STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. BUILDING _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/RAMSEUR	7166 JORDON ROAD RAMSEUR, NC 27316

(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 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 12/2/18 through 12/6/18. Immediate jeopardy was identified at: CFR 483.12 at tag F 600 at a scope and severity J CFR 483.25 at tag F 689 at a scope and severity J Tags F 600 and F 689 constituted Substandard Quality of Care Immediate jeopardy began on 6/2/18 and was removed on 12/6/18. An extended survey was conducted.	F 000		
F 600 SS=J	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 and interviews with the	F 600	This plan of correction constitutes a	12/21/18

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

Electronically Signed | 12/27/2018

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F 600	Continued From page 1 Speech Therapist (ST), physician, and staff, the facility failed to provide the necessary care and services recommended by the ST and ordered by the physician by neglecting to provide supervision and cueing for swallowing precautions during meal time for a resident at risk for aspiration for 1 of 3 residents reviewed with aspiration precautions. Resident #89 was observed by nursing staff with a mouth full of food making a vomiting noise after meal time. She was transferred to the Emergency Room by Emergency Medical Services and died in the ambulance on the way to the hospital. Immediate Jeopardy began on 6/2/18 at approximately 1:30 PM when Nursing Assistant #1 observed Resident #89 making a vomiting sound following the lunch meal that she had eaten in the dining room. She was assessed by nursing staff to have a large amount of ground/chewed food, estimated at 4 ounces, in her mouth. Emergency Medical Services (EMS) were contacted by facility staff to evaluate Resident #89 for the chief complaint of "choking". Resident #89 was en route to the hospital with EMS when she went into cardiac arrest and respiratory failure and was pronounced dead on 6/2/18 at 2:29 PM. The cause of death was asphyxia due to an occlusion of airway by bolus (a ball-like mixture of food and saliva) of food. Immediate Jeopardy was removed on 12/6/18 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (isolated and no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in	F 600	written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to continue to improve the quality of life of each resident. F 600 Based on the root cause analysis by the facility administrative staff and the facility Director of Nursing, facility staff did not provide direct supervision for resident #89 during meal. Immediate On 6/2/2018 at approximately 1:30pm, Resident was escorted from the dining room and was noted making a vomiting noise. The Certified Nursing Assistant immediately took the resident to the nurse's station where the nurse assessed resident having difficulty swallowing and showing signs of aspiration with audible wheezing. The nurse attempted to remove food particles from resident's mouth but was unsuccessful in removing all food particles and therefore dentures were removed to perform a mouth sweep. During this process the resident continued to try to chew and swallow. At this time	

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F 600	Continued From page 2	F 600		

place are effective.

The findings included:

Resident #89 was admitted to the facility on 3/28/17 with diagnoses that included dysphagia (difficulty swallowing) following cerebral infarction, aphasia (loss of ability to understand or express speech), hemiplegia (paralysis of one side of the body) affecting right dominant side, and Alzheimer' s disease.

A physician's order dated 4/17/17 indicated the physician agreed to a dietary order recommended by Speech Therapist (ST) #1. The order indicated Resident #89, " ...needs [one on one] supervision or dining room supervision to cue [resident] to take small bites, eat slow and swallow between bites, and to alternate solids [and] liquids". This 4/17/17 order remained in place throughout the remainder of Resident #89's stay at the facility.

The Nutrition/Dehydration Risk Assessment dated 5/6/18 indicated Resident #89 had severely impaired decision making, she was rarely/never understood, and she had impairment on one side of her upper extremities. She was assessed as dependent on staff for assistance with eating. Resident #89 was noted to have no swallowing disorders.

Resident #89's plan of care indicated she needed monitoring of nutritional status and weight status related to a diagnosis of dysphagia and Alzheimer's disease. This care plan, initiated on 2/19/18 and most recently reviewed/revised on 5/8/18. The interventions included, in part:

resident's lips became cyanotic and showing signs of difficulty breathing so the Heimlich maneuver was initiated by the nurse without success. Resident remained conscious and was moving air. The resident was taken from the nurse's station to her room in wheelchair by the Nurse supervisor, Nurse and Certified Nursing Assistant. Nurse supervisor suctioned resident to attempt to remove remaining food particles unsuccessfully. Resident's oxygen saturation was 79 percent, oxygen at 5 liters was applied via non-rebreather face mask. Physician Assistant and Responsible Party were notified at 1:40pm. The Physician Assistant stated to call Emergency Management Services. Emergency Services was called at 1:45pm and arrived at 2:00pm. First Responders took over care of the resident. Facility Nurse staff remained in room for support. First Responders applied oxygen with their regulator at fifteen liters per minute. At 2:10pm, the Emergency Management Technicians (EMT) arrived. They discussed with first responders and facility staff resident's condition and decision to suction resident in ambulance. First Responders and Emergency Management Technicians assisted the resident to the hall in her wheelchair, placed her on the gurney and proceeded to the ambulance. The EMTs remained in the ambulance for a few minutes and left the facility at 2:15pm. At 2:48pm the EMTs called to get next of kin contact information and informed the staff that the resident had died prior to reaching the

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F 600	Continued From page 3 - Provide Resident #89 with assist at meals to ensure optimal and safe oral intake. - Remind Resident #89 of swallowing precautions. The quarterly Minimum Data Set (MDS) assessment dated 5/9/18 indicated Resident #89's cognition was severely impaired. She had short-term and long-term memory problems and severely impaired decision making. Resident #89 was assessed as requiring the extensive assistance of 1 for eating. She was on a mechanically altered diet and had no swallowing disorders. Resident #89 had not received Speech Therapy during this MDS period. Resident #89's Nursing Assistant (NA) Kardex (care guide), undated, indicated Resident #89 she required one to one (1:1) supervision or dining room supervision. A review of the NA documentation of Resident #89's eating assistance for May 2018 indicated: - 8 meals were documented as independent with no set up - 8 meals were documented as supervision with set up only - 10 meals were documented as limited assistance of 1 - 1 meal was documented as extensive assistance of 1 - 28 meals were documented as dependent of 1 A review of the NA documentation of Resident #89's eating assistance for 6/1/18 through 6/2/18 indicated: - 6/1/18: 2 meals were documented with 1 noted as limited assistance of 1 and 1 noted as dependent of 1	F 600	hospital. On 6/2/18 an investigation was initiated immediately by the Director of Nursing and the Administrator and statements received from staff present in the dining room, at the nurse's station. At the conclusion of the investigation it was determined that the Certified Nursing Assistance was at the table providing assistance to another resident. According to the Certified nursing assistant's statement she followed aspiration precautions by setting up her tray, the chicken was in small pieces and saw her eating while helping another resident. During the facility investigation, the C.N.A. did not state or document in her statement that she did not provide supervision. Identification A 100% audit of Residents diagnosis was conducted by Director of Nursing (DON), Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON), Unit Manager (UM) and Director of Rehabilitation (DOR) for diagnosis of Dysphagia and Aphasia on 12/5/18 and 43 were identified with diagnosis of Dysphagia or Aphasia, 26 were identified with recommendations with swallowing guidelines. An information sheet, Swallowing Guidelines sheet, was implemented on 12/6/18 with current recommendations for those 26 identified with swallowing guidelines requiring supervision. The Swallowing Guidelines sheets (name, room number, diet, and recommendation from physician and speech therapist) are located in an	

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F 600	Continued From page 4 - 6/2/18 1 meal was documented, and it was noted as limited assistance of 1 An incident report dated 6/2/18 completed by Nurse #1 indicated Resident #89 had an incident of "substance ingestion" on 6/2/18 at 1:30 PM. The incident was initially reported by NA #1. The narrative of the incident read, "[NA #1] brought [Resident #89] out of dining room to nurses station, stating ' I think she needs some help ' . Nurse assessment completed with food noted in oral cavity. Another nurse [Nurse #2] removed some food particles from mouth and dentures. There was a large amount of well ground food and [Nurse #2] continued to remove food until no longer visible. As [Resident #89] began to wheeze, Heimlich maneuver was performed on resident. Mouth check repeatedly with no food noted." Resident #89's vital signs (VS) were noted as temperature 95.7, pulse 75, respirations 28, blood pressure (B/P) 100/70, and pain scale 0. The physician was notified at 1:40 PM. The immediate actions taken were noted as a mouth sweep, Heimlich, VS, oxygen (O2), 911 called, and Emergency Medical Services (EMS) transported Resident #89. The immediate post-incident actions indicated Resident #89 was sent to the Emergency Room (ER). A nursing note dated 6/2/18 completed by Nurse #1 indicated the following: "1:30 PM - [Resident #89] was brought into hallway by [NA #1] out of the dining room and stated resident was choking. Upon assessment [Resident #89] had a mouth full of food and was trying to chew and swallow the food. Encouraged resident to spit out food and resident refused to do so and clamped teeth together while still trying	F 600	aspiration precaution binder located in each dining room and each resident care kiosk. The swallowing guideline sheets and the kiosk are reconciled by the Assistant Director of Nurses and changes are updated when indicated by the physician or speech therapist. All 43 residents with diagnosis of Dysphagia and Aphasia care plans were reviewed by the Assistant Director of Nursing with no revisions required. CNAs will be assigned to residents identified requiring cueing and aspiration precautions by the charge nurse at the beginning each shift. Training of licensed and certified staff provided by SDC and DON on cueing and aspiration precautions and responsibilities initiated on 12/6/18. All licensed and certified nursing staff will receive this training prior to working next shift. This training will be included in new licensed and certified nursing staff orientation process. Systemic Measures put in place to ensure the plan of correction is effective and remains in compliance are: On 12/5/18 an implementation of a dining room staff sign-in sheet to include sign in times/sign out times as well as aspiration precaution and supervision to be provided. This information is located in a binder in each dining room and resident care kiosk. Management, Licensed Nursing or Department Head will monitor meal supervision, utilizing Dining Supervision Manager Observation sheet. Supervision is being provided to ensure aspiration and	

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F 600	Continued From page 5 to swallow the food. At this time writer attempted the Heimlich maneuver with no results. Able to remove dentures and resident had large amount of food in mouth and pockets of food in cheek as well as food stuck to the top denture. [Resident #89] began to have audible wheezing noted, oxygen saturation was 79% on [room air], heart rate 75, respirations 28, lips were cyanotic [(bluish discoloration indicating poor oxygen circulation)]. [Resident #89] taken to room and oxygen applied at 5 [liters per minute] via mask. 1:40 PM - Notified [Physician's Assistant] and [Responsible Party] of incident. New order given to send to ER. 1:45 PM - Called EMS for transport services. 2:00 PM - EMS arrived - VS oxygen saturation is 79%, [heart rate] 104, [respirations] 32, B/P 100/70. 2:15 pm EMS transported [Resident #89] to ER at this time". A physician's order dated 6/2/18 for Resident #89 indicated "send to ER for evaluation per family request and [physician]". A Resident Transfer Form dated 6/2/18 completed by Nurse #1 indicated Resident #89 was transferred to a local hospital. The reason for the transfer was noted to be "choking while eating chicken". The EMS record dated 6/2/18 was reviewed. The record indicated the following: The chief complaint for Resident #89 was "choking". While EMS were en-route to the facility the first responders on scene advised them Resident #89 was "condition red" (critical) with possible aspiration. The first responders advised EMS that Resident #89 had been reported to have placed a large amount of chicken in her mouth and began choking on it.	F 600	safety precautions are being followed during meals in the dining rooms and for residents that eat in their rooms. The Director of Nursing will assign managers to the dining rooms to include resident rooms. Effective 12/5/18, on-site licensed staff, certified staff and department heads were trained by SDC on the information provided on aspiration precautions and residents requiring supervision to ensure that safety precautions are being followed. This information is located in a binder in each dining room and resident care kiosk. Training on the Heimlich maneuver with return demonstration and proper use of suction machine was conducted as well. This education was provided by the Registered Nurse, Staff Development Coordinator (SDC) to Licensed staff and other licensed staff will be trained prior to next shift worked. Emergency equipment (suction machine) was placed 12/5/18 in the dining rooms, set-up was completed and instructions were given to Licensed Staff by the SDC. On 12/5/18 education was also provided by the SDC for nursing staff to ensure supervision is being provided during meals and ensure aspiration precautions and safety is being provided. Licensed and Certified Nursing staff were also educated on the signs and symptoms of aspiration. Effective 12/6/18, re-education on the facility abuse and neglect policy was initiated for all staff and completed. This education was provided by RN Staff Development Coordinator. Staff not educated by 12/6/18 will not be allowed to work until educated. Effective 12/6/18, education on	

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F 600	Continued From page 6 Facility staff removed all they could from Resident #89's mouth and throat. Resident #89 was moved from wheelchair to EMS stretcher and was taken out of facility onto the transport. During transportation to the ER Resident #89 was examined and was found to have chicken in her trachea. The chicken was removed. Resident #89 was then noted with decreased respiratory effort and her heartrate was decreasing into an extremely bradycardic (slow) rhythm. Approximately 2 minutes prior to arrival at the ER Resident #89 was noted with cardiac arrest and respiratory failure. A valid Do Not Resuscitate (DNR) was present with the resident and no resuscitative efforts were made. Resident #89's death was pronounced on 6/2/18 at 2:29 PM. Upon arrival at the ER the physician advised that since Resident #89 expired prior arrival that she was to be transferred to the morgue. Resident #89's physician was contacted, and he advised that since it was an "un-natural death" it needed to be a Medical Examiner ' s (ME) case. Resident #89 was transported to the morgue and was to be examined by the ME. A death certificate, signed by the Medical Examiner on 6/5/18, indicated Resident #89 choked on a bolus (a ball-like mixture of food and saliva) of chicken at the facility resulting in an accidental death on 6/2/18 with the immediate cause identified as "asphyxia - occlusion of airway by bolus of food". A phone interview was conducted with ST #1 on 12/5/18 at 3:30 PM. ST #1 indicated she no longer worked at the facility and she was unable to recall any specifics about Resident #89 without reviewing the speech therapy records. The speech therapy plan of care, speech therapy	F 600	providing supervision during meals to ensure aspiration precautions and safety is added to all new employee orientation. This education will also be conducted annually by SDC for all staff. CNAs will be assigned to residents identified requiring cueing and aspiration precautions by the charge nurse at the beginning each shift. Training of licensed and certified staff provided by SDC and DON on cueing and aspiration precautions and responsibilities initiated on 12/6/18. All licensed and certified nursing staff will receive this training prior to working next shift. This training will be included in new licensed and certified nursing staff orientation process. Monitoring Effective 12/6/18, The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Nurse Management, Licensed Nursing or Department Head will monitor meal supervision, utilizing Dining Supervision Manager Observation sheet. Supervision is being provided to ensure aspiration and safety precautions are being followed during meals in the dining rooms and for residents that eat in their rooms. Staff mentioned above will be assigned to each meal for supervision utilizing the Assignment calendar. The Director of Nursing will assign managers to the dining rooms to include resident rooms. This monitoring process will be continued by the Charge nurses on Saturday and Sunday. This monitoring will be conducted daily for four weeks, then	

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F 600	Continued From page 7 discharge plan, and dietary order for Resident #89 were reviewed with ST #1. The speech therapy plan of care dated 3/28/17 completed by ST #1 indicated speech therapy was necessary for Resident #89 due to dysphagia and aphasia. The physician's order dated 4/17/17 indicated a dietary order recommended by ST #1, " ... [Resident #89] needs [one on one] supervision or dining room supervision to cue [resident] to take small bites, eat slow and swallow between bites, and to alternate solids [and] liquids". Resident #89 ' s speech therapy discharge instructions dated 5/12/17 completed by ST #1 indicated aspiration precautions were to be continued with the provision of compensatory strategies for swallowing as well as strategies to maximize communication. ST #1 was asked about her expectations related to meal supervision for Resident #89. She stated that if Resident #89 ate in her room that 1:1 supervision was to be provided. She indicated if Resident #89 ate in the dining room she expected a staff member to be in the vicinity of her and for the staff member to provide compensatory strategy cues/aspiration precaution cues to the resident throughout the meal. She explained that these cues included reminders to take sitting up straight in her wheelchair, taking small sips, taking small bites, alternating between solids and liquids, and to swallow her food. Based on the staff schedule, the assignment schedule, and an interview with the Director of Nursing on 12/5/18 at 8:20 AM the NAs that were supposed to be in the dining room during lunch on 6/2/18 were NA #1, NA #2, and NA #3. The DON reported that NA #1 was supervising Resident #89 at the time of the incident. The DON revealed it was unknown how many	F 600	weekly x4, then monthly thereafter. Findings will be reported by the Director of Nursing in the monthly Quality Assurance and Performance Improvement committee meeting for recommendations or modifications until a pattern of compliance is achieved. Effective 12/6/18 the facility Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan or correction to ensure the facility attains and maintains substantial compliance. Compliance Date 12/21/18	

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F 600	Continued From page 8	F 600		

residents were eating lunch in the dining room at the time of the incident (6/2/18).

A written statement (incorrectly dated 5/2/18) completed by NA #1 was reviewed. NA #1 indicated that between 12:15PM and 1:30 PM on 6/2/18 she was in the dining room helping pass out trays and feeding residents. She noted that she set up Resident #89 ' s tray reporting that she had grilled chicken that was cut up into small pieces. NA #1 wrote, "I saw her eating while I was helping feed another resident". She indicated that around 1:30 PM lunch was over, and another NA removed Resident #89's tray. NA #1 reported she then started pushing Resident #89 in her wheelchair out of the dining room. She indicated that when she reached the dining room door with Resident #89 she heard the resident "making a noise like she was trying to throw up". NA #1 wrote that she pushed Resident #89 down the hall in her wheelchair and started yelling for Nurse #4 to help her. She indicated that when she reached the nurse's station Nurse #1, Nurse #2, and Nurse #4 were there. She indicated that the nurses removed about 4 ounces of food from Resident #89 ' s mouth.

A phone interview was conducted with NA #1 on 12/5/18 at 5:08 PM. The incident report and her written statement related to the incident of substance ingestion on 6/2/18 for Resident #89 was reviewed with NA #1. NA #1 was asked to describe the seating arrangements in the dining room for herself and Resident #89 on 6/2/18 during the lunch meal. She reported that Resident #89 was seated at one end of a rectangular table that had seating for 6 residents. She indicated that 2 seats were on each side of the table and one seat on each end of the table.

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She was unable to recall if all 6 of the seats were occupied by residents on 6/2/18 during the lunch meal. She reported that she was assisting another resident with eating on this date (6/2/18) during lunch and she believed the resident she was assisting was seated next to Resident #89. NA #1 was unable to recall with certainty if she was seated between Resident #89 and the resident she was assisting or if she was seated on the opposite side of the resident she was assisting. She stated that she recalled setting up Resident #89 ' s tray. She reported that Resident #89 had grilled chicken that had been cut up into small pieces as well as some vegetables. She indicated Resident #89 ate independently after set-up during lunch in the dining room on 6/2/18. She stated that she looked over at Resident #89 during the meal to make sure she was eating, but that she had not observed her during the whole meal as she was helping someone else. NA #1 was asked if she noticed if Resident #89 was eating fast, if she was swallowing, if she was holding food in her mouth, or if she required any cues to ensure she was safely eating. NA #1 stated, "to be honest with you I don't recall". She explained that she knows that Resident #89 was not choking or making any unusual sounds during the meal so she "didn't think there was anything she needed". She reported that after Resident #89 ' s tray had been cleared she was going to take her back to her room to lay down. She stated that she began to push Resident #89 by wheelchair out of the dining room when the resident started coughing. She indicated Resident #89 was making a noise like she was "trying to throw up". She reported she called out for one of the nurses to help and that it was Nurse #1 who first realized Resident #89 had food in her mouth. NA #1 was asked if she had

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observed Resident #89's mouth prior to transporting her out of the dining room and she revealed she had not. She stated that she would've approached Resident #89 from the side and then from behind, so she could push her wheelchair. She revealed she had not observed Resident #89 from the front before exit the dining room. She additionally revealed she had not noticed during the lunch meal that Resident #89 was not swallowing her food.

This interview with NA #1 continued. NA #1 was asked if Resident #89 required assistance with eating. She stated that most of the time Resident #89 ate independently after set-up and required no assistance. She was asked if Resident #89 had any specific dietary orders or care plan interventions related to aspiration precautions. She stated that Resident #89 was supposed to be observed while eating but explained that this was not 1:1 observation it was just checking on her to make sure she was eating. She was asked if Resident #89 required any specific cueing and she stated that the only cueing Resident #89 required was encouragement to eat as sometimes she just sat there rather than feeding herself. The physician's order dated 4/17/17 and was an active order on 6/2/18 that indicated Resident #89 needed cueing to take small bites, eat slow, swallow between bites, and to alternate solids liquids was reviewed with NA #1. NA #1 revealed she was not aware of this order and she had not provided any of these cues to Resident #89 on 6/2/18 or on any prior date.

A written statement dated 6/2/18 completed by NA #2 was reviewed. This indicated NA #2 walked into the dining room around 1:15 PM (6/2/18) and saw Resident #89 eating with her

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fingers. The resident was noted to be putting pieces of chicken in her mouth. NA #2 indicated that NA #1 told her she would stay in the dining room. NA #2 then left the dining room.

An interview was conducted with NA #2 on 12/5/18 at 10:37 AM. The incident report and her written statement related to incident of substance ingestion on 6/2/18 for Resident #89 was reviewed with NA #2. She stated that she was in and out of the dining room during the lunch meal on 6/2/18 and that she had not assisted Resident #89 with eating. She reported she saw Resident #89 in the dining room and that she was eating independently.

This interview with NA #2 continued. NA #2 was asked if Resident #89 required assistance with eating. She stated that some days Resident #89 ate independently after set-up and required no assistance, but other days she would just sit there and not eat so she needed some verbal encouragement. She was asked if Resident #89 had any specific dietary orders or care plan interventions related to aspiration precautions. NA #2 stated that the NAs were just supposed to watch Resident #89 to ensure she was eating. She indicated that this was not 1:1 observation it was just checking on her throughout the meal. NA #2 was asked if Resident #89 required any specific cueing and she stated that the only cueing Resident #89 required was encouragement to eat on some days. The physician's order dated 4/17/17 and was an active order on 6/2/18 that indicated Resident #89 needed cueing to take small bites, eat slow, swallow between bites, and to alternate solids liquids was reviewed with NA #2. NA #2 revealed she was not aware of this order and she had not

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provided any of these cues to Resident #89 when she assisted her with meals.

An interview was conducted with NA #3 on 12/4/18 at 2:45 PM. She stated that she recalled being in the dining room during lunch on 6/2/18. She reported that she was helping another resident eat and that she had not observed Resident #89. NA #3 was asked if Resident #89 required assistance with eating. She indicated that sometimes she fed herself and sometimes she needed assistance in the form of encouragement. She was asked if Resident #89 had and specific dietary orders, care plan interventions, or cues related to aspiration precautions. NA #3 reported she recalled that Resident #89 needed "checked up on" while she was eating just to make sure she was feeding herself because sometimes she just sat there with her food in front of her and had not fed herself.

A written statement dated 6/2/18 completed by Nurse #1 was reviewed. Nurse #1 indicated at approximately 1:30 PM NA #1 brought Resident #89 out of the dining room stating that "I think she needs some help". She indicated Resident #89 was assessed with a "mouth full of food and was trying to chew and swallow the food in her mouth". Nurse #1 wrote that she encouraged Resident #89 to spit out the food, but the resident had not done so. Nurse #2 was noted to also tell Resident #89 to spit out the food, but the resident had "clamped her mouth shut and was still chewing the food in her mouth". Nurse #2 removed the dentures from Resident #89's mouth and performed a mouth sweep. There was a "large amount" estimated at 4 ounces of "well ground food" removed from Resident #89's

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mouth. Nurse #2 continue to sweep Resident #89's mouth until no visible food was seen in her mouth. Resident #89 was then noted to begin wheezing and her "lips were blue". Nurse #1 indicated she performed the Heimlich on Resident #89 with no more food expelled from her mouth. NA #1 and Nurse #3 took Resident #89 to her room as Nurse #1 contacted the Physician's Assistant (PA) and the Responsible Party (RP) at approximately 1:40 PM. The PA gave the order for transfer to the ER.

A phone interview was conducted with Nurse #1 on 12/5/18 at 12:20 PM. The incident report, nursing note, and her written statement related to Resident #89's 6/2/18 incident of substance ingestion were reviewed with Nurse #1. She verified that she had completed all of these documents and confirmed the information as written. Nurse #1 stated that when NA #1 brought Resident #89 as brought out to the nurse's station that she "visibly could see [Resident #89] had a mouth full of food" and that she wouldn't spit the food out. Nurse #1 was asked if Resident #89 required any assistance with eating. She revealed she believed Resident #89 had an order to be supervised while eating and that she, "needed to be reminded to chew and swallow".

A written statement, undated, completed by Nurse #2 indicated that she was standing at the medication cart on 6/2/18 at approximately 1:30 PM when NA #1 brought Resident #89 up to the nurse's station and stated that something was wrong and that she thought the resident was choking. Nurse #2 indicated Resident #89 had a large amount of food in her mouth and that she was still chewing on the food. She wrote that she asked Resident #89 to spit the food out, but she

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had not done so. She reported that she had been able to do a mouth sweep and removed a large amount of well ground food and continued to remove food until no visible food was seen. She indicated that Resident #89 then began wheezing and had a "noted change in color". Nurse #2 reported that Nurse #1 performed the Heimlich on Resident #89. Resident #89 was then taken to her room by Nurse #3 and Nurse #4.

A phone interview was conducted with Nurse #2 on 12/4/18 at 4:11 PM. The incident report and her handwritten statement were reviewed with Nurse #2. She verified that when Resident #89 was brought out to the nurse's station by NA #1 and that it was apparent on visual observation alone that the resident had a mouth full of food.

A written statement dated 6/5/18 completed by Nurse #3 was reviewed. Nurse #3 indicated that around 1:30 PM on 6/2/18 she was walking toward the nurse ' s station when Nurse #1 and Nurse #2 called her over. They were surrounding Resident #89 who was seated in her wheelchair and were removing chewed food from her mouth. Nurse #3 wrote that Nurse #1 and Nurse #2 told her that Resident #89 "had too much food in her mouth to allow her to swallow". Resident #89 had audible wheezing and her lips and fingertips were discolored. Nurse #3 wrote that she and Nurse #4 took Resident #89 to her room and applied O2 with a mask at 5 lpm until first responders arrived.

A phone interview was conducted with Nurse #3 on 12/5/18 at 4:32 PM. The incident report and her written statement related to Resident #89's 6/2/18 incident of substance ingestion were reviewed with Nurse #3. Nurse #3 confirmed the information documented in her written statement.

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Nurse #3 stated that Resident #89 had no loss of consciousness at any point while at the facility. She reported Resident #89 continued with audible wheezing throughout the time period they were waiting for first responders.

A written statement dated 6/4/18 completed by Nurse #4 was reviewed. Nurse #4 indicated on 6/2/18 at approximately 1:30 PM NA #1 brought Resident #89 out of the dining room and stated that she thought the resident was choking. Nurse #4 wrote that Resident #89's mouth and cheeks were full of food and she was still chewing on the food. Resident #89 was asked to spit out the food and the resident just kept chewing and would not spit it out. Nurse #4 indicated Nurse #1 and Nurse #2 removed all visible food from Resident #89's mouth by hand.

A phone interview was conducted with Nurse #4 on 12/5/18 at 1:45 PM. She stated she was unable to recall any specifics about the incident of substance ingestion on 6/2/18 for Resident #89.

A phone interview was conducted with Resident #89's physician on 12/6/18 at 2:36 PM. The physician reported that he expected the recommendations of ST as well as his orders to be followed. He indicated aspiration precautions were expected to be implemented for any resident noted to be an aspiration risk.

An interview was conducted with the Director of Nursing (DON) on 12/4/18 at 4:20 PM. The DON revealed that when she investigated the 6/2/18 incident of substance ingestion for Resident #89 she determined the resident likely aspirated. She stated that her expectations were for staff to provide supervision and cueing as recommended

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by ST, as ordered by the physician, and as indicated in the care plan. She additionally stated that she expected aspiration precautions to be implemented for all residents identified as at risk for aspiration.

The Administrator and DON were notified of the Immediate Jeopardy on 12/5/18 at 3:03 PM.

On 12/6/18 at 7:06 PM the facility provided the following credible allegation of Immediate Jeopardy removal:

Address how corrective action will be accomplished for the resident found to have been affected by the deficient practice:

On 6/2/2018 at approximately 1:30pm, Resident was escorted from the dining room and was noted making a vomiting noise. The Certified Nursing Assistant immediately took the resident to the nurse ' s station where the nurse assessed resident having difficulty swallowing and showing signs of aspiration with audible wheezing. The nurse attempted to remove food particles from resident ' s mouth but was unsuccessful in removing all food particles and therefore dentures were removed to perform a mouth sweep. During this process the resident continued to try to chew and swallow. At this time resident ' s lips became cyanotic and showing signs of difficulty breathing so the Heimlich maneuver was initiated by the nurse without success. Resident remained conscious and was moving air. The resident was taken from the nurse ' s station to her room in wheelchair by the Nurse supervisor, Nurse and

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Certified Nursing Assistant. Nurse supervisor suctioned resident to attempt to remove remaining food particles unsuccessfully. Resident ' s oxygen saturation was 79 percent, oxygen at 5 liters was applied via non-rebreather face mask. Physician Assistant and Responsible Party were notified at 1:40pm. The Physician Assistant stated to call Emergency Management Services. Emergency Services was called at 1:45pm and arrived at 2:00pm. First Responders took over care of the resident. Facility Nurse staff remained in room for support. First Responders applied oxygen with their regulator at fifteen liters per minute. At 2:10pm, the Emergency Management Technicians (EMT) arrived. They discussed with first responders and facility staff resident ' s condition and decision to suction resident in ambulance. First Responders and Emergency Management Technicians assisted the resident to the hall in her wheelchair, placed her on the gurney and proceeded to the ambulance. The EMTs remained in the ambulance for a few minutes and left the facility at 2:15pm. At 2:48pm the EMTs called to get next of kin contact information and informed the staff that the resident had died prior to reaching the hospital. On 6/2/18 an investigation was initiated immediately by the Director of Nursing and the Administrator and statements received from staff present in the dining room, at the nurse ' s station. At the conclusion of the investigation it was determined that the Certified Nursing Assistance was at the table providing assistance to another resident. According to the Certified nursing assistant ' s statement she followed aspiration precautions by setting up her tray, the chicken was in small pieces and saw her eating while helping another resident. Upon interview with C.N.A. on 6/2/18 by Director of Nursing and

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Administrator, she would not admit to not providing supervision and cueing.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

A 100% audit of Residents diagnosis was conducted by Director of Nursing (DON), Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON), Unit Manager (UM) and Director of Rehabilitation (DOR) for diagnosis of Dysphagia and Aphasia on 12/5/18 and 43 were identified with diagnosis of Dysphagia or Aphasia, 26 were identified with recommendations with swallowing guidelines. An information sheet, Swallowing Guidelines sheet, was implemented on 12/6/18 with current recommendations for those 26 identified with swallowing guidelines requiring supervision. The Swallowing Guidelines sheets (name, room number, diet, and recommendation from physician and speech therapist) are located in an aspiration precaution binder located in each dining room and each resident care kiosk. The swallowing guideline sheets and the kiosk are reconciled by the Assistant Director of Nurses and changes are updated when indicated by the physician or speech therapist. All 43 residents with diagnosis of Dysphagia and Aphasia care plans were reviewed by the Assistant Director of Nursing with no revisions required. CNAs will be assigned to residents identified requiring cueing and aspiration precautions by the charge nurse at the beginning each shift. Training of licensed and certified staff provided by SDC and DON on cueing and aspiration precautions and responsibilities initiated on 12/6/18. All licensed and certified nursing staff will receive this training

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prior to working next shift. This training will be included in new licensed and certified nursing staff orientation process.

Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On 12/5/18 an implementation of a dining room staff sign-in sheet to include sign in times/sign out times as well as aspiration precaution and supervision to be provided. This information is located in a binder in each dining room and resident care kiosk. Management, Licensed Nursing or Department Head will monitor meal supervision, utilizing Dining Supervision Manager Observation sheet. Supervision is being provided to ensure aspiration and safety precautions are being followed during meals in the dining rooms and for residents that eat in their rooms. The Director of Nursing will assign managers to the dining rooms to include resident rooms. Effective 12/5/18, on-site licensed staff, certified staff and department heads were trained by SDC on the information provided on aspiration precautions and residents requiring supervision to ensure that safety precautions are being followed. This information is located in a binder in each dining room and resident care kiosk. Training on the Heimlich maneuver with return demonstration and proper use of suction machine was conducted as well. This education was provided by the Registered Nurse, Staff Development Coordinator (SDC) to Licensed staff and other licensed staff will be trained prior to next shift worked. Emergency equipment (suction machine) was placed 12/5/18 in the dining rooms, set-up was completed and instructions were

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given to Licensed Staff by the SDC. On 12/5/18 education was also provided by the SDC for nursing staff to ensure supervision is being provided during meals and ensure aspiration precautions and safety is being provided. Licensed and Certified Nursing staff were also educated on the signs and symptoms of aspiration. Effective 12/6/18, re-education on the facility abuse and neglect policy was initiated for all staff and completed. The facility Abuse and neglect policy reflects that not providing care in accordance with the resident care plan maybe constitute neglect. This education was provided by RN Staff Development Coordinator. Staff not educated by 12/6/18 will not be allowed to work until educated. Effective 12/6/18, education on providing supervision during meals to ensure aspiration precautions and safety is added to all new employee orientation. This education will also be conducted annually by SDC for all staff. CNAs will be assigned to residents identified requiring cueing and aspiration precautions by the charge nurse at the beginning each shift. Training of licensed and certified staff provided by SDC and DON on cueing and aspiration precautions and responsibilities initiated on 12/6/18. All licensed and certified nursing staff will receive this training prior to working next shift. This trainingwill be included in new licensed and certified nursing staff orientation process.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: and include dates when corrective action will be completed:

Effective 12/6/18, The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Nurse Management, Licensed

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Nursing or Department Head will monitor meal supervision, utilizing Dining Supervision Manager Observation sheet. Supervision is being provided to ensure aspiration and safety precautions are being followed during meals in the dining rooms and for residents that eat in their rooms. Staff mentioned above will be assigned to each meal for supervision utilizing the Assignment calendar. The Director of Nursing will assign managers to the dining rooms to include resident rooms. This monitoring process will be continued by the Charge nurses on Saturday and Sunday. This monitoring will be conducted daily for four weeks, then weekly x4, then monthly thereafter. Findings will be reported by the Director of Nursing in the monthly Quality Assurance and Performance Improvement committee meeting for recommendations or modifications until a pattern of compliance is achieved.

Effective 12/6/18 the facility Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan or correction to ensure the facility attains and maintains substantial compliance.
Compliance Date 12/6/18

The credible allegation of Immediate Jeopardy removal was validated on 12/6/18 at 7:10 PM. Record review indicated an audit was conducted and there were 43 residents with diagnoses of dysphagia or aphasia and 26 residents identified with recommendations for swallowing guidelines. The 26 residents identified with recommendations for swallowing guidelines had a Swallowing Guidelines sheet implemented with current recommendations identified. Observation of the dinner meal on 12/6/18 confirmed the dining

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F 600	Continued From page 22 room sign in sheet, aspiration precaution binder, and suction machine were all in place, a manager was present to provide monitoring during the meal, and residents requiring cueing and aspiration precautions were assigned an NA. A review of inservice sign in sheets as well as staff interviews verified education was initiated on 12/5/18 on aspiration precautions and responsibilities, the signs and symptoms of aspiration, cueing, residents requiring supervision to ensure safety precautions were being followed, and ensuring that supervision is provided during meals. Education also included the facility ' s abuse and neglect policy which reflected that not providing care in accordance with the resident ' s care plan may constant neglect. Licensed staff were provided with education on the Heimlich Maneuver and proper use of the suctioning machine. Any staff not inserviced by 12/6/18 were required to be inserviced prior to working on the floor.	F 600		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 604		12/21/18

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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 604	Continued From page 23 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to maintain an environment free of physical restraints by covered a resident' s hands with socks for 1 of 2 residents (Resident #53) reviewed for physical restraints. The findings included: Resident #53 was admitted to the facility on 10/18/13 with diagnoses that included Alzheimer ' s disease, dementia without behaviors, anxiety, and aphasia (loss of ability to understand or express speech). The quarterly Minimum Data Set (MDS) assessment dated 10/19/18 indicated Resident #53 had severe cognitive impairment. She rarely/never understands others and she was rarely/never understood by others. Resident #53 had physical behaviors and other behavioral symptoms on 1 to 3 days and rejection of care on	F 604	F 604 Based on the root cause analysis by the facility administrative staff and the facility Director of Nursing, the facility staff provided resident #53 a physical restraint without appropriate indications to treat a medical condition. Immediate Removed sock on left hand of resident #53 after it was observed by the surveyor at approximately 10:00am on December 3, 2018. Identification 100% audit of all residents in the facility was conducted on 12/4/2018 by Director of Nursing (DON), Assistant Director of Nursing (ADON), and or Unit Coordinator (UC) to identify any other residents with the potential to have a restraint without appropriate indications to treat a medical	

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	345523	A. BUILDING _____ B. WING _____	C 12/06/2018

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4 to 6 days. She required the extensive assistance of 2 or more for bed mobility, transfers, dressing, and toileting. She required the extensive assistance of 1 staff for personal hygiene. Resident #53 was assessed with no physical restraints (defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily which restricts freedom of movement or normal access to one ' s body).

A nursing note dated 11/16/18 indicated Resident #53 was observed "gnawing" on her left hand and fingers hard enough to leave self-inflicted marks to skin on fingers, top of hand, and the palm. A sock was placed on the left hand as a "distraction mechanism" without any success.

Resident #53 ' s current care plan indicated the problem area of the risk for skin breakdown. This area was most recently updated on 11/16/18 with an intervention that stated to apply socks to both hands when Resident #53 was agitated.

Review of the resident ' s medical record revealed no assessment for applying socks on the resident ' s hands was found in the record. Also, there was no information in the resident ' s medical record that specified what lesser restrictive methods or devices were attempted prior to applying socks to the resident ' s hands.

A nursing note dated 11/18/18 indicated Resident #53 chewed on her hand at times.

A Social Work note dated 11/20/18 indicated the facility staff met with the hospice staff to discuss Resident #53 ' s status. A discussion was had

symptom. No other residents were identified with physical restraint. Findings of this audit is located on the Physical Restraint Audit Tool.
Systemic
Measures put into place to ensure the plan of correction is effective and remains in compliance are: Effective 12/21/2018, the facility will complete a pre-restraint assessment for all residents on admission, readmission and quarterly to identify any resident for a need for a restraint to treat a medical symptom. If a restraint is indicated, an order will be obtained from the physician and a consent from Responsible Party (RP) will also be obtained. The interdisciplinary team (IDT) to include the DON, Minimum Data Set Coordinator (MDSC), and Social Worker (SW) will meet to discuss the need for any restraint prior to the restraint being applied and the care plan will be updated by the (MDSC) and the certified nursing assistant (CNA) kiosk will be updated by the ADON or UC.
Effective 12/21/2018, the IDT to include the DON, SW and MDSC, will discuss and review any resident with a restraint weekly in the Standards of Care Meeting for effectiveness and reduction of restraint.
All on-site licensed and certified staff were educated on definition of restraint, qualification of restraints and who can initiate a restraint by the Staff Development Coordinator (SDC) on 12/13/2018. All other licensed and certified staff will be educated prior to working next shift. This training will be included in new staff orientation. Training

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F 604	Continued From page 25 about Resident #53 biting her hand which was noted to most likely be triggered by agitation related to over-stimulus. Socks were noted to be in place to protect Resident #53 ' s hands. A nursing note dated 12/2/18 indicated Resident #53 bit at her hand frequently and that her family had suggested her hand be covered when she began to bite at it. Resident #53 ' s hand was noted to be covered at the family ' s request on 12/2/18. An observation was conducted on 12/2/18 at 5:30 PM of Resident #53. She was seated in a broda chair (wheelchair that can tilt to change positions) in the hallway of the memory care unit and a sock was covering her entire left hand. Resident #53 was noted with her mouth on the sock covered hand. A nursing note dated 12/3/18 indicated Resident #53 was rocking back and forth and was biting her hand. An observation was conducted on 12/3/18 at 9:30 AM of Resident #53. She was seated in a broda chair in the dining room of the memory care unit and a sock was covering her entire left hand. Resident #53 ' s mouth was not touching the sock covered hand. An observation was conducted on 12/6/18 at 9:30 AM of Resident #53. She was seated in a broda chair in the hallway of the memory care unit. There were no socks covering either of her hands and her mouth was not touching her hands. An interview was conducted with Nursing Assistant #8 on 12/6/18 at 9:27 AM. She	F 604	will be provided annually. Monitoring Restraints will be added to daily clinical rounds daily Monday through Friday to discuss by the DON, ADON, UC the need and orders for restraints. This will be completed daily x 2 weeks, then weekly x 2 weeks, monthly x 3 months. Results will be presented in Quality Assurance Performance Improvement meeting by the DON for recommendations and modifications until substantial compliance is achieved. Date of compliance 12/21/2018	

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reported that she was working on 12/3/18 during the first shift (7:00 AM to 3:00 PM). She confirmed Resident #53 had a sock covering her left hand during the morning of 12/3/18. She was unsure how long the sock was in place. She stated that Resident #53 bit at her hand and the sock was put on so she couldn ' t bite her skin. NA #8 indicated she was not very familiar with Resident #53, but she thought the resident was unable to remove the sock from her hand once it was put in place.

An interview was conducted with the Director of Nursing (DON) on 12/6/18 at 8:00 AM. She revealed she was aware staff had placed a sock on Resident #53 ' s left hand to prevent her from making contact with her skin when she was biting her hand. The DON further revealed that she first observed the sock in place on Resident #53 ' s hand on the morning of 12/3/18. She stated she had the staff remove it immediately because it was a physical restraint indicating that the sock would not have easily been removed by the resident and that it restricted normal access to her body.

The DON explained that she believed the sock was implemented at the request of Resident #53 ' s family, but she explained to the staff that they were not able to do everything the family requested and that they were not to place socks on Resident #53 ' s hands again. She stated that she expected physical restraints to only be implemented when there was medical symptom to justify its use and for it to be utilized for the minimum amount of time necessary. She further stated that she expected a restraint assessment be completed and a physician ' s order to be in place prior to the utilization of a physical restraint.

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F 604	Continued From page 27 This interview with the DON continued. The care plan related to skin that indicated the intervention of applying socks to Resident #53 ' s hands when she was agitated was reviewed with the DON. The DON revealed she was unaware this intervention was added to Resident #53 ' s care plan and that she was going to revise the care plan and remove the intervention as it was not appropriate. She stated that this intervention was added to the care plan by the facility ' s previous MDS Nurse (MDS Nurse #1). An interview was conducted with MDS Nurse #2 on 12/6/18 at 3:15 PM. The observations of Resident #53 with a sock covering her left on 12/2/18 at 5:30 PM and 12/3/18 at 9:30 AM were reviewed with MDS Nurse #2. The care plan related to skin that indicated the intervention of applying socks to Resident #53 ' s hands when she was agitated was reviewed with MDS Nurse #2. MDS Nurse #2 revealed she was unaware a sock was placed on Resident #53 ' s hand and she was also unaware that it was added to her care plan. She stated she believed placing a sock on Resident #53 ' s hand met the definition of a physical restraint indicating that the sock would not have easily been removed by the resident and that it restricted normal access to her body.	F 604		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and	F 623		12/21/18

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the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

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F 623	Continued From page 29 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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F 623	Continued From page 30 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to notify the Ombudsman in writing of resident discharges for 2 of 2 sampled residents (Residents #58 and #83). The findings included: 1. Resident #58 was originally admitted to the facility 8/1/18 with a readmission date of 10/24/18 and was discharged to the Hospice House on 11/26/18. His diagnoses included malignant neoplasm of left upper lobe of lung, pneumonia, history of pulmonary embolism (a blood clot in the lung) and dependency on oxygen. During an interview with the Social Worker on12/5/18 at 2:30 pm, she stated she had not sent written notification to the Ombudsman at the time of the resident's discharge. She further stated that prior to today she had not been sending written notification to the Ombudsman for discharges to other facilities. She explained that she had a monthly tracking log for all transfers, discharges and deaths that she would begin to send to the Ombudsman as of today. During an interview with the DON on 12/6/18 at	F 623	F 623 Based on the root cause analysis by the facility administrative staff and the facility Executive Director, facility staff did not notify the Ombudsman when residents are discharged from the facility. Immediate The Ombudsman was notified of discharges for resident #58 and resident #83 on 12/5/2018 by the Social Worker (SW) after speaking to the Surveyor at 2:30pm on 12/5/2018. Identification A 100% audit of all unplanned discharges and discharges initiated by the facility was conducted by the SW on 12/5/2018 to determine if notification was given to the Ombudsman. As of 12/5/2018, all discharges were sent to the Ombudsman. Systemic Measures put into place to ensure the plan of correction is effective and remains in compliance are: Effective 12/21/2018, the SW will print a list of discharges weekly, have the Executive Director (ED) review the form and send the information to the Ombudsman. Confirmation email	

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F 623	Continued From page 31 3:05pm she stated that it was her expectation for the Ombudsman to be notified in writing of all discharges. 2. Resident # 83 was admitted to the facility on 6/28/18 with multiple diagnoses including dementia. She was discharged to the hospital on 10/31/18 and was readmitted on 11/3/18. Review of the social worker's notes was conducted. There was no documentation that the ombudsman was notified in writing of the discharge to the hospital. An interview with the Social Worker (SW) was conducted on 12/5/18 at 2:30 PM. The SW stated that she was responsible for notifying the ombudsman in writing of residents who had been discharged from the facility. The SW stated that she had sent a list of discharges to the ombudsman today (12/5/18) and acknowledged that she had not notified the ombudsman of discharges in the past. On 12/5/18 at 2:45 PM, tried to interview the ombudsman but was not available. An interview with the Director of Nursing (DON) was conducted on 12/6/18 at 2:59 PM. The DON stated that she expected the ombudsman to be notified in writing of residents who had been discharged from the facility.	F 623	or fax will be kept with this discharge form. The ED educated the SW and Admissions Coordinator of the requirements of notifying the Ombudsman of unplanned discharges and facility- initiated discharges on 12/7/2018. Any new staff hired in these two roles will be educated on this process as well. Monitoring This process will be conducted weekly x 4 weeks, then monthly x 3 months. Results will be presented in Quality Assurance Performance Improvement meeting by the SW for recommendations and modifications until substantial compliance is achieved. Date of Compliance 12/21/2018	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the	F 637		12/21/18

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F 637	Continued From page 32 resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interview, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days after it was determined that a resident had a decline in two or more MDS areas (activities of daily living (ADL), weight loss and falls) for 1 of 1 sampled resident reviewed for significant change in status MDS (Resident #83). Findings included: Resident #83 was admitted to the facility on 6/28/18 with multiple diagnoses including dementia and anxiety disorder. The quarterly MDS assessment dated 10/1/18 indicated that Resident #83 had intact cognition. The assessment also indicated that Resident #83 needed limited assistance with 1 person with bed mobility, transfer, ambulation, dressing, toilet use, personal hygiene and bathing. The assessment further indicated that Resident #83 had no weight loss and had no falls. On 10/31/18, Resident #83 was discharged to the hospital after a fall and was readmitted on 11/3/18 with a new diagnosis of right femur fracture	F 637	F 637 Based on the root cause analysis by the facility administrative staff and the Director of Nursing, the MDS Coordinator did not complete a significant change assessment on resident #83. Immediate Resident #83 had a significant change assessment with an Assessment Reference Date (ARD) of 12/14/2018 completed by the Minimum Data Set Coordinator (MDSC). Identification All current active resident Minimum Data Sets (MDS) for the last 30 days were reviewed to determine if a significant change assessment was needed by MDSC, Minimum Data Set Assistant (MDSA), Director of Nursing (DON), Assistant Director of Nursing (ADON) or Unit Coordinator (UC) on 12/21/2018. 3 residents were identified requiring a significant change assessment and were opened for completion. Systemic Measures put into place to ensure the plan of correction is effective and remains	

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F 637	Continued From page 33 status- post surgery. The 14 days MDS assessment dated 11/17/18 was reviewed. The assessment indicated that Resident #83 needed extensive assistance with 2 persons with bed mobility, transfer, dressing, toilet use, personal hygiene and bathing. The assessment also indicated that ambulation did not occur during the assessment period. The assessment further indicated that Resident #83 had a significant weight loss. On 12/3/18 at 1:40 PM, Resident #83 was interviewed. She stated that she was independent with transfer, ambulation, toilet use, personal hygiene and bathing but after the fall she needed assistance from the staff to do stuff. On 12/5/18 at 11:20 AM, MDS Nurse #1 was interviewed. She stated that she did not complete a significant change in status MDS assessment for Resident #83 because Resident #83 was on physical therapy and after 30 days she might return to her baseline status. The MDS Nurse had verified that Resident #83 had declined in her ADLs after the fall and had a significant weight loss on the 14 day MDS assessment. The MDS Nurse further indicated that if Resident #83 would not return to her baseline in 30 days, she would complete a significant change in status MDS assessment. On 12/6/18 at 2:59 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS Nurse to complete a significant change in status MDS assessment as required in the regulation, 14 days after 2 or more changes in the MDS areas were determined.	F 637	in compliance are: The MDSC, MDSA, DON, ADON and UC will compare the current MDS to the previous MDS to determine if a significant change has occurred by evaluating section responses. MDSC and or DON will also review daily nursing 24- hour clinical reports at the daily clinical meeting to determine if a significant change has occurred in two or more areas according to the Resident Assessment Instrument (RAI) guidelines. The MDSC, MDSA and DON were educated on 12/21/2018 with regard to significant change in status assessments by the Regional MDS Nurse. Monitoring Weekly audit of MDSs on calendar will be conducted by the MDSC, MDSA, DON or ADON. Ten (10) random audits will be completed per week. If a significant change has occurred, the resident will be scheduled for a significant change assessment. Audits will be completed weekly x 4 weeks, then monthly for 3 months. Results will be presented in Quality Assurance Performance Improvement meeting by the MDS Nurse for recommendations and modifications until substantial compliance is achieved. Compliance date 12/21/2018	

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F 641	Continued From page 34	F 641		
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 code the Minimum Data Set accurately in the area of Activities of Daily Living (Resident #34) and for discharge (Resident #71 and #89) for 3 of 22 sampled residents. The findings included: 1. Resident #34 was admitted to the facility on 1/11/17 with diagnoses that included history of fractures to the right hip, left clavicle and left side of ribs, dementia, muscle weakness, and torticollis (abnormal neck position). A review of the most recent comprehensive MDS coded as an Annual assessment and dated 2/21/18 revealed the resident was confused with impaired long and short-term memory. The assessment had documentation that she required total assistance of staff members for all ADL's to include eating. She was coded as having limited range of motion to one upper and both lower extremities. The most recent MDS (Minimum Data Set) coded as a Quarterly assessment and dated 11/15/18, assessed the resident as having confusion with impaired short and long-term memory. The assessment had documentation that she required extensive assistance for eating, dressing, toileting, personal hygiene, transfers and was	F 641	F 641 Based on the root cause analysis by the facility administrative staff and the facility Director of Nursing, the MDSC did not properly code the MDS per the RAI guidelines. Immediate MDS for Resident #34 was modified to reflect the level of assistance required for Activities of Daily Living (ADL) on 12/21/2018 by the Minimum Data Set Coordinator (MDSC). MDS for Resident #71 was modified to reflect correct discharge location on 12/6/2018 by the Minimum Data Set Assistant (MDSA). Resident #89 was modified to reflect correct discharge location on 12/21/2018 by MDSA. Identification All current active resident Minimum Data Sets (MDS) for the last 30 days were reviewed to determine if a modification was needed based on Activities of Daily Living (ADL) and supportive documentation needed by MDSC, Director Nursing (DON), Assistant Director of Nursing (ADON), Unit Coordinator (UC) and Infection Prevention Nurse (IPN) on 12/21/2018. No other resident MDSs were identified with inaccurate coding related to	12/21/18

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F 641	Continued From page 35 totally dependent on 2 staff members for bathing. She was coded as having limited range of motion to both sides of her upper and lower extremities. A review of the resident's active care plan dated 11/26/18 revealed that she was care planned for requiring assistance with ADL's, required 2-person assistance for transfers with a hoyer lift and required full assistance with meals and fluids. A review of the nursing documentation for the period of 11/2/18 to present revealed the staff had consistently documented the resident required total assistance with all ADL's to include eating and was a hoyer lift transfer by 2 staff members. On 12/5/18 at 9:10 AM resident was observed requiring total assistance from staff to lift leg for skin assessment to heels as well as reposition self in bed. An interview was held with the MDS nurse #1 on 12/5/18 at 11:00 AM who explained that she coded the ADL portion of the assessment based on the ADL Assistance and Support form that was completed by the nursing assistants (NA). She stated that she coded the assessment based on the lowest level of assistance documented by the NA's. She stated that she went and observed the resident as well as reviewed the medical record for staff documentation, but that she was told to strictly go by the ADL form completed by the NA's. At the time of the interview she reviewed the nurses notes during the look back period for the most recent MDS and confirmed that it showed the resident required total assistance for all ADL' s to include meals but stated that could not use the total care due to the way the NA flow record was coded.	F 641	ADLs and discharge location. Systemic Measures put into place to ensure the plan of correction is effective and remains in compliance are: The MDSC, MDSA, DON, ADON or the UC will evaluate and compare the current MDS to the ADL coding which is entered by the Certified Nursing Assistants (CNA), review of nurse's notes and other discipline documentation daily of scheduled MDSs to ensure accurate coding of ADLs and discharge locations on the MDS per RAI guidelines. The MDSC and MDSA were in-serviced on 12/21/2018 with regard to accurate coding of MDS assessments for accuracy of ADLs and correct discharge location by the Regional MDS Nurse. Monitoring Weekly audit of ADL documentation and discharge locations will be conducted by the MDSC, MDSA, DON or ADON. Ten (10) random audits will be completed per week. If a modification is warranted, the resident will be scheduled for an assessment. Audits will be completed weekly x 4 weeks, then monthly for 3 months. Results will be presented in Quality Assurance Performance Improvement meeting by the MDSC for recommendations and modifications until substantial compliance is achieved. Date of Compliance 12/21/2018	

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F 641	Continued From page 36	F 641		

Review of the ADL Assistance and Support log for the MDS look back period of 11/9/18 through 11/15/18 revealed the resident was marked by NA's needing total dependence most of the time for bed mobility, transfers, dressing, eating, toileting, personal hygiene and bathing.

Observation occurred on 12/5/18 at 12:30 PM requiring total assistance from staff member for lunch. She was unable to hold spoon or cup at the time of the lunch meal.

During an interview with NA #5 on 12/6/18 at 9:30 AM it was confirmed that the resident required total assistance with all ADL's to include eating and was transferred by a hoyer lift with 2 staff members. She further stated that the majority of the ADL's require 2 staff members as the resident is unable to assist at all.

An interview occurred with LPN #5 on 12/6/18 at 9:55 AM, who stated that the resident required total assistance with all ADL' s to include eating. She further stated that when she provided medications to the resident she had to provide them to her to include liquids as the resident was unable to hold a spoon or cup.

During an interview with the Director of Nursing on 12/6/18 at 3:00 PM, who stated that it was her expectation for the MDS to be coded as an accurate reflection of the resident.

2. Resident # 71 was admitted to the facility on 11/1/18 with multiple diagnoses including dementia. The admission Minimum Data Set (MDS) assessment dated 11/8/18 indicated that Resident #71 had severe cognitive impairment.

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The discharge MDS assessment dated 11/27/18 indicated that Resident #71 was discharged to the hospital.

Review of Resident #71 nurse's notes dated 11/29/18 (late entry for 11/27/18) revealed that Resident #71 was discharged to home on 11/27/18.

An interview with MDS Nurse #2 was conducted on 12/6/18 at 3:19 PM. MDS Nurse #2 verified that Resident #71 was discharged to home on 11/27/18. After she reviewed the MDS assessment dated 11/27/18, she acknowledged that the discharge location was coded wrong, Resident #71 was discharged to home and not to the hospital.

An interview with the Director of Nursing (DON) was conducted on 12/6/18 at 2:59 PM. The DON stated that she expected the MDS assessment to be coded accurately.

3. Resident #89 was admitted to the facility on 3/28/17 with diagnoses that included dysphagia (difficulty swallowing) and Alzheimer's.

The 6/2/18 discharge Minimum Data Set (MDS) assessment indicated Resident #89 died in the facility.

A physician's order dated 6/2/18 indicated Resident #89 was to be sent to the Emergency Room (ER) for evaluation.

A Resident Transfer Form dated 6/2/18 completed by Nurse #1 indicated Resident #89 was transferred to a local hospital.

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F 641	Continued From page 38 A nursing note dated 6/2/18 completed by Nurse #1 indicated Resident #89 was taken by Emergency Medical Services (EMS) out of the facility at 2:15 PM for transport to the ER. A written statement dated 6/2/18 by Nurse #1 indicated at approximately 2:48 PM EMS called facility and reported that Resident #89 died before she ever got to the hospital. The EMS record dated 6/2/18 indicated Resident #89 was transported by EMS out of the facility. During the transport to the hospital Resident #89 expired and her death was pronounced at 2:29 PM in the ambulance. A phone interview was conducted with Nurse #1 on 12/5/18 at 12:20 PM. She verified that Resident #89 was alive when she left the facility with EMS on 6/2/18 and she died on the way to the hospital. An interview was conducted with the Director of Nursing on 12/6/18 at 2:57 PM. She indicated she expected the MDS to be coded accurately.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the	F 644		12/21/18

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F 644	Continued From page 39 PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to refer a resident with newly evident diagnoses of serious mental illnesses for Pre-Admission Screening and Annual Resident Review (PASARR) Level II screen for 1 of 1 resident reviewed for PASARR (Resident #78). The findings included: Resident #78 was admitted to the facility on 10/5/16 with no mental health diagnoses and a level I Pre-Admission Screening and Annual Resident Review (PASARR). A Psychiatric Physician ' s Assistant note for Resident #78 dated 6/26/18 indicated the diagnoses of psychotic disorder due to delusions, anxiety disorder, major depressive disorder, and pseudobulbar affect (inappropriate involuntary laughing or crying caused by a nervous system disorder). This note indicated that staff reported that Resident #78 was crying more and had increased delusions following a decrease in psychotropic medications. The annual Minimum Data Set (MDS) assessment dated 8/16/18 indicated Resident	F 644	F 644 Based on the root cause analysis by the facility administrative team and the Executive Director, the SW did not identify a resident with new onset serious mental illness and update the Pre-Admission Screening And Resident Review (PASARR) as required. Immediate A PASARR was sent for review for Resident #78 on 12/21/2018 by the Social Worker (SW). Identification A review was conducted by the Executive Director (ED) of all active resident's diagnosis to determine if any resident has a newly (since admission) evident diagnosis of serious mental illness. Any resident identified with a new diagnosis of serious mental illness will be reviewed by physician, in- house psychological services and if warranted sent for review to PASARR by the SW or Executive Director (ED). 3 residents were identified with onset of serious mental illness and submitted for review to PASARR. Social Worker was educated by ED of the requirements set forth for further	

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F 644	Continued From page 40 #78 ' s cognition was severely impaired. The staff assessment of Resident #78 ' s mood noted her feeling or appearing down/depressed/hopeless on 2 to 6 days, poor appetite or overeating on 7 to 11 days, and moving/speaking slowly or the fidgety/restless on 2 to 6 days. She had physical behaviors on 1 to 3 days. These behaviors were noted to put Resident #78 and others at significant risk of injury. Resident #78 was administered antipsychotic medication and antidepressant medication on 7 of 7 days. Her active diagnoses included psychotic disorder and depression. The Behavioral Symptoms Care Area Assessment (CAA) for the 8/16/18 MDS indicated Resident #78 was on Prozac (antidepressant) to assist with depression and Depakote (mood stabilizer) to assist with depression and anxiety. Seroquel (antipsychotic) was noted to be reinitiated after a failed Gradual Dose Reduction (GDR) in which Resident #78 presented with increased anxiety and tearful episodes that were difficult to console. The Psychotropic Medications CAA for the 8/16/18 MDS indicated Resident #78 was on Seroquel for delusions. The quarterly MDS assessment dated 11/29/18 indicated Resident #78 ' s cognition was severely impaired. The staff assessment of Resident #78 ' s mood noted her feeling or appearing down/depressed/hopeless on 7 to 11 days, poor appetite or overeating on 7 to 11 days, moving/speaking slowly or the fidgety/restless on 2 to 6 days, and being short-tempered/easily annoyed on 2 to 6 days. She had physical behaviors on 1 to 3 days and other behavioral symptoms daily. Resident #78 was administered	F 644	evaluations in regard to PASARR requirements on 12/21/2018. Any new employee in this department will be educated during new hire orientation. Systemic Measures put into place to ensure plan of correction is effective and remains in compliance are: Effective 12/21/2018, PASARRs will be added to daily clinical rounds daily Monday through Friday to be discussed by the DON, ADON, UC, SW and ED the need for PASARR review based on new diagnosis of serious mental illness. Monitoring This will be completed daily x 2 weeks, then weekly x 2 weeks, monthly x 3 months. Results will be presented in Quality Assurance Performance Improvement meeting by the SW for recommendations and modifications until substantial compliance is achieved. Date of compliance 12/21/2018	

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F 644	Continued From page 41	F 644		

antipsychotic medication and antidepressant medication on 7 of 7 days. Her active diagnoses included psychotic disorder and depression.

An observation was conducted of Resident #78 on 12/3/18 at 9:35 AM. She was seated in her wheelchair in the hallway of the memory care unit and she was crying. Nursing Assistant (NA) #8 was observed to provide hand holding and words of comfort to Resident #78.

An interview was conducted with the Social Worker (SW) on 12/5/18 at 11:10 AM. She stated she was aware that when a resident was newly diagnosed with a serious mental illness that was not present on admission that the resident needed to be referred for a PASARR re-evaluation. She indicated she was responsible for the completion of this referral. The SW confirmed that Resident #78 had a level I PASARR. Resident #78 ' s admission diagnoses that included no mental health diagnoses were reviewed with SW. Resident #78 ' s 8/16/18 and 11/29/18 MDS assessments that indicated the active diagnoses of psychotic disorder and depression as well as the use of antipsychotic medication and antidepressant medication were reviewed with the SW. The SW revealed she had not referred Resident #78 to the PASARR authority for a re-evaluation related to these new diagnoses as she thought it only applied to diagnoses like schizophrenia and bipolar disorder.

An interview was conducted with the Director of Nursing on 12/6/18 at 2:57 PM. She stated that she expected the regulations related to PASARR to be followed.

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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 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		12/21/18

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F 656	Continued From page 43 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to implement the care plan interventions related to feeding assistance and swallowing precautions for 3 of 3 residents (Residents #89, #33, and #57) reviewed for aspiration precautions. The findings included: 1. Resident #89 was admitted to the facility on 3/28/17 with diagnoses that included dysphagia (difficulty swallowing) following cerebral infarction, aphasia (loss of ability to understand or express speech), hemiplegia (paralysis of one side of the body) affecting right dominant side, and Alzheimer's disease. A physician's order dated 4/17/17 indicated the physician agreed to a dietary order change as recommended by Speech Therapist (ST) #1. The order indicated Resident#89, " ...needs [one on one] supervision or dining room supervision to cue [resident] to take small bites, eat slow and swallow between bites, and to alternate solids [and] liquids". This 4/17/17 order remained in place throughout the remainder of Resident #89 ' s stay at the facility. Resident #89's plan of care indicated she needed monitoring of nutritional status and weight status related to a diagnosis of dysphagia and Alzheimer's disease. This care plan, initiated on 2/19/18 and most recently reviewed/revised on 5/8/18, indicated Resident #89's diet was	F 656	F 656 Based on the root cause analysis by the facility administrative staff and the Director of Nursing, the facility staff failed to implement care plan interventions related to feeding assistance and swallowing precautions. Immediate Resident # 89 no longer resides in the facility. Resident # 33 care plan was revised to include approaches to reflect the needs during meals. Resident # 57 care plan was revised to include approaches to reflect the needs during meals. Identification A 100% audit of Residents diagnosis was conducted by Director of Nursing (DON), Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON), Unit Manager (UM) and Director of Rehabilitation (DOR) for diagnosis of Dysphagia and Aphasia on 12/5/18 and 43 residents were identified with a diagnosis of Dysphagia or Aphasia, 26 residents were identified with a recommendation with swallowing guidelines. A Swallowing Guidelines sheet, was implemented on 12/6/18 with current recommendations for 26 of the identified with swallowing indicating requiring supervision. The Swallowing	

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F 656	Continued From page 44 mechanical soft with finger foods. The interventions included, in part: - Provide Resident #89 with assist at meals to ensure optimal and safe oral intake. - Remind Resident #89 of swallowing precautions. The quarterly Minimum Data Set (MDS) assessment dated 5/9/18 indicated Resident #89's cognition was severely impaired. She had short-term and long-term memory problems and severely impaired decision making. Resident #89 was assessed as requiring the extensive assistance of 1 for eating. She was on a mechanically altered diet and had no swallowing disorders. Resident #89 had not received Speech Therapy during this MDS period. An incident report dated 6/2/18 completed by Nurse #1 indicated Resident #89 had an incident of "substance ingestion" on 6/2/18 at 1:30 PM. The incident was initially reported by Nursing Assistant (NA) #1. The narrative of the incident read, "[NA #1] brought [Resident #89] out of dining room to nurses station, stating ' I think she needs some help ' . Nurse assessment completed with food noted in oral cavity. Another nurse [Nurse #2] removed some food particles from mouth and dentures. There was a large amount of well ground food and [Nurse #2] continued to remove food until no longer visible". Based on the staff schedule, the assignment schedule, and an interview with the Director of Nursing on 12/5/18 at 8:20 AM NA #1 was responsible for supervision of Resident #89 during the lunch meal on 6/2/18. A written statement (incorrectly dated 5/2/18)	F 656	Guidelines sheets (name, room number, diet, and recommendation from physician and /or speech therapist) are located in an aspiration precaution binder located in each dining room and each resident care kiosk. The swallowing guideline sheets and the kiosk are reconciled by the Assistant Director of Nurses and changes are updated when indicated by the physician or speech therapist. All 43 residents with diagnosis of Dysphagia and Aphasia care plans were reviewed by the Assistant Director of Nursing with no revisions required. CNAs are assigned to the dining room each meal to assist residents requiring cueing and aspiration precautions by the charge nurse at the beginning each shift. Systemic Measures put into place to ensure the plan of correction is effective and remains in compliance are: Physician orders and speech therapy recommendations will be reviewed daily by DON, ADON, Minimum Data Set Coordinator (MDSC), UC or Weekend Nurse Manager (NM) to ensure orders and recommendations are being followed on the care plan either through initiation or revision and reconciled with Swallowing Guidelines sheet and CNA kiosk. Education was provided by the Executive Director to DON, ADON, MDSC, UC and NM regarding reviewing orders and recommendations, reviewing care plans, initiating care plans and revising care plans as warranted. Staff not educated by 12/21/18 will not be allowed to work until educated. Training	

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F 656	Continued From page 45 completed by NA #1 was reviewed. NA #1 indicated that between 12:15PM and 1:30PM on 6/2/18 she was in the dining room helping pass out trays and feeding residents. She noted that she set up Resident #89's tray reporting that she had grilled chicken that was cut up into small pieces. NA #1 wrote, "I saw her eating while I was helping feed another resident". She indicated that around 1:30 PM lunch was over, and another NA removed Resident #89's tray. NA #1 reported she then started pushing Resident #89 in her wheelchair out of the dining room. She indicated that when she reached the dining room door with Resident #89 she heard the resident "making a noise like she was trying to throw up". NA #1 wrote that she pushed Resident #89 down the hall in her wheelchair and started yelling for Nurse #4 to help her. She indicated that when she reached the nurse's station Nurse #1, Nurse #2, and Nurse #4 were there. She indicated that the nurses removed about 4 ounces of food from Resident #89 ' s mouth. A phone interview was conducted with NA #1 on 12/5/18 at 5:08 PM. The incident report and her written statement related to the incident of substance ingestion on 6/2/18 for Resident #89 was reviewed with NA #1. She stated that she recalled setting up Resident #89's tray. She indicated Resident #89 ate independently after set-up during lunch in the dining room on 6/2/18. She stated that she looked over at Resident #89 during the meal to make sure she was eating, but that she had not observed her during the whole meal as she was helping someone else. NA #1 was asked if she noticed if Resident #89 was eating fast, if she was swallowing, if she was holding food in her mouth, or if she required any cues to ensure she was safely eating. NA #1	F 656	of licensed and certified staff provided by SDC and DON on cueing and aspiration precautions and responsibilities as related to the care plan initiated on 12/6/18. All licensed and certified nursing staff will receive this training prior to working next shift. This training will be included in new licensed and certified nursing staff orientation process. Monitoring Physician orders and therapy recommendations will be added to the daily rounds Monday through Friday to be discussed by the DON, ADON, UC and MDSC to ensure physician orders and recommendations are being carried over to the care plan as well as the CNA Kardex. This will be completed daily x2 weeks, then weekly x2 weeks, then monthly x3 months. Results will be presented in the Quality Assurance and Performance Improvement (QAPI) meeting by the DON for recommendations and modifications until substantial compliance is achieved. Date of Compliance 12/21/2018	

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stated, "to be honest with you I don ' t recall".

This interview with NA #1 continued. NA #1 was asked if Resident #89 had any care plan interventions related to nutrition, eating, or swallowing/aspiration precautions. She stated that Resident #89 was supposed to be observed while eating but explained that this was not one on one observation it was just checking on her to make sure she was eating. She revealed she was not aware of any cueing related to swallowing precautions for Resident #89 and she confirmed she had not provided any of these cues to Resident #89 on 6/2/18 or on any prior date.

A phone interview was conducted with Nurse #1 on 12/5/18 at 12:20 PM. The incident report related to Resident #89's 6/2/18 incident of substance ingestion was reviewed with Nurse #1. She stated that when NA #1 brought Resident #89 out to the nurse's station that she "visibly could see [Resident #89] had a mouth full of food".

A phone interview was conducted with Nurse #2 on 12/4/18 at 4:11 PM. The incident report was reviewed with Nurse #2. She verified that when Resident #89 was brought out to the nurse's station by NA #1 that it was apparent on visual observation alone that the resident had a mouth full of food.

An interview was conducted with the Director of Nursing (DON) on 12/4/18 at 2:20 PM. The care plan related to nutrition for Resident #89 that indicated she was to be provided with assistance at meals to ensure optimal and safe oral intake and for the resident to be reminded of swallowing

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precautions was reviewed with the DON. She stated that swallowing precautions included ensuring the resident was sitting up straight and was not pocketing food. She additionally stated the swallowing precautions also included the provision of cueing to swallow the food, take small bites, eat slowly, and to alternate between solids and liquids. She revealed these care plan interventions had not been followed for Resident #89 on 6/2/18 during the lunch meal. She indicated her expectation was for the care plan interventions to be followed.

2. Resident #33 was admitted to the facility on 1/17/14 with diagnoses that included dysphagia (difficulty in swallowing) and Diabetes Mellitus.

The most recent comprehensive MDS assessment coded as an Annual and dated 7/20/18 revealed the resident was alert and oriented with periods of confusion. He required setup and supervision with meals. The assessment had documentation that he had coughing or choking during meals and when swallowing medications and received a mechanically altered diet.

Review of a Speech Therapy note dated 7/25/18 stated the resident required close supervision as he was at increased risk of aspiration (A condition in which food, liquids, saliva, or vomit is breathed into the airways). He was not to talk while eating, consume small portions, eat slow and use adaptive spoon.

The most recent MDS (Minimum Data Set) coded as a Quarterly assessment and dated 10/8/18, assessed the resident as alert and oriented with periods of confusion. He required setup and

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supervision with meals. The assessment had documentation that he had coughing or choking during meals or when swallowing medications and received a mechanically altered diet.

Review of the resident's active care plan dated 10/15/18 revealed the resident received a mechanically altered diet, had swallowing difficulties and required setup of the meal tray with supervision and cues. The safe swallow guidelines were to be utilized during meal time.

Review of Resident #33's Swallow Precautions Checklist revealed the following needs for the resident during meals: Pureed diet with nectar thick liquids, required constant supervision with verbal cues to take small bites, eat slow and alternate food and drink, sit upright during meals; no straws, a small cup with one sip then swallow two to three times; limit bite size to half a teaspoon or less, swallow 2 to 3 times with each bite, empty mouth before additional bites, alternate bites of food with sips of liquid, drink several sips of liquid at the end of the meal, remind resident to check for pocketed food with tongue or finger and check mouth after meals for pocketing; remind resident to slow down while eating, eliminate distractions, no talking while eating and sit up right for 20 to 30 minutes after eating. The Swallow Precautions Checklist was in a binder in the dining room, as well as the resident's medical record

Review of a FMP (Functional Maintenance Program) note dated 10/15/18 revealed the resident was started on the FMP for swallowing difficulties and was to use the modified spoon, follow aspiration precautions per swallowing precautions checklist and eat in the dining room

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with supervision of the nursing assistants (NA).

During an observation on 12/4/18 at 12:45 PM, resident #33 was eating lunch in the dining room. He had the appropriate diet and liquid consistency. No straws were present in his fluids and he was using a maroon spoon to eat with. The resident was observed eating fast, with small amounts of food present on the spoon and coughed three times during the lunch meal. No staff were observed providing any type of supervision, cues or reminders to the resident per the Swallow Precautions Checklist. The staff in the dining room were observed passing out trays and assisting other residents with their meals on the opposite side of the dining room.

An interview with the Staff Development Coordinator/FMP nurse occurred on 12/4/18 at 1:25 PM, who stated that the FMP NA monitors the resident's progress with meals once a week to see if he is following the swallowing precautions. She further stated that Resident #33 required cues during meals and that the NA's in the dining room were responsible for providing supervision and cues during his meals.

An interview was conducted with FMP Aide on 12/4/18 at 2:15 PM. She stated Resident #33 ate fast during meals and required cues to eat slow. She was able to state his correct diet consistency as well as no straws and the need for the maroon spoon with all meals. She added that the NA's in the dining room supervise him and provided cues to slow down while they were passing out trays and assisting other residents with their meals.

During an interview on 12/4/18 at 4:50 PM with NA #6, she explained that staff provide

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supervision and cues to Resident #33 while they are passing out other resident's trays and monitors the resident from the assisted dining tables. She was able to state the resident required supervision and cues to eat slow, must have his maroon spoon with all meals and was not to have any straws. She further stated that in the dining room was a binder with the Swallow Precautions Checklist for any resident that had special needs during a meal.

During an observation on 12/5/18 at 8:10 AM the resident was in the dining room eating breakfast. Correct diet and fluid consistency was present. Staff were observed passing out trays and assisting other residents with their meal. No cues or prompts were observed from staff during the breakfast meal.

During an interview with NA #2 on 12/5/18 at 10:45 AM, she could not confirm how supervision was provided for residents that require cues related to aspiration precautions other than to say if she heard them coughing she would ask if they were ok. She stated that no one sat at the table with Resident #33.

On 12/5/18 at 11:15 AM an interview occurred with NA #7, who stated that Resident #33 required cues to eat slow. She stated that he was one of the first residents to receive their tray and when the staff set it up they reminded him to eat slow, made sure that his liquids were thickened, and he had his maroon spoon. She stated that the resident was supervised while the other trays were being passed out. She further stated that a binder was present in the dining room with the Swallow Precautions Checklist for any resident with special needs during meals.

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During an interview with NA #5 on 12/6/18 at 9:30 AM, she stated that Resident #33 was supervised while staff were passing out trays and from the assisted dining tables with reminders to slow down when this was observed. She confirmed that he required supervision and cues per the Swallow Precautions Checklist.

During an interview on 12/6/18 at 3:00 pm the Director of Nursing stated that it was her expectation for the care plan to be followed.

3. Resident #57 admitted to the facility on 7/27/18 with diagnoses of Dementia, Parkinson's Disease, Protein Calorie Malnutrition, and difficulty swallowing. His most recent comprehensive assessment dated 11/29/18 revealed he was moderately cognitively impaired and required supervision of staff for meals. He was also coded as having coughing and choking during meals.

Review of Resident #57's Physician's Orders revealed an order for Regular Mechanical Soft and Honey Thick Liquids Diet dated 11/15/18.

A Swallow Precautions Checklist dated 11/16/18 stated Resident #57 required constant supervision, sitting upright 90 degrees when eating, taking small cup sips, taking one sip then swallow, cough and clear throat after each sip then swallow, alternate bites of food with sips of liquid at end of meal, bite size to half teaspoon or less, and check mouth after meals for pocketing.

A review of Resident #57's Care Plan which was updated on 11/30/18 revealed a care plan goal the resident would not display any signs of

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swallowing difficulty. The care plan further revealed Resident #57 should be supervised at meals, use an inner lip plate, and large grip utensils.

Interview with Nurse Aide #5 on 12/04/18 at 3:10 pm revealed Resident #57 usually eats in the dining room. She stated she does not sit with him when he eats and he eats his meals without constant staff supervision. She stated she was not aware of Resident #57 having any precautions for eating.

During an interview with Speech Therapist #2 on 12/5/18 at 8:35 am she stated Resident #57 requires constant supervision during meals. She stated there is a Swallowing Precautions Sheet in his Medical Record that the staff should follow. Speech Therapist #2 stated Resident #47 required constant supervision, sitting upright 90 degrees when eating, taking small cup sips, taking one sip then swallow, cough and clear throat after each sip then swallow, alternate bites of food with sips of liquid at end of meal, bite size to half teaspoon or less, and check mouth after meals for pocketing.

During an interview with Nurse Aide #2 on 12/5/18 at 12:41 pm she stated Resident #57 sits at the dining table with other residents and the staff follow-up, but they do not sit with him while he eats. She stated she watches him from another table while she assists other residents, so he does not receive constant staff supervision at meals.

An interview on 12/6/18 at 3:00 pm with the Director of Nursing revealed her expectation is staff would supervise residents with swallowing

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F 656	Continued From page 53 difficulties as ordered and follow the residents' care plan.	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 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to review and revise the care plan for falls (Resident #83), for hydration (Residents #72) and for nutrition (Resident # 89) for 3 of 22	F 657	F 657 Based on the root cause analysis by the facility administrative staff and the DON, the facility staff failed to review and revise	12/21/18

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F 657	Continued From page 54 sampled residents reviewed. Findings included: 1. Resident #83 was admitted to the facility on 6/28/18 and was readmitted on 11/3/18 with multiple diagnoses including right femur fracture. The quarterly Minimum Data Set (MDS) assessment dated 10/1/18 indicated that Resident #83 had intact cognition and had no falls. Resident #83's care plan dated 10/3/18 was reviewed. One of the care plan problems was Resident #83 was at risk for falls related to decrease mobility, weakness and had falls prior to admission. The goals was Resident #83 would experience no injurious falls thru next review. The approaches included keep environment clean and clutter free, orient to room and do not rearrange furniture or belongings unless to accommodate her preference, keep frequently used belongings within reach at all times, assist with activities of daily living (ADLs) as indicated, call light within reach at all times and encourage its use, monitor for safety frequently, encourage to ask for assistance when needing up, keep bed at low position with brakes locked, assist with toileting per protocol and as needed, encourage to lock brakes during transfer, therapy per order and administer medications as ordered and monitor for side effects. On 10/20/18, safety education to resident was provided and requested to allow staff to make her bed were added to the approaches. There were no changes to the care plan after 10/20/18. The nurse's notes and incident reports were reviewed. The note/report dated 10/20/18	F 657	care plans for falls, hydration and nutrition. Immediate Resident #83 care plan revised to include falls and interventions by ADON on 12/13/18. Resident #72 care plan revised to include fluid restrictions by the Registered Dietician on 12/17/2018. Resident #89 no longer resides in the facility. Identification A 100% audit of Residents with a fall in last 30 days was conducted by Director of Nursing (DON), Assistant Director of Nursing (ADON) and Unit Manager (UM) on 12/21/2018 and there were no care plans requiring revision for falls. 100% of residents on fluid restrictions were reviewed by DON, ADON and UM on 12/18/2018 and no care plans required revision. 100% audit of all resident nutrition care plans were reviewed by Registered Dietician on 12/13/2018 and no revisions required. Corrective actions will be accomplished for those residents having the potential to be effected by the same deficient practice. All have the potential to be affected at the time care plan is due. Systematic Measures put into place to ensure the plan of correction is effective and remains in compliance are: Effective 12/21/2018, Falls, fluid restriction and nutrition status will be added to daily clinical rounds daily	

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F 657	Continued From page 55 revealed that Resident # 83 had a fall and was noted to have a bruise to the right shin and a skin tear to left shin. On 10/31/18, the note/report revealed that Resident #83 had a fall and sustained a right femoral fracture. On 12/5/18 at 11:20 AM, MDS Nurse #1 was interviewed. The MDS Nurse verified that Resident #83 had a fall on 10/31/18 and sustained right femoral fracture. She indicated that Resident #83 was discharged to the hospital after the fall and was readmitted on 11/3/18. The MDS Nurse had verified that Resident #83 had declined in her ADLs after the fall. She also indicated that the Assistant Director of Nursing (ADON) was responsible for revising the care plan after every falls. On 12/5/18 at 11:22 AM, the ADON was interviewed. She stated that the falls committee had met and discussed residents who had falls. The ADON verified that Resident #83 had a fall with major injury and was admitted to the hospital on 10/31/18. She indicated that after readmission (11/3/18), the care plan should have been revised but it was not. On 12/6/18 at 2:59 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS Nurse to be responsible for revising the care plan every after falls. She stated that she expected the care plan of Resident #83 revised after she was readmitted from the hospital. 2. Resident #72 was admitted to the facility on 10/10/18 with multiple diagnoses including congestive heart failure (CHF). The admission	F 657	Monday through Friday to be discussed by the DON, ADON, MDSC or UC to ensure the care plan is revised accordingly. Education was provided by the Executive Director (ED) to the DON, ADON, MDSC MDSA and UC regarding reviewing and updating the care plans. Monitoring This will be completed daily x 2 weeks, then weekly x 2 weeks, then monthly x 3 months. Results will be presented by the ADON for recommendations and modifications until substantial compliance is achieved. Date of Compliance 12/21/2018	

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Minimum Data Set (MDS) assessment dated 10/17/18 indicated that Resident #72 had severe cognitive impairment.

Resident #72's care plan dated 10/19/18 was reviewed. One of the care plan problems was resident has the potential for fluid volume deficit related to use of diuretic. The goal was resident would not show signs and symptoms of dehydration daily. The approaches included monitor fluid intake and output daily, place straw in glass so resident can drink fluid independently, offer fluids when enter resident's room and with each medication pass and maintain fluids at bedside and remind/encourage resident to drink fluids throughout the day.

On 11/20/18, Resident #72 had a doctor's order for 1500 milliliter (ml) fluid restriction- dietary to provide 720 ml.

On 12/6/18 at 3:19 PM, MDS Nurse #2 was interviewed. She stated that the care plan for Resident #72 should have been revised when the order for the fluid restriction was written but it was not.

On 12/6/18 at 2:59 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS Nurse to be responsible for revising the care plan. She stated that she expected the care plan of Resident #72 revised when the fluid restriction was ordered.

3. Resident #89 was admitted to the facility on 3/28/17 with diagnoses that included dysphagia (difficulty swallowing) following cerebral infarction, aphasia (loss of ability to understand or express speech), hemiplegia (paralysis of one side of the

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body) affecting right dominant side, and Alzheimer's.

Resident #89's plan of care indicated the problem area of the need for monitoring of nutritional status and weight status related to a diagnosis of dysphagia and Alzheimer's. This care plan was initiated on 2/19/18 and most recently reviewed/revised on 5/8/18 by the Dietary Manager (DM). The interventions indicated Resident #89 was receiving speech therapy for dysphagia.

The quarterly Minimum Data Set (MDS) assessment dated 5/9/18 indicated Resident #89's cognition was severely impaired. She had short-term and long-term memory problems and severely impaired decision making. Resident #89 had not received Speech Therapy (ST) during this MDS period.

A review of the ST documentation indicated Resident #89 was discharged from their services on 5/12/17 and ST had not been reinitiated.

An interview was conducted with the DM on 12/5/18 at 2:20 PM. The care plan related to nutritional status (initiated 2/19/18 and last reviewed/revised 5/8/18) for Resident #89 that indicated she was receiving ST for dysphagia was reviewed with the DM. The DM stated that she was responsible for this care plan for Resident #89 and revealed that it should have been revised as ST had not been an active intervention in 2018.

An interview was conducted with the Director of Nursing on 12/4/18 at 2:00 PM. She verified that Resident #89 had not received ST since 2017.

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F 657	Continued From page 58 She stated she expected the care plans to reviewed and revised to reflect the resident's current status.	F 657		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with Speech Therapist, Registered Dietician, physician, and staff, the facility failed to supervise residents with aspiration precautions during meals for 3 of 3 residents (Residents #89, #33, and #57) reviewed for aspiration precautions. Resident #89 was observed by nursing staff with a mouth full of food making a vomiting noise after meal time. She was transferred to the Emergency Room by Emergency Medical Services and died in the ambulance on the way to the hospital. Immediate Jeopardy began on 6/2/18 at approximately 1:30 PM when Nursing Assistant #1 observed Resident #89 making a vomiting sound following the lunch meal that she had eaten in the dining room. She was assessed by nursing staff to have a large amount of ground/chewed food, estimated at 4 ounces, in her mouth. Emergency Medical Services (EMS) were contacted by facility staff to evaluate	F 689	F 689 Based on the root cause analysis by the facility administrative staff and the facility Director of Nursing, facility staff did not provide direct supervision for resident #89 during meal. Immediate On 6/2/2018 at approximately 1:30pm, Resident was escorted from the dining room and was noted making a vomiting noise. The Certified Nursing Assistant immediately took the resident to the nurse's station where the nurse assessed resident having difficulty swallowing and showing signs of aspiration with audible wheezing. The nurse attempted to remove food particles from resident's mouth but was unsuccessful in removing all food particles and therefore dentures were removed to perform a mouth sweep.	12/21/18

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F 689	Continued From page 59	F 689		

Resident #89 for the chief complaint of "choking". Resident #89 was en route to the hospital with EMS when she went into cardiac arrest and respiratory failure and was pronounced dead on 6/2/18 at 2:29 PM.

Immediate Jeopardy was removed on 12/6/18 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (isolated and no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective.

The findings included:

1. Resident #89 was admitted to the facility on 3/28/17 with diagnoses that included dysphagia (difficulty swallowing) following cerebral infarction, aphasia (loss of ability to understand or express speech), hemiplegia (paralysis of one side of the body) affecting right dominant side, and Alzheimer's disease.

A physician's order dated 4/17/17 indicated the physician agreed to a dietary order change as recommended by Speech Therapist (ST) #1. The order indicated, "[change] diet to [mechanical soft] finger foods. [Resident #89] needs [one on one] supervision or dining room supervision to cue [resident] to take small bites, eat slow and swallow between bites, and to alternate solids [and] liquids". This 4/17/17 order remained in place throughout the remainder of Resident #89's stay at the facility.

During this process the resident continued to try to chew and swallow. At this time resident's lips became cyanotic and showing signs of difficulty breathing so the Heimlich maneuver was initiated by the nurse without success. Resident remained conscious and was moving air. The resident was taken from the nurse's station to her room in wheelchair by the Nurse supervisor, Nurse and Certified Nursing Assistant. Nurse supervisor suctioned resident to attempt to remove remaining food particles unsuccessfully. Resident's oxygen saturation was 79 percent, oxygen at 5 liters was applied via non-rebreather face mask. Physician Assistant and Responsible Party were notified at 1:40pm. The Physician Assistant stated to call Emergency Management Services. Emergency Services was called at 1:45pm and arrived at 2:00pm. First Responders took over care of the resident. Facility Nurse staff remained in room for support. First Responders applied oxygen with their regulator at fifteen liters per minute. At 2:10pm the Emergency Management Technicians (EMT) arrived. They discussed with first responders and facility staff resident's condition and decision to suction resident in ambulance. First Responders and Emergency Management Technicians assisted the resident to the hall in her wheelchair, placed her on the gurney and proceeded to the ambulance. The EMTs remained in the ambulance for a few minutes and left the facility at 2:15pm. At 2:48pm the EMTs called to get next of kin contact

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F 689	Continued From page 60	F 689		

The Nutrition/Dehydration Risk Assessment dated 5/6/18 indicated Resident #89 had severely impaired decision making, she was rarely/never understood, and she had impairment on one side of her upper extremities. She was assessed as dependent on staff for assistance with eating. Resident #89 was noted to have no swallowing disorders and she was on mechanically altered diet.

Resident #89's plan of care indicated she needed monitoring of nutritional status and weight status related to a diagnosis of dysphagia and Alzheimer's disease. This care plan, initiated on 2/19/18 and most recently reviewed/revised on 5/8/18, indicated Resident #89's diet was mechanical soft with finger foods. The interventions included, in part:
- Provide Resident #89 with assist at meals to ensure optimal and safe oral intake.
- Remind Resident #89 of swallowing precautions.

The quarterly Minimum Data Set (MDS) assessment dated 5/9/18 indicated Resident #89's cognition was severely impaired. She had short-term and long-term memory problems and severely impaired decision making. Resident #89 was assessed as requiring the extensive assistance of 1 for eating. She was on a mechanically altered diet and had no swallowing disorders. Resident #89 had not received Speech Therapy during this MDS period.

The Nutrition Quarterly Assessment dated 5/9/18 completed by the Registered Dietician (RD) indicated Resident #89's diet was, "[mechanical] soft, finger foods" and she was noted with no swallowing issues. Her diagnoses included

information and informed the staff that the resident had died prior to reaching the hospital. On 6/2/18 an investigation was initiated immediately by the Director of Nursing and the Administrator and statements received from staff present in the dining room, at the nurse's station. At the conclusion of the investigation it was determined that the Certified Nursing Assistant was at the table providing assistance to another resident. According to the Certified nursing assistant's statement she followed aspiration precautions by setting up her tray, the chicken was in small pieces and saw her eating while helping another resident. During the facility investigation, the C.N.A. did not state or document in her statement that she did not provide supervision.

Identification
A 100% audit of Residents diagnosis was conducted by Director of Nursing (DON), Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON), Unit Manager (UM) and Director of Rehabilitation (DOR) for diagnosis of Dysphagia and Aphasia on 12/5/18 and 43 were identified with diagnosis of Dysphagia or Aphasia, 26 were identified with recommendations with swallowing guidelines. An information sheet, Swallowing Guidelines sheet, was implemented on 12/6/18 with current recommendations for those 26 identified with swallowing guidelines requiring supervision. The Swallowing Guidelines sheets (name, room number, diet, and

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F 689	Continued From page 61 dysphagia and Alzheimer's disease. Resident #89's Nursing Assistant (NA) Kardex (care guide), undated, indicated Resident #89's diet was mechanical soft with finger food and she required one to one (1:1) supervision or dining room supervision. A review of the NA documentation of Resident #89's eating assistance for May 2018 indicated: - 8 meals were documented as independent with no set up - 8 meals were documented as supervision with set up only - 10 meals were documented as limited assistance of 1 - 1 meal was documented as extensive assistance of 1 - 28 meals were documented as dependent of 1 A review of the NA documentation of Resident #89's eating assistance for 6/1/18 through 6/2/18 indicated: - 6/1/18: 2 meals were documented with 1 noted as limited assistance of 1 and 1 noted as dependent of 1 - 6/2/18 1 meal was documented, and it was noted as limited assistance of 1 An incident report dated 6/2/18 completed by Nurse #1 indicated Resident #89 had an incident of "substance ingestion" on 6/2/18 at 1:30 PM. The incident was initially reported by NA #1. The narrative of the incident read, "[NA #1] brought [Resident #89] out of dining room to nurses station, stating ' I think she needs some help ' . Nurse assessment completed with food noted in oral cavity. Another nurse [Nurse #2] removed	F 689	recommendation from physician and speech therapist) are located in an aspiration precaution binder located in each dining room and each resident care kiosk. The swallowing guideline sheets and the kiosk are reconciled by the Assistant Director of Nurses and changes are updated when indicated by the physician or speech therapist All 43 residents with diagnosis of Dysphagia and Aphasia care plans were reviewed by the Assistant Director of Nursing with no revisions required. CNAs will be assigned to residents identified requiring cueing and aspiration precautions by the charge nurse at the beginning each shift. Training of licensed and certified staff provided by SDC and DON on cueing and aspiration precautions and responsibilities initiated on 12/6/18. All licensed and certified nursing staff will receive this training prior to working next shift. This training will be included in new licensed and certified nursing staff orientation process. Systemic Measures put into place to ensure the plan of correction is effective and remains in compliance are: On 12/5/18 an implementation of a dining room staff sign-in sheet to include sign in times/sign out times as well as aspiration precaution and supervision to be provided. This information is located in a binder in each dining room and resident care kiosk. Management, Licensed Nursing or Department Head will monitor meal supervision, utilizing Dining Supervision	

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F 689	Continued From page 62 some food particles from mouth and dentures. There was a large amount of well ground food and [Nurse #2] continued to remove food until no longer visible. As [Resident #89] began to wheeze, Heimlich maneuver was performed on resident. Mouth check repeatedly with no food noted." Resident #89's vital signs (VS) were noted as temperature 95.7, pulse 75, respirations 28, blood pressure (B/P) 100/70, and pain scale 0. The physician was notified at 1:40 PM. The immediate actions taken were noted as a mouth sweep, Heimlich, VS, oxygen (O2), 911 called, and Emergency Medical Services (EMS) transported Resident #89. The immediate post-incident actions indicated Resident #89 was sent to the Emergency Room (ER). A nursing note dated 6/2/18 completed by Nurse #1 indicated the following: "1:30 PM - [Resident #89] was brought into hallway by [NA #1] out of the dining room and stated resident was choking. Upon assessment [Resident #89] had a mouth full of food and was trying to chew and swallow the food. Encouraged resident to spit out food and resident refused to do so and clamped teeth together while still trying to swallow the food. At this time writer attempted the Heimlich maneuver with no results. Able to remove dentures and resident had large amount of food in mouth and pockets of food in cheek as well as food stuck to the top denture. [Resident #89] began to have audible wheezing noted, oxygen saturation was 79% on [room air], heart rate 75, respirations 28, lips were cyanotic [(bluish discoloration indicating poor oxygen circulation)]. [Resident #89] taken to room and oxygen applied at 5 [liters per minute] via mask. 1:40 PM - Notified [Physician's Assistant] and [Responsible Party] of incident. New order given	F 689	Manager Observation sheet. Supervision is being provided to ensure aspiration and safety precautions are being followed during meals in the dining rooms and for residents that eat in their rooms. The Director of Nursing will assign managers to the dining rooms to include resident rooms. Effective 12/5/18, on-site licensed staff, certified staff and department heads were trained by SDC on the information provided on aspiration precautions and residents requiring supervision to ensure that safety precautions are being followed. This information is located in a binder in each dining room and resident care kiosk. Training on the Heimlich maneuver with return demonstration and proper use of suction machine was conducted as well. This education was provided by the Registered Nurse, Staff Development Coordinator (SDC) to Licensed staff and other licensed staff will be trained prior to next shift worked. Emergency equipment (suction machine) was placed 12/5/18 in the dining rooms, set-up was completed and instructions were given to Licensed Staff by the SDC. On 12/5/18 education was also provided by the SDC for nursing staff to ensure supervision is being provided during meals and ensure aspiration precautions and safety is being provided. Licensed and Certified Nursing staff were also educated on the signs and symptoms of aspiration. This education was provided by RN Staff Development Coordinator. Staff not educated by 12/6/18 will not be allowed to work until educated. Effective 12/6/18, education on providing supervision during meals to	

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F 689	Continued From page 63 to send to ER. 1:45 PM - Called EMS for transport services. 2:00 PM - EMS arrived - VS oxygen saturation is 79%, [heart rate] 104, [respirations] 32, B/P 100/70. 2:15 pm EMS transported [Resident #89] to ER at this time". A physician's order dated 6/2/18 for Resident #89 indicated "send to ER for evaluation per family request and [physician]". A Resident Transfer Form dated 6/2/18 completed by Nurse #1 indicated Resident #89 was transferred to a local hospital. The reason for the transfer was noted to be "choking while eating chicken". The EMS record dated 6/2/18 was reviewed. The record indicated the following: The chief complaint for Resident #89 was "choking". While EMS were en-route to the facility the first responders on scene advised them Resident #89 was "condition red" (critical) with possible aspiration. Upon EMS arrival on scene Resident #89 was seated upright in a wheelchair with first responders administering high flow O2 via mask. The first responders advised EMS that Resident #89 had been reported to have placed a large amount of chicken in her mouth and began choking on it. Facility staff removed all they could from Resident #89's mouth and throat. Resident #89 was moved from wheelchair to EMS stretcher and was taken out of facility onto the transport. During transportation to the ER Resident #89 was examined and was found to have chicken in her trachea. The chicken was removed. Resident #89 was then noted with decreased respiratory effort and her heartrate was decreasing into an extremely bradycardic (slow) rhythm.	F 689	ensure aspiration precautions and safety is added to all new employee orientation. This education will also be conducted annually by SDC for all staff. CNAs will be assigned to residents identified requiring cueing and aspiration precautions by the charge nurse at the beginning each shift. Training of licensed and certified staff provided by SDC and DON on cueing and aspiration precautions and responsibilities initiated on 12/6/18. All licensed and certified nursing staff will receive this training prior to working next shift. This training will be included in new licensed and certified nursing staff orientation process. Monitoring Effective 12/6/18, The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Nurse Management, Licensed Nursing or Department Head will monitor meal supervision, utilizing Dining Supervision Manager Observation sheet. Supervision is being provided to ensure aspiration and safety precautions are being followed during meals in the dining rooms and for residents that eat in their rooms. Staff mentioned above will be assigned to each meal for supervision utilizing the Assignment calendar. The Director of Nursing will assign managers to the dining rooms to include resident rooms. This monitoring process will be continued by the Charge nurses on Saturday and Sunday. This monitoring will be conducted daily for four weeks, then weekly x4, then monthly thereafter.	

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F 689	Continued From page 64 Approximately 2 minutes prior to arrival at the ER Resident #89 was noted with cardiac arrest and respiratory failure. A valid Do Not Resuscitate (DNR) was present with the resident and no resuscitative efforts were made. Resident #89's death was pronounced on 6/2/18 at 2:29 PM. Upon arrival at the ER the physician advised that since Resident #89 expired prior arrival that she was to be transferred to the morgue. Resident #89's physician was contacted, and he advised that since it was an "un-natural death" it needed to be a Medical Examiner's (ME) case. Resident #89 was transported to the morgue and was to be examined by the ME. A death certificate, signed by the Medical Examiner on 6/5/18, indicated Resident #89 choked on a bolus (a ball-like mixture of food and saliva) of chicken at the facility resulting in an accidental death on 6/2/18 with the immediate cause identified as "asphyxia - occlusion of airway by bolus of food". A phone interview was conducted with ST #1 on 12/5/18 at 3:30 PM. ST #1 indicated she no longer worked at the facility and she was unable to recall any specifics about Resident #89 without reviewing the speech therapy records. The speech therapy plan of care, speech therapy discharge plan, and dietary order for Resident #89 were reviewed with ST #1. The speech therapy plan of care dated 3/28/17 completed by ST #1 indicated speech therapy was necessary for Resident #89 due to dysphagia and aphasia. The physician's order dated 4/17/17 indicated a dietary order change as recommended by ST #1, "[change] diet to [mechanical soft] finger foods. [Resident #89] needs [one on one] supervision or dining room supervision to cue [resident] to take	F 689	Findings will be reported by the Director of Nursing in the monthly Quality Assurance and Performance Improvement committee meeting for recommendations or modifications until a pattern of compliance is achieved. Compliance Date 12/21/18	

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small bites, eat slow and swallow between bites, and to alternate solids [and] liquids". Resident #89's speech therapy discharge instructions dated 5/12/17 completed by ST #1 indicated aspiration precautions were to be continued with the provision of compensatory strategies for swallowing as well as strategies to maximize communication. ST #1 was asked about Resident #89's diet order that stated mechanical soft and finger foods. She reported that Resident #89 was able to have finger foods and/or mechanical soft foods. She stated that chicken in bite size pieces was appropriate for Resident #89 based on the diet order. ST #1 was asked about her expectations related to meal supervision for Resident #89. She stated that if Resident #89 ate in her room that 1:1 supervision was to be provided. She indicated if Resident #89 ate in the dining room she expected a staff member to be in the vicinity of her and for the staff member to provide compensatory strategy cues/aspiration precaution cues to the resident throughout the meal. She explained that these cues included reminders to take sitting up straight in her wheelchair, taking small sips, taking small bites, alternating between solids and liquids, and to swallow her food.

Based on the staff schedule, the assignment schedule, and an interview with the Director of Nursing on 12/5/18 at 8:20 AM the NAs that were supposed to be in the dining room during lunch on 6/2/18 were NA #1, NA #2, and NA #3. The DON reported that NA #1 was supervising Resident #89 at the time of the incident. The DON revealed it was unknown how many residents were eating lunch in the dining room at the time of the incident (6/2/18).

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A written statement (incorrectly dated 5/2/18) completed by NA #1 was reviewed. NA #1 indicated that between 12:15 PM and 1:30 PM on 6/2/18 she was in the dining room helping pass out trays and feeding residents. She noted that she set up Resident #89's tray reporting that she had grilled chicken that was cut up into small pieces. NA #1 wrote, "I saw her eating while I was helping feed another resident". She indicated that around 1:30 PM lunch was over, and another NA removed Resident #89's tray. NA #1 reported she then started pushing Resident #89 in her wheelchair out of the dining room. She indicated that when she reached the dining room door with Resident #89 she heard the resident "making a noise like she was trying to throw up". NA #1 wrote that she pushed Resident #89 down the hall in her wheelchair and started yelling for Nurse #4 to help her. She indicated that when she reached the nurse's station Nurse #1, Nurse #2, and Nurse #4 were there. She indicated that the nurses removed about 4 ounces of food from Resident #89's mouth.

A phone interview was conducted with NA #1 on 12/5/18 at 5:08 PM. The incident report and her written statement related to the incident of substance ingestion on 6/2/18 for Resident #89 was reviewed with NA #1. NA #1 was asked to describe the seating arrangements in the dining room for herself and Resident #89 on 6/2/18 during the lunch meal. She reported that Resident #89 was seated at one end of a rectangular table that had seating for 6 residents. She indicated that 2 seats were on each side of the table and one seat on each end of the table. She was unable to recall if all 6 of the seats were occupied by residents on 6/2/18 during the lunch meal. She reported that she was assisting

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another resident with eating on this date (6/2/18) during lunch and she believed the resident she was assisting was seated next to Resident #89. NA #1 was unable to recall with certainty if she was seated between Resident #89 and the resident she was assisting or if she was seated on the opposite side of the resident she was assisting. She stated that she recalled setting up Resident #89's tray. She reported that Resident #89 had grilled chicken that had been cut up into small pieces as well as some vegetables. She indicated Resident #89 ate independently after set-up during lunch in the dining room on 6/2/18. She stated that she looked over at Resident #89 during the meal to make sure she was eating, but that she had not observed her during the whole meal as she was helping someone else. NA #1 was asked if she noticed if Resident #89 was eating fast, if she was swallowing, if she was holding food in her mouth, or if she required any cues to ensure she was safely eating. NA #1 stated, "to be honest with you I don't recall". She explained that she knows that Resident #89 was not choking or making any unusual sounds during the meal so she "didn't think there was anything she needed". She reported that after Resident #89's tray had been cleared she was going to take her back to her room to lay down. She stated that she began to push Resident #89 by wheelchair out of the dining room when the resident started coughing. She indicated Resident #89 was making a noise like she was "trying to throw up". She reported she called out for one of the nurses to help and that it was Nurse #1 who first realized Resident #89 had food in her mouth. NA #1 was asked if she had observed Resident #89's mouth prior to transporting her out of the dining room and she revealed she had not. She stated that she

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would've approached Resident #89 from the side and then from behind, so she could push her wheelchair. She revealed she had not observed Resident #89 from the front before exit the dining room. She additionally revealed she had not noticed during the lunch meal that Resident #89 was not swallowing her food.

This interview with NA #1 continued. NA #1 was asked if Resident #89 required assistance with eating. She stated that most of the time Resident #89 ate independently after set-up and required no assistance. She was asked if Resident #89 had any specific dietary orders related to aspiration precautions. She stated that Resident #89 was supposed to be observed while eating but explained that this was not 1:1 observation it was just checking on her to make sure she was eating. She was asked if Resident #89 required any specific cueing and she stated that the only cueing Resident #89 required was encouragement to eat as sometimes she just sat there rather than feeding herself. The physician's order dated 4/17/17 and was an active order on 6/2/18 that indicated Resident #89 needed cueing to take small bites, eat slow, swallow between bites, and to alternate solids liquids was reviewed with NA #1. NA #1 revealed she was not aware of this order and she had not provided any of these cues to Resident #89 on 6/2/18 or on any prior date.

A written statement dated 6/2/18 completed by NA #2 was reviewed. This indicated NA #2 walked into the dining room around 1:15 PM (6/2/18) and saw Resident #89 eating with her fingers. The resident was noted to be putting pieces of chicken in her mouth. NA #2 indicated that NA #1 told her she would stay in the dining

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room. NA #2 then left the dining room.

An interview was conducted with NA #2 on 12/5/18 at 10:37 AM. The incident report and her written statement related to incident of substance ingestion on 6/2/18 for Resident #89 was reviewed with NA #2. She stated that she was in and out of the dining room during the lunch meal on 6/2/18 and that she had not assisted Resident #89 with eating. She reported she saw Resident #89 in the dining room and that she was eating independently.

This interview with NA #2 continued. NA #2 was asked if Resident #89 required assistance with eating. She stated that some days Resident #89 ate independently after set-up and required no assistance, but other days she would just sit there and not eat so she needed some verbal encouragement. She was asked if Resident #89 had any specific dietary orders related to aspiration precautions. NA #2 stated that the NAs were just supposed to watch Resident #89 to ensure she was eating. She indicated that this was not 1:1 observation it was just checking on her throughout the meal. NA #2 was asked if Resident #89 required any specific cueing and she stated that the only cueing Resident #89 required was encouragement to eat on some days. The physician's order dated 4/17/17 and was an active order on 6/2/18 that indicated Resident #89 needed cueing to take small bites, eat slow, swallow between bites, and to alternate solids liquids was reviewed with NA #2. NA #2 revealed she was not aware of this order and she had not provided any of these cues to Resident #89 when she assisted her with meals.

An interview was conducted with NA #3 on

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12/4/18 at 2:45 PM. She stated that she recalled being in the dining room during lunch on 6/2/18. She reported that she was helping another resident eat and that she had not observed Resident #89. NA #3 was asked if Resident #89 required assistance with eating. She indicated that sometimes she fed herself and sometimes she needed assistance in the form of encouragement. She was asked if Resident #89 had and specific dietary orders, care plan interventions, or cues related to aspiration precautions. NA #3 reported she recalled that Resident #89 was on a finger food diet and that she needed "checked up on" while she was eating just to make sure she was feeding herself because sometimes she just sat there with her food in front of her and had not fed herself.

A written statement dated 6/2/18 completed by Nurse #1 was reviewed. Nurse #1 indicated at approximately 1:30 PM NA #1 brought Resident #89 out of the dining room stating that "I think she needs some help". She indicated Resident #89 was assessed with a "mouth full of food and was trying to chew and swallow the food in her mouth". Nurse #1 wrote that she encouraged Resident #89 to spit out the food, but the resident had not done so. Nurse #2 was noted to also tell Resident #89 to spit out the food, but the resident had "clamped her mouth shut and was still chewing the food in her mouth". Nurse #2 removed the dentures from Resident #89's mouth and performed a mouth sweep. There was a "large amount" estimated at 4 ounces of "well ground food" removed from Resident #89's mouth. Nurse #2 continue to sweep Resident #89's mouth until no visible food was seen in her mouth. Resident #89 was then noted to begin wheezing and her lips had a change in color.

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Nurse #1 indicated she performed the Heimlich on Resident #89 with no more food expelled from her mouth. Resident #89's oxygen saturation (O2 sat) was noted as 79 % on room air and her "lips were blue". NA #1 and Nurse #3 took Resident #89 to her room as Nurse #1 contacted the Physician ' s Assistant (PA) and the Responsible Party (RP) at approximately 1:40 PM. The PA gave the order for transfer to the ER.

A phone interview was conducted with Nurse #1 on 12/5/18 at 12:20 PM. The incident report, nursing note, and her written statement related to Resident #89's 6/2/18 incident of substance ingestion were reviewed with Nurse #1. She verified that she had completed all of these documents and confirmed the information as written. Nurse #1 stated that when NA #1 brought Resident #89 as brought out to the nurse's station that she "visibly could see [Resident #89] had a mouth full of food" and that she wouldn't spit the food out. Nurse #1 was asked if Resident #89 required any assistance with eating. She revealed she believed Resident #89 had an order to be supervised while eating and that she, "needed to be reminded to chew and swallow".

A written statement, undated, completed by Nurse #2 indicated that she was standing at the medication cart on 6/2/18 at approximately 1:30 PM when NA #1 brought Resident #89 up to the nurse's station and stated that something was wrong and that she thought the resident was choking. Nurse #2 indicated Resident #89 had a large amount of food in her mouth and that she was still chewing on the food. She wrote that she asked Resident #89 to spit the food out, but she had not done so. She reported that she had been able to do a mouth sweep and removed a large

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amount of well ground food and continued to remove food until no visible food was seen. She indicated that Resident #89 then began wheezing and had a "noted change in color". Nurse #2 reported that Nurse #1 performed the Heimlich on Resident #89. The resident's O2 sat was 79% on room air and she was then taken to her room by Nurse #3 and Nurse #4. She indicated she went with Nurse #1 to prepare the paperwork to send Resident #89 to the ER.

A phone interview was conducted with Nurse #2 on 12/4/18 at 4:11 PM. The incident report and her handwritten statement were reviewed with Nurse #2. She verified that when Resident #89 was brought out to the nurse's station by NA #1 that it was apparent on visual observation alone that the resident had a mouth full of food. She stated that Resident #89 would not spit the food out and that she completed a mouth sweep resulting in a large amount of ground/chewed food being removed the resident's mouth.

A written statement dated 6/5/18 completed by Nurse #3 was reviewed. Nurse #3 indicated that around 1:30 PM on 6/2/18 she was walking toward the nurse's station when Nurse #1 and Nurse #2 called her over. They were surrounding Resident #89 who was seated in her wheelchair and were removing chewed food from her mouth. Nurse #3 wrote that Nurse #1 and Nurse #2 told her that Resident #89 "had too much food in her mouth to allow her to swallow". Resident #89 had audible wheezing and her lips and fingertips were discolored. Nurse #3 wrote that she and Nurse #4 took Resident #89 to her room and applied O2 with a mask at 5 lpm and she was noted to audibly moving air. Around 1:50 PM first responders arrived, and they applied O2 at 15

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lpm via mask. EMS arrived at approximately 2:00 PM and they transported Resident #89 from her wheelchair to the EMS stretcher and left the facility.

A phone interview was conducted with Nurse #3 on 12/5/18 at 4:32 PM. The incident report and her written statement related to Resident #89's 6/2/18 incident of substance ingestion were reviewed with Nurse #3. Nurse #3 confirmed the information documented in her written statement. Nurse #3 stated that Resident #89 had no loss of consciousness at any point while at the facility. She reported Resident #89 continued with audible wheezing throughout the time period they were waiting for first responders.

A written statement dated 6/4/18 completed by Nurse #4 was reviewed. Nurse #4 indicated NA #1 brought Resident #89 out of the dining room at approximately 1:30 PM stating, "Something is wrong with [Resident #89]. I think she might be choking". Nurse #4 wrote that Resident #89's mouth and cheeks were full of food and she was still chewing on the food. Resident #89 was asked to spit out the food and the resident just kept chewing and would not spit it out. Nurse #4 indicated Nurse #1 and Nurse #2 removed all visible food from Resident #89's mouth by hand.

A phone interview was conducted with Nurse #4 on 12/5/18 at 1:45 PM. She stated she was unable to recall any specifics about the incident of substance ingestion on 6/2/18 for Resident #89.

An interview was conducted with the RD on 12/5/18 at 11:55 AM. The Nutrition Quarterly Assessment dated 5/9/18 completed by the RD

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for Resident #89 that indicated her diet was mechanical soft, finger foods was reviewed. The RD indicated that if a resident had an order for "mechanical soft, finger foods" that the resident was able to receive either type of food. She revealed that sometime in the latter portion of June 2018 the facility ceased utilizing diet orders that contained more than one texture/consistency due to a directive from the corporate office. She explained that dietary orders, such as the order for Resident #89 that stated, "mechanical soft, finger foods", appeared to be contradictory orders as mechanical soft was a different texture than finger foods. She further explained that mechanical soft was normally ground food and finger foods were cut up into small/bite size pieces. She stated that at the time of her 5/9/18 note the facility was still regularly utilizing orders that contained more than one food texture/consistency. The RD was asked if this change with diet orders was related to the 6/2/18 incident of substance ingestion for Resident #89. She stated that she was unable to say because she was not involved in the facility's investigation of the incident.

A phone interview was conducted with Resident #89's physician on 12/6/18 at 2:36 PM. The physician reported that he expected the recommendations of ST as well as his orders to be followed. He indicated aspiration precautions were expected to be implemented for any resident noted to be an aspiration risk.

An interview was conducted with the Director of Nursing (DON) on 12/4/18 at 4:20 PM. The DON revealed that when she investigated the 6/2/18 incident of substance ingestion for Resident #89

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she determined the resident likely aspirated. She stated that her expectations were for staff to provide supervision and cueing as recommended by ST and as ordered by the physician. She additionally stated that she expected aspiration precautions to be implemented for all residents identified as at risk for aspiration.

The Administrator and DON were notified of the Immediate Jeopardy on 12/5/18 at 3:03 PM.

On 12/6/18 at 7:06 PM the facility provided the following credible allegation of Immediate Jeopardy removal:

Address how corrective action will be accomplished for the resident found to have been affected by the deficient practice:

On 6/2/2018 at approximately 1:30pm, Resident was escorted from the dining room and was noted making a vomiting noise. The Certified Nursing Assistant immediately took the resident to the nurse's station where the nurse assessed resident having difficulty swallowing and showing signs of aspiration with audible wheezing. The nurse attempted to remove food particles from resident's mouth but was unsuccessful in removing all food particles and therefore dentures were removed to perform a mouth sweep. During this process the resident continued to try to chew and swallow. At this time resident's lips became cyanotic and showing signs of difficulty breathing so the Heimlich maneuver was initiated by the nurse without success. Resident remained conscious and was moving air. The resident was

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taken from the nurse's station to her room in wheelchair by the Nurse supervisor, Nurse and Certified Nursing Assistant. Nurse supervisor suctioned resident to attempt to remove remaining food particles unsuccessfully. Resident's oxygen saturation was 79 percent, oxygen at 5 liters was applied via non-rebreather face mask. Physician Assistant and Responsible Party were notified at 1:40pm. The Physician Assistant stated to call Emergency Management Services. Emergency Services was called at 1:45pm and arrived at 2:00pm. First Responders took over care of the resident. Facility Nurse staff remained in room for support. First Responders applied oxygen with their regulator at fifteen liters per minute. At 2:10pm the Emergency Management Technicians (EMT) arrived. They discussed with first responders and facility staff resident's condition and decision to suction resident in ambulance. First Responders and Emergency Management Technicians assisted the resident to the hall in her wheelchair, placed her on the gurney and proceeded to the ambulance. The EMTs remained in the ambulance for a few minutes and left the facility at 2:15pm. At 2:48pm the EMTs called to get next of kin contact information and informed the staff that the resident had died prior to reaching the hospital. On 6/2/18 an investigation was initiated immediately by the Director of Nursing and the Administrator and statements received from staff present in the dining room, at the nurse's station. At the conclusion of the investigation it was determined that the Certified Nursing Assistant was at the table providing assistance to another resident.
According to the Certified nursing assistant's statement she followed aspiration precautions by setting up her tray, the chicken was in small

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pieces and saw her eating while helping another resident. Upon interview with C.N.A. on 6/2/18 by Director of Nursing and Administrator, she would not admit to not providing supervision and cueing.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

A 100% audit of Residents diagnosis was conducted by Director of Nursing (DON), Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON), Unit Manager (UM) and Director of Rehabilitation (DOR) for diagnosis of Dysphagia and Aphasia on 12/5/18 and 43 were identified with diagnosis of Dysphagia or Aphasia, 26 were identified with recommendations with swallowing guidelines. An information sheet, Swallowing Guidelines sheet, was implemented on 12/6/18 with current recommendations for those 26 identified with swallowing guidelines requiring supervision. The Swallowing Guidelines sheets (name, room number, diet, and recommendation from physician and speech therapist) are located in an aspiration precaution binder located in each dining room and each resident care kiosk. The swallowing guideline sheets and the kiosk are reconciled by the Assistant Director of Nurses and changes are updated when indicated by the physician or speech therapist All 43 residents with diagnosis of Dysphagia and Aphasia care plans were reviewed by the Assistant Director of Nursing with no revisions required. CNAs will be assigned to residents identified requiring cueing and aspiration precautions by the charge nurse at the beginning each shift. Training of licensed and certified staff provided by SDC and DON on cueing and aspiration precautions and

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responsibilities initiated on 12/6/18. All licensed and certified nursing staff will receive this training prior to working next shift. This training will be included in new licensed and certified nursing staff orientation process.

Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On 12/5/18 an implementation of a dining room staff sign-in sheet to include sign in times/sign out times as well as aspiration precaution and supervision to be provided. This information is located in a binder in each dining room and resident care kiosk. Management, Licensed Nursing or Department Head will monitor meal supervision, utilizing Dining Supervision Manager Observation sheet. Supervision is being provided to ensure aspiration and safety precautions are being followed during meals in the dining rooms and for residents that eat in their rooms. The Director of Nursing will assign managers to the dining rooms to include resident rooms. Effective 12/5/18, on-site licensed staff, certified staff and department heads were trained by SDC on the information provided on aspiration precautions and residents requiring supervision to ensure that safety precautions are being followed. This information is located in a binder in each dining room and resident care kiosk. Training on the Heimlich maneuver with return demonstration and proper use of suction machine was conducted as well. This education was provided by the Registered Nurse, Staff Development Coordinator (SDC) to Licensed staff and other licensed staff will be trained prior to next shift worked. Emergency equipment (suction

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machine) was placed 12/5/18 in the dining rooms, set-up was completed and instructions were given to Licensed Staff by the SDC. On 12/5/18 education was also provided by the SDC for nursing staff to ensure supervision is being provided during meals and ensure aspiration precautions and safety is being provided. Licensed and Certified Nursing staff were also educated on the signs and symptoms of aspiration. This education was provided by RN Staff Development Coordinator. Staff not educated by 12/6/18 will not be allowed to work until educated. Effective 12/6/18, education on providing supervision during meals to ensure aspiration precautions and safety is added to all new employee orientation. This education will also be conducted annually by SDC for all staff. CNAs will be assigned to residents identified requiring cueing and aspiration precautions by the charge nurse at the beginning each shift. Training of licensed and certified staff provided by SDC and DON on cueing and aspiration precautions and responsibilities initiated on 12/6/18. All licensed and certified nursing staff will receive this training prior to working next shift. This training will be included in new licensed and certified nursing staff orientation process.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: and include dates when corrective action will be completed:

Effective 12/6/18, The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Nurse Management, Licensed Nursing or Department Head will monitor meal supervision, utilizing Dining Supervision Manager Observation sheet. Supervision is being provided

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to ensure aspiration and safety precautions are being followed during meals in the dining rooms and for residents that eat in their rooms. Staff mentioned above will be assigned to each meal for supervision utilizing the Assignment calendar. The Director of Nursing will assign managers to the dining rooms to include resident rooms. This monitoring process will be continued by the Charge nurses on Saturday and Sunday. This monitoring will be conducted daily for four weeks, then weekly x4, then monthly thereafter. Findings will be reported by the Director of Nursing in the monthly Quality Assurance and Performance Improvement committee meeting for recommendations or modifications until a pattern of compliance is achieved.
Effective 12/6/18 the facility Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan or correction to ensure the facility attains and maintains substantial compliance.
Compliance Date 12/6/18

The credible allegation of Immediate Jeopardy removal was validated on 12/6/18 at 7:10 PM. Record review indicated an audit was conducted and there were 43 residents with diagnoses of dysphagia or aphasia and 26 residents identified with recommendations for swallowing guidelines. The 26 residents identified with recommendations for swallowing guidelines had a Swallowing Guidelines sheet implemented with current recommendations identified. Observation of the dinner meal on 12/6/18 confirmed the dining room sign in sheet, aspiration precaution binder, and suction machine were all in place, a manager was present to provide monitoring during the meal, and residents requiring cueing and aspiration precautions were assigned an NA. A

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review of inservice sign in sheets as well as staff interviews verified education was initiated on 12/5/18 on aspiration precautions, the signs and symptoms of aspiration, cueing, and residents requiring supervision to ensure safety precautions were in place. Licensed staff were provided with education on the Heimlich Maneuver and proper use of the suctioning machine. Any staff not inserviced by 12/6/18 were required to be inserviced prior to working on the floor.

2. Resident #33 was admitted to the facility on 1/17/14 with diagnoses that included dysphagia (difficulty in swallowing) and Diabetes Mellitus.

The most recent comprehensive MDS assessment coded as an Annual and dated 7/20/18 revealed the resident was alert and oriented with periods of confusion. He required setup and supervision with meals. The assessment had documentation that he had coughing or choking during meals and when swallowing medications and received a mechanically altered diet.

Review of a Speech Therapy note dated 7/25/18 stated the resident required close supervision as he was at increased risk of aspiration (A condition in which food, liquids, saliva, or vomit is breathed into the airways). He was not to talk while eating, consume small portions, eat slow and use adaptive spoon.

Review of Resident #33's Swallow Precautions Checklist dated 9/20/18 revealed the following needs for the resident during meals: Pureed diet with nectar thick liquids, required constant supervision with verbal cues to take small bites, eat slow and alternate food and drink, sit upright

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during meals; no straws, a small cup with one sip then swallow two to three times; limit bite size to half a teaspoon or less, swallow 2 to 3 times with each bite, empty mouth before additional bites, alternate bites of food with sips of liquid, drink several sips of liquid at the end of the meal, remind resident to check for pocketed food with tongue or finger and check mouth after meals for pocketing; remind resident to slow down while eating, eliminate distractions, no talking while eating and sit up right for 20 to 30 minutes after eating.

The most recent MDS (Minimum Data Set) coded as a Quarterly assessment and dated 10/8/18, assessed the resident as alert and oriented with periods of confusion. He required setup and supervision with meals. The assessment had documentation that he had coughing or choking during meals or when swallowing medications and received a mechanically altered diet.

Review of the resident's active care plan dated 10/15/18 revealed the resident received a mechanically altered diet, had swallowing difficulties and required setup of meal tray with supervision and cues. The safe swallow guidelines were to be utilized during meal time.

Review of a FMP (Functional Maintenance Program) note dated 10/15/18 revealed the resident was started on the FMP for swallowing difficulties and was to use the modified spoon, follow aspiration precautions per swallowing precautions checklist and eat in the dining room with supervision of the nursing assistants (NA).

Review of a physician order dated 11/12/18 revealed Resident #33 to begin a pureed diet with

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nectar thick liquids, no straws and to use the small maroon spoon with all meals due to difficulty swallowing.

During an interview with Resident #33 on 12/4/18 at 10:10 AM, he indicated that he used a pink spoon and wasn't supposed to talk with meals. He was unable to state any other precautions that were needed during meals.

During an observation on 12/4/18 at 12:45 PM, resident #33 was eating lunch in the dining room. He had the appropriate diet and liquid consistency. No straws were present in his fluids and he was using a maroon spoon to eat with. The resident was observed eating fast, with small amounts of food present on the spoon and coughed three times during the lunch meal. No staff were observed providing any type of supervision, cues or reminders to the resident per the Swallow Precautions Checklist. The staff in the dining room were observed passing out trays and assisting other residents with their meals on the opposite side of the dining room.

During an interview with the Staff Development Coordinator/FMP nurse on 12/4/18 at 1:25 PM she stated that the FMP NA monitored the resident's progress with meals once a week to see if he was following the swallowing precautions. She further stated that Resident #33 required cues during meals and that the NA's in the dining room were responsible for providing supervision and cues during his meals.

An interview was conducted with FMP Aide on 12/4/18 at 2:15 PM, who stated Resident #33 ate fast during meals and required cues to eat slow. She was able to state his correct diet consistency

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as well as no straws and the need for the maroon spoon with all meals. She added that the NA's in the dining room supervised him and provided cues to slow down while they were passing out trays and assisting other residents with their meals.

On 12/4/18 at 2:30 PM an observation was made of the Swallow Precautions Checklists which were kept in a binder in the dining room. A sign in sheet was present at the front of the binder for staff to sign in and out for each meal they were present for in the dining room.

During an interview on 12/4/18 at 4:50 PM, NA #6 explained the staff provided supervision and cues to Resident #33 while they were passing out other resident's trays and monitored the resident from the assisted dining tables. She was able to state the resident required supervision and cues to eat slow, must have his maroon spoon with all meals and was not to have any straws. She further stated that in the dining room was a binder with the Swallow Precautions Checklist for any resident that had special needs during a meal.

During an observation on 12/5/18 at 8:10 AM the resident was in the dining room eating breakfast. Correct diet and fluid consistency was present. Staff were observed passing out trays and assisting other residents with their meal. No cues or prompts were observed from staff during the breakfast meal.

During an interview with NA #2 on 12/5/18 at 10:45 AM, she could not confirm how supervision was provided for residents that required cues related to aspiration precautions other than to say if she heard them coughing she would ask if they

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were ok. She stated that staff did not sit at the table with Resident #33.

During an interview with NA #7 on 12/5/18 at 11:15 AM, who stated that Resident #33 required cues to eat slow. She stated that he was one of the first residents to receive their tray and when the staff set it up they reminded him to eat slow, made sure that his liquids were thickened, and he had his maroon spoon. She stated that the resident was supervised while the other trays were being passed out. She further stated that a binder was present in the dining room with the Swallow Precautions Checklist for any resident with special needs during meals.

During an interview on 12/6/18 at 9:30 AM, NA #5 stated that Resident #33 was supervised while staff were passing out trays and from the assisted dining tables with reminders to slow down when this was observed. She confirmed that he required supervision and cues per the Swallow Precautions Checklist.

An interview was conducted with Speech Therapist #2 on 12/6/18 at 11:00 AM. She stated that Resident #33 had been seen by Speech Therapy multiple times in the past due to swallowing difficulties and that he required cues and reminders to eat slow and not talk while eating. She stated that he did better with verbal cues when the tray was setup and occasionally thru out the meal. She explained that she completed the Swallow Precautions Checklist on all residents with swallowing difficulties based on the evaluation and updated with any changes. She explained that constant supervision (as noted on Resident #33 Swallow Precaution's Checklist) meant the resident should be within

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eyesight of the staff.

During an interview on 12/6/18 at 3:00 pm the Director of Nursing stated that it was her expectation for all residents with swallowing difficulties to be appropriately supervised during meals times.

3. Resident #57 admitted to the facility on 7/27/18 with diagnoses of Dementia, Parkinson's Disease, Protein Calorie Malnutrition, and difficulty swallowing.

Review of Resident #57's Physician's Orders revealed an order for Regular Mechanical Soft and Honey Thick Liquids Diet dated 11/15/18.

A Swallow Precautions Checklist dated 11/16/18 stated Resident #57 required constant supervision, sitting upright 90 degrees when eating, taking small cup sips, taking one sip then swallow, cough and clear throat after each sip then swallow, alternate bites of food with sips of liquid at end of meal, bite size to half teaspoon or less, and check mouth after meals for pocketing.

Resident #57's most recent comprehensive Minimum Data Set Assessment dated 11/29/18 revealed he was moderately cognitively impaired and required supervision of staff for meals. He was also coded as having coughing and choking during meals.

A review of Resident #57's Care Plan which was updated on 11/30/18 revealed a care plan goal the resident would not display any signs of swallowing difficulty. The care plan further revealed Resident #57 should be supervised at meals, use an inner lip plate, and large grip utensils.

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F 689	Continued From page 87 Interview with Nurse Aide #5 on 12/04/18 at 3:10 pm revealed she was not aware Resident #57 required any precautions for eating. She stated he usually eats in the dining room and sometimes she will cue him to eat. She stated she does not sit with him when he eats. During an interview with Speech Therapist #2 on 12/5/18 at 8:35 am she stated Resident #57 requires constant supervision during meals. She stated there is a Swallowing Precautions Sheet in his Medical Record that the staff should follow. During an interview with Nurse Aide #2 on 12/5/18 at 12:41 pm she stated Resident #57 sits at the dining table with other residents and the staff follow-up, but they do not sit with him while he eats. She stated she watches him from another table while she assists other residents. An interview on 12/6/18 at 3:00 pm with the Director of Nursing revealed her expectation is staff would supervise residents with swallowing difficulties as ordered and follow the residents' care plan.	F 689		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756		12/21/18

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F 756	Continued From page 88 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Pharmacy Consultant, the Physician, the Physician's Assistant, and staff, the Pharmacy Consultant failed to identify and address the use of an antibiotic prescribed on an indefinite basis and without an adequate clinical indication for use (Residents #10 and #65) and also failed to identify and address an as needed (PRN) psychotropic medication that was prescribed for	F 756	F 756 Based on the root cause analysis by the facility administrative staff and the DON, staff did not ensure orders for antibiotics and psychotropic medications had a rationale and duration for medication. Resident #10 antibiotic will be reviewed by the Urologist at an appointment on 1/9/19 as recommended by physician to	

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F 756	Continued From page 89 greater than 14 days with no documented rationale (Resident #57) for 3 of 6 residents reviewed for unnecessary medications. The findings included: 1. Resident #10 was admitted to the facility on 11/12/18 with diagnoses that included Alzheimer ' s and a personal history of Urinary Tract Infections (UTIs). A review of Resident #10's care plan dated 9/11/18 revealed the problem area of the risk for UTIs. This care plan indicated Resident #10 was on a prophylactic antibiotic with no symptoms of an acute UTI. A review of Resident #10's active physician's orders was conducted on 12/5/18. Resident #10 had an active order dated 11/26/15 for Trimethoprim (antibiotic) 100 milligrams (mg) once daily for UTI prophylaxis. A review of Resident #10's Medication Administration Records from 1/1/2018 through 12/5/18 revealed she had received Trimethoprim 100 mg once daily. An interview was conducted with Nurse #6 on 12/5/18 at 4:00 PM. She reported that Resident #10 was on Trimethoprim as a prophylactic related to a history of UTIs. She revealed Resident #10 had been on Trimethoprim since her admission to the facility in November of 2015. She stated that Resident #10 did not have an acute UTI. A review of Resident #10's monthly Drug Regimen Reviews (DRRs) from November 2017	F 756	determine adequate clinical rationale and duration for medication. Resident #65 antibiotic was reviewed by physician and it was determined that the medication would be discontinued on 12/14/18 and the resident would be monitored for signs and symptoms of urinary tract infection. Resident #57 psychotropic medication ordered to be used as needed (prn)was reviewed by physician it was determined the medication was to be discontinued 12/14/18. Identification 100% audit of antibiotics and psychotropic medications were reviewed by the DON, ADON, UC or IPN to determine clinical rationale and duration for the use of medication on 12/21/18. No antibiotics or psychotropic medications were identified requiring new physician orders for rationale and duration. Pharmacist was in facility and completed 100% drug review on 12/17/2018 with focus on psychotropics and antibiotic therapy. Systemic Measures put into place to ensure the plan of correction is effective and remains in compliance are: Physician orders will be reviewed daily by DON, ADON, UC or Weekend Nurse Manager (NM) to ensure orders for antibiotics and psychotropic medications have rationale and duration. If clarification is indicated, physician will be contacted for recommendations. Education was provided by the Executive Director to Physician Assistant (PA), DON, ADON, UC and NM regarding reviewing orders for psychotropic medications and	

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F 756	Continued From page 90 through October 2018 made no mention of the prophylactic Trimethoprim. The monthly DRR for Resident #10 dated 11/12/18 completed by the Pharmacy Consultant identified that Trimethoprim was prescribed for UTI prophylaxis. The Pharmacy Consultant had not addressed the use of the prophylactic Trimethoprim. An interview with the Director of Nursing (DON) on 12/6/18 at 8:00 am revealed she expected all antibiotics to have a clinical indication for use. She stated she did not think there were any prophylactic antibiotics in the building. A phone interview was conducted with the Pharmacy Consultant on 12/6/18 at 2:15 PM. The Pharmacy Consultant was asked if she identified and addressed the use of prophylactic antibiotics that were prescribed indefinitely during her monthly DRRs. She stated that she generally noted on her review if a resident was on a prophylactic antibiotic, but that she would not have made any recommendations to the physician related to the order unless there were complicating medical factors such as renal failure. The order for Resident #10 ' s prophylactic Trimethoprim that had been in place since 11/26/15 was reviewed with the Pharmacy Consultant. She confirmed she had made no recommendations related to Resident #10's prophylactic Trimethoprim. A phone interview was conducted with the Physician's Assistant on 12/6/18 at 1:50 pm. He revealed he was not aware that Resident #10 was on Trimethoprim prophylactically. He stated his expectation was for all antibiotics to have an	F 756	antibiotics for rationale and duration. Licensed nursing staff were re-educated on unnecessary medications, 14 days prn use and stop dates on antibiotics unless supporting documentation is in place by DON, ADON, UC and IPN. Staff not educated by 12/21/18 will not be allowed to work until educated. This education will be added to new hire orientation for licensed nursing staff. Monitoring Physician orders for antibiotics and psychotropic medications will be reviewed daily in clinical rounds Monday through Friday and discussed by the DON, ADON and UC to ensure physician orders have rationale and duration of use. This will be completed daily x 2 weeks, then weekly x 2 weeks, then monthly x 3 months. Results will be presented in QAPI meeting by DON for recommendations and modifications until substantial compliance is achieved. Date of Compliance 12/21/2018	

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adequate clinical indication for use to prevent residents from becoming resistant to antibiotics.

A phone interview was conducted with Resident #10' physician/facility's Medical Director on 12/6/18 at 2:36 PM. He stated that he was involved with the monitoring of antibiotic usage at the facility. He indicated his expectation was for all antibiotics to have an adequate clinical indication. He reported that he had not initiated any orders for prophylactic antibiotics at the facility and that he tried to coordinate with external providers such as specialists or surgeons to address prophylactic orders for any of his residents.

A follow up interview was conducted with the DON on 12/6/18 at 2:57 PM. She stated that she expected the Pharmacy Consultant to identify and address the use of an antibiotic prescribed with no stop date and without an adequate clinical indication for use.

2. Resident #65 was admitted to the facility on 8/5/16 and most recently readmitted on 5/11/17 with diagnoses that included dementia and a personal history of Urinary Tract Infections (UTIs).

A review of Resident #65's care plan dated 9/11/18 revealed the problem area of the risk for UTIs. This care plan indicated Resident #65 was on a prophylactic antibiotic.

A review of Resident #65's active physician's orders was conducted on 12/5/18. Resident #65 had an active order dated 4/30/18 for Cefdinir (antibiotic) 300 milligrams (mg) once daily for UTI

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prophylaxis.

A review of Resident #65's Medication Administration Record from 5/1/18 through 12/5/18 revealed she received Cefdinir 300 mg once daily.

A review of the Pharmacy Consultants monthly Drug Regimen Reviews (DRRs) for Resident #10 was conducted. The Pharmacy Consultant identified that Resident #10 was on Cefdinir for UTI prophylaxis on her 7/14/18 review, 8/10/18 review, 10/8/18 review, and the 11/20/18 review. The Pharmacy Consultant had not addressed the use of the prophylactic Cefdinir.

An interview was conducted with Nurse #6 on 12/6/18 at 12:00 PM. She reported that Resident #65 was on Cefdinir as a prophylactic related to a history of UTIs. She stated that Resident #65 had been on Cefdinir for "a long time". She indicated that Resident #65 did not have an active UTI.

An interview with the Director of Nursing (DON) on 12/6/18 at 8:00 am revealed she expected all antibiotics to have a clinical indication for use. She stated she did not think there were any prophylactic antibiotics in the building.

A phone interview was conducted with the Pharmacy Consultant on 12/6/18 at 2:15 PM. The Pharmacy Consultant was asked if she identified and addressed the use of prophylactic antibiotics that were prescribed indefinitely during her monthly DRRs. She stated that she generally noted on her review if a resident was on a prophylactic antibiotic, but that she would not

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have made any recommendations to the physician related to the order unless there were complicating medical factors such as renal failure. The order for Resident #65 ' s prophylactic Cefdinir that had been in place since 4/30/18 was reviewed with the Pharmacy Consultant. She confirmed she had made no recommendations related to Resident #65 ' s prophylactic Cefdinir.

A phone interview was conducted with the Physician's Assistant on 12/6/18 at 1:50 pm. He revealed he was not aware that Resident #65 was on Cefdinir prophylactically. He stated his expectation was for all antibiotics to have an adequate clinical indication for use to prevent residents from becoming resistant to antibiotics.

A phone interview was conducted with Resident #65's physician/facility's Medical Director on 12/6/18 at 2:36 PM. He stated that he was involved with the monitoring of antibiotic usage at the facility. He indicated his expectation was for all antibiotics to have an adequate clinical indication. He reported that he had not initiated any orders for prophylactic antibiotics at the facility and that he tried to coordinate with external providers such as specialists or surgeons to address prophylactic orders for any of his residents.

A follow up interview was conducted with the DON on 12/6/18 at 2:57 PM. She stated that she expected the Pharmacy Consultant to identify and address the use of an antibiotic prescribed with no stop date and without an adequate clinical indication for use.

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3. Resident #57 was admitted to the facility on 7/27/18 with diagnoses of right hip fracture, history of falls, and dementia.

Resident #57's Physician's Orders were reviewed and revealed an order for Trazodone 50 milligrams one tablet by mouth at bedtime as needed for insomnia written 9/24/18.

A review of the September 2018 Medication Administration Record for Resident #57 revealed he received a sedative, Trazadone 50 milligrams one tablet by mouth once daily at bedtime for insomnia, and it was changed to an as needed order for Trazodone 50 milligrams give one tablet by mouth at bedtime as needed for insomnia on 9/24/18.

A review of the Pharmacist's Note dated 10/9/18 revealed Resident #59's Trazodone was changed to an as needed medication. It was not recorded in the note that the physician was notified the medication should not be used as an as needed medication for more than 14 days.

A review of the October 2018 Medication Administration Record for Resident #57 revealed the facility continued to have an as needed order for Trazodone 50 milligrams give one tablet by mouth at bedtime as needed for insomnia.

A review of the November 2018 Medication Administration Record for Resident #57 revealed the facility continued to have an as needed order for Trazodone 50 milligrams give one tablet by mouth at bedtime as needed for insomnia.

A review of a Physician's Progress Note dated 11/12/18 by the Physician's Assistant revealed the

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F 756	Continued From page 95	F 756		

resident was not evaluated for the use of psychotropic medications. He was seen for a fall from his wheelchair.

A Pharmacist's Note dated 11/13/18 revealed Resident #57's medications were reviewed but there was no mention of the Sedative, Trazodone, being ordered as needed for greater than 14 days.

A Pharmacist's Note dated 11/20/18 revealed a review of Resident #57's psychotropic medications due to a history of falls but no review of the sedative, Trazodone, being ordered as needed for greater than 14 days.

A review of the most recent Minimum Data Set Assessment which was a Significant Change Assessment dated 11/29/18 revealed Resident #57 was moderately cognitively impaired and required extensive assistance with transfers to and from the bed and chair, extensive assistance with moving in bed, and extensive assistance with toileting.

A review of Resident #57's Care Plan which was updated on 11/30/18 revealed a care plan for Risk for Side Effects related to Psychotropic Medication Use due to Dementia with Behaviors. The care plan goal stated the resident would remain free of side effects of psychotropic medications. Resident #57 also had a care plan for Risk of Alteration in Sleep Pattern related to Insomnia with a goal to have decreased the nights of insomnia.

A telephone interview with the Physician's Assistant on 12/6/18 at 2:02 pm revealed he was not aware all psychotropic meds were limited to

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F 756	Continued From page 96 how long they could be used as needed without re-evaluating the need for the medication. He stated he thought that only antipsychotics were considered psychotropic medications. He stated he would begin ordering all psychotropic medications that were as needed to be used for 14 days and then re-evaluate the need for the medication. During a telephone interview with the Pharmacy Consultant on 12/6/18 at 2:16 pm she stated it was up to the physician to re-evaluate a resident for psychotropic medication use. An interview with the Director of Nursing on 12/6/18 at 3:05 pm revealed she stated she would expect the pharmacist to monitor all residents on psychotropic medications for any issues and notify the Physician if an as needed psychotropic medication is ordered for more than 14 days.	F 756		
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---	F 758		12/21/18

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F 758	Continued From page 97 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Pharmacist and Physician Assistant interviews the facility failed to provide documentation of a rationale for psychotropic medications that were ordered by the physician as needed for more than	F 758	F 758 Based on the root cause analysis by the facility administrative staff and the DON, facility staff did not ensure psychotropic medications had rationale and duration of	

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F 758	Continued From page 98 14 days for 2 of 5 sampled residents reviewed for unnecessary medications (Residents #57 and #79). Findings included: 1. Resident #57 was admitted to the facility on 7/27/18 with diagnoses of right hip fracture, history of falls, and dementia. Resident #57's Physician's Orders were reviewed and revealed an order for Trazodone 50 milligrams one tablet by mouth at bedtime as needed for insomnia written 9/24/18. A review of the September 2018 Medication Administration Record for Resident #57 revealed he received a sedative, Trazadone 50 milligrams one tablet by mouth once daily at bedtime for insomnia, and it was changed to an as needed order for Trazodone 50 milligrams give one tablet by mouth at bedtime as needed for insomnia on 9/24/18. A review of the October 2018 Medication Administration Record for Resident #57 revealed the facility continued to have an as needed order for Trazodone 50 milligrams give one tablet by mouth at bedtime as needed for insomnia. A review of the November 2018 Medication Administration Record for Resident #57 revealed the facility continued to have an as needed order for Trazodone 50 milligrams give one tablet by mouth at bedtime as needed for insomnia. A review of the Pharmacist's Note dated 10/9/18 revealed Resident #59's Trazodone was changed to an as needed medication.	F 758	medication. Resident #57 psychotropic medication ordered to be used as needed (prn)was reviewed by physician it was determined the medication was to be discontinued 12/14/18. Resident #79 psychotropic medication ordered to be used prn was reviewed by the physician and it was determined the medication was to be discontinue on 12/11/18. Identification 100% audit of psychotropic medications were reviewed by the DON, ADON, UC or IPN to determine clinical rationale and duration for the use of medication on 12/21/18. No psychotropic medications were identified requiring new physician orders for rationale and duration. Pharmacist was in facility and completed 100% drug review on 12/17/18 with focus on psychotropic medications. Systemic Measures put into place to ensure the plan of correction is effective and remains in compliance are: Physician orders will be reviewed daily by DON, ADON, UC or Weekend Nurse Manager (NM) to ensure orders for psychotropic medications have rationale and duration. If clarification is indicated, physician will be contacted for recommendations. Education was provided by the Executive Director to Physician Assistant (PA), DON, ADON, UC and NM regarding reviewing orders for psychotropic medications for rationale and duration. Pharmacy Director educated the Pharmacist on psychotropic medications requiring rationale and	

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F 758	Continued From page 99 A review of a Physician's Progress Note dated 11/12/18 by the Physician's Assistant revealed the resident was not evaluated for the use of psychotropic medications. He was seen for a fall from his wheelchair. A Pharmacist's Note dated 11/13/18 revealed Resident #57's medications were reviewed but there was no mention of the Sedative, Trazodone, being ordered as needed. A Pharmacist's Note dated 11/20/18 revealed a review of Resident #57's psychotropic medications due to a history of falls but no review of the sedative, Trazodone, being ordered as needed. A review of the most recent Minimum Data Set Assessment which was a Significant Change Assessment dated 11/29/18 revealed Resident #57 was moderately cognitively impaired and required extensive assistance with transfers to and from the bed and chair, extensive assistance with moving in bed, and extensive assistance with toileting. A review of Resident #57's Care Plan which was updated on 11/30/18 revealed a care plan for Risk for Side Effects related to Psychotropic Medication Use due to Dementia with Behaviors. The care plan goal stated the resident would remain free of side effects of psychotropic medications. Resident #57 also had a care plan for Risk of Alteration in Sleep Pattern related to Insomnia with a goal to have decreased the nights of insomnia. A telephone interview with the Physician's	F 758	duration on 12/11/18. Licensed nursing staff were re-educated on unnecessary medications, 14 days prn use and stop dates on psychotropic medications unless supporting documentation is in place by DON, ADON, UC and IPN. Staff not educated by 12/21/18 will not be allowed to work until educated. This education will be added to new hire orientation for licensed nursing staff. Monitoring Physician orders for psychotropic medications will be reviewed daily in clinical rounds Monday through Friday and discussed by the DON, ADON and UC to ensure physician orders have rationale and duration of use. This will be completed daily x 2 weeks, then weekly x 2 weeks, then monthly x 3 months. Results will be presented in QAPI meeting by DON for recommendations and modifications until substantial compliance is achieved. Date of Compliance 12/21/2018	

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Assistant on 12/6/18 at 2:02 pm revealed he was not aware all psychotropic meds were limited to how long they could be used as needed without re-evaluating the need for the medication. He stated he thought that only antipsychotics were considered psychotropic medications. He stated he would begin ordering all psychotropic medications that were as needed to be used for 14 days and then re-evaluate the need for the medication.

During a telephone interview with the Pharmacy Consultant on 12/6/18 at 2:16 pm she stated it was up to the physician to re-evaluate a resident for psychotropic medication use.

An interview with the Director of Nursing on 12/6/18 at 3:05 pm revealed she expected all psychotropic medications that are ordered as needed to be re-evaluated every 14 days for the use of the psychotropic. She stated she would expect the pharmacist to monitor all resident's on psychotropic medications for any issues.

2. Resident # 79 was admitted to the facility on 7/13/18 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 11/14/18 indicated that Resident #79 had severe cognitive impairment and had other behavioral symptoms not directed towards others.

On 9/10/18, Resident #79 had a doctor's order for Ativan (antianxiety drug) 1 milligrams (mgs) by mouth twice a day as needed (PRN). The order had no stop date.

On 10/26/18, Resident #79 had a doctor's order for Ativan 1 mgs by mouth twice a day PRN for agitation for 4 months.

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F 758	Continued From page 101 Review of the Medication Administration Records (MARs) revealed that Resident #79 had received the Ativan one time in September 2018 (9/18/18) and twice in October 2018 (10/9 and 10/10) and none in November 2018. Resident #79's nurse's notes were reviewed. The notes revealed that Resident #79 had agitation on 9/18/18 and Ativan was administered. There were no notes on 10/26/18 to indicate as to why the PRN Ativan was ordered for 4 months. The doctor's progress notes for Resident #79 were reviewed for September, October and November 2018. The notes did not have documented rationale for the use of the PRN Ativan beyond 14 days. On 12/5/18 at 10:50 AM, the Physician Assistant (PA) was interviewed. The PA stated that he was the one who ordered the PRN Ativan on 10/26/18 for 4 months. He indicated that he was not familiar with the regulations regarding the use of PRN psychotropic drugs. He was not aware that he had to document the rationale if he ordered the PRN psychotropic drug beyond 14 days. On 12/6/18 at 2:59 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the doctors including the PA to follow the regulations for PRN psychotropic drugs. She indicated that PRN psychotropic drugs should only be ordered for 14 days unless indicated and the rationale documented.	F 758		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	F 881		12/21/18

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F 881	Continued From page 102 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Medical Director, Physician's Assistant, Pharmacy Consultant, and staff, the facility failed to follow the Antibiotic Stewardship Program as evidenced by the use of prophylactic (preventative) antibiotics for 3 of 3 sampled residents (Residents #10, #65, and #84) reviewed for antibiotic usage. The findings included: 1. Resident #10 was admitted to the facility on 11/12/18 with diagnoses that included Alzheimer's and a personal history of Urinary Tract Infections (UTIs). The annual Minimum Data Set (MDS) assessment dated 9/10/18 indicated Resident #10's cognition was severely impaired. She received an antibiotic on 7 of 7 days. Resident #10 had no active diagnosis of a UTI or any other infection. She was assessed as requiring the extensive assistance of 2 or more staff with toileting and she was always incontinent of bladder and bowel. The Care Area Assessment related to urinary	F 881	F 881 Based on the root cause analysis by the facility administrative staff and the DON, facility staff did not follow antibiotic stewardship program. Immediate Resident #10 antibiotic was reviewed by physician to determine adequate clinical rationale and duration of treatment. Antibiotic was discontinued 12/14/18. Resident #65 antibiotic was reviewed by physician to determine adequate clinical rationale and duration of treatment. Appointment is set for 1/9/19 with the Urologist as recommended by the physician to determine the medical need of the medication and duration. Resident #84 antibiotic was reviewed by physician to determine adequate clinical rationale and duration of treatment. Appointment set for 1/9/19 with the Urologist as recommended by the physician to determine the medical need of the medication and duration. Resident discharged home on 12/22/18. Identification 100% audit was conducted of all residents receiving antibiotics was conducted by the	

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F 881	Continued From page 103 incontinence for Resident #10's 9/10/18 annual MDS indicated she was at risk for UTIs related to history of UTI and incontinence. Resident #10 received Trimethoprim as a prophylactic (preventative) measure and had no acute UTIs. A review of Resident #10's care plan dated 9/11/18 revealed the problem area of the risk for UTIs. This care plan indicated Resident #10 was on a prophylactic antibiotic with no symptoms of an acute UTI. A review of Resident #10's active physician's orders was conducted on 12/5/18. Resident #10 had an active order dated 11/26/15 for Trimethoprim (antibiotic) 100 milligrams (mg) once daily for UTI prophylaxis. A review of Resident #10's Medication Administration Records from 1/1/2018 through 12/5/18 revealed she had received Trimethoprim 100 mg once daily. An interview was conducted with Nurse #6 on 12/5/18 at 4:00 PM. She reported that Resident #10 was on Trimethoprim as a prophylactic related to a history of UTIs. She revealed Resident #10 had been on Trimethoprim since her admission to the facility in November of 2015. She stated that Resident #10 did not have an acute UTI. An interview with the Director of Nursing (DON) on 12/6/18 at 8:00 am revealed she expected all antibiotics to have a clinical indication for use. She stated she did not think there were any prophylactic antibiotics in the building. The Director of Nursing indicated that prophylactic antibiotics were not in accordance with the	F 881	DON, ADON, UC or IPN. No other residents were identified to be receiving prophylactic antibiotics. Pharmacist was in facility and completed 100% drug review on 12/17/18 with focus on antibiotic medications. Systemic Measures put into place to ensure the plan of correction is effective and remains in compliance are: Physician orders will be reviewed daily by DON, ADON, UC or Weekend Nurse Manager (NM) to ensure the physician orders for antibiotics will have proper rationale and duration. If clarification is indicated, physician will be contacted for recommendations. Education on antibiotic stewardship was provided by the Executive Director to Physician Assistant (PA), DON, ADON, UC and NM regarding reviewing orders for antibiotics for rationale and duration. Pharmacy Director educated the Pharmacist on antibiotic stewardship. Licensed nursing staff were educated on antibiotic stewardship by DON, ADON, UC or NM on 12/12/18. Staff not educated by 12/21/18 will not be allowed to work until educated. Monitoring Physician orders for antibiotic medications will be reviewed daily in clinical rounds Monday through Friday and discussed by the DON, ADON and UC to ensure physician orders have rationale and duration of use. This will be completed daily x 2 weeks, then weekly x 2 weeks, then monthly x 3 months. Results will be presented in QAPI meeting by DON for	

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F 881	Continued From page 104 Antibiotic Stewardship Program (ASP). A phone interview was conducted with the Physician's Assistant on 12/6/18 at 1:50 pm. He revealed he was not aware that Resident #10 was on Trimethoprim prophylactically. He stated his expectation was for the ASP to be followed to prevent residents from becoming resistant to antibiotics. A phone interview was conducted with Resident #10's physician/facility's Medical Director on 12/6/18 at 2:36 PM. He stated that he was involved in the ASP at the facility. He indicated that prophylactic antibiotics were not in accordance with the ASP. He reported that he had not initiated any orders for prophylactic antibiotics at the facility and that he tried to coordinate with external providers such as specialists or surgeons to address prophylactic orders for any of residents. A phone interview was conducted with the Pharmacy Consultant on 12/6/18 at 2:15 PM. She indicated she began working at this facility in August 2018. The Pharmacy Consultant was asked if she identified and addressed the use of prophylactic antibiotics that were prescribed indefinitely during her monthly Drug Regimen Reviews. She stated that she generally noted on her review if a resident was on a prophylactic antibiotic, but that she would not have made any recommendations to the physician related to the order unless there were complicating medical factors such as renal failure. The order for Resident #10's prophylactic Trimethoprim that had been in place since 11/26/15 was reviewed with the Pharmacy Consultant. She confirmed she had made no recommendations related to	F 881	recommendations and modifications until substantial compliance is achieved. Date of Compliance 12/21/2018	

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Resident #10's prophylactic Trimethoprim. The Pharmacy Consultant revealed she was unaware that prophylactic antibiotics were not in accordance with the ASP.

A follow up interview was conducted with the DON on 12/6/18 at 2:57 PM. She stated that she expected the ASP to be followed.

2. Resident #65 was admitted to the facility on 8/5/16 and most recently readmitted on 5/11/17 with diagnoses that included dementia and a personal history of Urinary Tract Infections (UTIs).

The annual Minimum Data Set (MDS) assessment dated 8/10/18 indicated Resident #65's cognition was intact. She received an antibiotic on 7 of 7 days. Resident #65 had no active diagnosis of a UTI or any other infection. She was assessed as requiring the extensive assistance of 2 or more staff with toileting. Resident #65 was frequently incontinent of bladder and always incontinent of bowel.

The Care Area Assessment related to urinary incontinence for Resident #65's 8/10/18 MDS indicated she required staff assistance with toileting and had frequent bladder incontinence. She was noted to be at risk for UTI recurrence but had not shown any acute UTI symptoms.

A review of Resident #65's care plan dated 9/11/18 revealed the problem area of the risk for UTIs. This care plan indicated Resident #65 was on a prophylactic antibiotic.

A review of Resident #65's active physician's

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orders was conducted on 12/5/18. Resident #65 had an active order dated 4/30/18 for Cefdinir (antibiotic) 300 milligrams (mg) once daily for UTI prophylaxis.

A review of Resident #65's Medication Administration Record from 5/1/18 through 12/5/18 revealed she received Cefdinir 300 mg once daily.

An interview was conducted with Nurse #6 on 12/6/18 at 12:00 PM. She reported that Resident #65 was on Cefdinir as a prophylactic related to a history of UTIs. She stated that Resident #65 had been on Cefdinir for "a long time". She indicated that Resident #65 did not have an acute UTI.

An interview with the Director of Nursing (DON) on 12/6/18 at 8:00 am revealed she expected all antibiotics to have a clinical indication for use. She stated she did not think there were any prophylactic antibiotics in the building. The Director of Nursing indicated that prophylactic antibiotics were not in accordance with the Antibiotic Stewardship Program (ASP).

A phone interview was conducted with the Physician's Assistant on 12/6/18 at 1:50 pm. He revealed he was not aware that Resident #65 was on Cefdinir prophylactically. He stated his expectation was for the ASP to be followed to prevent residents from becoming resistant to antibiotics.

A phone interview was conducted with Resident #65's physician/facility ' s Medical Director on 12/6/18 at 2:36 PM. He stated that he was involved in the ASP at the facility. He indicated

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that prophylactic antibiotics were not in accordance with the ASP. He reported that he had not initiated any orders for prophylactic antibiotics at the facility and that he tried to coordinate with external providers such as specialists or surgeons to address prophylactic orders for any of his residents.

A phone interview was conducted with the Pharmacy Consultant on 12/6/18 at 2:15 PM. She indicated she began working at this facility in August 2018. The Pharmacy Consultant was asked if she identified and addressed the use of prophylactic antibiotics that were prescribed indefinitely during her monthly Drug Regimen Reviews. She stated that she generally noted on her review if a resident was on a prophylactic antibiotic, but that she would not have made any recommendations to the physician related to the order unless there were complicating medical factors such as renal failure. The order for Resident #65's prophylactic Cefdinir that had been in place since 4/30/18 was reviewed with the Pharmacy Consultant. She confirmed she had made no recommendations related to Resident #65's prophylactic Cefdinir. The Pharmacy Consultant revealed she was unaware that prophylactic antibiotics were not accordance with the ASP.

A follow up interview was conducted with the DON on 12/6/18 at 2:57 PM. She stated that she expected the ASP to be followed.

3. Resident #84 was admitted to the facility on 11/12/18 with diagnoses of encephalopathy, history of fall, dementia, and hypertensive kidney disease. Her most recent comprehensive Minimum Data Set Assessment dated 11/19/18

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revealed she was severely cognitively impaired and required extensive assistance with moving about in bed, transfer to and from bed, and toileting. It also revealed she was incontinent of bowel and bladder.

A review of Resident #84's Physician's Orders revealed she had an order for Trimethoprim 100 milligrams, an antibiotic, take one by mouth daily prophylactic dated 11/4/18.

Review of Resident #84's Medication Administration record revealed she had received 100 milligrams of Trimethoprim daily from 11/12/18 to 12/6/18.

A review of Resident #84's Care Plan dated 11/15/18 revealed she had a care plan for Risk of Complications related to prophylactic antibiotic use.

A review of the Physician's Progress Note dated 11/15/18 at 9:00 am written by the Physician's Assistant revealed Resident #84 was seen and assessed as "no signs of infection" and "having no fever".

An interview with the Director of Nursing on 12/6/18 at 8:00 am revealed she would expect all antibiotics to have a clinical indication for use. She stated she did not think there were any prophylactic antibiotics in the building. The Director of Nursing indicated that prophylactic antibiotics were not in accordance with the Antibiotic Stewardship.

A telephone interview with the Physician's Assistant on 12/6/18 at 1:50 pm revealed he was not aware that Resident #84 was on

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F 881	Continued From page 109 Trimethoprim prophylactically. He stated his expectation is that the Antibiotic Stewardship would be followed to prevent residents from becoming resistant to antibiotics.	F 881		