

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345174</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/02/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA PINES AT ASHEVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>91 VICTORIA ROAD</b> <b>ASHEVILLE, NC 28801</b>		
(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 554 SS=D	<p>Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)</p> <p>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, resident, and staff interviews the facility failed to assess the ability to safely self-administer medications for 1 of 1 resident reviewed for self-administering medications (Resident #291).</p> <p>Findings included:</p> <p>Resident #291 was admitted to the facility 10/24/18 with diagnoses which included hypertension and edema.</p> <p>The entry Minimum Data Set (MDS) was completed 10/24/18 and the admission assessment was incomplete and read as still in process.</p> <p>During an observation on 10/29/18 at 10:42 AM, a 16-ounce bottle approximately 1/3 full of 50 % isopropyl alcohol was sitting on the nightstand of a private room assigned to Resident #291.</p> <p>During an interview on 10/29/18 at 10:42 AM, Resident #291 explained the alcohol was in his possession when admitted to the facility. He explained the alcohol was used to keep his uncircumcised penis clean which also help prevent swelling and soreness. He also revealed a 0.33-ounce tube of triple antibiotic inside the nightstand drawer which was also used after the alcohol was applied. Resident #291 revealed he</p>	F 554	<p>The plan for correcting the specific deficiency:</p> <p>The alleged deficiency occurred when the interdisciplinary team (IDT) failed to assess that resident #291 could safely clean his penis with alcohol and apply triple antibiotic ointment after cleaning his penis with alcohol. The alleged deficiency also occurred when the facility failed to inventory personal belongings when resident #291 was admitted. The alcohol and triple antibiotic ointment was immediately removed upon notification.</p> <p>On November 8, 2018, resident #291 was assessed for self-administration of medications. During the assessment, the resident vocalized he didn't wish to provide his own treatments or self-administer medications.</p> <p>The licensed nursing staff and un-licensed nursing staff will be re-educated by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Social Services Director by November 30, 2018, about completing an inventory of resident's belongings upon admission and the process to follow when medication items are located at the bedside.</p> <p>The licensed nursing staff will be</p>	11/30/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/29/2018

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

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F 554	<p>Continued From page 1</p> <p>had been keeping the area clean by using the alcohol and ointment for more than 30 years.</p> <p>An observation on 10/30/18 at 8:27 AM, revealed the alcohol bottle remained on the nightstand at the resident's bedside.</p> <p>Review of Resident #291's physician orders revealed no order was in the chart for self-administering medications.</p> <p>Review of the facility policy and procedure revised 12/16 named self-administration of medications. Read in part: Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy interpretation and implementation:</p> <p>1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident.</p> <p>5. The staff and practitioner will document their findings and the choices of residents who are able to self-administer medications.</p> <p>8. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on medication cart or in the treatment cart. Nursing will transfer the unopened medication to the resident when the resident request them.</p> <p>11. The nursing staff will routinely check self-administering medications and will remove expired, discontinued, or recalled medications.</p> <p>13. The staff and practitioner will periodically reevaluate a resident's ability to continue to</p>	F 554	<p>re-educated by the Director of Nursing, Assistant Director of nursing, Staff Development Coordinator or Nurse Supervisor on the process of self-administration of medications for a resident by November 30, 2018.</p> <p>Procedure for implementing the plan: An updated inventory of resident belongings will be completed by November 30, 2018.</p> <p>The IDT will interview current residents and new admissions beginning on November 26, 2018, with a BIMS score of 8 or higher to determine if appropriate for self-administration of medications. Care plans will be updated to reflect self-administration and physician orders obtained for self-administration upon review of the IDT.</p> <p>The licensed nursing staff and un-licensed nursing staff will be in-serviced on completing an inventory of resident's belongings upon admission by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinator or Nurse Supervisor by November 30, 2018. No licensed or un-licensed nursing staff will be allowed to work until re-education has been completed. The re-education will be added to new hire orientation.</p> <p>The licensed nursing staff and un-licensed nursing staff will be re-educated by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinator or Nurse Supervisor on the</p>		

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F 554	<p>Continued From page 2</p> <p>self-administer medications.</p> <p>During an interview on 10/31/18 at 8:39 AM, Resident #291 revealed he moved the alcohol bottle to the nightstand drawer. The resident explained he had used the alcohol and ointment daily since being admitted.</p> <p>During an interview on 10/31/18 at 9:41 AM, Nurse Aide (NA) #5 confirmed there was a bottle of isopropyl alcohol in the Resident #291's room and she had not seen this until now. She explained whenever a resident was admitted an itemized record was kept in their chart detailing their personal items. She didn't think residents could have isopropyl alcohol. She revealed the NA or nurse working at the time the resident was admitted was responsible for checking and recording personal items. If she noticed a resident had something they weren't supposed to keep in their room or on their person she reported to the Social Services Director, the Assistant Director of Nursing, or whoever was in charge.</p> <p>During an interview on 10/31/18 at 9:57 AM, Nurse #6 explained a personal items list should be filed in Resident #291's chart but was unable to locate the list. Nurse #6 confirmed she would have the Nurse Practitioner (NP) review his medications and assess him for being capable of self-administering. If the NP felt the treatment was appropriate and Resident #291 was cognitively intact a physician's order would be obtained for the resident to self-administer. She also explained the nurse could provide the treatment if the resident allowed and if they had known he was using those items. She revealed finding a 3/4 full bottle of a wound cleansing solution and a 1 oz tube of 1 % hydrocortisone</p>	F 554	<p>process of self-administration of medications for a resident by November 30, 2018. No Licensed or un-licensed nursing staff will be allowed to work until re-education has been completed. This education will be added to new hire orientation.</p> <p>A letter was drafted to families and patients outlining the necessity for patients and families to notify the facility of medications that are brought into the facility.</p> <p>Patients and families during the admission process will be given a letter explaining the self-administration process.</p> <p>Monitoring plan:</p> <p>Weekly audits of new admissions will be completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinator, Nurse Supervisor or Social Services Director to determine if the inventory of resident belongings is completed for 12 weeks.</p> <p>Weekly interviews of 5 residents with a BIMS score of 8 or higher will be conducted by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinator, Nurse Supervisor or Social Services Director to determine resident's desire to self-administer medications for 12 weeks.</p> <p>Effective November 30, 2018, the Social Services Director and Director of Nursing will report findings of the audits and observations to the Quality Assurance and</p>		

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F 554	Continued From page 3 cream in the nightstand drawer. She labeled and removed all the items from the resident's room and explained she would keep them on the treatment cart. She revealed the belongings should have been reviewed by the NP and an inventory sheet filed of personal items and that wasn't done.  During an interview on 10/31/18 at 11:44, the Director of Nursing revealed it was her expectation an inventory of personal items was done when the resident was admitted, and he was evaluated by the Medical Doctor (MD) before allowed to and self-administer medications. She explained the nurse reviews the personal items list and she expected the alcohol, wound care product, and ointments would've been labeled and placed on the treatment cart. She expected the items were not stored in the resident's room until he was evaluated by the MD for safe use and wasn't aware of a resident at the facility who was able to self-administer medications.	F 554	Performance Committee for any additional monitoring or modifications of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains n compliance.  The charge nurse is responsible for the medication care and the assigned room for that cart and will be responsible to check each resident room daily to ensure no medications are at bedside for a period of 3 months.  The Director of Nursing, Assistant Director of Nursing, Unit Coordinator, Nurse Supervisor will do visualization of 10 resident rooms weekly for a period of 3 months for medications at the bedside.  Title of person responsible for implementing the plan: The Administrator and the Director of Nursing are responsible to ensure implementation of this plan,		
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 observations, record review, resident and staff interviews the facility failed to place a dependent resident ' s call light within reach to	F 558	The plan for correcting the specific deficiency:	11/30/18	

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F 558	<p>Continued From page 4</p> <p>allow the resident to request staff assistance when needed for 1 of 1 resident reviewed for accommodation of needs (Resident #76).</p> <p>The findings included:</p> <p>Resident #76 was admitted to the facility 10/19/99 with diagnoses including aphasia and abnormal posture among others. The significant change Minimum Data Set (MDS) dated for 10/01/18 indicated Resident #76 required extensive to total assistance for all Activities of Daily Living (ADL) care. The MDS further indicated Resident #76 was alert and oriented and also had physical impairments of both upper and lower extremities.</p> <p>An observation of Resident #76 on 10/29/18 at 4:59 PM revealed his call light (touch pad alarm) was laying on his bed out of reach as he was sitting in his wheelchair. When asked if he was able to reach and use his call light Resident #76 used his communication board and pointed to the word "no."</p> <p>An observation of Resident #76 on 10/30/18 at 4:21 PM revealed his call light was laying on his bed out of reach as he was sitting in his wheelchair in his room.</p> <p>An observation of Resident #76 on 10/30/18 at 5:03 PM revealed his call light was laying on his bed out of reach as he was sitting in his wheelchair in his room.</p> <p>An observation of Resident #76 on 10/31/18 at 4:40 PM revealed his call light was laying on his bed out of reach as he was sitting in his wheelchair in his room.</p>	F 558	<p>The alleged deficiency occurred when the facility staff did not place the call light for dependent resident #76 within reach when he was in his wheelchair. The call light was placed within reach immediately upon notification.</p> <p>The interdisciplinary team (IDT) re-assessed resident #76 ability to push his call light from his wheelchair.</p> <p>Therapy completed a screen on November 27, 2018, to determine if type of call light was appropriate based on ability to use.</p> <p>Care plan was updated to reflect changes.</p> <p>By November 30, 2018, current staff to include licensed and un-licensed nursing staff, housekeeping, dietary and activities will be re-educated by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Nurse Supervisor on placing call lights within reach of resident #76.</p> <p>The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Nurse Supervisor will audit #76 daily for 4 weeks when up in wheelchair to ensure call light is within reach.</p> <p>Procedure for implementing the plan:</p> <p>By November 30, 2018, current staff to include licensed and un-licensed nursing staff, housekeeping, dietary and activities will be re-educated by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Nurse Supervisor on placing call lights within</p>		

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F 558	<p>Continued From page 5</p> <p>During an interview with Nurse #1 on 11/01/18 at 11:20 AM it was revealed that Resident #76 was unable to use his right arm or hand but was able to use two fingers on his left hand to use his call light.</p> <p>An observation of Resident #76 on 11/01/18 at 11:27 AM revealed his touch pad alarm was laying on his bed out of reach as he was sitting in his wheelchair in his room.</p> <p>During an interview with Nursing Assistant (NA) #1 on 11/01/18 at 12:04 PM, NA #1 stated Resident #76 had very limited movement but used a communication board to make his needs known. NA #1 also stated Resident #76 used his call light when he needed assistance from staff. NA #1 and the surveyor went to the room of Resident #76 where the call light continued to be out of reach and laying on top of his bed. NA #1 stated she had been in the room around 11:00 AM and had not noticed the call light was out of reach. NA #1 further stated the NA that assisted Resident #76 with breakfast may have moved his call light out of his reach.</p> <p>During an interview with Nurse #2 on 11/01/18 at 12:29 PM, Nurse #2 stated that call light should be in reach of the resident at all times unless they were in the hallway. Nurse #2 also stated the call light should be in a place where the resident could access it from the bed or from the wheelchair.</p> <p>During an interview with NA #2 on 11/01/18 at 12:34 PM, NA #2 stated she had given assistance to Resident #2 for breakfast and had knocked his call light off the bed about 3 times so she had picked it up and placed it at the foot of the bed.</p>	F 558	<p>reach for dependent residents. Current staff will not be able to work until re-educated and this education has been added to the new hire orientation.</p> <p>Daily round sheets were developed to be utilized by department managers. Department Managers are assigned residents to monitor daily and ensure the call lights are within reach at all times.</p> <p>Monitoring the plan:</p> <p>Daily audits of 10 dependent residents will be conducted daily for 2 weeks, 3 x a week for 2 weeks and weekly for 8 weeks to ensure call lights are within reach. These audits will be completed b the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Nurse Supervisor or Department Manager.</p> <p>Weekly interview of 5 dependent residents with BIMS score of 8 or higher will be completed by the IDT to ensure call lights are within reach. These interviews will be performed by the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Department Manager.</p> <p>Effective November 30, 2018, the Director of Nursing will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Committee can modify this plan to ensure the facility remains in compliance.</p>		

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F 558	Continued From page 6 NA #2 stated she did not place it in reach for Resident #76 when she left the room because she forgot to.  During an interview with the Director of Nursing (DON) on 11/01/18 at 12:41PM, the DON stated her expectations were for the call light to always be within reach of a resident when they are in their room in bed or up in the wheelchair.	F 558	Title of person responsible for implementing the plan:  The Administrator and Director of Nursing are responsible for the implementation of this plan.		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.	F 578		11/30/18	

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F 578	<p>Continued From page 7</p> <p>(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.</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews the facility failed to provide staff with accurate records identifying code status for 2 of 22 residents reviewed for advance directives (Resident # 291 and Resident #292).</p> <p>Findings included:</p> <p>1.Resident #291 was admitted to the facility 10/24/18 with diagnoses which included hypertension and edema.</p> <p>The entry Minimum Data Set (MDS) dated 10/24/18 was reviewed and revealed no completed cognitive assessment for Resident #291. An admission assessment was still in process.</p> <p>Review of the computer and physical chart on 10/30/18 at 10:57 AM revealed there was no code status accessible for staff to honor Resident #291's advanced directive.</p> <p>During an interview on 10/30/18 at 5:35 PM, the</p>	F 578	<p>The plan for correcting the specific deficiency:</p> <p>The alleged deficiency occurred when the facility failed to properly identify and communicate the code status for resident #291 and #292.</p> <p>The Nurse Practitioner met with resident #291 and #292 to confirm wishes for advanced directives and code status on October 31, 2018, for #292 and #291 on November 8, 2018, upon return from hospital.</p> <p>Resident #291 and #292 advanced directive based on interview, physician and family have been updated to reflect status.</p> <p>Care plan has been updated to reflect current advance directive status.</p> <p>Community Liaison, Social Services Director, Director of Nursing and Assistant Director of Nursing were re-educated on November 1, 2018, by the Regional Director of Clinical Services on the</p>		



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F 578	<p>Continued From page 8</p> <p>Community Liaison explained the advance directive should be completed and in the resident's chart the day of admission to address code status. She reviewed Resident #291's admission packet which contained a full code agreement signed by the resident dated 10/25/18. She didn't know why it wasn't updated in the chart and explained the Social Services Director was the person in charge of scanning the record into the computer chart.</p> <p>During an interview on 10/30/18 at 5:43 PM, the Social Services Director confirmed she was in charge of updating the code status in residents' chart. She confirmed the code status was not available in Resident #291's chart for staff to review during an emergency. She explained it should have been updated in the resident's physical and/or computer chart and confirmed an code status agreement was signed by the resident on 10/25/18.</p> <p>Review of the physician orders revealed on 10/30/18 an order for Full Code status was written.</p> <p>The care plan was updated on 10/30/18 and read in part: resident and/or resident's family have chosen a full code status. The goal was for Resident #291's wishes regarding Advanced Directive would be honored through next review. The interventions in place for staff read as: in the event of cardiac arrest, instruct a staff member to call 911 and immediately initiate Cardiopulmonary Resuscitation (CPR). The medical record contains a physician's order to support code status, medical record contains state specific advanced directive forms and/or appropriate legal forms.</p>	F 578	<p>process of obtaining an advance directive and communicating that advance directive to everyone and placing it in the medical record.</p> <p>By November 30, 2018, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Social Services Director will re-educate current licensed nursing staff and medical records on the advance directive process.</p> <p>Procedure for implementing the plan:</p> <p>Advance Directive validation audit of current residents will be completed by interdisciplinary team by November 30, 2018.</p> <p>By November 30, 2018, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Social Services Director will re-educate current licensed nursing staff on the advance directive process. Current licensed nursing staff will not be allowed to work until re-educated and this education has been added to the new hire orientation.</p> <p>New admissions and readmissions will have their advanced directive reviewed with the family or resident as appropriate by the Admission Director, Community Liaison, Social Services Director and the Director of Nursing. The completed advance directive will be given to the Social Services Director and the Director of Nursing or the Assistant Director of Nursing. The Social Services Director will place the advance directive paperwork in the doctor's box for signature. The Director of Nursing will communicate to</p>		

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F 578	<p>Continued From page 9</p> <p>During an interview on 10/31/18 at 11:44 AM, the Director of Nursing revealed it was her expectation the code status would be determined at admission if possible and a physician's order placed in the physical/computer chart available for staff to access during an emergency. She indicated the advanced directive had been placed in Resident #291's chart along with a physician's order for staff to access during an emergency to correct the problem.</p> <p>2. Resident #292 was admitted to the facility on 09/11/18 with a re-entry on 10/19/18. Diagnoses for Resident #292 included diabetes among others.</p> <p>The 5 day Medicare Admission Minimum Data Set (MDS) dated 10/26/18 revealed Resident #292 was alert and oriented with no cognitive impairment.</p> <p>Record review of the hard chart and computer revealed no code status was accessible for the staff to honor the advance directives for Resident #292.</p> <p>During an interview on 10/30/18 at 5:35 PM, the Community Liaison explained the advance directives should be completed and in the resident's chart the day of admission to address code status. The Community Liaison also revealed the Social Services Director (SSD) was in charge of scanning the record into the computer chart.</p> <p>During an interview on 10/30/18 at 5:56 PM, Nurse #1 stated if there was no paperwork in the chart or on the computer a resident would be</p>	F 578	<p>the physician the request on the advance directive and an order will be obtained and placed in the medical record.</p> <p>The Social Services Director or Minimum Data Nurse will update the care plans to reflect current advance directives decisions.</p> <p>The interdisciplinary team will discuss and verify the status of the advance directive during each resident and family meeting.</p> <p>Monitoring the plan:</p> <p>The Director of Nursing or Assistant Director of Nursing will review 5 new/readmissions weekly for 4 weeks and monthly for 2 months to validate the advance directive is in place and it reflects the correct information.</p> <p>New admissions and re-admissions will be reviewed daily by the Director of Nursing, Assistant Director of Nursing or Nurse Supervisor to validate the completion of the advance directive and communication of the advance directive to the Interdisciplinary team.</p> <p>Effective November 30, 2018, the Social Services Director or the Director of Nursing will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance.</p>		

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F 578	<p>Continued From page 10</p> <p>considered a full code. Nurse #1 verified in the computer Resident #292 had no code status listed.</p> <p>During an interview on 10/30/18 at 6:04 PM, the SSD explained that Resident #292 had admission paperwork from 09/11/18 and he wanted to be listed as "Do Not Resuscitate." The SSD also stated he came in on 09/11/18 and left against medical advice on 09/16/18 and was readmitted from the hospital back to the facility on 10/19/18. The SSD retrieved his previous chart from his admission on 09/11/18 and it revealed a DNR form dated for 07/11/18. The SSD stated this was an oversight and it should have been dated 09/11/18. The SSD further stated she was responsible for putting the DNR forms on the FNP/MD board in the office at the facility was she was unsure who was responsible for getting that information on the chart.</p> <p>Review of physician's orders verified a "DNR" code had been signed and dated by the Family Nurse Practitioner (FNP) on 9/12/18.</p> <p>During an interview on 10/31/18 at 11:44 AM, the Director of Nursing (DON) stated her expectations were for the code status to be determined upon admission and a physician's order placed in the physical/computer chart available for staff to access during an emergency.</p> <p>During an interview on 11/01/18 at 10:02 AM, Resident #292 stated a family member filled out his paperwork upon admission and he did not remember anyone asking him about being a full code or a DNR. Resident #292 also stated if he signed paperwork about his code status he could not remember doing so. Resident #292 further</p>	F 578	<p>Title of the person responsible for implementing this plan:</p> <p>The Social Services Director and the Director of Nursing are responsible for implementing this plan.</p>		

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F 578	Continued From page 11 stated if staff came in and found him not breathing, he wanted everything done for him that could possibly be done to bring him back because he "wasn't ready to go yet."	F 578			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)  §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		11/30/18	

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F 580	<p>Continued From page 12</p> <p>State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff and physician interviews, the facility failed to notify the physician when a resident's scheduled dialysis treatment conflicted with administering medications resulting in 7 missed doses of a phosphate binder and 4 missed doses of an anticoagulant (blood thinner) for 1 of 1 resident reviewed for dialysis (Resident #241).</p> <p>Findings included:</p> <p>Resident #241 admitted to the facility on 10/24/18 with multiple diagnoses that included end-stage renal disease, dependence on renal dialysis (process used to cleanse the blood of impurities), hemiplegia, and diabetes.</p> <p>Review of the entry Minimum Data Set dated</p>	F 580	<p>The plan for correcting the specific deficiency:</p> <p>The alleged deficiency occurred when the licensed nurse failed to notify the physician regarding resident #241 missing medications due to dialysis. Physician was notified immediately when the facility became aware.</p> <p>Resident #241 discharged home from the facility on November 14, 2018.</p> <p>By November 30, 2018, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or the Nurse Supervisor will re-educate the current licensed nurses on the protocol to notify the physician when medications are not administered according to the times ordered, ie missed medications.</p> <p>Procedure for implementing the plan:</p>		

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F 580	<p>Continued From page 13</p> <p>10/24/18 revealed Resident #241 was admitted to the facility following an inpatient rehabilitation stay at another facility.</p> <p>During an interview on 10/31/18 at 5:45 PM, Resident #241 voiced concerns that she did not receive her "binder" medications when she returned from dialysis on 10/30/18. Resident #241 was unable to recall the exact time she returned to the facility.</p> <p>Review of Resident #241's Medication Administration Record (MAR) for October 2018 revealed the following physician orders: 10/24/18: Heparin Sodium Solution (medication used to prevent the formation of blood clots) 5000 unit/milliliter (ml) - inject 5000 units subcutaneously three times a day at 8:00 AM, 1:00 PM and 8:00 PM for clotting prevention related to chronic embolism and thrombosis (blood clots in the veins). It was noted on the MAR that Resident #241 did not receive the scheduled 1:00 PM doses on 10/25/18, 10/27/18 and 10/30/18. 10/25/18 and discontinued on 10/25/18: Renagel (medication that binds phosphates in the stomach and prevents them from being absorbed into the body) 800 milligrams (mg) - give 3 tablets by mouth three times a day with food at 8:00 AM, 12:00 PM and 5:00 PM related to end-stage renal disease. It was noted on the MAR that Resident #241 did not receive the scheduled 12:00 PM dose on 10/25/18. 10/25/18: Renvela (medication that binds phosphates in the stomach and prevents them from being absorbed into the body) 800 milligrams (mg) - give 3 tablets three times a day</p>	F 580	<p>By November 30, 2018, the Director of Nursing, the Assistant Director of Nursing, Staff Development Coordinator or the Nurse Supervisor will re-educate the current licensed nurses on the protocol to notify the physician when medications are not administered according to the times ordered, ie missed medications. Current licensed nursing staff will not be allowed to work until re-educated and this education has been added to the new hire orientation.</p> <p>The Director of Nursing, Assistant Director of Nursing, Unit Coordinator or Nurse Supervisor will audit daily for 4 weeks then weekly for 8 weeks missed medication report in Point Click Care and follow up on any missed doses of medication.</p> <p>Monthly the Director of Nursing, Assistant Director of Nursing, Unit Coordinator or Nurse Supervisor will audit daily for 4 weeks then weekly for 8 weeks missed medication report in Point Click Care and follow up on any missed doses of medication.</p> <p>Monthly the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Nurse Supervisor will observe nurses conducting medication administration. They will observe for compliance when a medication is not administered to the resident to determine if the physician is notified.</p> <p>Audit of current residents receiving dialysis to ensure that medication times have been adjusted to accommodate</p>		

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F 580	<p>Continued From page 14</p> <p>with meals at 8:00 AM, 12:00 PM and 5:00 PM related to end-stage renal disease. It was noted on the MAR that Resident #241 did not receive the scheduled 12:00 PM doses on 10/27/18 and 10/30/18 or the scheduled 5:00 PM doses on 10/25/18 and 10/30/18.</p> <p>10/26/18: Renvela 800 mg - give 2 tablets two times a day with snacks at 10:00 AM and 1:00 PM related to end-stage renal disease. It was noted on the MAR that Resident #241 did not receive the scheduled 1:00 PM doses on 10/27/18 or 10/30/18.</p> <p>Review of Resident #241's MAR for November 2018 revealed the following physician orders:</p> <p>10/24/18: Heparin Sodium Solution 5000 unit/ml - inject 5000 units subcutaneously three times a day at 8:00 AM, 1:00 PM and 8:00 PM for clotting prevention related to chronic embolism and thrombosis. It was noted on the MAR that Resident #241 did not receive the scheduled 1:00 PM dose on 11/01/18.</p> <p>10/25/18: Renvela mg -give 3 tablets three times a day with meals at 8:00 AM, 12:00 PM and 5:00 PM related to end-stage renal disease. It was noted on the MAR that Resident #241 did not receive the scheduled 12:00 PM dose on 11/01/18.</p> <p>10/26/18: Renvela 800 mg - give 2 tablets two times a day with snacks at 10:00 AM and 1:00 PM related to end-stage renal disease. It was noted on the MAR that Resident #241 did not receive the scheduled 1:00 PM dose on /18.</p> <p>During an interview on 11/01/18 at 5:40 PM Nurse #7 stated Resident #241 went to dialysis 3 days a week on Tuesday, Thursday and Saturday. Nurse #7 explained Resident #241 did not receive her afternoon scheduled doses of</p>	F 580	<p>when out of the facility for dialysis will be completed by November 30, 2018.</p> <p>Monitoring the plan:</p> <p>The Director of Nursing will audit dialysis residents weekly for 12 weeks to ensure medications are administered as ordered and if not, that physician is notified.</p> <p>Unit Coordinator or Nurse Supervisor will interview each dialysis resident weekly for 12 weeks No ensure each one is receiving their prescribed medications.</p> <p>Effective November 30, 2018, the Director of Nursing will report the findings of the audits and reviews to the Quality Assurance and Performance committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Committee can modify this plan to ensure the facility remains in compliance.</p> <p>The person responsible for implementing the plan:</p> <p>The Director of Nursing is responsible for implementing this plan.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 580	<p>Continued From page 15</p> <p>Heparin and Renvela on the days she was at dialysis and they would document on the MAR she was out of the facility during administration time. She added the physician was aware that Resident #241 missed the afternoon doses of medication on dialysis days and she had not yet discussed with him the possibility of adjusting the administration times so she would not miss her scheduled doses. Nurse #7 confirmed Resident #241 did not receive her evening doses of Renvela or Heparin upon her return to the facility on 10/30/18. Nurse #7 explained she was not working that evening and was unsure why the doses were not administered.</p> <p>During an interview on 11/02/18 at 10:00 AM the Medical Director (MD) stated he was not aware Resident #241 did not receive her scheduled doses of Renvela or Heparin on the days she attended dialysis. He stated he did not feel that Resident #241's missed doses of Renvela and Heparin were significant or life-threatening and explained Heparin was used to flush the port during the process of dialysis treatments. The MD added he would expect for nursing staff to notify him when doses of any type of medication were missed in order to give him the opportunity to make an adjustment.</p> <p>During an interview on 11/02/18 at 11:12 AM the Director of Nursing (DON) revealed she was unaware that Resident #214 missed her scheduled doses of Renvela and Heparin on the days she attended dialysis. The DON stated it was her expectation for nursing staff to notify the MD or Family Nurse Practitioner when medications were missed so they could review</p>	F 580			



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F 580	Continued From page 16 and make adjustments to the administration times.	F 580			
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1)  §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility neglected to provide incontinence care for 1 of 4 dependent resident reviewed for activities of daily of living (Resident #18).  Findings included:  Resident #18 was admitted to the facility 12/13/04 with diagnoses which included Cerebral palsy and Non-Alzheimer's Dementia.  Review of the quarterly Minimum Data Set (MDS) dated 10/11/18 assessed cognitive patterns and identified inattention behaviors were continuously present with disorganized thinking. Rejection of	F 600		11/30/18	
			The plan for correcting the specific deficiency:  The alleged deficiency occurred when the facility staff failed to ensure incontinence care was given to resident #18 timely. Resident #18 was provided incontinent care immediately upon notification of findings. Licensed and un-licensed nursing staff, dietary staff, activity staff, housekeeping staff, therapy staff and social services staff will be re-educated by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Nurse Supervisor by November 30, 2018, on the		

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F 600	<p>Continued From page 17</p> <p>care was not identified. The MDS assessment included activities of daily and described extensive assistance was needed with transfers, toileting, and always being incontinent of bladder and bowel. Range of motion identified impairment on both upper and lower extremities.</p> <p>Review of the care plan last revised on 10/18/18 identified there was a risk for complications related to incontinence. The goal was for complications related to incontinence were avoided or minimized daily through the next review date. Interventions in place included provide incontinence care on routine rounds and as needed.</p> <p>During an observation made on 10/29/18 at 12:40 PM, Resident #18 was seated in a wheel chair at a table in the assisted dining room. Resident #18 was wearing gray pants with a darker color of gray at the groin area which appeared wet with a strong odor resembling urine. Resident #18 was propelled by a staff member out of the dining room to a shared room.</p> <p>During observations on 10/29/18 at 12:52 PM, Resident #18 continued wearing gray pants which were a darker color at the groin area and appeared to be wet with a strong odor resembling urine. On 10/29/18 at 12:55 PM Resident #18 self-propelled out of the shared room into the hallway. On 10/29/18 at 12:57 PM, the Social Service Director (SSD) pushed Resident #18 back to the shared room. The SSD was noted to speak to Nurse #3 and Nurse Aide (NA) #4. Nurse #3 remained at the medication cart and the NA #4 continued to pick up dirty trays from resident rooms on the hallway where Resident #18 was located. On 10/29/18 at 1:32 PM,</p>	F 600	<p>protocol regarding incontinence care. This education will also include that all staff are responsible to alert the nursing staff if incontinence care needs to be provided as evidenced by visual observations or olfactory signs and to follow up.</p> <p>The Administrator, Director of Nursing or Social Services Director will visually observe and interview resident #18 daily for 5 days, then 3 x week for 3 weeks and weekly for 8 weeks to ensure incontinence care is performed timely.</p> <p>Procedure for implementing the plan:</p> <p>Licensed and un-licensed nursing staff, dietary staff, activity staff, housekeeping staff, rehabilitation staff and social services staff will be re-educated by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Nurse Supervisor on the protocol regarding incontinence care by November 30, 2018. This education will also include that all staff are responsible to alert the nursing staff if incontinence care needs to be provided as evidenced by visual observations or olfactory signs and to follow up. Current staff will not be allowed to work until re-education is complete and this education has been added to the new hire orientation.</p> <p>The Director of Nursing, Assistant Director of Nursing, Unit Coordinator, Nurse Supervisor, Facility Consultant and or Minimum Data Set Nurse will visually audit and interview 20 residents weekly for 4 weeks, then 10 residents per week x</p>		

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F 600	<p>Continued From page 18</p> <p>Resident #18 remained dressed in gray pants with a darker color at the groin area with a strong odor resembling urine. On 10/29/18 at 1:50 PM, Resident #18 again self-propelled out of the room. On 10/29/18 at 2:00 PM, Nurse #3 administered Resident #18 medication while seated in the wheelchair at the entrance door of the shared room. On 10/29/18 at 2:20 PM, the Activity Director pushed Resident #18 to the shared room. On 10/29/18 at 2:35 PM, NA #3 entered Resident #18's shared room. She was holding 2 clear plastic bags; 1 bag with a heavy saturated incontinence product and the second bag with a pair of gray pants. There was a strong odor resembling urine in the room.</p> <p>During an interview on 10/29/18 at 2:35 PM, NA #3 confirmed Resident #18 had an incontinence episode of bladder and bowel and she had just provided care for the first time since her break while doing her rounds. She confirmed urine had soaked through the incontinence product to the gray pants and the pants had a strong odor resembling urine. She explained being responsible for Resident #18's care and most days she would lay the resident in bed after lunch and provide incontinence care if needed but today took her break first. She explained there were other NA's and the nurse available on the hallway to provide care while she was on break.</p> <p>During an interview on 10/29/18 at 2:48 PM, the SSD explained she told NA #4 Resident #18 was wet and needed incontinence care. NA #4 told her she would take care of it and confirmed it was approximately 1:00 PM when she spoke with NA #4. The SSD revealed NA #4 was the only person she told Resident #18 appeared to be wet and needed incontinence care.</p>	F 600	<p>8 weeks to ensure resident is clean and dry.</p> <p>Monitoring the plan:</p> <p>The Administrator, Director of Nursing or Social Services Director will visually audit and interview 5 residents weekly for 12 weeks to ensure the resident is clean and dry.</p> <p>Effective November 30, 2018, the Director of Nursing will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance.</p> <p>Title of the person responsible for implementing the plan:</p> <p>The Director of Nursing is responsible for implementing the plan.</p>		

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F 600	<p>Continued From page 19</p> <p>During an interview on 10/29/18 at 2:59 PM, NA #4 explained after the SSD reported Resident #18 appeared wet and needed incontinence care, she reported that to Nurse #3 then continued collecting dirty trays on the hallway. She revealed after all the trays were collected she went on break. While on her break she told NA #3 who was also on break, Resident #18 needed incontinence care. She confirmed after being informed by the SSD she continued collecting dirty trays, went on break, and did not check to ensure Resident #18 had been provided incontinence care.</p> <p>During an interview on 10/29/18 at 4:30 PM, Nurse #3 confirmed being responsible for Resident #18's care. She overheard the SSD tell an NA Resident #18 needed assistance but couldn't recall which NA was told. She didn't note an odor resembling urine or identify a wet area on the gray pants when administering the resident's medication and thought the NA had provided incontinence care. Nurse #3 explained she monitors resident care was provided by visually checking residents and would expect NA's would ask for help when needed. She denied NA #4 informed her Resident #18 needed incontinence care.</p> <p>During an interview on 10/31/18 at 10:56, the Activities Director explained she didn't visually note or smell incontinence when she assisted Resident #18 to the shared room.</p> <p>During an interview on 10/31/18 at 11:24 AM, the Director of Nursing (DON) revealed it was her expectations when staff were informed a resident needed incontinence care it was provided timely</p>	F 600			

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F 600	Continued From page 20 and if staff were busy to ask for assistance. She expected incontinence care was provided before staff went on break or before picking up dirty trays from resident rooms.  During an interview on 11/02/18 at 3:32 PM, the DON revealed her expectations were for staff to provide incontinence care before going on break. She revealed the staff she had spoken to had not identified Resident #18 was visibly wet with a strong odor resembling urine. She felt there was no neglect by staff related to providing Resident #18 incontinence care as needed.  During an interview on 11/02/18 at 5:01 PM, the Administrator explained the staff she had spoken to had not identify the resident's gray pants appeared wet in the groin area or note a strong odor resembling urine. She agreed if staff were aware a resident needed incontinence care it should be provided in a timely manner which she described as being subjective. She didn't feel staff neglected Resident #18.	F 600			
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)  §483.12(b) The facility must develop and implement written policies and procedures that:  §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,  §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and  §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		11/30/18	

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F 607	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their abuse policy and procedures by not reporting a resident's allegation of sexual abuse to the administrator and State Survey Agency within two hours of the allegation being made for 1 of 1 resident (Resident #73) reviewed for abuse.</p> <p>Findings included:</p> <p>A review of the facility policy and procedure titled "Abuse Investigating and Reporting", with a revised date of December 2016, read in part: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.</p> <p>Reporting: 2). Suspected abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported within two hours. 3). Alleged abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported within two hours if the alleged events have resulted in serious bodily injury; or if the events that cause the allegation do not involve abuse or not resulted in serious bodily injury, the report must be made within twenty-four hours.</p> <p>Resident #73 was admitted to the facility on</p>	F 607	<p>The plan for correcting the specific deficiency:</p> <p>The initial allegation report was submitted for resident #73 on October 23, 2018. Resident #73 no longer resides in the facility.</p> <p>Procedure for implementing the plan:</p> <p>The regional nurse consultant re-educated the Administrator and the Director of Nursing on the facility policy regarding reporting allegations and the time frame required on November 2, 2018. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Administrator will re-educate current licensed and un-licensed nursing staff, housekeeping staff, dietary staff, rehabilitation staff, activity staff and leadership staff on facility policy regarding reporting allegations and the time frame required by November 30, 2018. No current employee will be allowed to work until re-education and this education has been added to the new hire orientation. A review by the facility administrator and regional nurse consultant was conducted on November 2, 2018 of the previous 30 days of initial allegation reports. No other initial allegation reports were found to be out of compliance with reporting requirement.</p>		

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F 607	<p>Continued From page 22</p> <p>06/12/18 with diagnoses that included Parkinson's disease, blindness in left eye and major depression.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated 10/01/18 indicated Resident #73 was cognitively intact and required extensive to total staff assistance with all Activities of Daily Living (ADL). The MDS revealed Resident #73 rejected care 1 to 3 days during the 7-day assessment period but did not display any delusions, hallucinations or other types of behavior.</p> <p>Review of the Initial Allegation Report (IAR) completed by the Administrator on 10/23/18 listed the type of allegation as "Resident Abuse" and revealed Resident #73 alleged she was repeatedly assaulted by a white male wearing scrubs 10/19/18 through 10/21/18. It was noted on the IAR that the resident did not report the alleged incident until 10/20/18 when she was seen by the Psychiatrist for a routine visit. Further review revealed the IAR was submitted to the State Agency on 10/23/18 at 8:44 PM.</p> <p>Review of the facility's investigation revealed the facility was notified of the allegation of abuse by the Ombudsman on 10/23/18. The documentation of the investigation included: A signed statement by Nurse #1 dated 10/23/18 which read in part, "Psychiatrist talked to me last Saturday (10/20/18) and stated Resident #73 told her she was raped. Psychiatrist said that Resident #73 had Post Traumatic Stress Disorder (PTSD). Resident #73 only talked to the Psychiatrist about this, never mentioned anything</p>	F 607	<p>A log will be maintained by the Administrator that documents all notifications to the State Survey Agency, including resident name, fax cover sheet, confirmation page, allegation, date, time of discovery and time of notification. Log will be placed in binder maintained by the Administrator.</p> <p>The log maintained by the Administrator will be reviewed by the regional nurse upon visits to ensure timely reporting.</p> <p>Monitoring the plan:</p> <p>The Regional Nurse Consultant will audit all initial reporting allegations weekly for 4 weeks and monthly for 2 months ensure timely reporting.</p> <p>Effective November 30, 2018, the Administrator will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance.</p> <p>Title of person responsible for implementing the plan:</p> <p>The Administrator is responsible for implementing this plan.</p>		

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F 607	<p>Continued From page 23</p> <p>to me last Saturday or Sunday when I was her nurse."</p> <p>Interviews with staff and alert and oriented residents. It was noted no residents or staff reported seeing any strange males in the facility or going into Resident #73's room during the timeframe of the alleged incident.</p> <p>A facility timeline dated 10/23/18 indicated the Ombudsman was in the facility at approximately 3:30 PM following a call from Resident #73 who alleged she was raped over the weekend by a male that smelled like smoke. It was noted the police were notified of the allegation by the facility at approximately 4:10 PM and arrived at the facility to speak to Resident #73 at approximately 4:35 PM and Resident #73 was sent to the hospital for evaluation at approximately 5:20 PM.</p> <p>Resident #73 was not in the facility at the time of the investigation and was unable to be interviewed.</p> <p>During interviews on 10/30/18 at 5:07 PM and 5:35 PM, Nurse #1 confirmed she provided care to Resident #73 on 10/19/2018, 10/20/18 and 10/21/18. Nurse #1 stated Resident #73 never mentioned anything to her and was "shocked" when the Psychiatrist told her on 10/20/18 that Resident #73 disclosed she had been raped. Nurse #1 added she did not report the incident to Administration at the time because the Psychiatrist indicated Resident #73 had "Parkinson's hallucinations", suffered from PTSD and thought she was having a "flashback" from childhood trauma. Nurse #1 stated Resident #73 displayed no signs or symptoms of trauma, distress or abnormal behavior when she provided care to her during the time of the alleged incident.</p>	F 607			



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F 607	Continued From page 24  The Psychiatrist who treated Resident #73 was no longer employed and unable to be interviewed.  During an interview on 11/02/18 at 8:49 AM the Administrator stated she was aware of the regulatory time frame for reporting abuse allegations and explained she was notified of Resident #73's allegation of rape by the Ombudsman on 10/23/18 at approximately 4:00 PM. She stated Nurse #1 did not report the allegation on 10/20/18 to Administration due to the Psychiatrist stating Resident #73 was hallucinating. She acknowledged the IAR was not submitted to the State Agency until 8:44 PM on 10/23/18 and explained they did not get it submitted on time due to focusing on the investigation.	F 607			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments for antipsychotic medication for 2 of 30 sample residents (Resident #3 and Resident #73) reviewed for MDS accuracy.  Findings included:  1. Resident #3 was admitted to the facility on	F 641	The plan for correcting the specific deficiency:  The deficiency occurred because the facility failed to accurately code the MDS for resident #3 and #73. Minimum Data Set Nurse modified the assessment for resident #3 and #73 to reflect the correct coding on November 1, 2018 (#3) and November 2, 2018 (#73).	11/30/18	

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F 641	<p>Continued From page 25</p> <p>12/01/17 with multiple diagnoses including dementia, Parkinson disease, psychotic disorder, and chronic pain.</p> <p>A review of the physician order dated 12/01/17 revealed the physician had ordered to start Resident #3 on Clozapine 50 milligram (mg) three tablets daily at bedtime for thought disorder.</p> <p>A review of the electronic medication administration record (eMAR) for July 2018 indicated that Resident #3 had been receiving Clozapine 50 mg, 3 tablets by mouth once daily at bedtime for thought disorder from 07/01/18 through 07/30/18.</p> <p>A review of Resident #3's quarterly MDS assessment dated 07/09/18 indicated the "Antipsychotic Medication Review" at N0450 under Section N had been coded as "Antipsychotic were not received". On the other hand, under the "Medication Received" at N0410 in Section N coded Resident #3 had received antipsychotic for 7 days during the 7-day look back period.</p> <p>On 11/01/18 at 11:59 AM an interview was conducted with MDS Nurse #1 who acknowledged that she was not the one who responsible for the completion of section N for the MDS dated 07/09/18. She stated if the MDS Nurse checked section N0410 as 7 days, then section N0450 should checked "Yes" to "Antipsychotics were received on a routine basis only" to be consistent with the coding at N0410 part A.</p> <p>On 11/01/18 at 12:15 PM an interview was conducted with MDS Nurse #2 who</p>	F 641	<p>The procedure for implementing the plan:</p> <p>Section N of the MDS, for all current residents, for census date November 23, 2018, will be audited for accuracy by the Regional Minimum Data Set (MDS) Nurse Consultant or Regional Nurse Consultant. Opportunities corrected by the MDS Coordinators.</p> <p>MDS staff will be re-educated by the Regional MDS Consultant by November 30, 2018, regarding the importance of accurately coding the MDS, specifically, medications.</p> <p>Regional MDS Consultant will audit section N by comparing the Medication Administration Record (MAR) during the Assessment Reference Date (ARD) with the coding information under section N of 5 Minimum Data Sets per week x 12 weeks to ensure accuracy.</p> <p>Monitoring the plan:</p> <p>Effective November 30, 2018, the Minimum Data Set (MDS) Nurse will report the findings of the audits and reviews to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remain in compliance.</p> <p>Title of person responsible for implementing the plan:</p>		

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F 641	<p>Continued From page 26</p> <p>acknowledged that she was the MDS nurse who responsible for the completion of Section N for the MDS dated 07/09/18. She stated the entry at section N0450 was an error. She should have checked "Yes" instead of "No" under section N0450. MDS Nurse #2 stated she would correct the error and resubmit the correction as soon as possible. She attributed the incident as an isolated human error.</p> <p>On 11/01/18 at 04:22 PM an interview was conducted with the Director of Nursing (DON) who stated that the incident was an isolated error due to carelessness. She expected the MDS nurse to correct the error and resubmit the correction as soon as possible. It was her expectation for all the MDS nurses to assess all the residents accurately and in a timely manner.</p> <p>On 11/02/18 at 05:26 PM an interview was conducted with the Administrator who stated that the incorrect MDS coding was a human error. It was her expectation for all the MDS to be coded accurately with consistency to avoid confusion of users.</p> <p>2. Resident # 73 admitted to the facility on 06/12/18 with diagnoses that included Parkinson's disease and major depression.</p> <p>Review of Resident #73's medical record revealed a physician's order dated 09/24/18 which read in part, "Nuplazid (antipsychotic medication used to treat hallucinations and delusions associated with Parkinson's disease) 17 milligrams (mg) - give 2 tablets by mouth one time a day for Parkinson's/hallucinations."</p>	F 641	The Minimum Data Set Nurse and the Administrator are responsible for implementing the plan.		

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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 641	Continued From page 27  Review of the quarterly Minimum Data Set (MDS) dated 10/01/18 indicated Resident #73 received no antipsychotic, antidepressant or hypnotic medications during the 7-day assessment period.  During an interview on 11/02/18 at 3:30 PM MDS Nurse #2 acknowledged she was the one responsible for coding section N of the MDS for Resident #73's assessment dated 10/01/18. MDS Nurse #2 confirmed Resident # 73 had a physician's order for Nuplazid and explained she did not realize that it was an antipsychotic medication. MDS Nurse #2 stated it was an error and a corrected MDS would be submitted to accurately reflect Resident #73 received antipsychotic medication 4 days during the 7-day assessment period.  During an interview on 11/02/18 at 3:33 PM the Director of Nursing stated it was her expectation for MDS assessments to be accurately coded.	F 641			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		11/30/18	

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F 656	<p>Continued From page 28</p> <p>describe the following -</p> <p>(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</p> <p>(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).</p> <p>(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.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observations, resident, and staff interviews the facility failed to implement care plan interventions by not providing incontinence care as needed and failed to develop a dental care plan for identified broken teeth for 2 of 4 dependent resident reviewed for activities of daily of living (Resident #18, Resident</p>	F 656	<p>Plan for correcting the specific deficiency:</p> <p>The alleged noncompliance occurred when the licensed and un-licensed nursing staff failed to implement care plan interventions for incontinence care for resident #18 and when the Minimum data</p>		

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F 656	<p>Continued From page 29 #79).</p> <p>Findings included:</p> <p>1. Resident #18 was admitted to the facility 12/13/04 with diagnoses which included Cerebral palsy and Non-Alzheimer's Dementia.</p> <p>The quarterly Minimum Data Set (MDS) dated 10/11/18 assessed cognitive patterns and identified inattention behaviors were continuously present with disorganized thinking. Rejection of care was not identified. The MDS assessment included activities of daily and described extensive assistance was needed with transfers, toileting, and always being incontinent of bladder and bowel. Range of motion identified impairment on both upper and lower extremities.</p> <p>Review of the care plan last revised on 10/18/18 identified there was a risk for complications related to incontinence. The goal was for complications related to incontinence were avoided or minimized daily through the next review date. Interventions in place included provide incontinence care on routine rounds and as needed.</p> <p>During an observation made on 10/29/18 at 12:40 PM revealed Resident #18 was seated in a wheel chair at a table in the assisted dining room. Resident #18 was wearing gray pants which were a darker gray color at the groin area and appeared wet with a strong odor resembling urine. Resident #18 was propelled by a staff member out of the dining room to a shared room.</p> <p>During continuous observations on 10/29/18 at 12:52 PM, Resident #18 continued wearing gray</p>	F 656	<p>set nurse (MDS) failed to develop a dental care plan for resident #79.</p> <p>On November 1, 2018, the current MDS nurse reviewed and revised the current comprehensive person-centered care plan with measurable objectives to include dental needs for resident #79.</p> <p>By November 30, 2018, the Director of Nursing (DON), Assistant Director of Nursing (ADON), the Staff Development Coordinator (SDC) or MDS nurse will re-educate the licensed and un-licensed nursing staff on following the care plan for resident #18</p> <p>By November 30, 2018, the regional MDS nurse will re-educate the current MDS nurse on how to develop and implement a plan of care to include dental care and communicating interventions to care givers.</p> <p>Procedure for implementing the plan:</p> <p>By November 30, 2018 the regional MDS consultant/nurse consultant will complete an audit of current resident's section M of the MDS to determine if comprehensive person-centered care plan with measurable objectives were completed on resident's that were coded to have issues. Comprehensive person-centered care plan with measurable objectives were completed and put into place for any resident coded to have issues in section M of the MDS.</p> <p>By November 30, 2018, the Director of Nursing (DON), Assistant Director of Nursing (ADON), the Staff Development</p>		

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F 656	<p>Continued From page 30</p> <p>pants which were a darker color at the groin area and appeared to be wet with a strong odor resembling urine. On 10/29/18 at 12:55 PM Resident #18 self-propelled out of the shared room into the hallway. On 10/29/18 at 12:57 PM, the Social Service Director (SSD) pushed Resident #18 back to the shared room. The SSD was noted to speak to Nurse #3 and Nurse Aide (NA) #4. Nurse #3 remained at the medication cart and the NA #4 continued to pick up dirty trays from resident rooms on the hallway where Resident #18 was located. On 10/29/18 at 1:32 PM, Resident #18 remained dressed in gray pants with a darker color at the groin area with a strong odor resembling urine. On 10/29/18 at 1:50 PM, Resident #18 again self-propelled out of the room. On 10/29/18 at 2:00 PM, Nurse #3 administered Resident #18 medication while seated in a wheelchair at the entrance door of the shared room. On 10/29/18 at 2:20 PM, the Activity Director pushed Resident #18 to the shared room. On 10/29/18 at 2:35 PM, NA #3 entered Resident #18's shared room. She was holding 2 clear plastic bags; 1 bag with a heavy saturated incontinence product and the second bag with a pair of gray pants. There was a strong odor resembling urine in the room.</p> <p>During an interview on 10/29/18 at 2:35 PM, NA #3 confirmed Resident #18 had an incontinence episode of bladder and bowel and she had just provided care for the first time since her break while doing her rounds. She confirmed urine had soaked through the incontinence product to the gray pants and the pants had a strong odor resembling urine. She explained being responsible for Resident #18's care and most days she would lay the resident in bed after lunch and provide incontinence care if needed but today</p>	F 656	<p>Coordinator(SDC) or Minimum Data Set Nurse(MDS) will re-educate the licensed and un-licensed nursing staff on following the comprehensive person-centered care plan for residents. No licensed or un-licensed nursing staff will be allowed to work until re-education is completed and this education was added to the new hire orientation.</p> <p>By November 30, 2018, the Regional MDS consultant/ nurse consultant will re-educate the interdisciplinary(IDT) team on how to develop comprehensive person-centered care plans.</p> <p>Monitoring the plan:</p> <p>The regional MDS consultant/nurse consultant will audit five care plans per week for 12 weeks to ensure comprehensive person centered care plans are developed for dental care.</p> <p>The Director of Nursing(DON),Assistant Director of Nursing(ADON), or unit coordinator will audit five care plans per week for twelve weeks to ensure the interventions are being followed for those residents care planned for incontinence.</p> <p>Effective November 30, 2018, the Minimum Data Set Nurse (MDS) will report the findings of the audits and reviews to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance.</p>		

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F 656	<p>Continued From page 31</p> <p>took her break first. She explained there were other NA's and the nurse available on the hallway to provide care while she was on break.</p> <p>During an interview on 10/29/18 at 2:48 PM, the SSD explained she told NA #4 Resident #18 was wet and needed incontinence care. NA #4 told her she would take care of it and she confirmed it was approximately 1:00 PM when she told NA #4. The SSD revealed NA #4 was the only person she told Resident #18 needed incontinence care and appeared to be wet.</p> <p>During an interview on 10/29/18 at 2:59 PM, NA #4 explained after the SSD reported Resident #18 needed incontinence care and appeared wet she reported that to Nurse #3 and continued collecting dirty trays on the hallway. She revealed after all the trays were collected she went on break. While on her break she told NA #3 who was also on break, Resident #18 needed incontinence care. She then confirmed after being informed by the SSD she continued collecting dirty trays, went on break, and did not check to ensure Resident #18 had been provided incontinence care.</p> <p>During an interview on 10/29/18 at 4:30 PM, Nurse #3 confirmed being responsible for Resident #18's care. She had overheard the SSD telling an NA Resident #18 needed assistance but couldn't recall which NA was told. She didn't note an odor resembling urine or identify an area on the gray pants that appeared wet when administering the resident's medication and thought the NA had provided incontinence care. Nurse #3 explained she monitors resident care was provided by visually checking residents and would expect NA's would ask for help when</p>	F 656	<p>Title of person responsible for implementing the plan</p> <p>The MDS Coordinator and the Director of Nursing services are responsible to ensure implementation of this plan of correction.</p>		



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F 656	<p>Continued From page 32</p> <p>needed. She denied NA #4 informed her Resident #18 needed incontinence care.</p> <p>During an interview on 10/31/18 at 11:24 AM, the Director of Nursing (DON) revealed it was her expectations when staff were informed a resident needed incontinence care it was provided as needed and if staff were busy to ask for assistance. She expected incontinence care was provided before staff went on break or provided before picking up dirty trays from resident rooms.</p> <p>Based on observation, record review and staff interviews the facility failed to develop and implement a care plan for dental services in 1 of 3 residents reviewed for dental care (Resident #79).</p> <p>The findings included:</p> <p>Resident #79 was admitted to the facility 06/27/17 with diagnoses including diabetes and depression among others. The annual Minimum Data Set (MDS) dated 04/09/18 revealed Resident #79 had "obvious or likely cavity or broken natural teeth."</p> <p>Review of the Care Area Assessment (CAA) from the annual MDS revealed the following: "at risk for mouth pain and problems chewing related to missing and broken teeth" and "will proceed with care plan to promote good oral hygiene."</p> <p>Review of Resident #79's current care plans revealed no care plan for addressing dental care.</p> <p>An observation of Resident #79's mouth on 10/30/18 at 9:15 AM revealed missing teeth in the</p>	F 656			

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F 656	Continued From page 33 lower and upper jaws bilaterally and broken teeth in the upper jaw.  During an interview with MDS Nurse #2 on 11/01/18 at 1:40 PM, she reviewed the MDS and the CAA and stated there should have been a care plan developed for dental issues for Resident #79 and it was an accidental oversight.  During an interview with the Administrator on 11/01/18 at 2:36 PM, she stated her expectations were for a care plan to be completed if it had been designated on the CAA that a care plan should be done.	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. (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	F 657		11/30/18	

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F 657	<p>Continued From page 34</p> <p>disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to review and revise a care plan to accurately reflect the preferred code status for 1 of 3 residents (Resident #67) reviewed for advanced directives.</p> <p>Findings included:</p> <p>Resident #67 admitted to the facility on 10/24/17 with multiple diagnoses that included vascular dementia.</p> <p>Review of Resident #67's Electronic Medical Record (EMR) listed his code status as "Full Code."</p> <p>Review of the monthly Physician Orders summaries for the period May 2018 through September 2018 revealed an order dated 10/14/17 which read, "Full Code." Review of the monthly Physician Orders summary for October 2018 revealed an order dated 10/30/18 which read, "(indefinite) Full Code."</p> <p>Review of Resident #67's advanced directive care plan, last reviewed on 08/31/18, revealed the following problem area, "Do Not Resuscitate (DNR). Resident #67 and/or family have chosen a code status of DNR" with the goal his wishes would be honored.</p>	F 657	<p>The plan for correcting the specific deficiency</p> <p>The alleged deficiency occurred because the interdisciplinary team(IDT) failed to revise the care plan of resident #67 to reflect his current code status. This care plan was revised to reflect full code upon notification on November 1, 2018.</p> <p>On November 2, 2018, the nurse consultant re-educated the IDT on advance directives and reviewing and revising care plans to reflect current advance directive wishes.</p> <p>Procedure for implementing the plan</p> <p>By November 30, 2018, the IDT will complete an audit of current residents to validate the advance directive, physician orders and care plan reflected the wishes of the resident/POA.</p> <p>The Social Worker will be responsible for updating the care plan with any advance directive changes as of November 5, 2018.</p> <p>On November 2, 2018, the Nurse Consultant re-educated the licensed nursing staff on communicating advance directive and changes to the IDT. No licensed nurse will be allowed to work until re-education is completed and this education has been added to new hire</p>		

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F 657	<p>Continued From page 35</p> <p>Review of the quarterly Minimum Data Set (MDS) dated 09/30/18 indicated Resident #67 was coded with severe impairment in cognition for daily decision making.</p> <p>During an interview on 11/01/18 at 12:45 PM MDS Nurse #2 explained the Social Services Director (SSD) created, updated and revised advanced directive care plans for residents. After reviewing Resident #67's EMR, MDS Nurse #2 confirmed he was listed as Full Code but care planned in error as a DNR.</p> <p>During an interview on 11/01/18 at 1:00 PM the SSD explained resident care plans were reviewed during care plan meetings and revised as needed. She added any member of the interdisciplinary team could update care plans, including advanced directives. After reviewing Resident #67's EMR, she confirmed he was listed as a Full Code but care planned as a DNR. The SSD stated she did not develop Resident #67's advance directive care plan and was unable to explain why it did not reflect his preferred code status.</p> <p>During an interview on 11/01/18 at 2:36 PM the Administrator stated it was her expectation for care plans to accurately reflect a resident's current code status.</p>	F 657	<p>orientation.</p> <p>Monitoring the Plan: The regional MDS Consultant or Nurse Consultant will audit five care plans per week for twelve weeks to ensure advance directives are care planned according to the documentation of resident's wishes. Effective November 30, 2018, the Minimum Data Set Nurse (MDS) will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for three months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance.</p> <p>Title of person responsible for implementing the plan: The Minimum Data Set Nurse (MDS) and Director of Nursing Services are responsible to ensure implementation of this plan of correction.</p>		
F 677 SS=D	<p>ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)</p> <p>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced</p>	F 677		11/30/18	

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F 677	<p>Continued From page 36</p> <p>by: Based on record review, observations, resident, and staff interviews the facility failed to provide incontinence care timely and trim long fingernails for 2 of 4 dependent resident reviewed for activities of daily of living (Resident #18, Resident #49).</p> <p>Findings included:</p> <p>1. Resident #18 was admitted to the facility 12/13/04 with diagnoses which included Cerebral palsy and Non-Alzheimer's Dementia.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated 10/11/18 assessed cognitive patterns and identified inattention behaviors were continuously present with disorganized thinking. Rejection of care was not identified. The MDS assessment included activities of daily and described extensive assistance was needed with transfers, toileting, and always being incontinent of bladder and bowel. Range of motion identified impairment on both upper and lower extremities.</p> <p>Review of the care plan last revised on 10/18/18 identified there was a risk for complications related to incontinence. The goal was for complications related to incontinence were avoided or minimized daily through the next review date. Interventions in place included provide incontinence care on routine rounds and as needed.</p> <p>During an observation made on 10/29/18 at 12:40 PM revealed Resident #18 was seated in a wheel chair at a table in the assisted dining room. Resident #18 was wearing gray pants which were a darker gray color at the groin area and</p>	F 677	<p>The plan for correcting the specific deficiency:</p> <p>The alleged deficiency occurred when the certified nursing assistant (CNA) failed to provide timely incontinence care for resident #18. Resident #18 received incontinence care but did not receive incontinence care when taken back to the unit by the social worker due to CNA completing other duties. The licensed nurse also failed to ensure resident #49 fingernails were trimmed after the CNA had made a comment on the shower sheet. Resident #49 nails were trimmed when staff was made aware.</p> <p>By November 30, 2018, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinator or Nurse Supervisor will re-educate licensed and certified staff regarding providing timely incontinence care and trimming fingernails.</p> <p>Procedure for implementing the plan:</p> <p>An audit of current resident's fingernails will be completed by the Director of Nursing, Assistant Director of Nursing, Unit Coordinator or nurse supervisor by November 30, 2018. Nails will be trimmed as necessary.</p> <p>Re-education was provided to Certified Nurse Aides and licensed nurses by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinator or Nurse Supervisor will be completed by November 30, 2018, with</p>		

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F 677	<p>Continued From page 37</p> <p>appeared wet with a strong odor resembling urine. Resident #18 was propelled by a staff member out of the dining room to a shared room.</p> <p>During continuous observations on 10/29/18 at 12:52 PM, Resident #18 continued wearing gray pants which were a darker color at the groin area and appeared to be wet with a strong odor resembling urine. On 10/29/18 at 12:55 PM Resident #18 self-propelled out of the shared room into the hallway. On 10/29/18 at 12:57 PM, the Social Service Director (SSD) pushed Resident #18 back to the shared room. The SSD was noted to speak to Nurse #3 and Nurse Aide (NA) #4. Nurse #3 remained at the medication cart and the NA #4 continued to pick up dirty trays from resident rooms on the hallway where Resident #18 was located. On 10/29/18 at 1:32 PM, Resident #18 remained dressed in gray pants with a darker color at the groin area with a strong odor resembling urine. On 10/29/18 at 1:50 PM, Resident #18 again self-propelled out of the room. On 10/29/18 at 2:00 PM, Nurse #3 administered Resident #18 medication while seated in a wheelchair at the entrance door of the shared room. On 10/29/18 at 2:20 PM, the Activity Director pushed Resident #18 to the shared room. On 10/29/18 at 2:35 PM, NA #3 entered Resident #18's shared room. She was holding 2 clear plastic bags; 1 bag with a heavy saturated incontinence product and the second bag with a pair of gray pants. There was a strong odor resembling urine in the room.</p> <p>During an interview on 10/29/18 at 2:35 PM, NA #3 confirmed Resident #18 had an incontinence episode of bladder and bowel and she had just provided care for the first time since her break while doing her rounds. She confirmed urine had</p>	F 677	<p>the expectation for maintaining the proper length of dependent resident fingernails. Certified Nurse Aides were provided education to ensure nails are cleaned and trimmed on shower days and as needed. Current staff will not be allowed to work until re-education is complete and this education has been added to the new hire orientation.</p> <p>The shower sheets completed by the certified nursing assistants are to be signed by the licensed nurse to ensure nail care is delivered and to follow up on any communication regarding nail care on the shower sheet.</p> <p>The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinator or Nurse Supervisor will visually observe the nails of 10 residents weekly for 12 weeks to ensure they are trimmed and clean.</p> <p>Licensed and un-licensed nursing staff, dietary staff, activity staff, housekeeping staff, rehabilitation staff and social services staff will be re-educated by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinator or Nurse Supervisor by November 30, 2018, on the protocol regarding incontinence care. This education will also include that all staff are responsible to alert the nursing staff if incontinence care needs to be provided as evidenced by visual observations or olfactory signs and to follow up. Current staff will not be allowed to work until re-education is complete and this education has been added to the new hire orientation.</p>		

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F 677	<p>Continued From page 38</p> <p>soaked through the incontinence product to the gray pants and the pants had a strong odor resembling urine. She explained being responsible for Resident #18's care and most days she would lay the resident in bed after lunch and provide incontinence care if needed but today took her break first. She explained there were other NA's and the nurse available on the hallway to provide care while she was on break.</p> <p>During an interview on 10/29/18 at 2:48 PM, the SSD explained she told NA #4 Resident #18 was wet and needed incontinence care. NA #4 told her she would take care of it and she confirmed it was approximately 1:00 PM when she spoke with NA #4. The SSD revealed NA #4 was the only person she told Resident #18 appeared to be wet and needed incontinence care.</p> <p>During an interview on 10/29/18 at 2:59 PM, NA #4 explained after the SSD reported Resident #18 appeared wet and needed incontinence care, she reported that to Nurse #3 then continued collecting dirty trays on the hallway. She revealed after all the trays were collected she went on break. While on her break she told NA #3 who was also on break, Resident #18 needed incontinence care. She confirmed after being informed by the SSD she continued collecting dirty trays, went on break, and did not check to ensure Resident #18 had been provided incontinence care.</p> <p>During an interview on 10/29/18 at 4:30 PM, Nurse #3 confirmed being responsible for Resident #18's care. She had overheard the SSD tell an NA Resident #18 needed assistance but couldn't recall which NA was told. She didn't note an odor resembling urine or identify a wet area on</p>	F 677	<p>The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinator, Nurse Supervisor, Facility Consultant and/or Minimum Data Set Nurse will visually audit and interview 20 residents weekly for 4 weeks, then 10 residents per week 8 weeks to ensure resident incontinent care is completed timely.</p> <p>Monitoring the plan:</p> <p>The Administrator will visually audit and interview 5 residents weekly for 12 weeks to ensure the residents nails are trimmed, neat and clean according to their plan of care.</p> <p>Effective November 30, 2018, the Director of Nursing will report the findings of the audits and reviews to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure that facility remains in compliance.</p> <p>Title of the person responsible for implementing the plan: The Director of Nursing is responsible for implementing this plan.</p>		

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F 677	<p>Continued From page 39</p> <p>the gray pants when administering the resident's medication and thought the NA had provided incontinence care. Nurse #3 explained she monitors resident care was provided by visually checking residents and would expect NA's would ask for help when needed. She denied NA #4 informed her Resident #18 needed incontinence care.</p> <p>During an interview on 10/31/18 at 10:56, the Activities Director explained she didn't visually note or smell incontinence when she assisted Resident #18 to the shared room.</p> <p>During an interview on 10/31/18 at 11:24 AM, the Director of Nursing (DON) revealed it was her expectations when staff were informed a resident needed incontinence care it was provided timely and if staff were busy to ask for assistance. She expected incontinence care was provided before staff went on break or provided before picking up dirty trays from resident rooms.</p> <p>Resident #49 was admitted to the facility on 01/07/18 with diagnoses which included diabetes mellitus (DM), muscle weakness, peripheral neuropathy, and chronic obstructive pulmonary disease (COPD).</p> <p>A review of the most recent Minimum Data Set (MDS) dated 09/13/18 revealed Resident # 49 was cognitively intact with no histories of rejection of care. The MDS indicated Resident #49 required extensive assist to total dependence with all Activities of Daily Living (ADL's) except only needing supervision with eating. The MDS</p>	F 677			



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F 677	<p>Continued From page 40</p> <p>further coded Resident #49 with total dependence with one person physical assist for bathing.</p> <p>Review of care plan that was last revised on 05/21/18 described Resident #49 as requiring extensive assistance with his ADLs due to decreased strength, balance, and activity tolerance related to exacerbation of COPD. The care plan specified Resident #49 with the goal of reaching the highest level of self-participation in ADL's daily through next review date. Interventions included providing assistance with showers or bed baths per Resident #49's choice, and offering set up and assistance for oral care, facial hygiene, combing hair and shaving.</p> <p>Review of shower records for Resident #49 indicated he was scheduled for shower two times weekly on first shift of Monday and Thursday. Review of shower record dated 10/29/18 revealed Resident #49 had received shower provided by Nurse Aide (NA) #1 on that day. NA #1 had documented Resident #49 as needed fingernails cut in the shower sheet dated 10/29/18.</p> <p>An observation on 10/29/18 at 10:38 AM revealed all 10 fingernails of Resident #49 were extended 3-4 millimeter (mm) beyond the fingertips. However, none of the fingernails were observed with brownish substances underneath. In a subsequent interview, Resident #49 stated his fingernails had not been trimmed for over one month. Normally he did not have to request fingernail trimming as the nurse would trim it for him in a timely manner. Resident #49 added he would like to have his fingernails trimmed in a timely manner and stayed clean all the time.</p> <p>During subsequent observations that were</p>	F 677			

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F 677	<p>Continued From page 41</p> <p>conducted on 10/30/18 at 09:50 Am and 10/31/18 at 08:49 AM, Resident #49's fingernails remained untrimmed. However, no brownish substances were observed under each fingernail.</p> <p>A joint observation was conducted on 10/31/18 at 04:15 PM with the Unit Manager (UM). She stated the NA who had provided shower for Resident #49 should notify the hall nurses of nail care needs. Residents did not have to ask for fingernail care as it had to be offered when needed. She acknowledged that Resident #49's fingernails of about 3-4 mm extended from the fingertips needed to be trimmed and nursing staff should pay more attention to Residents when providing care. It was her expectation for nursing staff to provide fingernail cares as needed and in a timely manner.</p> <p>On 11/01/18 at 10:57 AM an interview was conducted with Nurse #5 who acknowledged that Resident #49 was a diabetic and she was responsible to trim his fingernails when needed. She denied any NAs had ever notified her regarding Resident #49's fingernail care needs recently. Normally she would trim residents in her hall routinely when she was working on Saturday. Nurse # 5 indicated she had interacted with Resident #49 during her shift frequently and admitted she had not paid enough attention to his fingernail care needs recently.</p> <p>In an interview conducted on 11/01/18 at 11:07 AM, Nurse Aide (NA) #1 stated she was one of the NA who had provided shower to Resident #49 on 10/29/18. NA #1 stated she checked Resident #49's fingernails routinely during shower and noted it needed to be trimmed. She did not notify any nurses about Resident #49's fingernail care</p>	F 677			

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F 677	Continued From page 42 needs after she had documented the shower sheets. NA #1 was aware that Resident #49 was a diabetic and his fingernails needed to be trimmed by a nurse.  On 11/01/18 at 04:22 PM an interview was conducted with the Director of Nursing (DON) who stated it was her expectation for nursing staff to provide fingernail care to dependent resident who was unable to carry out their own ADL tasks as needed in a timely manner. She also expected the NAs who provided shower to resident to communicate with the nurses whenever fingernail care was needed.	F 677			
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	F 758		11/30/18	

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F 758	<p>Continued From page 43</p> <p>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§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</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§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 reviews, consultant pharmacist, Family Nurse Practitioner (FNP) and the Medical Director (MD) interviews, the facility failed to ensure physician's orders for as needed (PRN) psychotropic medications were time limited in duration and provide rationales for therapy exceeding 14 days for 1 of 5 sampled residents (Residents #54) reviewed for unnecessary medications.</p> <p>Findings included:</p>	F 758	<p>The plan for correcting the specific deficiency:</p> <p>The alleged deficiency occurred when the licensed nurse failed to ensure a physician's order was time limited to 14 days for prn psychotropic medication. The physician and or nurse practitioner (NP) failed to document rational for therapy that exceeded 14 days for resident (#54). On November 1, 2018, the NP documented the rational to continue the PRN Ativan order for resident #54.</p>		

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F 758	<p>Continued From page 44</p> <p>Resident #54 was admitted to the facility on 04/22/07 and later re-admitted on 09/06/18 with diagnoses that included anxiety, depression, and diabetic Miletus.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated 09/13/18 revealed Resident #54 was cognitively intact with no histories of rejection of care. The MDS indicated Resident #54 required extensive assist with all Activities of Daily Living (ADLs). The MDS further coded Resident #54 with unclear speech and was not on antianxiety medication on the 7-day look back periods.</p> <p>Review of physician's order indicated Ativan (anxiolytic medication) 0.5 milligram (mg), 1 tablet orally every 4 hours as needed (PRN) for anxiety/short of breath was ordered for Resident #54 on 09/13/18. There was no stop date indicated for this PRN anxiolytic medication order. A review of the current physician's order for Resident #54 on 11/01/18 revealed this PRN antianxiety order had not been updated with a stop date.</p> <p>Review of physician progress notes dated 10/04/18 revealed the FNP had visited Resident #54 and acknowledged the PRN Ativan order that was initiated on 09/13/18 for anxiety. The FNP decided to continue current medications unchanged after this visit. No intended duration of therapy or rationales for the extension were documented in the medical record. This PRN Ativan order had been 7 days past the 14 days limitation by the time of the visit.</p> <p>Review of consultant pharmacist consultation report dated 10/18/18 revealed the Consultant</p>	F 758	<p>By November 30, 2018, the licensed nurses will re-educated by the Director of Nursing regarding the guidelines for PRN use of psychotropic medications and if an order is obtained it must be time limited not to exceed 14 days unless reviewed by the Director of Nursing.</p> <p>Procedure for implementing the plan: By November 30, 2018, the licensed nurses will be re-educated by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Nurse Supervisor regarding the guidelines for PRN use of psychotropic medications and if an order is obtained it must be time limited not to exceed 14 days unless reviewed by the Director of Nursing. No current licensed nurse will be allowed to work until re-education is complete and this education has been added to the new hire orientation.</p> <p>The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinator or Nurse Supervisor will complete an audit on current residents receiving PRN psychotropic medications to ensure all were limited to 14 days and rational was documented by November 30, 2018. Any residents receiving PRN psychotropic medications the rational as of November 30, 2018, is documented in the medical record and PRN psychotropic medications have an end date of 14 days.</p> <p>The consultant pharmacist will review PRN psychotropic orders for residents and notify both the medical doctor and the Director of Nursing if no end date is</p>		

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F 758	<p>Continued From page 45</p> <p>Pharmacist had recommended the physician to discontinue PRN Ativan unless the physician documented the intended duration of therapy and the rationales for the extension. The physician declined the recommendation on 10/31/18 without giving any rationales except stated to continue this anxiolytic therapy for another 14 days.</p> <p>Review of Resident #54's medication administration record (MAR) revealed she had received the PRN Ativan one time on 09/21/18 and another time on 10/30/18.</p> <p>In an interview conducted on 11/01/18 at 01:09 PM, the Consultant Pharmacist (CP) indicated he was aware of the new regulations for PRN psychotropic medications. The CP noticed the PRN Ativan order when he was conducting the monthly Medication Regimen Review (MRR) on 09/17/18. He did not make any recommendations during that visit as the PRN Ativan order was not 14 days yet. When he revisited the facility for MRR again on 10/18/18, he noted the PRN Ativan order was still active. He made recommendations to the physician to consider to discontinue the PRN anxiolytic therapy or to document the intended duration of therapy and the rationales for the extension. The CP stated after he had completed all the MRRs for the facility, he sent all his recommendations to the Director of Nursing (DON) via email on 10/23/18.</p> <p>In a phone interview conducted on 11/01/18 at 04:04 PM, the MD stated he would set a stop date of 2 weeks whenever he prescribed a PRN psychotropic medication and would document the rationales and intended duration of therapy in medical record if he decided to extend the</p>	F 758	<p>present and if rational of use is not included in the medical record during his monthly review.</p> <p>Director of Nursing, Assistant Director of Nursing, Unit Coordinator or Nurse Supervisor will bring a copy of the previous days orders to the morning clinical review to ensure any orders for PRN psychotropics include stop dates.</p> <p>Monitoring plan: The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinator of Nurse Supervisor will review 5 charts weekly for 12 weeks of residents receiving PRN psychotropic medications to ensure a stop date is included and the rational is documented in the medical record.</p> <p>Effective November 30, 2018, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator will report the findings of the audits and reviews to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance.</p> <p>Title of person responsible for implementing this plan:  The Director of Nursing and Administrator are responsible</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA PINES AT ASHEVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>91 VICTORIA ROAD</b> <b>ASHEVILLE, NC 28801</b>		
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F 758	Continued From page 46 therapy for more than 14 days. However, the MD added without any documentation of intended duration of therapy and rationales did not mean that the FNP failed to assess or evaluate Resident #54 during the 10/04/18 visit. The MD attributed the failure to document the duration of therapy and rationales as an oversight.  In a phone interview conducted on 11/01/18 at 04:13 PM, the FNP acknowledged that she had assessed Resident #54 during the visit on 10/04/18. She recalled Resident # 54 had expressed her needs for the PRN Ativan due to intermittent episodes of anxiety. The FNP added she had forgotten to document the intended duration of therapy and rationales for the extension in the medical records.  In an interview conducted on 11/01/18 at 04:22 PM, the DON stated it was a human error for the FNP's failure to document the intended duration of therapy and rationales during the visit on 10/04/18. It was her expectation for all the prescribers to follow the new Centers for Medicare & Medicaid Services (CMS) PRN psychotropic medication regulations.  An interview was conducted with the Administrator on 11/02/18 at 5:36 PM. She stated it was her expectation for all the prescribers to follow CMS regulations when prescribing PRN psychotropic medication.	F 758			
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5)  §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.	F 791		11/30/18	

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F 791	Continued From page 47  §483.55(b) Nursing Facilities. The facility-  §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;  §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;  §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;  §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and  §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.	F 791			



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F 791	<p>Continued From page 48</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews the facility failed to offer routine dental services in a timely manner for 1 of 3 sampled residents reviewed for dental concerns. (Resident #79).</p> <p>The findings included:</p> <p>Resident #79 was admitted to the facility 06/27/17 with diagnoses including diabetes and depression among others. The annual Minimum Data Set (MDS) dated 04/09/18 revealed Resident #79 had "obvious or likely cavity or broken natural teeth."</p> <p>Review of the Care Area Assessment (CAA) from the annual MDS revealed the following: "at risk for mouth pain and problems chewing related to missing and broken teeth" and "will proceed with care plan to promote good oral hygiene."</p> <p>Review of Resident #79's current care plans revealed no care plan for addressing dental care.</p> <p>Review of Resident #79's recent visits from the Family Nurse Practitioner (FNP) dated 3/20/18, 5/16/18, 7/11/18 and 9/12/18 all indicated the following: "throat - intact dentition, moist mucous membranes without exudate or erythema." No documentation was present that a dental exam had occurred during any of these visits.</p> <p>An observation of Resident #79's mouth on 10/30/18 at 9:15 AM revealed missing teeth in the lower and upper jaws bilaterally and broken teeth in the upper jaw. Resident #79 stated when she was admitted she told a staff member that she wanted to see the dentist but no one had ever</p>	F 791	<p>The plan for correcting the specific deficiency:</p> <p>The alleged deficiency occurred when the facility failed to offer routine dental services to resident #79. Resident #79 requested upon admission to be seen by a dentist and the facility social worker failed to follow up. It is noted that the resident did not complain of pain and had no weight loss issues.</p> <p>Resident #79 was seen by the dentist on November 20, 2018.</p> <p>Procedure for implementing the plan:</p> <p>On November 5, 2018, the administrator re-educated the social worker to ensure that each resident is seen by dental services annually at a minimum.</p> <p>By November 30, 2018, the Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will re-educate the licensed nurses to check oral cavity on admission and to notify social services if resident requests dental services.</p> <p>By November 30, 2018, the social worker will perform an audit of current residents to ensure each has been seen by the dentist within the last 12 months and if not, they will be placed on the list to be seen upon the next visit.</p> <p>By November 30, 2018, the Director of Nursing will have the licensed nurses perform oral exams on current residents to update information in medical record.</p>		

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F 791	<p>Continued From page 49</p> <p>followed up with her about it. Resident #79 also stated her teeth had not been cleaned in over a year and she would like to have them pulled out so she could get dentures.</p> <p>Review of resident's admission information revealed Resident #79 was her own responsible party. The admission information further indicated she had a friend that was listed only as an emergency contact.</p> <p>Record review of all residents seen for a yearly dental visit in the facility and out of the facility revealed Resident #79 had not had dental services to address her broken and missing teeth.</p> <p>An interview on 10/31/18 at 9:27 AM revealed the Social Services Director (SSD) did not have a list from Senior Dental Care of residents that had refused care in the past year. The SSD verified with Senior Dental Care they did not have a documented visit or attempted visit with refusal from Resident #79.</p> <p>An interview on 10/31/18 at 1:37 PM with the Business Office Manager revealed Resident #79 had qualified for Medicaid eligible services.</p> <p>The SSD presented a list of dental services available at the facility monthly in the past year. They are as follows:</p> <p>11/14/17 Treatment 12/27/17 Hygiene 01/10/18 Clinical 02/20/18 Hygiene 03/21/18 Dentures 04/24/18 Hygiene</p>	F 791	<p>Monitoring the plan:</p> <p>The Social Worker or Director of Nursing will review new admissions weekly for 12 weeks to ensure residents who request to be seen by the dentist have an appointment made.</p> <p>The Social Worker will audit current residents quarterly X 4 to determine if they are due to be seen annually by the dentist and if so make the appointment upon consent.</p> <p>Effective November 30, 2018, the Social Worker will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months then quarterly x 3. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance.</p> <p>Title of the person responsible for implementing the plan:</p> <p>The Administrator is responsible for implementing the plan.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 791	<p>Continued From page 50</p> <p>05/30/18 Clinical 06/19/18 Hygiene 07/31/18 Treatment 08/24/18 Hygiene 09/04/18 Clinical 10/19/18 Hygiene 11/20/18 Treatment</p> <p>During an interview on 10/31/18 at 2:45 PM Resident #79 was observed to tell the SSD that she had told a staff member when she was admitted that she wanted to see the dentist but no one had followed up with her.</p> <p>During an interview on 11/01/18 at 2:36 PM the Administrator indicated that Resident #79 was independent and able to set up her own appointments. The Administrator stated her expectations were for every resident to be seen for dental concerns.</p>	F 791			