STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING ______ B. WING ______	C 01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	**6590 TRYON ROAD CARY, NC 27518**

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 01/07/19 through 01/11/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ONZD11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification survey was conducted on 1/07/19 through 1/11/19. There were no deficiencies cited as a result of the complaint investigation survey Event ID ONZD11.	F 000		
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 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	F 623		1/14/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/14/2019

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

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F 623	Continued From page 1 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: (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	F 623		

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F 623	Continued From page 2 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. §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, staff interviews, and ombudsman interviews, the facility failed to provide written notification to the resident, resident's representative and/or the ombudsman when the residents were discharged to the hospital or home. This was evident for 3 of 3	F 623	Resident #78 no longer resides at the facility. Resident #76 no longer resides at the facility. Resident #10 was readmitted to the facility on 11/20/2018. The Director of Nursing and / or Nursing	

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F 623

Continued From page 3

residents reviewed for discharge (Resident #10, Resident #76, and Resident #78).

The findings included:

1. Resident #10 was admitted to the facility on 12/30/13 with diagnoses that included epilepsy and cognitive communication deficit. Review of Resident #10's most recent quarterly Minimum Data Set (MDS) assessment dated 10/4/18 revealed Resident #10 was assessed as severely cognitively impaired.

Review of a nurse's note dated 11/19/18 revealed Resident #10 was sent to the hospital for evaluation of seizures.

Review of a nurse's note dated 11/20/18 revealed Resident #10 was readmitted to the facility from the hospital on 11/20/18.

A review of the medical record revealed no written notice of discharge was provided to the resident representative for the resident's hospital transfer on 11/19/18. No written notice was forwarded to the ombudsman.

During an interview with the Social Worker on 1/9/19 at 4:25 PM she indicated she was unaware that written notice of discharge was sent to the resident or resident's representative and ombudsman for emergent hospital transfers. She reported the Admissions office contacted the resident or resident's representative after hospitalization.

During an interview with the Administrator on 1/10/19 at 11:08 AM she indicated it was her expectation written notice of discharge would be

F 623

Supervisor reviewed the last 30 days of discharges to identify notification to responsible party of discharge as well as the Ombudsman on 1/10/19. Social Work was educated by the Executive Director on notification to the Ombudsman on 1/10/19. The Executive director educated the Business office manager and the Admissions Director to follow up on the next business day of a facility based discharge by calling the responsible party to inform them of the bed hold. The Admission Director and / or Executive Director will be responsible for sending written notification the family.

The Director of Nursing will perform quality improvement monitoring of facility based transfers two times a week for eight weeks, the monthly for three months for offering bed hold and notifying the Ombudsman.

The Executive Director introduced the plan to the Quality Improvement committee on 1/11/19. The Executive Director is responsible for this plan. The results of the quality improvement monitoring will be reviewed monthly at the QAPI meeting. The QAPI committee meeting consists of but not limited to the Medical Director, Executive Director, DON, Activities Director, Social Services, MDS Nurse, Maintenance, Activities, Laundry and Housekeeping, and a minimum of one direct care giver.

Quality improvement monitoring modified based on findings.

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F 623	Continued From page 4	F 623		

sent to the resident or resident's representative with a copy forwarded to the ombudsman as required by regulations for emergent hospital transfers by the Admissions Coordinator. She stated the facility would begin sending these written notices as required.

During an interview with the Ombudsman on 1/11/19 at 3:51 PM she indicated she had not received
written notices of resident's discharges from the facility in several months.

2. Resident #76 was admitted to the facility on 9/6/17 with diagnoses that included chronic obstructive pulmonary disease, hyperlipidemia and dementia.

Review of a nurse's note dated 12/2/18 revealed Resident #76 was transferred to the hospital for an evaluation after a fall. Review of an additional nurse's note dated 12/2/18 revealed Resident #76 did not return to the facility.

Review of a nurse's note dated 12/2/18 revealed the resident representative elected to place the resident in another facility upon discharge from the hospital.

A review of the medical record revealed no written notice of discharge was provided to the resident representative for the resident's hospital transfer on 12/2/18.

During an interview with the Social Worker on 1/9/19 at 4:25 PM she indicated she was unaware that written notice of discharge was sent to the resident or resident's representative and ombudsman for emergent hospital transfers.

F 623 Continued From page 5 F 623

She reported the Admissions office contacted the resident or resident's representative after hospitalization.

During an interview with the Administrator on 1/10/19 at 11:08 AM she indicated it was her expectation written notice of discharge would be sent to the resident or resident's representative with a copy forwarded to the ombudsman as required by regulations for emergent hospital transfers by the Admissions Coordinator. She stated the facility would begin sending these written notices as required.

During an interview with the Ombudsman on 1/11/19 at 3:51 PM she indicated she had not received written notices of resident's discharges from the facility in several months.

3. Resident #78 was admitted to the facility on 10/3/18 with diagnoses which included atrial fibrillation and coronary artery disease.

A review of Resident #78's medical record included a Discharge Note dated 10/16/18 and authored by the Physician's Assistant (PA) who helped care for the resident during his stay at the facility. The note reported Resident #78 was seen on 10/16/18 for a planned discharge due to non-coverage by his insurance. The resident planned to return to his home with Home Health services and follow-up with his primary care physician.

Further review of the resident's medical record revealed there was no documentation to indicate the Ombudsman received written notification of Resident #78's discharge from the facility on 10/17/18.

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F 623	Continued From page 6 An interview was conducted on 1/9/19 at 4:25 PM with the facility's Social Worker. During the interview, the Social Worker reported she did not notify the Ombudsman in writing of resident discharges/transfers. A telephone interview was conducted on 1/11/19 at 3:41 PM with the Ombudsman. Upon inquiry, the Ombudsman reported she had not routinely received monthly updates on transfers/discharges of residents from the facility. When asked, the Ombudsman reported she did not receive a written notification of Resident #78's discharge in October 2018. An interview was conducted on 1/11/19 at 3:54 PM with the facility's Director of Nursing (DON). During the interview, the DON reported he would expect the Ombudsman to be notified of all discharges.	F 623		
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 observations, staff and resident interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect the provision of an anticoagulant for 1 of 5 residents reviewed for Unnecessary Medications (Resident #37) and to reflect the use of oxygen therapy for 1 of 1 resident reviewed for Respiratory Care. (Resident #69)	F 641	Resident #69 MDS was modified on 1/11/19 to accurately reflect resident condition by the Regional MDS Nurse. Resident #37 MDS was modified on 1/10/19 to accurately reflect resident condition by the Regional MDS Nurse. On 1/8/19 the Executive Director, Social Services, Regional MDS and Regional	1/14/19

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F 641	Continued From page 7 Findings included: 1. Resident #37 was admitted to the facility on 7/18/18. Her active diagnoses included anemia, hypertension and pulmonary embolism. Review of Resident #37's physician's orders for November 2018 revealed Resident #37 was ordered to receive Eliquis (an anticoagulant medication) 5 milligrams by mouth twice a day. Review of Resident #37's medication administration record for November 2018 revealed Resident #37 received Eliquis twice a day as ordered from 11/1/18 to 11/30/18. Review of Resident #37's MDS assessment dated 11/22/18 revealed Resident #37 was coded as not receiving an anticoagulant medication in section N0410 question E. During an interview on 1/10/19 at 10:06 AM MDS Nurse #1 stated Resident #37 did receive an anticoagulant medication during the assessment reference date for the MDS dated 11/22/18. She concluded Resident #37's MDS assessment dated 11/22/18 was not coded correctly because it did not reflect the resident received an anticoagulant medication. During an interview on 1/10/19 at 10:08 AM the MDS Coordinator stated it was her expectation the use of an anticoagulant medication be captured correctly on the MDS assessment and it was not correct on the 11/22/18 MDS assessment for Resident #37. During an interview on 1/10/19 at 11:38 AM the	F 641	DON completed a quality improvement monitor of current resident's MDS's coding for accuracy related to anticoagulants. On 1/14/19 a quality improvement monitor of current resident MDS's coding for accuracy related to oxygen was completed. Any issues identified were addressed. The Regional MDS coordinator re-educated the MDS Coordinator and the Assistant MDS coordinator on 1/8 - 14/2019 related to accuracy of the MDS. The Director of Clinical Services, Executive Director, and / or Nursing supervisor to perform quality improvement monitoring of accuracy of the MDS related to anticoagulants and the use of oxygen one time a week for four weeks, and monthly for three months. The Executive Director introduced this plan to the Quality Assurance Performance Improvement Committee on 1/11/2019. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring to be reviewed at monthly QAPI committee meeting. QAPI committee meeting consists of but not limited to Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance director, MDS Nurse, Dietary manager, housekeeping and laundry manager, and one direct caregiver. Quality improvement monitoring scheduled modified based on findings.	

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F 641	Continued From page 8 Director of Nursing stated it was his expectation medications be accurately captured on resident MDS assessments. He concluded the MDS assessment for Resident #37 dated 11/22/18 was incorrect and would be corrected. 2. Resident #69 was initially admitted to the facility on 12/7/16, with re-entry from a hospital on 1/23/17. The resident's cumulative diagnoses included chronic obstructive pulmonary disease and chronic hypoxemic (low blood oxygen levels) respiratory failure. A review of Resident #69's current physician orders included an order initiated on 1/23/17 for the provision of oxygen at 4 liters per minute via nasal cannula due to chronic hypoxemic respiratory failure. A review of Resident #69's quarterly Minimum Data Set (MDS) assessment dated 12/18/18 was completed. The assessment revealed Resident #69 had intact cognitive skills for daily decision making. Section O of the MDS did not indicate she received oxygen therapy while a resident. An interview was conducted on 1/11/19 at 9:17 AM with Resident #69. At the time of the interview, the resident was observed to be sitting in a wheelchair in her room with a nasal cannula in place. The oxygen concentrator was turned on and set to provide oxygen at 4 liters per minute. Upon inquiry, the resident reported she wore her oxygen (via nasal cannula) whenever she was in her room. An interview was conducted on 1/11/19 at 11:10 AM with MDS Nurse #1. MDS Nurse #1 reported upon review of Resident #69's MDS dated 12/18/18, she had determined the resident did	F 641		

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F 641	Continued From page 9 receive oxygen treatment during the assessment's 7-day look back period. The nurse stated this MDS had been coded incorrectly. An interview was conducted on 1/11/19 at 3:54 PM with the facility's Director of Nursing (DON). During the interview, the DON stated he would expect a resident's MDS assessment to be coded correctly.	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 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 record review and staff interviews the facility failed to refer a resident with a newly evident diagnosis of a serious mental illness for a Preadmission Screening and Resident Review (PASARR) level II for 1 of 2 residents reviewed	F 644	Resident #37 PASRR was sent for review and the MDS was updated on 1/8/19 by the MDS coordinator. On 1/8/19 the Executive Director, Social	1/14/19

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F 644 Continued From page 10
for PASARR. (Resident #37)

Findings included:

Review of Resident #37's PASARR Level I Determination Notification letter dated 7/12/18 revealed the resident was assessed to be Level I. There were no further PASARR referrals for Resident #37 in the medical record.

Resident #37 was readmitted to the facility on 8/18/18. Her primary diagnosis was acute respiratory failure. Resident #37 had no mental health related diagnoses including bipolar disorder noted on readmission to the facility on 8/18/18.

Review of Resident #37's hospital discharge summary dated 8/8/18 revealed the resident's diagnoses included aspiration pneumonia, acute encephalopathy, alcohol abuse, hyponatremia, diabetes mellitus, hypertension, respiratory failure, and dementia associated with alcoholism without behavioral disturbances. Resident #37 did not have a diagnosis of bipolar disorder.

Review of a psychiatric progress note dated 8/9/18 revealed Resident #37 was seen by psychiatric services for an initial consult. Resident #37 was seen by psychiatric services related to staff reporting anxiety, agitation, verbal aggression, and physical aggression. The progress note specified facility staff reported the resident had mood fluctuation and was not easily redirectable. The diagnoses included anxiety, unspecified schizophrenia, depression, and dementia.

Review of a psychiatric progress note dated

F 644

Services, and Regional Director of Nursing and the Regional MDS coordinator completed a Quality Monitoring of current residents PASRR to current diagnosis to validate residents had the correct level PASRR in their medical record. Any issues identified were addressed.

The Regional MDS Coordinator re-educated the MDS coordinator and the Assistant MDS coordinator on 1/8/19 on accurate coding related to PASRR. The Director of Nursing educated psychological services on notifying the facility of any added or changed diagnosis to a resident so that the facility can determine if a new PASRR is needed on 1/9/19. The Social Worker will be responsible for making the referral to PASRR if needed. The Executive Director to perform Quality Improvement monitoring of new admission PASRR one time a week for eight weeks, then monthly times three months. New Psychological progress notes will be reviewed prior to filing by the Director of Nursing and / or Executive Director for any new diagnosis one time a week for eight weeks, then monthly times three months.

The Executive Director introduced this plan to the Quality Assurance Performance Improvement Committee on 1/11/2019. The Executive Director is responsible for the plan. Results of Quality Improvement Monitoring will be reviewed at monthly QAPI committee meetings QAPI committee meeting

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F 644	Continued From page 11 11/21/18 revealed Resident #37 was seen for medication management and facility staff reporting outbursts at the nurses' station. The diagnoses were changed to anxiety, dementia, and bipolar disorder. Review of Resident #37's minimum data set assessment dated 11/22/18 revealed the resident was assessed as moderately cognitively impaired. The resident had verbal symptoms directed towards others 1 to 3 days of the 7 day lookback period. Her active diagnoses included anemia, hypertension, dementia, depression, and psychotic disorder. Bipolar disorder was not noted as an active diagnosis. Review of Resident #37's active diagnoses revealed bipolar disorder was added to her active diagnosis with an onset dated of 12/26/18. During an interview on 1/8/19 at 3:58 PM the Social Worker stated the PASARR screen in July 2018 was the last PASARR screen performed on the resident. She further stated this was a PASARR Level I. She further stated Resident #37 was not referred to have a new screening with the new onset diagnosis of Bipolar Disorder. She stated the primary diagnoses for Resident #37 was Respiratory Failure. She stated the new diagnosis for bipolar disorder was made during a psychiatric consult in November 2018 and added to their system in December. She concluded she did not know why the previous social worker did not refer Resident #37 at that time for a PASSAR level II referral. During an interview on 1/8/19 at 4:11 PM the Administrator stated if a PASARR referral was supposed to be done for Resident #37 when the	F 644	consists of but not limited to : Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance director, Dietary Manager, Housekeeping Manager, laundry manager, MDS Nurse and a minimum of one direct caregiver. Quality Improvement Monitoring scheduled modified based on findings.	

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F 644	Continued From page 12 new diagnosis of bipolar disorder was identified, it was her expectation the social worker completed the referral.	F 644		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 27 medication opportunities, resulting in a medication error rate of 7.4% for 2 of 9 residents (Resident #52 and Resident #75) observed during medication pass. The findings included: 1. Resident #52 was admitted to the facility on 5/30/17 with re-entry from a hospital on 9/11/17. Her cumulative diagnoses included end stage renal disease requiring hemodialysis. On 1/8/19 at 3:56 PM, Nurse #1 was observed as she prepared and administered medications to Resident #52. The administered medications included 3 packets of 0.8 grams (g) sevelamer mixed with approximately 90 milliliters (ml) water in a cup. Sevelamer is a medication used to lower high blood phosphorus levels in patients who are on dialysis due to severe kidney disease.	F 759	Resident #52 physician was notified of medication of error on 1/8/19 by Regional Director of Clinical Services and new orders were obtained. Resident #75 physician was notified of medication error on 1/8/19 by Regional director of Clinical Services and no new orders were received. Both residents responsible parties were notified by the Regional director of Clinical Services on 1/8/19. The Nurse involved was re-educated on the 5 rights to Medication Administration on 1/8/19 by the Director of Nursing. On 1/8/19 Regional director of Clinical services reviewed medication orders to identify any other residents on the medication and administration times were changed to follow manufacturers recommendations. The Director of Nursing and / or Nursing Supervisor educated licensed nurses on the 5 rights of medication administration and following manufacturers	1/14/19

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F 759	Continued From page 13 A review of Resident #52's January 2019 Physician Orders included a current order for sevelamer 0.8 g to be given as 3 packets (for a total dose of 2.4 g) by mouth three times daily with meals. The sevelamer was scheduled for administration at 8:00 AM, 12:00 PM, and 5:00 PM. According to Lexi-Comp, a comprehensive on-line drug information resource, sevelamer should be administered with meals. An interview was conducted on 1/8/19 at 5:16 PM with Nurse #1. Upon request, the nurse reviewed the pharmacy auxiliary label on the bag containing packets of sevelamer dispensed from the pharmacy. The auxiliary label read, in part: "Take this medication with a meal." At that time, Nurse #1 reported she was not aware of the need to provide this medication with a meal. Upon inquiry, the nurse stated she probably should have administered the medication within ½ hour of the meal. On 1/8/19 at 5:26 PM, an observation was conducted as the evening meal trays were delivered to Resident #52's hall (one and one-half hours after the sevelamer was administered to the resident). An interview was conducted on 1/9/19 at 10:02 AM with one of the facility's consultant pharmacists (Consultant Pharmacist #1). During the interview, the pharmacist stated she had reviewed the manufacturer's instructions, which indicated sevelamer should be given with a meal. She also reported calling the manufacturer of the medication for additional information and was told the longer the duration between the medication	F 759	recommendations 1/8-14/19. The Director of Nursing and / or nursing supervisor to perform random quality monitoring of medication administration for the five rights and following manufactures recommendations one time a week, each shift, for eight weeks, then monthly for two months. Nurses who have not received education, will be educated before working their next assigned shift by the nursing supervisor. The Executive Director introduced this plan to the QAPI committee on 1/11/19. The Director of Nursing is responsible for the plan. The results of the quality monitoring will be reviewed monthly at the QAPI meeting. QAPI members included but not limited to: medical director, executive director, director of nursing, activities, social services, maintenance, housekeeping, dietary, MDS Nurse and at a minimum one direct caregiver. Quality improvement monitoring scheduled modified based on findings.	

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F 759	Continued From page 14	F 759		

administration and meal consumption, the less effective the medication would be. When asked if giving the medication one and one-half hours prior to the meal was too long of a time span, she stated, "Yes."

A telephone interview was conducted on 1/10/19 at 10:52 AM with Consultant Pharmacist #2. Consultant Pharmacist #2 reported he had consulted to the facility for the past year. When the med pass observation of sevelamer administration in relation to Resident #52's mealtime was discussed, the pharmacist stated he thought, "It would be a timing issue."

An interview was conducted on 1/10/19 at 5:08 PM with the facility's Director of Nursing (DON). Upon inquiry, the DON stated he had been informed of the med pass observations and concerns identified with the timing of medications in relation to meals. When asked about the timing of Resident #52's sevelamer administration, the DON stated the facility would definitely follow the doctor's order to give this medication with meals, not one and one-half hours prior to the meal service.

2. Resident #75 was admitted to the facility on 1/25/16 with reentry from a hospital on 7/15/18. Her diagnoses included peripheral artery disease (a circulatory problem in which narrowed arteries reduce blood flow to the extremities, most commonly affecting the legs).

A review of Resident #75's January 2019 Physician Orders included a current order for 50 mg cilostazol to be given as 1 tablet by mouth twice daily for a diagnosis of peripheral artery disease (initiated on 8/22/17). Cilostazol is an

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anti-platelet medication and a vasodilator. It works by preventing certain blood cells (platelets) from sticking together and by widening blood vessels in the legs to increase blood flow. The cilostazol was scheduled for administration at 9:00 AM and 9:00 PM.

On 1/8/19 at 8:59 AM, Nurse #2 was observed as she prepared medications for administration to Resident #75. The medications included one-50 milligram (mg) tablet of cilostazol crushed in applesauce. On 1/8/19 at 9:06 AM, the cilostazol was administered to the resident. At the time of the medication administration, Resident #75 was observed to have a partially eaten breakfast meal on the bedside table placed in front of her. An observation was also made of the resident as she drank from a vanilla shake (provided on her breakfast tray) immediately after the medication was given.

According to Lexi-Comp, a comprehensive on-line drug information resource, cilostazol should be administered 30 minutes before or 2 hours after meals.

A review of the meal schedule provided by the facility indicated the resident's hall was to receive breakfast trays at 8:30 am. The exact timing of tray delivery was not observed.

An interview was conducted on 1/8/19 at 10:10 AM with Nurse #2. Upon request, the nurse reviewed the pharmacy auxiliary label on the bubble pack card containing the cilostazol tablets dispensed from the pharmacy. The auxiliary label read: "Take 30 minutes before or 2 hours after food." Upon review of the resident's Medication Administration Record (MAR), Nurse #2 stated

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F 759	Continued From page 16 she gave the medication within one hour of the scheduled administration time. However, she also acknowledged the resident had her meal tray and had eaten some of her breakfast at the time of the med administration. An interview was conducted on 1/9/19 at 9:15 AM with one of the facility's consultant pharmacists (Consultant Pharmacist #1). During the interview, the pharmacist reported the timing of the cilostazol administration to Resident #75 was brought to her attention on 1/8/19. Consultant Pharmacist #1 stated she explained to the facility staff the medication needed to be given at least 30 minutes before breakfast due to the absorption of the drug. Based on the manufacturer's specifications/instructions, the pharmacist reported the administration times for the cilostazol were changed to 6:30 AM and 4:00 PM. A telephone interview was conducted on 1/10/19 at 10:52 AM with Consultant Pharmacist #2. Consultant Pharmacist #2 reported he had consulted to the facility for the past year. During the interview, the observation of cilostazol administration during Resident #75's mealtime was discussed. The pharmacist acknowledged the manufacturer specified cilostazol should be administered 30 minutes before or 2 hours after meals. However, Consultant Pharmacist #2 questioned the significance of the manufacturer's instructions on the timing of cilostazol administration in relation to meals. An interview was conducted on 1/10/19 at 5:08 PM with the facility's Director of Nursing (DON). Upon inquiry, the DON stated he had been informed of the med pass observations and	F 759		

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F 759	Continued From page 17 concerns identified with the timing of medications in relation to meals. When asked about the timing of Resident #75's cilostazol administration, the DON stated the facility should follow the doctor's order or the manufacturer's instructions on how the medication was to be given. He stated cilostazol should be administered 1/2 hour before or 2 hours after a meal.	F 759		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883		1/14/19

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F 883	Continued From page 18 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to have an effective immunization program that ensured the resident's medical record included a record of vaccination and pneumococcal immunization status for two of five residents reviewed for pneumococcal vaccinations (Resident #58 and Resident #69). The findings included: A review of the Centers for Disease Control and Prevention vaccine information statement (dated	F 883	Resident #58 consent for Pneumococcal Vaccine reflects she got it in the community prior to coming to the facility dated 1/11/19. Resident #69 was offered the Pneumococcal Vaccine on 1/14/19; new orders received from the physician. Quality improvement monitoring of current residents to identify other residents that may desire to have Pneumococcal Vaccine was completed 1/11- 14/19 by the Regional director of Clinical Services and /	

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8/17) used by the facility read, in part: "The Advisory Committee on Immunization Practice recommends two pneumococcal vaccines for adults 65 years of age and older ....If you are 65 or older and have not had a pneumonia vaccine, you should receive one dose of PCV13 (pneumococcal conjugate vaccine) now, and in 12 months get a dose of PPSV23 (pneumococcal polysaccharide vaccine). If you have had a pneumonia vaccine after the age of 65, then you received the PPSV23 and should receive the second vaccine, PCV13."

1. Resident #58 was admitted to the facility on 2/8/13. The resident's cumulative diagnoses included diabetes. Record review revealed Resident #58 was currently 86 years old.

A review of Resident #58's medical record revealed there was no documentation to indicate whether the resident received or refused either of pneumococcal vaccines.

A review of the resident's most recent quarterly Minimum Data Set (MDS) assessment dated 12/13/18 was reviewed. Section O of the MDS assessment indicated the resident's pneumococcal vaccination was not up to date. The reason why the pneumococcal vaccination was not received was noted as, "Not offered."

An interview was conducted on 1/10/19 at 3:58 PM with the facility's Director of Nursing (DON) and Administrator. Upon inquiry, the Administrator reported any vaccination provided to a resident should be documented on the resident's Medication Administration Record (MAR) and the Immunization Record kept in the medical record.

F 883

or Director of Nursing.

On 1/14/19 the Director of Nursing re-educated licensed Staff on administering and/or offering the Pneumococcal Vaccine to new admissions to the facility. The Director of Clinical Services and / or the Nursing Supervisor will perform random quality monitoring of new admissions for offering / providing the pneumococcal vaccine two times a week for four weeks, one time a week for eight weeks, then monthly for three months. Once consent obtained and/ or vaccine administered, it will be recorded in the medical record and / or EMR for tracking.
Nurses who did not receive the education, will be educated before working their next assigned shift by the nursing supervisor.

The executive director introduced this plan to the QAPI committee on 1/11/19. The Director of Nursing is responsible for the plan. Results of the Quality Improvement monitoring will be reviewed monthly at the QAPI committee meeting. QAPI committee consists of but not limited to : medical director, executive director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping manager, MDS Nurse and a minimum of one direct caregiver.

Quality improvement monitoring schedule modified based on findings.

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F 883	Continued From page 20 A follow-up interview was conducted on 1/11/19 at 7:30 AM with the Administrator. At that time, the Administrator reported no additional immunization records were found for Resident #58 to determine whether or not the resident has received or refused either of the pneumococcal vaccines. Upon further inquiry, the Administrator reported there may be logs with additional vaccination information in the facility. However, the information could not be located at this time due to a recent change of staff. The Administrator reported an audit of "the entire building" would need to be conducted to determine residents' vaccination status. An interview was conducted on 1/11/19 at 10:07 AM with MDS Nurse #1 in the presence of the Regional MDS Coordinator. During the interview, the MDS nurse was asked what resources were used to identify the vaccination status of residents reviewed for an MDS assessment. The nurse stated she looked in the resident's medical record for this information. Additionally, some information may be available in the facility's computerized records, the residents' MARs, and their Immunization Record kept on the chart. She also noted that new residents may have admission paperwork which included vaccination records. The Regional MDS Coordinator stated vaccination consents kept in the medical record were another source of information. Upon their request, a follow-up interview was conducted on 1/11/19 at 10:35 AM with the Administrator and Director of Nursing (DON). The Administrator and DON reported there wasn't a facility policy/procedure which addressed the monitoring/documentation of vaccinations. The	F 883		

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Administrator reported the facility recognized they had a problem with this issue.

A follow-up interview was conducted on 1/11/19 at 11:10 AM with MDS Nurse #1. During the interview, the MDS Nurse #1 reported she coded Resident 58 ' s 12/13/18 MDS assessment to indicate her pneumococcal vaccination was not up to date because there was no documentation in the medical record to indicate the resident had received the pneumococcal vaccination. Upon further inquiry, the MDS Coordinator joined the interview. The MDS Coordinator reported the facility use to keep a log for monitoring the immunization status of residents, but the log was no longer up to date.

2. Resident #69 was initially admitted to the facility on 12/7/16, with re-entry from a hospital on 1/23/17. The resident's cumulative diagnoses included chronic obstructive pulmonary disease and chronic hypoxemic (low blood oxygen levels) respiratory failure. Record review revealed Resident #69 was currently 72 years old.

A review of Resident #69's medical record revealed there was no documentation on the resident's Immunization Record to indicate whether the resident received or refused either of the pneumococcal vaccines.

A review of the resident's most recent quarterly Minimum Data Set (MDS) assessment dated 12/18/18 was reviewed. Section O of the MDS assessment indicated the resident's pneumococcal vaccination was not up to date. The reason why the pneumococcal vaccination was not received was noted as, "Not offered."

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F 883	Continued From page 22 An interview was conducted on 1/10/19 at 3:58 PM with the facility's Director of Nursing (DON) and Administrator. Upon inquiry, the Administrator reported any vaccination provided to a resident should be documented on the resident's Medication Administration Record (MAR) and the Immunization Record kept in the medical record. A follow-up interview was conducted on 1/11/19 at 7:30 AM with the Administrator. At that time, the Administrator provided a copy of Resident #69's 11/17 MAR retrieved from her thinned chart. The MAR indicated the resident was vaccinated with PCV13 on 11/29/17. No additional immunization records were found to indicate whether or not Resident #69 had received the PPSV23 vaccination. Upon further inquiry, the Administrator reported there may be logs with additional vaccination information in the facility. However, the information could not be located at this time due to a recent change of staff. The Administrator reported an audit of "the entire building" would need to be conducted to determine residents' vaccination status. An interview was conducted on 1/11/19 at 10:07 AM with MDS Nurse #1 in the presence of the Regional MDS Coordinator. During the interview, the MDS nurse was asked what resources were used to identify the vaccination status of residents reviewed for an MDS assessment. The nurse stated she looked in the resident's medical record for this information. Additionally, some information may be available in the facility's computerized records, the residents' MARs, and their Immunization Record kept on the chart. She also noted that new residents may have admission paperwork which included vaccination	F 883		

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F 883	Continued From page 23 records. The Regional MDS Coordinator stated vaccination consents kept in the medical record were another source of information. Upon their request, a follow-up interview was conducted on 1/11/19 at 10:35 AM with the Administrator and Director of Nursing (DON). The Administrator and DON reported there wasn't a facility policy/procedure which addressed the monitoring/documentation of vaccinations. The Administrator reported the facility recognized they had a problem with this issue. A follow-up interview was conducted on 1/11/19 at 11:10 AM with MDS Nurse #1. During the interview, the MDS Nurse #1 reported she coded Resident 69's 12/18/18 MDS assessment to indicate her pneumococcal vaccination was not up to date because there was no documentation in the medical record to indicate the resident had received the pneumococcal vaccination. Upon further inquiry, the MDS Coordinator joined the interview. The MDS Coordinator reported the facility use to keep a log for monitoring the immunization status of residents, but the log was no longer up to date.	F 883		