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	345213	A. BUILDING _____ B. WING _____	C 02/19/2019

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UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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F 000	INITIAL COMMENTS The survey team entered the facility on 2/6/19 to conduct a complaint survey and exited on 2/8/19. Additional information was obtained on 2/11/19, 2/12/19, and 2/19/19. Therefore, the exit date was changed to 2/19/19.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		3/20/19

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

Electronically Signed | 03/12/2019

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F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, family interview, and physician interview for one (Resident # 3) of three sampled residents with pressure sores, the facility failed to notify the physician and the responsible party when the resident's skin started to swell. The findings included: Record review revealed Resident # 3 was initially admitted to the facility on 2/10/15. The resident had diagnoses of vascular dementia, history of stroke with right hemiplegia and hemiparesis, peripheral vascular disease, atherosclerotic heart disease, stage II chronic kidney disease, and osteoarthritis. According to the record the resident was hospitalized from 12/19/18 to 12/23/18. for a hip fracture. The resident was readmitted to the facility on 12/23/18.	F 580	F-580 This plan of correction constitutes a 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 or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root cause: The Executive Director and Director of Nursing discussed on 3/11/19 to identify	

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F 580	Continued From page 2 Review of the resident's readmission Minimum Data Set, assessment, dated 12/30/18, revealed the resident was cognitively impaired and needed extensive assistance with her bed mobility. The resident was also assessed to need total assistance with her hygiene and bathing needs. The resident was incontinent of bladder and bowel. The resident was assessed to have one Stage II pressure sore. On 1/24/19 at 8:23 AM Nurse # 1 made a nursing entry and documented that the resident had edema (swelling) in her left labia, and "per resident painful to touch." The nurse noted the resident's temperature was 98.9. Nurse # 1 was interviewed on 2/8/19 at 6:20 AM and reported the following. She had noticed the swelling in the resident's labia on the evening of 1/23/19 soon after she had given her bedtime medications, and documented the swelling on 1/24/19. There had been an order to obtain a urine specimen on 1/23/19 because the resident seemed confused. When she started to catheterize the resident for the urine specimen, she noted that the resident's left labia was swollen. The nurse stated the resident's skin pigmentation was dark, and therefore she could not tell if it was discolored. The resident did yell out as if in pain, but she had recent hip surgery and pain was not unusual for her nor could the resident state where she hurt. Therefore, according to the nurse, it was not apparent that the resident's pain was definitely originating from the labia area. According to Nurse # 1 the area was monitored and the unit manager and the Nurse Practitioner, who were scheduled to be in the facility the next morning, were notified on the AM of 1/24/19.	F 580	the root cause of this alleged non-compliance. Root cause analysis conducted revealed, the alleged non-compliance resulted from Nurse #1 failed to properly inform the physician of a change in condition (Residents #3). For affected residents: Resident #3 attending physician was notified during the survey on 2/8/19 about the change in resident # 3 skin. For other residents with the potential to be affected: By 3/15/19 a 100% audit of current resident□s notes, 24 hours reports and incident reports for last 30 days will be completed by the Director of Nursing (DON), Asst. Director of Nursing (ADON) and unit managers to determine if any other residents had experienced a change in condition that the Responsible party (RP) or the Physician (MD) would needed to have been notified with. Appropriate additional notifications were made by 3/15/19. Facility plan to prevent re-occurrence: Effective 3/20/2019, and moving forward, licensed nursing staff will ensure residents change in condition will be notified to the Responsible party (RP) and the Physician (MD). Starting 3/15/2019, the Director of Nursing, Assistant Director of Nursing, and/or Unit managers will complete 100% education for all licensed nursing staff, to	

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F 580	Continued From page 3 According to an interview with the resident's medical physician on 2/8/19 at 12:35 PM, he had not been notified on 1/23/19 when the resident's labia began to swell. According to the physician he was always available and the staff should have called him on 1/23/19 when the resident's labia began swelling. According to an interview with the resident's responsible party on 2/7/19 at 12:00 PM, he had not been informed of the resident's swollen labia on 1/23/19.	F 580	include full time, part time and as needed employee. The education will include, notification of a change in condition will be reported to the Responsible Party and the Physicians. Any licensed nurse or certified medication aide not educated by 3/20/19 will not be allowed to work until educated. Effective 3/20/2019, the Director of Nursing, Assistant Director of Nursing, and/or Unit Managers will review the previous days notes, 24-hour report and incident reports during the morning clinical meeting to ensure if a change in a resident□s condition was reported to RP and MD. This review will be stored in the Daily Clinical Binder. Monitoring: Effective 3/20/2019, the Director of Nursing, Assistant Director of Nursing or designee to monitor the nurse□s notes, 24-hour report and incident logs daily, five days a week for four weeks, then three days a week for four additional weeks to ensure notification of RP and the residents□ MD of any change in condition. The weekend Supervisor will audit all orders, 24- hours reports and incident logs to ensure all items have the appropriate follow-up for Saturday and Sunday for eight weeks. This monitoring will be documented on the □Notification of change Monitoring Tool□. Effective 3/20/2019, Executive Director and/or Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and	

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F 580	Continued From page 4	F 580	Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party: The Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged non-compliance to ensure the facility remains in substantial compliance. Compliance Date: 3/20/19	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and physician interview, the facility failed to assure a	F 686	F-686	3/20/19

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F 686	Continued From page 5 wound physician assessed and treated a changing pressure ulcer as ordered by the resident's medical physician for 1 of 3 residents reviewed with pressure ulcer's (Resident #3). The findings included: Record review revealed Resident # 3 was initially admitted to the facility on 2/10/15. The resident had diagnoses of vascular dementia, history of stroke with right hemiplegia and hemiparesis, peripheral vascular disease, atherosclerotic heart disease, stage II chronic kidney disease, and osteoarthritis. According to the record the resident was hospitalized from 12/19/18 to 12/23/18 for a hip fracture. The resident was readmitted to the facility on 12/23/18 and resided there until her discharge on 1/24/19. The resident was 89 years of age. Review of the admission Minimum Data Set (MDS) assessment, dated 12/30/18, revealed Resident #3 needed extensive assistance with her bed mobility, and total assistance with her hygiene and bathing needs. She was incontinent of bladder and bowel, and was assessed to have one Stage II pressure sore. Review of Resident #3's readmission care plan, dated 1/9/19, revealed she had a Stage II pressure sore to her Coccyx area, and was at risk for further skin problems. Interventions included: skin is checked daily with care and notify MD of abnormalities. Review of physician orders dated 12/24/18 revealed an order for a low air loss mattress. Record review revealed documentation the resident received the pressure relieving mattress to her bed.	F 686	Root Cause: The Wound Care Nurse, Executive Director, and the Director of Nursing discussed on 3/12/19 to identify the root cause of this alleged non-compliance. Root-cause analysis conducted revealed the alleged non-compliance resulted from inadequate understanding concerning how consults are handled. As a result, the facility failed to follow-up with a consult for a wound care physician to evaluate resident #3 wound. For affected resident: Resident # 3 was admitted to the hospital, no further intervention needed at this time For other residents with the potential to be affected On 3/12/19 a review of all current wounds was completed the nurse consultant to ensure all wounds with changes, the MD has been notified and all recommendations have been follow up on. Facility plan to prevent re-occurrence: The DON/ADON or Unit Mangers will review physician orders and 24-hour report daily Monday through Friday to ensure all orders have been follow-up on in the Clinical Meeting. The Weekend Supervisor will review all orders written on the week-end to ensure follow-up and report to the DON/ADON on Monday. The DON/ADON will in-service all licensed nursing staff on ensuring when taking an order from the physician they immediately	

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F 686	Continued From page 6 Review of nursing notes revealed an entry by the Wound Nurse on 12/28/18 at 4:58 PM that read the resident had a Stage II shearing area to her Coccyx area which measured 5.2 cm (centimeters) X 4.9 (centimeters). The area was described as 100 % granulation tissue (healing tissue) with diffuse edges and no exudate. Review of physician orders dated 12/28/18 revealed an order for a hydrocolloid (a type of dressing) dressing to be applied to the coccyx and to be changed every three days and as needed. Review of Resident # 3's, nursing notes and December, 2018 and January, 2019 TARs (Treatment Administration Records) revealed documentation the resident received hydrocolloid dressing changes for the pressure ulcer following the 12/28/18 order. Review of nursing notes revealed an entry by the Wound Nurse on 1/10/19 at 4:29 PM that read Resident #3's Stage II Coccyx pressure sore was 4.0 cm X 0.9 cm and was 100% granulation tissue. There was scant exudate. Review of physician orders revealed a telephone order was obtained by the Wound Nurse on 1/14/19 to change the dressing order. The new order was to clean the wound, apply Santyl and Calcium Alginate to the wound, and cover it with an ABD pad (a type of dressing cover). The dressing was to be changed daily. (Santyl is an ointment used to remove dead tissue on the wound surface and within the wound bed of a pressure sore while the ointment also preserves healthy tissue; Calcium Alginate helps to absorb	F 686	enter into the computer and fax any consults for the Wound Care Physician directly to their office along with any consents to treat to allow for follow up. Monitoring: Effective 3/20/2019, the Director of Nursing, Assistant Director of Nursing or designee are to monitor the nurse□s notes, 24-hour report and incident logs daily, five days a week for four weeks, then three days a week for four additional weeks to ensure follow up to recommendations from the resident physician. The weekend Supervisor will audit all orders, 24- hours reports and incident logs to ensure all items have the appropriate follow-up for Saturday and Sunday for eight weeks. The DON/ADON will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for two months. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party: The Executive Director and the Director of Nurising will be ultimately responsible to ensure implementation of this plan of correction for this alleged non-compliance to ensure the facility remains in substantial compliance. Compliance Date: 3/20/19	

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wound exudate).

Review of the January nursing notes and January, 2019 TAR revealed documentation Resident # 3 received the Santyl and Calcium Alginate wound dressing as ordered on a daily basis to treat her pressure sore.

Review of nursing notes and Wound Assessment Reports did not reveal a corresponding wound assessment on 1/14/19 when the order was changed.

Interview with Resident #3's Physician on 2/8/19 at 12:35 PM revealed the 1/14/19 order was given because the resident's wound had some eschar (dead tissue) in the wound bed. The Physician stated the facility had a Wound Physician who consulted, evaluated, and treated facility resident's pressure sores. The Physician further stated a consult should have been initiated on 1/14/19 when the resident's wound showed eschar and the wound physician should have been involved in the resident's wound care thereafter. According to the physician he thought an order for a referral had been given on 1/14/19 when he gave the order for the change in wound care.

Review of the record revealed no evidence of a Wound Physician referral for Resident #3 on 1/14/19.

Review of the medical record revealed on 1/14/19 at 1:20 PM the Registered Dietician (RD) made an entry in the record noting that the resident was consuming zero percent of her meals on multiple occasions and had a significant weight loss. The RD recommended a vitamin supplement and Med

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Pass 2.0 (a protein supplement) twice per day. Record review revealed the Med pass was initiated on 1/14/19 and the vitamin supplement on 1/15/19.

Review of the Wound Assessment Report dated 01/16/19 revealed the Wound Nurse noted Resident #3's Coccyx pressure sore was 100% necrotic tissue and measured 3.50 cm X 1.60 cm with .5 cm depth. The Wound Nurse also noted the resident would be evaluated and treated by the Wound Physician on the next visit.

Review of physician orders revealed on 1/21/19 a telephone order was written for the Wound Physician to treat Resident #3 her next visit. There was also a telephone order on 1/21/19 for Amoxicillin 500 mg (milligrams), an antibiotic, three times per day for 10 days to treat a wound infection. It was also noted on the physician's orders on 1/21/19 that the resident's RP gave permission for the Wound Physician to treat the resident.

Review of Resident # 3's January MAR (Medication Administration Record) revealed the resident started receiving Amoxicillin 500 mg at 1:00 PM on 1/21/19 and continued to receive this antibiotic as ordered through her date of discharge on 1/24/19.

The Wound Nurse was interviewed on 2/7/19 at 11:10 AM and again on 2/12/19 at 1:20 PM, and reported the following. She stated she had obtained the order for the Wound Physician to see the resident on 1/14/19 from the physician when eschar first appeared in the pressure sore. On 1/14/19 she had also obtained the responsible party's consent for the Wound Physician to see

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the resident. She did not know what happened to the order, but validated the order was missing from the resident's record. She rewrote the order on 1/21/19, and did not want to back date the order. Therefore, she dated the 1/14/19 order as an order for 1/21/19 in the resident's record. She had handed the Wound Physician Resident # 3's information on 1/17/19. She did not recall why the Wound Physician did not evaluate the resident's pressure sore on 1/16/19 when the Wound Physician was in the building. On 1/21/19 she noticed the pressure ulcer sore had a foul odor. She had called the resident's medical physician and obtained an order for Amoxicillin since the resident had not been evaluated yet by the Wound Physician. The wound nurse stated it was her responsibility to assure the referral was done, and she did not recall what she had done with the referral order when she had obtained it. She further stated Resident #3's pressure sore continued to have a foul odor on 1/22/19, and the Wound Physician had not seen the resident. The Wound Nurse stated she knew the Wound Physician often utilized Flagyl, an antibiotic, in the wound bed in a pressure sore which had a foul odor, and she talked to the Nurse practitioner to obtain the order on 1/22/19 after she had completed the wound dressing on 1/22/19.

Review of physician orders revealed on 1/22/19 an order was obtained through the Nurse Practitioner for Flagyl 500 mg to be crushed and placed in the wound bed daily.

Review of the Resident's Treatment Administration Records revealed the resident started receiving the crushed Flagyl in her wound bed on her next daily dressing change; which was 1/23/19.

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An interview with the Wound Physician on 2/8/19 at 11:03 AM and again on 2/11/19 at 2:35 PM revealed she was at the facility on 1/16/19 and 1/17/19, but did not see Resident #3 on either of those dates. According to the Wound Physician, she was handed the resident's discharge summary and demographics at the end of her day on 1/17/19, but there had been no formal physician referral or family consent given for her to see the resident. According to the Wound Physician, the paperwork would have needed to have been in order for her to see the resident on 1/16/19 or 1/17/19, and she did not see the resident until 1/24/19.

A follow up interview conducted with the Wound Physician on 2/12/19 at 1:20 PM revealed she saw Resident #3's pressure sore on 1/24/19 for the first time. The pressure sore was described by the Wound Physician to be "heavily necrotic" and "extensive." The pressure sore was also described as draining. The Wound Physician stated she started to debride the pressure sore, but it became evident the resident's pressure sore was in need of further services than she could provide at the facility.

Review of Resident #3's medical record revealed the Nurse Practitioner and the Wound Physician had evaluated the resident together on 1/24/19, and the decision was made to transfer the resident to the hospital for her to receive evaluation and treatment.

Review of hospital records dated 1/24/19 revealed in the Emergency Room, Resident #3 was identified to have a very large, foul smelling necrotic Stage IV decubitus ulcer and was

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diagnosed as having an infection of the soft tissue below the pressure sore. Resident #3 was hospitalized for care and services of the pressure ulcer.

Interview with the emergency room physician on 2/11/19 at 2 PM revealed the soft tissue infection occurring underneath the pressure sore would not have been evident to the facility staff.

An interview with the facility Wound Nurse on 2/12/19 at 1:20 PM revealed the following. The Wound Nurse stated the NP, physician, nor the Wound Physician looked at Resident #3's pressure sore with her prior to 1/24/19, but the changes prior to the date of 1/24/19 were changes she had visualized in other debilitated, elderly residents who had poor nutritional intake. The Wound Nurse stated the Wound Physician usually visited once per week. The Wound Nurse knew there had been a mistake in the referral not being done for 1/16/19, but she stated she was aware the resident was receiving the Santyl for the necrosis and both an oral antibiotic and antibiotic in the wound bed. She therefore thought it would be acceptable that the resident's wound be evaluated by the Wound Physician on the Wound Physician's next weekly scheduled date in the facility. According to the Wound Nurse the next time the Wound Physician was in the facility following 1/16/19 and 1/17/19 was the date of 1/24/19. According to the Wound Nurse, although a mistake had been made in assuring the Wound Physician referral was done, she had continued to communicate with the resident's physician and/or NP to assure treatment orders were updated and carried out as the wound changed. The Wound Nurse said the pressure sore seemed to change more from the time she viewed it on 1/23/19 than

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F 686	Continued From page 12 when she viewed it on 1/24/19. On the AM of 1/24/19, she was aware the Wound Physician would be in the facility on 1/24/19 and would evaluate the most recent changes. Interview with Resident #3's facility medical physician on 2/19/19 at 4:50 PM revealed there were contributing factors to the resident developing an infection beneath the pressure sore which included the resident's advanced age which compromised her ability to fight off infection, her refusal to eat, her dementia, and her recent hip surgery which led to decreased immobility. The physician stated he had not assessed Resident #3's pressure sore when it started becoming necrotic or odorous because he had ordered that the wound physician oversee the care of the wound.	F 686		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician interviews, for one (Resident # 2) of three sampled residents with a diagnosis of Schizophrenia, the facility failed to obtain mental	F 740	F-740 Root Cause: The Director of Nursing and the Executive	3/20/19

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health services when the resident starting exhibiting symptoms of mental illness. The findings included:

According to Resident #2's hospital records with an admission date of 11/28/18 and discharge date of 12/4/18, the resident was hospitalized because she had developed blisters on her legs. The hospital physician noted the etiology of the blisters was likely secondary to the resident living without heating or plumbing for the previous month before her hospitalization. According to the resident's record, the resident had a diagnosis of Schizophrenia, diabetes, hypertension, and heart failure.

The resident was admitted to the facility on 12/4/18. Record review revealed Resident # 2 resided at the facility from 12/4/18 to 12/11/18.

Review of the resident's hospital discharge summary and facility admission orders revealed no medications were ordered to treat the resident's Schizophrenia.

Review of Resident # 2's base line care plan, dated 12/4/18, revealed a notation under "Mental Health Needs" that the resident had a diagnosis of Schizophrenia. A care plan intervention was listed as "psych referral."

Review of cumulative facility orders revealed no medication was ordered to treat the resident's Schizophrenia until the day of her discharge; 12/11/18. On this date a one- time dose of Haldol and a one- time dose of Ativan were ordered, but according to the record, were never administered. Thus, according to the record, the resident never received any medications to treat her

Director discussed on 3/12/19 to identify the root cause of this alleged non-compliance. Root-cause analysis conducted revealed the alleged non-compliance resulted from inadequate training/understanding of staff to recognize and treat behaviors such as refusing medications and ensuring resident with behaviors are on the correct medication. As a result, the facility failed to ensure that resident #2 was on the correct medication and behaviors were followed up with a psychiatric consult.

For affected resident:
Resident # 3 was admitted to the hospital, no further intervention needed at this time

For other residents with the potential to be affected:
On 3/11/19 a review of all residents was completed by the Admission Director and the Minimal Data Nurse (MDS) to identify any residents with behavior to ensure all behaviors have been care planned and the RP and MD are aware. Medications will be reviewed for the residents with noted behaviors by the Pharmacist for any recommended changes by 3/13/19.

Facility plan to prevent re-occurrence:
The DON will in-service all staff on recognizing behaviors and reporting them timely to the nurse. The DON/ADON will in-service the licensed staff on notifying the MD/RP on any changes in behaviors. Changes in behaviors will be reviewed at Clinical Meetings. Any noted behaviors will immediately be reported to the

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F 740	Continued From page 14 Schizophrenia from 12/4/18 to 12/11/18. Review of the resident's five day admission Minimum Data Set Assessment, dated 12/11/18, revealed the resident had a BIMS (brief interview for mental status) of 12; which indicated the resident had some degree of cognitive impairment. The resident was also assessed to have physical, verbal, and other behaviors towards others. Review of the resident's December, 2018 Medication Administration Record (MAR) revealed the following medications were refused by Resident # 2. Nurse # 3 noted 5:00 PM dose Glucophage (for diabetes) was refused on 12/5/18 Nurse # 4 noted 9:00 AM dose Glucophage was refused on 12/7/18 Nurse # 4 noted 5:00 PM dose Glucophage was refused on 12/7/18 Nurse # 5 noted 9:00 AM dose Glucophage was refused on 12/9/18 Nurse # 5 noted 5:00 PM dose Glucophage was refused on 12/9/18 Nurse # 6 noted 9:00 AM dose of Lasix (a diuretic) was refused on 12/10/18 Nurse # 6 noted 9:00 AM dose of Lisinopril (for hypertension/ heart failure) was refused on 12/10/18 Nurse # 6 noted 9:00 AM dose Glucophage was refused on 12/10/18 Nurse # 6 noted 9:00 AM dose of Advair was refused on 12/10/18 Nurse # 6 noted 9:00 PM dose of Advair was refused on 12/10/18 Nurse # 5 had noted on the December, 2018 MAR that the resident refused the medications on	F 740	attending physician for any recommendations. Residents with behaviors will have a behavior monitoring sheet to record and track any behaviors. The Director of Nursing and Nursing Consultant in-serviced the Medical Director and Licensed Nursing Staff on the services provided by the Mental Health Provider that included: 1) Triage number that staff can call anytime they need help dealing with a mentally ill Resident. 2) Availability of Mental Health Specialist more than one day per week if needed. Monitoring: The DON will review at Clinical Monday through Friday any behavior that need to be follow-up with notification the attending physician five days a week for four weeks then weekly for four additional weeks. Administrator and/or the Social Worker will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party: The Administrator and the Social Worker will be ultimately responsible to ensure implementation of this plan of correction for this alleged non-compliance to ensure the facility remains in substantial compliance.	

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F 740	Continued From page 15 12/9/18 because she thought they were poison. On 12/10/18 at 3:44 PM Nurse # 6 documented in a nursing entry that the resident was in the hallway singing and talking to herself. The nurse noted she could not understand what the resident was stating, and that the resident refused her medications and treatments to her legs. The nurse documented that the resident told her (the nurse) that she was trying to poison her. On 12/11/18 at 2:02 AM Nurse # 8 documented the following in a nursing entry. The resident had refused her evening medications, and attempted to become combative with the nurse. The resident stayed in her room talking and singing. On 12/11/18 at 7:04 AM, Nurse # 8 documented that the resident had become combative during the night, and tried to throw water on staff. The resident had gone into another resident's room, and hit the resident on the leg. The police and EMS (emergency medical services) were called, and the resident refused to go with them. On 12/11/18 at 1:50 PM, the director of nursing (DON) documented the resident had been placed on one on one supervision following her refusal to go with EMS, and an order had been obtained from the physician for the resident to be involuntarily committed for mental health care. Nurse # 3 was interviewed on 2/7/19 at 10:25 AM and reported the following. When she had cared for Resident # 2 on 12/5/18, the resident spit her Glucophage out and told the nurse that the nurse was trying to poison her. According to Nurse # 3, there had been a different administrator at this time period, and the resident also complained to	F 740	Compliance Date: 3/20/19	

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the former administrator that she was being poisoned. Nurse # 3 stated she looked at the resident's record and saw she had a diagnosis of Schizophrenia. She did not call the physician that night. The nurse stated she thought they were going to obtain a psychiatric consult for the resident, but she did not work with the resident after 12/5/18 and did not know what happened.

Nurse # 5 was interviewed on 2/8/19 at 7:12 AM and reported the following. The resident appeared normal upon admission. The next time she worked with her, the resident would pick and choose the medications she would take because she thought some were poison, and the resident wanted to call poison control. Nurse # 5 stated she (the resident) would sing and dance a lot, but she never showed aggressive behaviors towards other residents. Nurse # 5 stated she thought she had talked to the DON, the social worker (SW), and faxed something to the physician regarding the resident's behaviors.

NA # 1 was interviewed on 2/6/19 at 4:30 PM and reported the following. She had routinely cared for Resident # 2. The entire time she took care of the resident the resident had behaviors. NA # 1 reported the resident appeared to dance with someone who was not there. The resident would tell the NA that she (the NA) needed to watch out for certain people; that they were going to get her. The NA said it was as if the resident was trying to prophesy (tell things that would happen in the future). The NA stated there were times when she (the NA) would knock on the resident's door and call her name several times to enter. The resident would not respond and just stare off in space. NA # 1 reported the resident generally stayed in her room, and did not wander or bother

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other residents.

NA # 2 was interviewed on 2/8/19 at 7:00 AM. NA # 2 reported the following. She routinely took care of Resident # 2 at night. The resident did not generally sleep well, she would talk to herself and sing, but did not bother others and generally stayed in her room.

NA # 3 was interviewed on 2/7/19 at 7:20 AM and reported the following. The resident was very quiet when she first took care of her. Over time she started having behaviors and would talk to the walls and herself. She never witnessed the resident bother another resident.

The Unit Manager (UM) (Unit Manager # 2) was interviewed on 2/6/19 at 4:20 PM. The UM reported the following. When the resident was first admitted, the resident did not seem to be exhibiting behaviors for the first 24 to 48 hours. Then she started talking to herself within her room, and did not trust the staff. She refused her medications. She would also not sleep well. Her behaviors progressed, but the UM did not think the resident had been at the facility long enough to have a psychiatric evaluation. According to the UM, the facility's psychiatric provider came to the facility one time per week.

Nurse # 8 was interviewed on 2/6/19 at 3:02 PM, and reported the following. Routinely the resident normally stayed in her room at night, and liked to sing. She had been refusing her medications and would push against her door to keep the nurses from coming into the room at times. Prior to the night of 12/10/18, she did not wander into others rooms, or show aggression to other residents. Nurse # 8 had worked a 12 hour shift starting at

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7:00 PM on 12/10/18 to 7:00 AM on 12/11/18. The resident had refused her evening medications that night and stayed in her room. Around 12:00 midnight, the resident started coming into the hallway and standing at her doorway. She would just look around. Then hours later she started walking in the halls and became very loud. A that point, the nurse closed all the resident's doors, and stayed with Resident # 2 or appointed one of the NAs to stay with her if she could not. The resident opened some of the resident's doors, would look in, but was redirected by the nurse. Around 5:00 AM the resident started walking fast, and the nurse continued to follow her at a distance that would not antagonize the resident. Resident # 2 went into Resident # 1's room. As she (Resident # 2) got to Resident # 1's bedside, Nurse # 2 stated she was right behind the resident and entering through the doorway. Resident # 2 hit Resident # 1's leg one time, and then Nurse # 2 placed herself between Resident # 2 and Resident # 1's bed to intervene. Resident # 2 was redirected out of Resident # 1's room, and this only took about one minute. Resident # 1 was checked and his leg was not hurt. While staff assisted to watch Resident # 2, the DON, the police, the physician, and EMS were called. The police arrived around 5:04 AM and stayed until around 6:30 AM. The resident had gone back into her room during that time, and the police were not able to convince the resident she needed to go to the hospital. The physician had given orders for IM (intramuscular) Haldol and Ativan, but the nurse did not give the medication because she did not feel she could safely administer the medication, and at the time the resident was back in her room and had calmed down.

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A review of Resident # 1's record revealed the resident had been assessed for injury related to the incident, and he had no injuries or distress.

The DON was interviewed on 2/6/19 at 5:05 PM and reported the following. He had assessed Resident # 1 also, talked with him, and confirmed he was not hurt or disturbed by the incident in anyway on 12/11/18. When Resident # 2 refused to go with the EMS and police on 12/11/18, the resident had remained in her room, and a staff member was placed at her door. He and the SW went to the magistrate's office to obtain commitment papers for the resident per a physician's order, and police came and served the papers on 12/11/18.

The facility SW was interviewed on 2/7/19 at 7:38 AM. The SW reported the following. The SW was not aware the resident had no medication ordered for her Schizophrenia during her residency. The SW stated the Mental Health Service provider was usually in the facility on Thursdays, but the provider would send someone to the facility if there was an emergency for a resident to be seen. The SW stated she was made aware of the resident's behaviors on 12/11/18, and that was the day the resident was involuntarily committed.

Review of the facility's contract for "Professional Services Agreement for Mental Health," dated 6/26/18, revealed the Mental Health Provider had agreed to provide emergency services to the facility's residents. According to the agreement, there was a 24 hour triage number that the facility was to call if they needed assistance from their mental health provider. Also per the contract the Mental Health Provider would "visit center as appropriate to provide psychiatric services."

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Interview with Resident # 2's physician on 2/8/19 at 9:49 AM revealed the physician recalled the nurses talking to him about the resident refusing her medications. The physician recalled around the day before the resident's discharge, he had talked to the staff about getting a psychiatric evaluation for the resident. The physician thought the facility's Mental Health Provider only visited one time per week in the facility. The physician stated he talked to the facility staff multiple times on the resident's last day when she was sent out by involuntary commitment.

Interview with the facility medical director on 2/8/19 at 12:35 PM revealed no one had mentioned concerns to him regarding psychiatric services not being provided for a resident. Resident # 2's behaviors, which preceded her involuntary commitment, were shared with the medical director, and the medical director stated the resident should have had mental services available for her prior to her commitment. It was his expectation that the facility's contracted Mental Health Provider should be available to assist the facility staff every day if they were needed.

The physician, who oversees Mental Health Services (MHS) for the facility's contracted provider, was interviewed on 2/8/19 at 3:10 PM, and confirmed they had never received a referral for Resident # 2. The MHS physician stated they are not a crisis provider, but do have a triage number that the facility staff can call at any time, and they help the facility develop a plan to deal with a mentally ill resident. The MHS physician stated they do have mental health specialists that are available to come to the facility more than one

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F 740	Continued From page 21 day per week if there was a need to do so. The facility would need to call their triage line and let them evaluate the best course of action. The MHS provider stated the optimal course of action to assure mentally ill residents receive services is the following: When a mentally ill resident is admitted to the facility and the staff note the resident has a mental illness or certain psychotropic drugs, they should initiate getting consent for mental health services at the time of admission and alert the MH service provider at that point. The MHS physician stated the facility had been given a list of mental health diagnoses and a list of medications that should trigger the referral, and they should reference the list at a resident's admission and start the referral right away.	F 740		