the medications in the future. The root cause for the oversight of the expired medication on the night cart was due to the medication cart only being checked every two months. Pharmacy will monitor drugs on the night cart monthly to ensure	

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F 761	Continued From page 57 by mouth once daily. -- One vial containing approximately 20 capsules of Preservision AREDS (a vitamin/mineral supplement) dispensed for Resident #208. A review of Resident #208 ' s scheduled medications revealed the resident had a current order to receive Preservision AREDS as one capsule by mouth once daily. -- One vial containing approximately 30 tablets of 50 milligrams (mg) imipramine (an antidepressant) dispensed for Resident #358. A review of Resident #358 ' s scheduled medications revealed the resident had a current order to receive 200 mg of imipramine by mouth every night at bedtime. --One vial containing approximately 30 tablets of 80 milligrams (mg) sotalol (an antiarrhythmic agent) dispensed for Resident #357. A review of Resident #357 ' s scheduled medications revealed the resident had a current order to receive 80 mg sotalol by mouth every 12 hours. --One vial containing approximately 25 tablets of 75 milligrams (mg) diclofenac EC (a non-steroidal anti-inflammatory drug) dispensed for Resident #357. A review of Resident #357 ' s scheduled medications revealed the resident had a current order to receive 75 mg diclofenac EC by mouth two times a day. --Two vials containing 7.5 milligrams (mg) mirtazapine (an antidepressant) dispensed for Resident #65. One of the vials contained 6 tablets and the second vial contained 4 tablets of mirtazapine. A review of Resident #65 ' s scheduled medications revealed the resident had a current order to receive 7.5 mg mirtazapine via gastrostomy tube every night at bedtime. --One vial containing 16 capsules of Preservision AREDS (a vitamin/mineral supplement) dispensed for Resident #105. A review of	F 761	there are no expired medications. Education with the pharmacists has been completed on labeling and storing medications properly. 3. This will be added to the facility's Quality assurance Program to be monitored monthly times 12 months by the PI nurse to ensure 100% compliance. This will be discussed in the QAPI meeting scheduled for 8/21/2108. The audits will include checking the medications on the night cart and the floor medication carts for expiration dates and expired drugs. 4. Barbara Collins, DON will be responsible for implementing the acceptable plan of correction.	

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Resident #105 ' s scheduled medications revealed the resident had a current order to receive Preservision AREDS as one capsule by mouth once daily.
--One vial containing 16 tablets of 150 milligrams (mg) bupropion XL (an antidepressant) dispensed for Resident #105. A review of Resident #105 ' s scheduled medications revealed the resident had a current order to receive 150 mg bupropion XL as one tablet by mouth once daily.

Interviews were conducted on 7/26/18 at 12:10 PM, 12:23 PM, and 12:34 PM with Nurse #9. During the interviews, Nurse #9 confirmed the medication vials were not labeled with an expiration date. The nurse stated, "Yes, it looks like it ' s all of the bottled ones (are missing an expiration date)." When Nurse #9 was asked how she would know if the medications were expired, Nurse #9 stated, "That ' s a good question."

An interview was conducted on 7/26/18 at 2:23 PM with Pharmacist #1. Pharmacist #1 reported she had just been made aware that all vials of medication labeled and dispensed from the facility ' s on-site pharmacy were missing an expiration date. She reported the pharmacy technician was pulling the medication vials off of the hall med carts and writing the appropriate expiration date(s) on each vial of medication dispensed.

An interview was conducted on 7/27/18 at 5:30 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported most issues concerning the expiration dates on the medications were likely attributed to the November 2017 change in the facility ' s

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computer software. Her expectation was for the pharmacists to address the concerns identified and she expressed confidence they would do so.

1.b. An observation was made on 7/26/18 at 12:45 PM of the 1611-1620 medication cart. The observation revealed the following medications stored on the med cart were not labeled with an expiration date:
--One vial containing approximately 15 tablets of 325 milligrams (mg) aspirin dispensed for Resident #88. A review of Resident #88 ' s scheduled medications revealed the resident had a current order to receive 325 mg aspirin as one tablet by mouth once daily.
--One vial containing approximately 30 tablets of 500 milligrams (mg) calcium carbonate (a mineral supplement) dispensed for Resident #59. A review of Resident #59 ' s scheduled medications revealed the resident had a current order to receive 500 mg calcium carbonate as one tablet by mouth twice daily.
--One vial containing approximately 15 capsules of 24 micrograms (mcg) lubiprostone (a gastrointestinal agent) dispensed for Resident #59. A review of Resident #59 ' s scheduled medications revealed the resident had a current order to receive 24 mcg lubiprostone as one capsule by mouth daily with breakfast.
--One vial containing 2 capsules of 50,000 units Vitamin D2 (a vitamin supplement) dispensed for Resident #207. A review of Resident #207 ' s scheduled medications revealed the resident had a current order to receive 50,000 units Vitamin D2 as one capsule by mouth once a week.
--One vial containing approximately 10 capsules of 0.5 milligrams (mg) dutasteride (a medication used to treat benign prostatic hyperplasia) dispensed for Resident #21. A review of Resident

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#21 ' s scheduled medications revealed the resident had a current order to receive 0.5 mg dutasteride as one capsule by mouth once daily.

An interview was conducted on 7/26/18 at 12:55 PM with Nurse #9. Nurse #9 confirmed the medication vials were not labeled with an expiration date.

An interview was conducted on 7/26/18 at 2:23 PM with Pharmacist #1. Pharmacist #1 reported she had just been made aware that all vials of medication labeled and dispensed from the facility ' s on-site pharmacy were missing an expiration date. She reported the pharmacy technician was pulling the medication vials off of the hall med carts and writing the appropriate expiration date(s) on each vial of medication dispensed.

An interview was conducted on 7/27/18 at 5:30 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported most issues concerning the expiration dates on the medications were likely attributed to the November 2017 change in the facility ' s computer software. Her expectation was for the pharmacists to address the concerns identified and she expressed confidence they would do so.

1.c. An observation was made on 7/26/18 at 3:08 PM of the 1203-1207 medication cart. The observation revealed the following medications stored on the med cart were not labeled with an expiration date:
--One vial containing 7 capsules of 100 milligrams (mg) doxycycline (an antibiotic) dispensed for Resident #43. A review of Resident #43 ' s scheduled medications revealed

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the resident had a current order to receive 100 mg doxycycline as one capsule by mouth two times daily.
--One vial containing 7 tablets of 1 milligram (mg) ropinirole (an anti-Parkinson ' s agent) dispensed for Resident #70. A review of Resident #70 ' s scheduled medications revealed the resident had a current order to receive 1 mg ropinirole as one tablet by mouth once daily at bedtime.

An interview was conducted on 7/26/18 at 3:10 PM with Nurse #5. Nurse #5 confirmed the medication vials were not labeled with an expiration date.

An interview was conducted on 7/26/18 at 2:23 PM with Pharmacist #1. Pharmacist #1 reported she had just been made aware that all vials of medication labeled and dispensed from the facility ' s on-site pharmacy were missing an expiration date. She reported the pharmacy technician was pulling the medication vials off of the hall med carts and writing the appropriate expiration date(s) on each vial of medication dispensed.

An interview was conducted on 7/27/18 at 5:30 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported most issues concerning the expiration dates on the medications were likely attributed to the November 2017 change in the facility ' s computer software. Her expectation was for the pharmacists to address the concerns identified and she expressed confidence they would do so.

1.d. An observation was made on 7/26/18 at 3:18 PM of the 1708-1716 medication cart. The observation revealed the following medication

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stored on the med cart was not labeled with an expiration date:
--One vial containing 23 tablets of 0.25 milligrams (mg) triazolam (an antianxiety medication) dispensed for Resident #8. A review of Resident #8 ' s scheduled medications revealed the resident had a current order to receive 0.25 mg triazolam as one tablet by mouth once daily at bedtime.

An interview was conducted on 7/26/18 at 3:20 PM with Nurse #6. Nurse #6 confirmed the medication vial was not labeled with an expiration date.

An interview was conducted on 7/26/18 at 2:23 PM with Pharmacist #1. Pharmacist #1 reported she had just been made aware that all vials of medication labeled and dispensed from the facility ' s on-site pharmacy were missing an expiration date. She reported the pharmacy technician was pulling the medication vials off of the hall med carts and writing the appropriate expiration date(s) on each vial of medication dispensed.

An interview was conducted on 7/27/18 at 5:30 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported most issues concerning the expiration dates on the medications were likely attributed to the November 2017 change in the facility ' s computer software. Her expectation was for the pharmacists to address the concerns identified and she expressed confidence they would do so.

1.e. An observation was made on 7/26/18 at 3:32 PM of the 1101-1102/1113-1115 medication cart. The observation revealed the following

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medication stored on the med cart was not labeled with an expiration date:
--One vial containing 31 tablets of 2.5/0.025 milligrams (mg) diphenoxylate/atropine (an anti-diarrheal medication) dispensed for Resident #58. A review of Resident #58 ' s scheduled medications revealed the resident had a current order to receive 2.5/0.025 mg diphenoxylate/atropine as one tablet by mouth 4 times daily as needed for diarrhea.

An interview was conducted on 7/26/18 at 3:35 PM with Nurse #3. Nurse #3 confirmed the medication vial was not labeled with an expiration date. When the nurse was asked how she would know if this medication was expired, she stated, "I can ' t tell."

An interview was conducted on 7/26/18 at 2:23 PM with Pharmacist #1. Pharmacist #1 reported she had just been made aware that all vials of medication labeled and dispensed from the facility ' s on-site pharmacy were missing an expiration date. She reported the pharmacy technician was pulling the medication vials off of the hall med carts and writing the appropriate expiration date(s) on each vial of medication dispensed.

An interview was conducted on 7/27/18 at 5:30 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported most issues concerning the expiration dates on the medications were likely attributed to the November 2017 change in the facility ' s computer software. Her expectation was for the pharmacists to address the concerns identified and she expressed confidence they would do so.

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F 761	Continued From page 64 2. Accompanied by the facility ' s Staff Development Coordinator (SDC), an observation was made on 7/26/18 at 11:46 AM of the 1600 Hall Med Room. The observation revealed one vial containing two tablets of 250 milligrams (mg) cefuroxime was stored in the night cart of the medication room. The vial of cefuroxime tablets was labeled with an expiration date of 7/6/18. An interview was conducted on 7/26/18 at 11:48 AM with the facility ' s SDC. Upon inquiry, the SDC confirmed the cefuroxime tablets were expired and needed to be removed from the night cart. An interview was conducted on 7/27/18 at 5:30 PM with the facility ' s Director of Nursing (DON). Her expectation was for the pharmacists to address the concerns identified and she expressed confidence they would do so.	F 761		
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.	F 812		8/24/18

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F 812	Continued From page 65 §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 control moisture which was leaking from an overhead ceiling vent onto the belt where meal trays were prepared, and failed to dry kitchenware prior to stacking it in storage and placing food into it. The facility also failed to clean all interior surfaces of the microwave, and failed to discard abraded soup and cereal bowls. Findings included: 1. During observation of the trayline operation on 07/25/18 , beginning at 11:02 AM, condensation was leaking from a vent in the ceiling onto the belt where meal trays were being assembled. At 11:05 AM on 07/25/18 condensation from the overhead vent fell onto the lid of a resident's meal tray which was in the process of being used to cover the resident's food (until there was surveyor intervention). At 3:07 PM on 07/27/18 the dietary manager (DM) stated condensation from the ceiling air vent was a periodic problem depending on the outside temperature. She explained the hotter it was outside, the more condensation leaked out of the vent. She reported in the past the facility had put down towels to catch some of the moisture. She commented she thought a call had been placed to maintenance last week about the condensation problem, but they had not had a chance to assess the situation yet. According to the DM, it would be difficult to know what possible	F 812	1. The condensation issue has been resolved. The wet dishes and pans were removed during the survey and the abraded dishes have been removed. The microwave was properly cleaned. The facility failed to prevent excess moisture in the kitchen, to properly dry dishes, to discard abraded bowls and clean the top interior of the microwave. 2. The root cause analysis for the condensation was the temperature in the kitchen and the tray line being directly under the vents. The root cause for the wet dishes was due to the lack of the staff not ensuring the dishes were dry prior to storing and placing food in them. The root cause for the microwave having dried food particles was the lack of the staff wiping the microwave without looking at the top inside of the microwave. The top should have been wiped first and then the sides. The root cause for the abraded dishes is the lack of the kitchen staff to replace dishes as soon as they become abraded. The staff have been educated on all deficient areas on 8/8/2018. . 3. A walkthrough of the kitchen will be conducted weekly times 4 then monthly times 12 if 100% compliance was reached to monitor for the deficient areas. This will be added to the facility's Quality Assurance Program to be monitored by the PI nurse to ensure 100% compliance	

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F 812	Continued From page 66 contaminants might be incorporated in the condensation so it was essential to prevent any leaking moisture from making contact with the food or meal trays. She explained that if the condensation contaminated the food or trays then residents could possibly get sick. At 3:28 PM on 07/27/18 a dietary employee stated the more the air conditioning ran, the more condensation leaked from the air vent in the ceiling. She reported maintenance had adjusted the air flow in the past to try to help with the problem. She commented the vent which leaked the most was over the steam table and trayline belt which posed a problem because condensation falling into food or onto meal trays could cause contamination issues with the potential to make residents sick. 2. During initial tour of the kitchen, beginning at 11:20 AM on 07/23/18, 5 of 18 tray pans stacked on top of one another in storage had moisture trapped inside of them. At 10:15 AM on 07/25/18 a dietary employee was in the process of placing lettuce into a wet plastic soup/cereal bowl and placing beets into two wet plastic dessert bowls (until there was surveyor intervention). At 3:07 PM on 07/27/18 the dietary manager (DM) stated she did not think that the dietary employees were examining the inside of tray pans and kitchenware well enough before stacking them in storage or filling them with food. She reported she thought the facility needed to increase air movement in the kitchen to speed up drying times. At this time the hospital Food Service Director commented that in his kitchen	F 812	is achieved. The walkthrough will include monitoring for wet dishes and pots, abraded dishes, condensation from the vent dropping on the tray line and dishes, cleanliness of the microwave. 4. Barbara Collins, DON is responsible for implementing the acceptable plan of correction.	

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quaternary sanitizer was placed in cold water which seemed to bring about quicker drying of kitchenware run through the three-compartment sink system. The DM commented dietary staff had been in-serviced prior to the survey about making sure kitchenware was completely dry before stacking it in storage or placing food in it. According to the DM, kitchenware that stayed wet for long periods of time had the potential to grow bacteria and make residents sick.

At 3:28 PM on 07/27/18 a dietary employee stated all dietary staff had been in-serviced multiple times before survey that all kitchenware had to be completely dry before stacking it in storage or placing food in it. She reported otherwise germs and bacteria could grow in the moisture.

3. During initial tour of the kitchen, beginning at 11:20 AM on 07/23/18, the top interior surface of the microwave had dried food particles on it.

During follow-up visits to the kitchen on 07/25/18 at 8:22 AM and 10:26 AM and on 07/27/18 at 3:05 PM the top interior surface of the microwave had dried food particles on it.

At 3:07 PM on 07/27/18 the dietary manager (DM) stated her expectation was that all interior surfaces in the microwave be wiped down after each meal. She reported the microwave was on the facility cleaning schedule, and the group responsible for its cleaning was rotated. She commented that dried food particles from the interior top of the microwave could fall into fresh food which was being cooked or reheated in the microwave, causing contamination and possible sickness.

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At 3:28 PM on 07/27/18 a dietary employee stated when she cleaned the microwave she always started with the interior top so that dried food particles which fell onto the rest of the microwave could be cleaned up without causing cross-contamination. She reported moisture created by heating foods could cause dried food particles on the interior top of the microwave to loosen and fall into fresh food causing contamination.

4. At 10:19 AM on 07/25/18 13 of 28 plastic soup and cereal bowls had abraded interior surfaces. At this time the dietary manager (DM) reported she would order more of these bowls so the facility would not have to use damaged ones.

At 3:07 PM on 07/27/18 the DM stated dietary staff had been instructed to throw out damaged kitchenware, including items with chips, cracks, and abrasions, so that materials used to make the kitchenware did not slough off into the food. She also reported that it was easy to harbor bacteria and germs in damaged kitchenware because it was more difficult to clean and sanitize kitchenware surfaces compromised by cracks, chips, and abrasions.

At 3:28 PM on 07/27/18 a dietary employee stated when rings were created in the plastic soup and cereal bowls by microwaving foods in them, the dietary staff was supposed to count the bowls and dispose of them. She reported bacteria and germs could hide in the abraded surfaces and possibly make residents sick. She commented counts of the damaged kitchenware were forwarded to the DM so she would know how many pieces of replacement kitchenware to

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F 812	Continued From page 69 order.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility's quality assurance (QA) process failed to prevent the reoccurrence of deficient practice related to stacking kitchenware wet and placing food in wet kitchenware in a repeat deficiency at F371/F812. The re-citing of F371/F812 for these problems 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 ... dry kitchenware prior to stacking it in storage and placing food into it. Review of the facility's survey history revealed F371/F812 was cited for stacking kitchenware wet and placing food in wet kitchenware during the facility's 08/10/17 annual recertification/complaint investigation survey, and was re-cited for the same reasons during the current 07/27/18 annual recertification/complaint investigation survey.	F 867	1. The facility has always taken pride in our Quality Improvement Program. We meet monthly and address issues as they surface. The kitchen had been monitored closely for wet kitchenware after we had been previously cited for this. 2. The Director of Nursing will take responsibility for the Dietary Manager monitoring the deficient areas everyday and reporting the findings to her on a daily basis. If the Dietary manager is absent, another person will be assigned to do the monitoring and reporting. The dietary staff has been educated on this on 8/8/2018. The root cause for this deficiency is the lack of daily monitoring and inspection of the kitchen by management and continuous education with the dietary staff. 3. This will be added to the facility Quality Assurance Program to be monitored closely monthly times 12 months to ensure 100% compliance. Audits for this deficiency will include daily monitoring by the dietary manager or appointed staff with daily reporting of the findings to the	8/24/18

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F 867	Continued From page 70 At 3:07 PM on 07/27/18 the Dietary Manager (DM) stated apparently staff had not been educated enough to look at the interior surfaces of kitchenware before stacking it in storage and placing food in it. She reported it appeared that staff were placing the wet kitchenware on drying racks as instructed during in-servicing following the facility's 2017 survey, but were removing the kitchenware too quickly from drying racks. She also commented that the 2018 summer seemed even more humid than the 2017 summer. At this time the hospital Food Service Director stated that it in 2017 the facility did not explore enough the need to increase air movement in the kitchen He also reported that perhaps using cold water in the three-compartment sanitizing sink rather than warm/hot water should have been tried in the facility since doing so in the hospital kitchen reduced moisture accumulation on kitchenware. .	F 867	Director. This will be discussed in the next QAPI meeting scheduled for 8/21/2018. 4. Barbara Collins, DON will be responsible for implementing the acceptable plan of correction.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		8/24/18

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reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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F 880	Continued From page 72 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to disinfect a shared glucometer (device used to measure a resident ' s blood glucose or blood sugar level) after the glucometer was used for 1 of 5 residents observed to have blood glucose monitoring (Resident #72); and, failed to perform hand hygiene between residents (Resident #55 and #13) during 1 of 3 continuous observations of a medication administration pass. The findings included: A review of the facility ' s policy for the use of the [Brand Name] Blood Glucose Monitoring System included instructions for the cleaning/disinfecting of a shared glucose meter. The procedure included a notation which indicated the cleaning/disinfecting of a shared glucose meter was required between each patient use. The procedure read, in part: " ...#4. Use a Germicidal Wipe to disinfect by gently wiping the surfaces of the meter three times vertically and three times horizontally. Use additional wipes as needed. Note: Carefully wipe around the meter test strip port area, making sure that no liquid enters the test strip port. #5. Allow the surfaces of the meter to remain	F 880	1. The facility has always taken pride in our infection control program. The staff have been trained to properly disinfect the glucometer machines and proper hand hygiene. During the survey the glucometer was not cleaned appropriately during a FSBS on Resident #72 and resident #1. Proper hand hygiene was not done during the survey by a nurse administering medications to residents #55 and #13. 2. The root cause of this deficiency is the lack of knowledge of the staff to clean the machine per manufacturers instructions which state it has to be wet by the disinfectant for two minutes and then air dry. The facility feels the staff being nervous may have played a part in this deficiency since this was a new nurse being followed by the surveyor. Staff have been educated on the proper way to clean the machines and we have also received additional educational information from the local health department on properly cleaning the glucometers. Staff has also been educated on proper hand hygiene. Education began immediately during the survey.	

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F 880	Continued From page 73 damp with the disinfecting solution for one full minute. #6. Dry the meter surfaces thoroughly with a soft cloth or gauze after cleaning. Visually verify that no solution is seen anywhere on the meter at the completion of cleaning." On 7/24/18 at 4:17 PM, Nursing Assistant (NA) #3 was observed as she put on gloves and used a glucometer to obtain a blood glucose reading for Resident #72. After checking the resident ' s blood glucose, NA #3 removed her gloves and washed her hands. A continuous observation was made as NA #3 then entered Resident #1 ' s room at 4:22 PM with equipment to check his vital signs and supplies to do a blood glucose check. These supplies included the same glucometer used to check Resident #72 ' s blood glucose and a container of germicidal (disinfectant) wipes. NA #3 was observed as she checked Resident #1 ' s vital signs, then donned gloves. At 4:23 PM, the NA put a blood glucose test strip into the glucometer, wiped the resident's finger with an alcohol pad, and picked up a lancet. Prior to pricking the resident's finger, the NA was asked to stop the procedure and a request was made for her to step out into the hall. On 7/24/18 at 4:24 PM, the NA was asked when she would need to disinfect the shared glucometer. The NA stated she needed to disinfect the meter between each resident. When asked more about this, the NA stated, "Oh, I didn't disinfect it." The NA then re-entered Resident #1's room and took a germicidal wipe from the container of wipes. The NA was timed as she wiped the shared glucometer with a germicidal wipe for 10 seconds, waited 10 seconds, and then re-inserted a glucose test strip into the meter. The NA prepared to prick the resident's finger for the	F 880	3. This will be added to the facility's Quality Assurance Program to be monitored monthly times 12 months to ensure 100% compliance. The monitoring will be completed by the PI nurse. The results will be discussed in the QAPI meeting scheduled for 8/21/2018. The audits for this deficiency includes monitoring the staff properly washing hands during med passes and glucose checks and cleaning the glucometer between residents correctly. 4. Barbara Collins, DON will be responsible for implementing the acceptable plan of correction.	

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blood glucose check when she was asked to stop the procedure once again. When the NA stepped out into the hallway, inquiry was made as to how she had been instructed to disinfect the shared glucometer. The NA stated she was supposed to wipe off the glucometer with the germicidal wipe and then wait two minutes before using it. The container of germicidal wipes was brought out into the hallway and the manufacturers' instructions were reviewed. The manufacturer ' s labeling on the container of germicidal wipes read, in part: "To disinfect nonfood contact surfaces only: Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two (2) minutes. Let air dry." Upon inquiry, NA #3 stated she would typically ask the hall nurse if she was unsure about something or had questions.

On 7/24/18 at 4:35 PM, Nurse #6 joined the NA. An interview was conducted with the hall nurse at that time. During the interview, the hall nurse stated the NA needed to wait 2 minutes after thoroughly wiping the glucometer with a germicidal wipe. Nurse #6 reviewed the manufacturer's instructions and encouraged NA #3 to use the wipes to ensure the glucometer remained wet for the two minutes, then allow it to air dry. The hall nurse remained present while the NA disinfected the shared glucometer and checked Resident #1 ' s blood glucose.

An interview was conducted on 7/24/18 at 5:50 PM with the facility's Staff Development Coordinator (SDC). During the interview, the SDC was asked when the facility's shared glucometer needed to be disinfected and how it was to be done. The SDC stated the glucometer needed to be disinfected between each resident.

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He stated the germicidal wipes used at the facility required the meter to be wet for two minutes and air dried before being used again. The SDC was made aware of the concerns observed related to the disinfection of the shared glucometer.

A second interview was conducted on 7/25/18 at 3:15 PM with the SDC. During the interview, the facility ' s policy on the disinfection of the shared glucometer was discussed. The SDC reported the germicidal wipes used by the facility were the correct wipes. Although the facility policy indicated the glucometer should remain damp for only one minute, the SDC reported the manufacturer ' s instructions for the germicidal wipes would take precedence over the instructions stated in their policy. A follow-up interview was conducted with the SDC on 7/27/18 at 11:45 AM. During this interview, the SDC reported the facility shared their policy on glucometer disinfection with the hospital and would need to work with the hospital administrative staff to change this policy. The SDC reported his in-servicing with facility staff directed the nurses and nursing assistants to follow the manufacturer's instructions for the disinfection of a shared glucometer.

An interview was conducted on 7/27/18 at 5:30 PM with the facility ' s Director of Nursing (DON) regarding the disinfection of a shared glucometer. The DON stated her expectation for the disinfection of the glucometer was, "That it be cleaned."

2) A review of the facility's policy (revised 8/2012) on Infection Control included a procedure on handwashing, hand antisepsis, hand skin protection, and hand skin care. This procedure

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read, in part:
"I. Indication for handwashing and hand antisepsis:
...F. Decontaminate hands after contact with a patient ' s intact skin (e.g. when taking a pulse or blood
pressure, or lifting a patient)
..."
"V. Important Information:
...B. Wash in/Wash out
Hand Hygiene at room entry-ensures that hands are clean before planned and unplanned contact with the patient or the items in the patient ' s environment to prevent the introduction of germs to the patient environment.
Hand Hygiene at room exit-ensures that hands are clean upon the exit of one patient care environment to prevent the introduction of germs to the caregiver or common areas, especially after body fluid exposure."

On 7/24/18 at 8:17 AM, Nurse #7 was observed as she prepared 13 oral medications, one eye drop, one nasal spray, one dry powder inhaler, and two nebulizer solutions for administration to Resident #55. After prepping the medications for administration, the nurse entered the resident's room. Nurse #7 was observed as she handed Resident #55 a medicine cup with his oral meds and the resident took the medications. The nurse next donned gloves and administered the nasal spray. She then assisted Resident #55 to use the dry powder inhaler and handed him a cup of water to rinse his mouth out and another cup used to spit the water out. Still wearing the same pair of gloves, the nurse administered an eye drop into each of the resident's eyes. At 8:35 AM, the nurse disassembled the resident's nebulizer mask and instilled one vial of nebulizer solution

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into the medication cup of the nebulizer. While still wearing the same gloves, the nurse positioned the nebulizer mask over the Resident #55's nose/mouth. The nurse removed her left glove and returned to the medication cart while still wearing the right glove. At 8:37 AM, the nurse took off her remaining glove, wiped off the Spiriva inhaler, and made notations in the resident's electronic Medication Administration Record to indicate his medications had been administered. At 8:40 AM, Nurse #7 began to pull medications for the next resident (Resident #13). At 8:43 AM, the nurse re-entered Resident #55 ' s room, disassembled his nebulizer mask and instilled the contents of his second nebulizer solution into the med cup of the nebulizer. She then placed the mask over Resident #55's nose/mouth. At 8:45 AM, the nurse returned to the med cart and continued to pull the medications for Resident #13, which included eye drops, a nasal spray, and oral medications. A continuous observation was made as the nurse failed to wash her hands or use hand sanitizer at any point in time during the med pass administration observation. Nurse #7 was observed as she poured a cup of water for Resident #13, gathered her medications and a pair gloves, and entered Resident #13 ' s room at 8:53 PM to administer the medications. At 8:54 AM, the nurse handed the oral medications in a cup to Resident #13. The resident agreed to take only one of the oral medications at that time. The eye drops and nasal spray were not administered.

An interview was conducted on 7/24/18 at 9:00 AM with Nurse #7. During the interview, the nurse was asked when she would usually wash her hands or use hand sanitizer during a medication administration pass. The nurse

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stated she realized she had not washed her hands after she came out of Resident #55 ' s room and walked to the med cart. However, Nurse #7 reported she did not have any hand sanitizer on the med cart and didn't want to call attention to it at that point.

An interview was conducted on 7/27/18 at 5:30 PM with the facility ' s Director of Nursing (DON) regarding the staff ' s failure to perform hand hygiene during the medication pass observation. The DON stated her expectation was, "She should have cleaned her hands between residents."