STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345293	A. BUILDING _____ B. WING _____	C 04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

(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 3/31/19 through 4/4/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #CYLY11.	E 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		5/1/19

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

Electronically Signed | 04/27/2019

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident and staff interview, the facility failed to provide dignity by not covering the urinary catheter bag (Resident # 66) and by not providing dignity during meals by serving the meal tray in bed (Resident #75) for 2 of 4 sampled residents reviewed for dignity. Findings included: 1. Resident #66 was admitted to the facility on 10/5/18 with multiple diagnoses including urinary retention. The quarterly Minimum Data Set (MDS) assessment dated 2/22/19 indicated that Resident #66 had impaired cognition and had an indwelling urinary catheter. Resident #66's care plan dated 3/01/19 was reviewed. One of the care plan problems was Resident #66 had a urinary catheter and the goal was resident would be free from urinary tract infection. The approaches did not include covering the urinary catheter bag for dignity. Resident #66 was observed in bed on 3/31/19 at 3:30 PM and 4/1/19 at 9:05 AM and 1:45 PM. He had an indwelling urinary catheter and the urinary	F 550	F550 For residents affected by the issue: Resident without a privacy bag for urinary catheter bags, resident without the privacy bag was provided a privacy bag. The Staff Facilitator assured privacy bag was in place for resident 66 4/24/19. Resident 75 was observed eating in bed with tray on over bed table by facility Nurse Consultant on 4/24/19. Other potentially affected residents: All residents with catheters were audited for privacy bags, no other residents were identified as not having privacy bags by staff facilitator on 4/24/19. An audit of other residents that choose to have meals in bed revealed no other residents eating with meal trays on bed on 4/25/19 by facility nurse consultant. Measures implemented: All Nursing staff were in-serviced on requirement of using privacy bags on catheter bags. Nursing staff were in-serviced that resident trays are to be placed on the bed side table by director of nursing between 4/18/19 through 4/29/19. These in-services were added to nursing staff orientation starting	

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F 550	Continued From page 2 catheter bag was not covered and was visible from the hallway. Interview with NA #7 was conducted on 4/1/19 at 1:50 PM. NA #7 stated that the urinary catheter bag was only covered when the resident was out of bed or out of the room. Interview with the Unit Manager (UM) #1 was conducted on 4/1/19 at 2:10 PM. The UM stated that catheter bag should be covered at all times for privacy/dignity. Interview with the Director of Nursing (DON) was conducted on 4/4/19 at 11:25 AM. The DON stated that she expected urinary catheter bags to be covered at all times for privacy/dignity reason. 2. Resident #75 was admitted to the facility on 1/26/11 with multiple diagnoses including dementia. The annual Minimum Data Set (MDS) assessment dated 3/15/19 revealed that Resident #75 had moderate cognitive impairment and was independent with eating. Resident #75's care plan dated 3/20/19 revealed that resident was able to feed self after tray set up including opening resident's condiments and to encourage resident to eat meals in the dining room. The care plan did not address resident's eating preference in bed or out of bed during meals. On 3/31/19 at 6:05 PM, Resident #75 was observed lying in bed. The head of the bed (HOB) was elevated at 45 degrees and his dinner tray was in bed beside him. The resident was	F 550	on 4/18/19. Monitoring to maintain compliance: The Unit Manager/Wound Nurse will monitor for 12 weeks, 3 catheters per day, 5 times per week. The Unit Manager will monitor 5 residents daily, 5 times a week, for 12 weeks to ensure compliance with meal trays on bedside table. The Activities of daily living audit tool will be used. The Wound Nurse and Unit Manager will report to the Director of Nursing any issues. The Wound Nurse and Unit Manager will correct issues on the spot and re-educate staff if compliance is not maintained. The Wound Nurse and Unit Manager will report to the Quality Assurance/Performance Improvement committee on compliance. Corrective action compliance date: May 1, 2019	

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F 550	Continued From page 3	F 550		

holding a cup of soup, and was able to feed himself but was spilling the soup on his shirt. During the observation, there was an over the bed table next to resident's bed with full of personal stuff (water pitcher, box of tissue paper, cups) and a nebulizer machine. When interviewed if his preference to serve his tray in bed, Resident #75 did not answer.

On 4/1/19 at 9:17 AM and on 4/2/19 at 8:50 AM, Resident #75 was observed lying in bed with HOB at 45 degrees and with his meal tray served in bed. The over the bed table was still full of personal stuff and nebulizer.

An interview was conducted with NA #12 on 4/2/19 at 8:56 AM. NA #12 stated that the resident's tray was served in bed for the resident to reach his food. NA #12 verified that the resident's over the bed table was full of personal stuff and his nebulizer but she would not comment that was the reason why the tray was served in bed instead of using his over the bed table. The NA also did not indicate that it was the resident's preference to serve his tray in bed. NA #12 also reported that Resident #75 was able to sit up in bed or in the wheelchair.

An interview with Nurse #4 was conducted on 4/2/19 at 10:56 AM. Nurse #4 stated that she didn't know why the NAs were serving Resident 75's meal tray in bed. The nurse further stated that she didn't think that was resident's preference to eat with the tray in his bed.

An interview was conducted with Unit Manager (UM) #1 on 4/2/19 at 11:00 AM. The UM stated that she was not aware that Resident #75 was served his meal tray in bed. She indicated that

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F 550	Continued From page 4 she expected the NAs to serve the meal trays using the over the bed table and for the resident to be positioned at sitting position if eating in bed or by sitting at the edge of the bed or in the wheelchair. On 4/3/19 at 8:54 AM, Resident #75 was observed sitting at the edge of the bed with his breakfast tray on top of the over bed table in front of him. When interviewed, Resident #75 stated that he liked it better sitting while eating. Interview with the Director of Nursing (DON) was conducted on 4/4/19 at 11:00 AM. The DON stated that she expected the staff to honor resident's preferences for dining. The DON stated that Resident #75 preferred to have his meal tray served in bed however the DON was unable to provide documentation that this was resident's preference.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		5/9/19

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F 561	Continued From page 5 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to provide showers as scheduled for 1 of 2 residents (Resident #74) reviewed for choices. The findings included: Resident #74 was admitted to the facility on 10/3/18 with diagnoses that included chronic obstructive pulmonary disease, spinal stenosis, muscle weakness, and unsteadiness on feet. Resident #74's care plan included the focus area of bathing. This area was last revised on 10/15/18 and included the intervention of total dependence of 1 for bathing. The quarterly Minimum Data Set (MDS) assessment dated 1/10/19 indicated Resident #74's cognition was intact. She had no behaviors and no rejection of care. Resident #74 was dependent on 1 for bathing.	F 561	F561 For residents affected by the issue: For the affected resident the facility showered the resident April 5, 2019. Other potentially affected residents: On 4/18/2019 & 4/19/2019 the unit manager audited all resident showers to ensure showers provided per schedule. There were 2 negative findings which were addressed by 4/18/2019 & 4/19/2019 by the resident being showered or refusal documented. Measures implemented: Initiated were the shift to shift communication book, updated residents shower preferences, updated staff daily assignment sheets, and staff were in-serviced on expectations of shower schedule completeness. The auditing will be recorded on the activities of daily living audit tool. Monitoring to maintain compliance: Certified Nursing Assistants and Licensed Nurses were in-serviced on the	

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F 561	Continued From page 6 A review was conducted of the Nursing Assistant (NA) bathing/shower documentation for Resident #74 from 3/1/19 through 4/3/19. Resident #74 was scheduled to receive showers on Tuesdays and Fridays. The documentation indicated that she received showers on 4 of 10 scheduled shower days (3/1/19, 3/5/19, 3/19/19, and 3/22/19). Resident #74 was provided with a full bed bath instead of a shower on 5 of 10 scheduled shower days (3/8/19, 3/12/19, 3/26/19, 3/29/19, and 4/2/19) and a partial bed bath on 1 of 10 scheduled shower days (3/15/19). An interview was conducted with Resident #74 on 3/31/19 at 4:35 PM. She reported that her preferred method of bathing was a shower and that her showers were scheduled for Tuesdays and Fridays. She revealed that she had not been receiving her showers as scheduled and that her last shower was two Fridays ago (3/22/19). An interview was conducted with NA #12 on 4/1/19 at 1:56 PM. She stated that the facility had a shower team consisting of 2 NAs and she was one of them. She revealed there were times she was pulled from the shower team to an assignment on the floor. An interview was conducted with NA #13 on 4/4/19 at 2:38 PM. She stated that she was a member of the shower team. The shower team worked Monday, Tuesday, Thursday, and Friday from 5 AM to 3 PM to provide showers. Residents on A beds were provided showers every Monday and Thursday and B beds were provided showers every Tuesday and Friday. NA #13 reported that showers were not provided on Wednesday, Saturday or Sunday nor were they provided after 3 PM. She revealed there were	F 561	requirement of completing daily scheduled showers by the Director of Nursing and the Staff Facilitator on initiated in-servicing on 4/18/19 and completed on 4/24/19. Daily monitoring of shower completion by the Unit Managers will be completed on 5 residents for 5 days a week for 12 weeks. Additionally, the Staff Facilitator has added the in-service to staff orientation program. Unit Manager will report to the Director of Nursing any concerns of incomplete showers. The Unit Manager and Director of Nursing will report to the Quality Assurance/Performance Improvement committee on compliance of completing showers. Corrective action compliance date: May 9, 2019	

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F 561	Continued From page 7	F 561		

times the shower team was pulled to work an assignment on the floor. She further revealed that there were times when a bed bath was provided instead of a shower. She stated that a shower was provided when there was time.

On 4/4/19 at 1:55 PM, Unit Manager (UM) #2 was interviewed. UM #2 reported that there were times the shower team was assigned to work on the floor due to high staff turnover. He indicated that this happened as recently as last week. He stated that he expected the NA assigned to the resident to provide showers as scheduled when the shower team was pulled to the floor. UM #2 confirmed that Resident #74 ' s showers were scheduled for Tuesdays and Fridays. The NA bathing/shower documentation for Resident #74 from 3/1/19 through 4/3/19 was reviewed with UM #2. He reported that Resident #74 had no refusals of showers during this time period and he verified that her showers were not consistently provided as scheduled.

An interview was conducted with the Director of Nursing (DON) on 4/4/19 at 1:00 PM. She stated that she expected the staff to provide showers as scheduled, but that she was aware this was not always happening. She confirmed that there were times the shower team was assigned to work on the floor. The DON stated that she expected the NA assigned to the resident to provide showers when the shower team was pulled. She reported that she just started a Performance Improvement Plan (PIP) related to showers within the last week and she believed the problem was being addressed. The DON was informed that there continued to be unresolved issues with showers being provided as scheduled as evidenced by Resident #74

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F 561	Continued From page 8 receiving a full bed bath rather than a shower on her scheduled shower day of 4/2/19. A follow up interview was conducted with the DON on 4/4/19 at 3:15PM. She indicated she expected resident preferences related to bathing needs to be honored and for showers to be provided on the resident ' s scheduled shower days.	F 561		
F 623 SS=C	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 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	F 623		5/9/19

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F 623	Continued From page 9	F 623		

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 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

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F 623	Continued From page 10 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 review and family and staff interviews, the facility failed to provide the resident and/or resident representative written notification of the reason for transfer to the hospital for 7 or 7 residents reviewed for hospitalization (Resident #11, #65, #52, #75, #80, #13 and #60). The findings included:	F 623	F623 The plan of correcting the specific deficiency Residents #11, 65, 52, 75, 80, 13 and 60□s resident and/or resident representative were mailed the notice of nursing home transfer or discharge indicating the reason for the transfer on 5/9/19 by the administrator.	

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F 623	Continued From page 11 1) Resident #11 was originally admitted to the facility on 8/29/08 with diagnoses that included stroke with paralysis, gastrostomy tube (a feeding tube) and pain. A medical record review revealed the resident was transferred to the hospital on 12/12/18 for a gastrostomy tube replacement and was admitted to the hospital the same day for respiratory distress. There was no documentation of a written notice of hospital discharge provided to the resident's responsible party. A review of Resident #11's most recent Minimum Data Set (MDS) coded as an annual assessment and dated 1/8/19 revealed he had severe cognitive deficits. During an interview on 4/2/19 at 11:45am with Nurse #4, she explained that when a hospital discharge/transfer occurred, the resident's responsible party was notified by phone. She added that the only written information provided was the bed hold policy sent with the resident. On 4/2/19 at 11:47am an interview occurred with the Unit Manager #1. She stated that the nurses called the resident's responsible party by phone regarding the discharges to the hospital and a copy of the bed hold policy was sent with the resident. She further stated the Social Worker mailed a copy of the bed hold policy to the responsible party. The Social Worker was interviewed on 4/2/19 at 11:50am. She explained that she was responsible for sending a copy of the bed hold policy to the resident's responsible party. She added that the Ombudsman came once month	F 623	The plan for identifying of potential residents affected On 4/24/19 the facility consultant reviewed the unplanned discharges for the past 7 days for documentation of the notice nursing home discharge being provided. Following the audit notification letters were sent. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/25/19 the business office was in-serviced by the administrator on issuing the notice of nursing home discharge with each unplanned discharge including emergency room visit. In morning stand up meeting, discharges are reviewed and administrator and/or business office manager process notices of discharge. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The Administrator and/or Director of Nursing will review all discharges weekly x 12 weeks to ensure the notice of nursing home discharge was provided for all unplanned discharges. This audit will be documented on the discharge audit tool. The results of the discharge Audit Tool will be compiled by the Administrator and/or Director of Nursing and presented to the Quality Improvement Committee monthly x 3months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	

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and received a list of all the discharges. Resident #11 was readmitted to the facility on 12/14/18.

A phone call was placed to Resident #11's responsible party on 4/3/19 at 11:05am. A message was left for a return call. A return call was not received from the representative.

On 4/4/19 at 11:43am a telephone interview occurred with the Admissions Director. She stated that she was responsible for the admission process and did not notify or send anything in writing to the resident's representative when a hospital discharge occurred.

An interview was conducted with the Director of Nursing on 4/4/19 at 3:15pm. She stated the nurses informed the residents and called the responsible party when a discharge to the hospital occurred, but not in writing. She stated she did not know the facility was to inform the resident and/or responsible party in writing of the reason for the discharge to the hospital but would expect the regulation to be followed.

2) Resident #65 was admitted to the facility on 10/10/18 with diagnoses that included end stage kidney disease on hemodialysis, Congested Heart Failure (CHF) and Diabetes Mellitus.

A review of Resident #65's most recent Minimum Data Set (MDS) coded as a quarterly assessment and dated 1/29/19 revealed she was cognitively intact.

A medical record review revealed the resident was transferred to the hospital on 1/4/19 and

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2/22/19. There was no documentation of a written notice of hospital discharge provided to the resident's responsible party.

During an interview on 4/2/19 at 11:45am with Nurse #4, she explained that when a hospital discharge occurred the resident's responsible party was notified by phone. She added that the only written information provided was the bed hold policy sent with the resident.

On 4/2/19 at 11:47am an interview occurred with the Unit Manager #1. She stated that the nurses called the resident's responsible party by phone regarding the discharges to the hospital and a copy of the bed hold policy was sent with the resident. She further stated the Social Worker mailed a copy of the bed hold policy to the responsible party.

The Social Worker was interviewed on 4/2/19 at 11:50am. She explained that she was responsible for sending a copy of the bed hold policy to the resident's responsible party. She added that the Ombudsman came once month and received a list of all the discharges. Resident #65 was readmitted to the facility on 1/22/19 and 2/27/19.

A phone call was placed to Resident #65's responsible party on 4/3/19 at 11:00am. A message was left for a return call. A return call was not received from the representative.

On 4/4/19 at 11:43am a telephone interview occurred with the Admissions Director. She stated that she was responsible for the admission process and did not notify or send anything in writing to the resident's representative when a

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hospital discharge occurred.

An interview was conducted with the Director of Nursing on 4/4/19 at 3:15pm. She stated the nurses informed the residents and called the responsible party when a discharge to the hospital occurred, but not in writing. She stated she did not know the facility was to inform the resident and/or responsible party in writing of the reason for the discharge to the hospital but would expect the regulation to be followed.

3) Resident #52 was admitted to the facility on 10/10/18 with diagnoses that included dysphagia (difficulty swallowing) and seizure disorder.

A medical record review revealed the resident was transferred to the hospital on 10/31/18, 1/15/19 and 3/2/19. There was no documentation of a written notice of hospital discharge provided to the resident's responsible party.

A review of Resident #52's most recent Minimum Data Set (MDS) coded as a quarterly assessment and dated 3/14/19 revealed he had severe cognitive deficits.

During an interview on 4/2/19 at 11:45am with Nurse #4, she explained that when a hospital discharge/transfer occurred the resident's responsible party was notified by phone. She added that the only written information provided was the bed hold policy sent with the resident.

On 4/2/19 at 11:47am an interview occurred with the Unit Manager #1. She stated that the nurses called the resident's responsible party by phone

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regarding the discharges to the hospital and a copy of the bed hold policy was sent with the resident. She further stated the Social Worker mailed a copy of the bed hold policy to the responsible party.

The Social Worker was interviewed on 4/2/19 at 11:50am. She explained that she was responsible for sending a copy of the bed hold policy to the resident's responsible party. She added that the Ombudsman came once month and received a list of all the discharges. Resident #52 was readmitted to the facility on 11/1/18, 1/16/19 and 3/4/19.

A telephone interview was conducted with Resident #52's responsible party on 4/4/19 at 10:20am. She indicated that she had received a phone call from the nurse at the time of his hospital discharge and received the bed hold policy in the mail. She further stated that she had not received any written notices of hospital discharges at those times.

On 4/4/19 at 11:43am a telephone interview occurred with the Admissions Director. She stated that she was responsible for the admissions process and did not notify or send anything in writing to the resident's representative when a hospital discharge occurred.

An interview was conducted with the Director of Nursing on 4/4/19 at 3:15pm. She stated the nurses informed the residents and called the responsible party when a discharge to the hospital occurred, but not in writing. She stated she did not know the facility was to inform the resident and/or responsible party in writing of the reason for the discharge to the hospital but would

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expect the regulation to be followed.

4. Resident #13 was admitted to the facility on 5/5/17 with multiple diagnoses including dementia. The annual Minimum Data Set (MDS) assessment dated 1/1/19 indicated that Resident #13 had moderate cognitive impairment.

Review of Resident #13's nurse's notes revealed that he was discharged and was admitted to the hospital on 3/16/19 due to hypernatremia. The notes did not indicate that Resident #13's responsible party (RP) was notified in writing of the reason for the discharge.

On 4/2/19 at 11:45 AM, Nurse #4 was interviewed. Nurse #4 stated that she normally called the RP to notify him/her of the discharge and the reason for the discharge. Nurse #4 added that the Social Worker (SW) was responsible for sending a copy of the bed hold policy to the RP when the resident was discharged.

On 4/2/19 at 11:50 AM, the SW was interviewed. The SW stated that she was responsible for sending a copy of the bed hold policy to the RP but she was not responsible for notifying the RP in writing of the reason for the discharge.

On 4/3/19 at 11:01 AM, Resident #13's RP was called and he/she stated that he/she had not received a letter from the facility informing him/her that the resident was discharged to the hospital and the reason for the discharge. The RP reported that Resident #13 was discharged to hospice from the hospital.

On 4/4/19 at 11:05 AM, the Director of Nursing

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(DON) was interviewed. The DON stated that she was not aware of the regulation that the facility had to notify the RP in writing when a resident was discharged to the hospital. The DON added that nurses had been notifying the RP when a resident was discharged by phone but not in writing. She indicated that she expected the regulation to be followed for notification.

On 4/4/19 at 11:43 AM, the Admission Director was interviewed. She stated that she was responsible for admissions but she was not responsible for notifying the RP when a resident was discharged to the hospital.

5. Resident #80 was originally admitted to the facility on 12/7/17 with multiple diagnoses including dementia. The admission Minimum Data Set (MDS) assessment dated 2/28/19 indicated that Resident #80 had impaired cognition.

Review of Resident #80's nurse's notes revealed that he was discharged and was admitted to the hospital on 11/30/18 due to shallow and labored breathing and with low oxygen saturation of 86% on room air and on 4/2/19 due to unresponsiveness and wheezing. The notes did not indicate that Resident #80's responsible party (RP) was notified in writing of the reason for the discharge.

On 4/2/19 at 11:45 AM, Nurse #4 was interviewed. Nurse #4 stated that she normally called the RP to notify him/her of the discharge and the reason for the discharge. Nurse #4 added that the Social Worker (SW) was responsible for sending a copy of the bed hold

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policy to the RP when the resident was discharged.

On 4/2/19 at 11:50 AM, the SW was interviewed. The SW stated that she was responsible for sending a copy of the bed hold policy to the RP but she was not responsible for notifying the RP in writing of the reason for the discharge.

Attempted to call the RP of Resident #80 but was unsuccessful.

On 4/4/19 at 11:05 AM, the Director of Nursing (DON) was interviewed. The DON stated that she was not aware of the regulation that the facility had to notify the RP in writing when a resident was discharged to the hospital. The DON added that nurses had been notifying the RP when a resident was discharged by phone but not in writing. She indicated that she expected the regulation to be followed for notification.

On 4/4/19 at 11:43 AM, the Admission Director was interviewed. She stated that she was responsible for admissions but she was not responsible for notifying the RP when a resident was discharged to the hospital. The Admission Director reported that Resident #80 was readmitted back to the facility from the hospital.

6. Resident #75 was originally admitted to the facility on 1/26/11 with multiple diagnoses including dementia. The annual Minimum Data Set (MDS) assessment dated 3/15/19 indicated that Resident #75 had moderate cognitive impairment.

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Review of Resident #75's nurse's notes revealed that he was discharged and was admitted to the hospital on 2/1/19 due to shortness of breath and on 2/12/19 due to shortness of breath and low oxygen saturation of 87% on 3 liters of oxygen. The notes did not indicate that Resident #75's responsible party (RP) was notified in writing of the reason for the discharge.

On 4/2/19 at 11:45 AM, Nurse #4 was interviewed. Nurse #4 stated that she normally called the RP to notify him/her of the discharge and the reason for the discharge. Nurse #4 added that the Social Worker (SW) was responsible for sending a copy of the bed hold policy to the RP when the resident was discharged.

On 4/2/19 at 11:50 AM, the SW was interviewed. The SW stated that she was responsible for sending a copy of the bed hold policy to the RP but she was not responsible for notifying the RP in writing of the reason for the discharge.

Attempted to call the RP of Resident #75 but was unsuccessful.

On 4/4/19 at 11:05 AM, the Director of Nursing (DON) was interviewed. The DON stated that she was not aware of the regulation that the facility had to notify the RP in writing when a resident was discharged to the hospital. The DON added that nurses had been notifying the RP when a resident was discharged by phone but not in writing. She indicated that she expected the regulation to be followed for notification.

On 4/4/19 at 11:43 AM, the Admission Director was interviewed. She stated that she was

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responsible for admissions but she was not responsible for notifying the RP when a resident was discharged to the hospital. The Admission Director reported that Resident #75 was readmitted back to the facility from the hospital

7. Resident #60 was admitted to the facility on 7/1/18 and readmitted on 2/11/19 with diagnoses that included dementia.

The quarterly Minimum Data Set (MDS) assessment dated 1/10/19 indicated Resident #60 had short-term and long-term memory problems and severely impaired decision making.

A medical record review revealed the resident was transferred to the hospital on 2/9/19. There was no documentation of a written notice of hospital discharge provided to the resident's responsible party. Resident #60 was readmitted to the facility on 2/11/19.

During an interview on 4/2/19 at 11:45 AM with Nurse #4, she explained that when a hospital discharge occurred the resident's responsible party was notified by phone. She added that the only written information provided was the bed hold policy sent with the resident.

On 4/2/19 at 11:47 AM an interview occurred with the Unit Manager #1. She stated that the nurses called the resident's responsible party by phone regarding the discharges to the hospital and a copy of the bed hold policy was sent with the resident. She further stated the Social Worker mailed a copy of the bed hold policy to the responsible party.

The Social Worker was interviewed on 4/2/19 at

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F 623	Continued From page 21 11:50 AM. She explained that she was responsible for sending a copy of the bed hold policy to the resident's responsible party. She added that the Ombudsman came once month and received a list of all the discharges. A family interview was attempted by phone with Resident #60's responsible party on 4/1/19 at 11:30 AM. On 4/4/19 at 11:43 AM a telephone interview occurred with the Admissions Director. She stated that she was responsible for the admission process and did not notify or send anything in writing to the resident's representative when a hospital discharge occurred. An interview was conducted with the Director of Nursing on 4/4/19 at 3:15 PM. She stated the nurses informed the residents and called the responsible party when a discharge to the hospital occurred, but not in writing. She stated she did not know the facility was to inform the resident and/or responsible party in writing of the reason for the discharge to the hospital but would expect the regulation to be followed.	F 623		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive	F 636		5/1/19

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assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes

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F 636	Continued From page 23 prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to comprehensively assess a resident on the Minimum Data Set (MDS) assessment in the areas of cognition and mood for 1 of 22 sampled residents whose MDS assessments were reviewed (Resident #60). The findings included: Resident #60 was admitted to the facility on 7/1/18 and most recently readmitted on 2/11/19 with diagnoses that included dementia. A nursing note dated 2/11/19 indicated Resident #60 was alert, pleasantly confused, and consistently talking. The quarterly Minimum Data Set (MDS) assessment dated 2/14/19 indicated Resident #60 had clear speech, was sometimes understood by others, and sometimes understood others. Section C, the Cognitive Patterns section, was not comprehensively assessed for Resident #60. Question C0100 was coded to indicate Resident #60 was rarely/never understood and a Brief Interview for Mental Status (BIMS) was not conducted. Section D, the	F 636	F 636 Affected resident On 4/25/19 the corporate reimbursement auditor reviewed resident #60 who is not able to be interviewed based on staff interviews and resident status. Potential affected residents On 4/24/19 the facility nurse consultant completed an audit of all residents' cognition and mood assessments completed in last 30 days to ensure all minimum data set assessments (MDS) have been completed appropriately with zero negative findings. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/17/19, the corporate MDS consultant in-serviced the facility social worker (SW), and MDS nurses related to accurately coding the MDS on Cognition Sect C01100 and Mood Sect D0100 as per the resident assessment instrument (RAI) manual. This in-service was added to the orientation on 4/25/19 by the director of nursing (DON) for any new facility SW and MDS nurses.	

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F 636	Continued From page 24 Mood section, was not comprehensively assessed for Resident #60. Question D0100 was coded to indicate Resident #60 was rarely/never understood and the resident mood interview was not conducted. Sections C and D of Resident #60's 2/14/19 MDS were completed by the Social Worker (SW). An interview was conducted with the SW on 4/4/19 at 4:46 PM. The SW indicated she completed Sections C and D of Resident #60's quarterly MDS assessment dated 2/14/19. Sections C and D of the 2/14/19 MDS for Resident #60 were reviewed with the SW. She reported that Resident #60 was unable to provide sensical answers for the BIMS and the resident mood interview, so she completed the staff interview instead. The SW indicated she was unaware of the coding instructions specified in the Resident Assessment Instrument (RAI) manual for the completion of the resident interviews in Sections C and D. An interview was conducted with the Director of Nursing (DON) on 4/4/19 at 3:15 PM. She indicated her expectation was for all residents to be comprehensively assessed in all areas of the MDS.	F 636	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The MDS nurse, DON, and/or staff facilitator will audit 3 completed MDS assessments weekly x 12 weeks to ensure that Cognition and Mood assessment is accurate as per RAI manual. This audit will be documented on the minimum data set audit tool. The monthly Quality Assurance/Performance Improvement committee will review the results of the minimum data set audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly Quality Assurance/Performance Improvement committee to the quarterly executive Quality Assurance/Performance Improvement committee for further recommendations and oversight. Compliance date May 1, 2019	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		5/1/19

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F 641	Continued From page 25 Based on record review, observation, resident interview, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medications (Residents #28, #67, and #75), falls (Resident #28), activities of daily living (Resident #28), tracheostomy care (Resident #34), active diagnoses (Resident #22), tube feeding (Resident #52), and pain (Resident #51) for 7 of 22 sampled residents. The findings included: 1. Resident #67 was admitted to the facility on 10/11/18 with diagnoses that included Diabetes Mellitus (DM) and hemiplegia (paralysis of one side of the body). Resident #67's February 2019 physician's order summary included the following medications administered by injection: - Exenatide (anti-diabetic medication) pen injection 2 milligram (mg) powder for suspension, subcutaneous injection once weekly - Depo-testosterone injection 200 mg/milliliter (ml), intramuscular injection once every 2 weeks The quarterly Minimum Data Set (MDS) assessment dated 2/22/19 indicated Resident #67's cognition was intact. He was noted with 3 injections and 2 insulin injections during the 7-day MDS look back period. The Medication Section of Resident #67 ' s 2/22/19 MDS was coded by MDS Nurse #2. A review of Resident #67 ' s Medication Administration Record (MAR) for the 7-day look back period of the 2/22/19 MDS (2/16/19 through 2/22/19) indicated Resident #67 was administered Exenatide injection and	F 641	F641 Accuracy of Assessments The plan of correcting the specific deficiency By 4/25/19 the minimum data set assessments for residents #28, #67, #75, #34, #22, #52, and #51 were modified by minimum data set nurses (MDS) and submitted to the national repository. The procedure for implementing the acceptable plan of correction for the specific deficiency cited Audit of all residents with submitted comprehensive MDS assessments submitted and accepted in last 30 days to ensure falls, medications, activities of daily living, tracheostomy care, fractures, tube feeding, and pain were accurately coded by facility consultant completed from 4/24/19 through 4/25/19. No additional negative findings noted. Systemic changes The MDS nurse was in-serviced by the corporate reimbursement auditor on correctly coding the of the MDS assessment per the resident assessment instrument (RAI) manual, including falls, medications activities of daily living, tracheostomy care, fractures, tube feeding, and pain on 4/17 and 4/18/19. Any newly hired MDS nurses will be in-serviced by facilities corporate reimbursement auditor to accurately code the MDS assessments to include falls. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements	

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F 641	Continued From page 26 Depo-testosterone injection on 2/16/19. Resident #67 was administered no other injections of any type during the 2/22/19 MDS look back period. An interview was conducted with MDS Nurse #2 on 4/1/19 at 4:08 PM. She stated she began working as an MDS Nurse at this facility a little over a month ago. She reported she had no prior experience coding the MDS. The Medication Section of the 2/22/19 quarterly MDS for Resident #67 was reviewed with MDS Nurse #2. She confirmed she coded this section. The MAR for Resident #67 for the look back period of the 2/22/19 MDS was reviewed with MDS Nurse #2. She stated that this 2/22/19 MDS for Resident #67 was coded inaccurately for injections and insulin injections. MDS Nurse #2 revealed she was just learning the coding rules and she made a mistake. An interview was conducted with the Director of Nursing on 4/4/19 at 3:15 PM. She indicated she expected the MDS to be coded accurately. 2. Resident #28 was admitted to the facility on 12/21/17 with diagnoses that included dementia, major depressive disorder, and repeated falls. 2a. The modified quarterly Minimum Data Set (MDS) assessment dated 12/26/18 indicated Resident #28's cognition was severely impaired. She was coded with 2 or more falls with no injury since her prior MDS assessment (10/3/18). A review of Resident #28's incident reports and nursing notes indicated that Resident #28 sustained the following falls from 10/4/18 through	F 641	The director of nursing, and/ or staff facilitator, will audit 3 completed MDS assessments weekly x 12 weeks to ensure falls, medications, activities of daily living, tracheostomy care, fracture, tube feeding, and pain were coded correctly using the MDS Audit Tool. The monthly Quality Assurance/Performance Improvement committee will review the results of the MDS Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or director of nursing (DON) will present the findings and recommendations of the monthly Quality Assurance/Performance Improvement committee to the quarterly executive Quality Assurance/Performance Improvement committee for further recommendations and oversight. Compliance date: May 1, 2019	

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12/26/18:
- 10/20/18 fall that resulted in a bump to the forehead
- 11/5/18 fall that resulted in a "knot" to the back of her head
- 12/2/18 fall that resulted in 4 staples to the back of her head

An interview was conducted with MDS Nurse #1 on 4/3/19 at 10:40 AM. She stated that a previous MDS Nurse completed the falls sections of Resident #28's 12/26/18 quarterly MDS. MDS Nurse #1 indicated she signed the assessment to verify it was complete. MDS Nurse #1 stated that they utilized the risk management section of the Electronic Medical Records (EMR) to code the MDS for falls. She reviewed the risk management section of Resident #28's EMR and verified that the 12/26/18 modified quarterly MDS was coded inaccurately for falls.

2b. The quarterly Minimum Data Set (MDS) assessment dated 3/18/19 indicated Resident #28's cognition was severely impaired. She was coded with 1 fall with no injury since her prior MDS assessment (12/26/18).

A review of Resident #28's incident reports and nursing notes indicated that Resident #28 sustained the following falls from 12/27/18 through 3/18/19:
- 1/13/19 fall that resulted in 5 staples to her head
- 1/17/19 fall with no injury
- 1/20/19 fall with no injury
- 2/5/19 fall with no injury
- 2/10/19 fall that resulted in bruising to her eye, face, and deltoid
- 2/10/19 fall with no injury
- 3/18/19 fall with no injury

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An interview was conducted with MDS Nurse #2 on 4/3/19 at 10:40 AM. She indicated she began working as an MDS Nurse at this facility a little over a month ago. She reported she had no prior experience coding the MDS. She stated she coded the section related to falls for Resident #28's 3/18/19 MDS. MDS Nurse #2 stated that she utilized the risk management section of the Electronic Medical Records (EMR) to code the MDS for falls. She reviewed the risk management section of Resident #28's EMR and verified that the 3/18/19 quarterly MDS was coded inaccurately for falls. MDS Nurse #2 stated that she was still learning how to operate the EMR and she made an error.

2c. A review of the March 2019 physician's order summary indicated Resident #28 was ordered Pristiq (antidepressant medication) 50 milligrams (mg) once daily.

The quarterly Minimum Data Set (MDS) assessment dated 3/18/19 indicated Resident #28 ' s cognition was severely impaired. She was coded with no antidepressant usage during the 7-day MDS look back period.

A review of Resident #28's Medication Administration Record (MAR) for the 7-day look back period of the 3/18/19 MDS (3/12/19 through 3/18/19) indicated Resident #28 was administered the antidepressant medication Pristiq on 7 of 7 days.

An interview was conducted with MDS Nurse #2 on 4/3/19 at 10:40 AM. She indicated she began working as an MDS Nurse at this facility a little over a month ago. She reported she had no prior

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experience coding the MDS. She stated she coded the section related to medications for Resident #28's 3/18/19 MDS. The medication section of Resident #28's 3/18/19 quarterly MDS was reviewed with MDS Nurse #2. The March 2019 MAR that indicated Resident #28 was administered the antidepressant Pristiq on 7 of 7 days was reviewed with MDS Nurse #2. She stated that she was not aware Pristiq was an antidepressant medication and this was why she had not coded it on the MDS.

2d. The quarterly Minimum Data Set (MDS) assessment dated 3/18/19 indicated Resident #28's cognition was severely impaired. She was coded as independent with set up help only for bed mobility, transfers, walking in room, walking on unit, locomotion on unit, locomotion off unit, and eating. Resident #28 was coded as dependent of 1 for dressing and toileting.

A review of the Nursing Assistant (NA) documentation for Resident #28's Activities of Daily Living (ADLs) during the 3/18/19 MDS look back period (3/12/19 through 3/18/19) revealed the following:
- Bed mobility ranged from independent with no set up assistance to dependent with 1 assist
- Transfers ranged from independent with no set up assistance to extensive with 1 assist
- Walking in room ranged from independent with no set up assistance to extensive with 1 assist
- Walking on unit ranged from independent with no set up assistance to extensive with 1 assist
- Locomotion on unit ranged from independent with no set up assistance to dependent with 1 assist
- Locomotion off unit ranged from independent

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with no set up assistance to dependent with 1 assist
- Eating ranged from independent with no set up assistance to dependent with 1 assist
- Toileting ranged from limited with assist to dependent with 1 assist
- Dressing ranged from extensive with 1 assist to dependent with 1 assist

An interview was conducted with MDS Nurse #2 on 4/3/19 at 10:40 AM. She indicated she began working as an MDS Nurse at this facility a little over a month ago. She reported she had no prior experience coding the MDS. She stated she coded the section related to ADLs for Resident #28's 3/18/19 MDS. The ADL section of Resident #28's 3/18/19 quarterly MDS was reviewed with MDS Nurse #2. The NA documentation of ADLs for Resident #28 during the 3/18/19 MDS look back period (3/12/19 through 3/18/19) was reviewed with MDS Nurse #2. MDS Nurse #2 revealed she was still in the process of learning how to code the MDS for ADLs.

An interview was conducted with the Director of Nursing on 4/4/19 at 3:15 PM. She indicated she expected the MDS to be coded accurately.

3. Resident #22 was admitted to the facility on 5/15/18 with diagnoses of unspecified abnormalities of gait and age-related osteoporosis.

A review of Resident #22's annual Minimum Data Set (MDS) dated 1/8/19 revealed the resident had a severely impaired cognition. The resident required extensive assistance of 1 staff for transfers, dressing, and toileting. The active diagnoses were arthritis, osteoporosis, and

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difficulty walking. The MDS was not coded for the diagnoses of fracture of right humerus (arm) or fall.

A review of Resident #22's Incident Report dated 12/18/18 revealed the resident complained of pain to the right arm. A head to toe assessment revealed no signs or symptoms of injury. The resident stated she fell, was hollering out for help and found on her room floor. The resident was alert but confused (baseline).

Resident #22 nurses' note dated 12/21/2018 at 11:00 am documented the resident was assessed and noted her right shoulder to be asymmetrical with her left shoulder. The resident could not lift her right arm without pain. The Family Nurse Practitioner (FNP) assessed the resident and determined she should be seen in Emergency Room (ER).

A review of Resident #22's ER note dated 12/21/18 revealed she fell three days ago at the facility transferring. There was a history of osteoporosis. The resident was noted not using her right arm today as usual. X-ray report revealed fracture of right humerus, non-union that was subacute and chronic appearing.

An interview was conducted on 4/2/19 at 10:00 am with the Director of Nursing (DON) who stated that there were multiple transcription error contributing to MDS errors and an audit was in progress. The DON further stated that she expected the MDS to be accurately coded.

An interview was conducted on 4/4/19 at 2:00 pm with the MDS Coordinator who stated that the fracture diagnosis was missed and would be

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corrected.

4. Resident #34 was admitted to the facility on 12/21/15 with diagnoses of esophageal obstruction and tracheostomy.

A review of Resident #34's quarterly MDS dated 1/22/19 revealed the resident had an intact cognition and required total dependence for transfer and extensive assistance for all other activities of daily living (ADLs). The active diagnoses were pneumonia and respiratory failure. The resident was oxygen dependent. The MDS was coded "No" for tracheostomy care.

On 4/1/19 at 9:30 am an interview was conducted with Resident #34 who stated that facility staff and Hospice staff manage her tracheostomy care each shift.

On 4/1/19 at 9:30 am an observation was done of Resident #34. The resident had no shortness of breath or respiratory distress noted. The resident had a capped tracheostomy with a slit gauze surrounding that was dry and intact. She was able to cough and clear her secretions independently and does not require suctioning.

A review of Resident #34's treatment administration record documentation for January 2019 revealed tracheostomy care each day and as needed.

An interview was conducted on 4/2/19 at 10:00 am with the DON who stated that she expected the MDS to be accurately coded.

An interview was conducted on 4/4/19 at 2:00 pm

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with the MDS Coordinator who stated that the tracheostomy was missed and would be corrected.

5. Resident #51 was admitted to the facility on 1/20/11 with the diagnoses of dysphagia, dementia, restlessness, and agitation.

A review of Resident #51's quarterly MDS dated 2/1/19 revealed the resident had severely impaired cognition with no speech and was rarely understood or understands. The resident required total dependence for all ADLs. The active diagnoses were contractures of hips and knees, restless leg syndrome, and extrapyramidal and movement disorder. Pain assessment for administration of medication was coded "no" for scheduled and as needed.

Physician order dated 1/1/2019 revealed documentation that Resident #51 had Tylenol 650 mg three times a day (TID).

A review of Resident #51's January and February 2019 treatment administration record revealed the resident received Tylenol 650 mg TID for the entire quarterly MDS lookback period dated 2/1/19.

An interview was conducted on 4/1/19 at 3:30 pm with Nurse #1 who stated that Resident #51 received Tylenol three times a day for generalized pain.

An interview was conducted on 4/2/19 at 10:00 am with the Director of Nursing (DON) who stated that she expected the MDS to be accurately coded.

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An interview was conducted on 4/4/19 at 2:00 pm with the MDS Coordinator who stated that the pain medication administration for pain assessment was missed and would be corrected.

6) Resident #52 was admitted to the facility on 10/10/18 with diagnoses that included dysphagia (difficulty swallowing), and seizure disorder.

A review of the Quarterly Minimum Data Set (MDS) assessment dated 11/16/18 indicated the resident received 51% or more calories via the Percutaneous Endoscopic Gastrostomy (PEG- a way of receiving nutrition) tube.

A review of the Quarterly MDS assessment dated 2/5/19 revealed the resident received 51% or more calories via the PEG tube.

The most recent MDS coded as a quarterly assessment and dated 3/4/19, assessed the resident with severe cognitive impairment. He required total assistance from staff for eating via the PEG tube. It was noted that he received 26 to 50% of calories thru the PEG tube.

A nursing note dated 3/16/19 indicated the resident did not eat or drink anything by mouth and received 100% of his meals via the PEG tube.

Review of Resident #52's active care plan revealed a care plan in place for nutrition via the PEG tube due to dysphagia and nothing by mouth (NPO) status. Appropriate goals and interventions were present.

A review of the current physician orders revealed

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Resident #52 received a continuous enteral feeding at 40 milliliters (ml) per hour via the PEG tube.

On 4/4/19 at 9:05am an interview was conducted with the MDS Nurse #1. After reviewing the nutrition area on the 3/4/19 MDS, she stated the dietary manager coded that section.

On 4/4/19 at 9:20am an interview occurred with the Dietary Manager. She reviewed the nutrition area on the 3/4/19 MDS and stated the 26-50% of calories thru the PEG tube was marked in error and should have been 51% or more.

During an interview with the Director of Nursing on 4/4/19 at 3:20pm she stated it was her expectation for the MDS to coded accurately.

7. Resident #75 was originally admitted to the facility on 1/26/11 with multiple diagnoses including dementia. The annual Minimum Data Set (MDS) assessment with assessment reference date (ARD) of 3/15/19 indicated that Resident #75 had moderate cognitive impairment and had received an anticoagulant medication for 7 days during the assessment period.

Review of Resident #75's physician's orders for March 2019 revealed no order for an anticoagulant medication.

Resident #75's March 2019 Medication Administration Record (MAR) was reviewed and revealed that Resident #75 had not received an anticoagulant medication during the assessment period.

Interview with MDS Nurse #1 was conducted on

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F 641	Continued From page 36 4/1/19 at 3:43 PM. MDS Nurse #1 reviewed Resident #75's orders and MARs and verified that Resident #75 did not have an order for an anticoagulant medication and had not received an anticoagulant medication during the assessment period. The MDS Nurse indicated that it was a coding error on her part, the annual MDS dated 3/15/19 was inaccurate. Interview with the Director of Nursing (DON) on 4/4/19 at 11:05 AM was conducted. The DON stated that she expected the MDS assessment to be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must 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	F 656		5/9/19

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F 656	Continued From page 37 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff and resident interviews, the facility failed to develop a care plan for tracheostomy care interventions (Resident #34) and range of motion/contracture prevention (Resident #51), and failed to implement the care plan for nutrition (Resident #51), for eating assistance (Resident #60), for nail care (Resident #51), for suicidal interventions (Resident #24), and for falls (Resident #28), for 5 of 22 residents reviewed. Findings included: 1. Resident #34 was admitted to the facility on 12/21/15 with diagnoses of esophageal obstruction and tracheostomy. A review of Resident #34's quarterly Minimum Data Set (MDS) dated 1/22/19 revealed the resident had an intact cognition and required total	F 656	F656 The plan of correcting the specific deficiency By 4/25/19 resident #34's care plan was updated to include tracheostomy care, and #51's care plan was updated to include decreased range of motion (therapy) by the minimum data set nurse (MDS), or facility consultant. On 4/24/19 the facility consultant observed resident #51's meal tray that included the care planed interventions for nutrition. On 4/24/19 the facility consultant observed meal assistance being provided to resident # 60 as designated on care plan. On 4/24/19 the facility consultant	

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F 656	Continued From page 38 dependence for transfer and extensive assistance all other activities of daily living (ADLs). The active diagnoses were pneumonia and respiratory failure. The resident was oxygen dependent. The MDS was coded "No' for tracheostomy care. A review of Resident 34's care plan updated on 1/22/19 revealed no tracheostomy interventions were identified. On 4/1/19 at 9:30 am an interview was conducted with Resident #34 who stated that facility and Hospice staff manage her tracheostomy care each shift. The resident had no concerns. On 4/1/19 at 9:30 am an observation was done of Resident #34. The resident had no shortness of breath or respiratory distress noted. The resident had a capped tracheostomy with a slit gauze surrounding that was dry and intact. She was able to cough and clear her secretions independently and does not require suctioning. On 4/3/19 at 3:20 pm an interview was conducted with the Treatment Nurse (TN) who stated when Hospice does not provide the resident care services, the facility nurse provided tracheostomy care which included daily dressing change and cannula cleaning as needed. Facility care provided was documented on each resident's treatment administration record. Hospice changed the tracheostomy device every month and documented in the Hospice narrative notes in the resident's medical record. On 4/4/19 at 9:30 am an interview was conducted with the MDS Coordinator who stated she was responsible for Resident #34's care plan. The	F 656	observed the nails of resident #51 to ensure nail care had been provided as designated by care plan. The care plan was updated on 4/24/19 by facility consultant for resident # 24 to ensure suicide precautions were current and accurate. On 4/24/19 the facility consultant observed resident #28 and all interventions on fall care plan were in place. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/25/19 the facility consultant audited all residents with tracheostomy to ensure interventions and care plan in place with no negative findings. On 4/24/19 the MDS nurses audited all residents with contractures to ensure care plan in place. There was 1 negative finding. Negative findings immediately addressed by the auditor. On 4/24/19 the facility consultant observed breakfast for residents in community dining with no negative findings noted related to assistance being provided per care plan. On 4/26/19 nursing staff audited all residents' nails. No negative findings were noted. On 4/24/19 the facility consultant completed an audit of residents with a care plan for suicide precautions. All interventions in place, no negative findings. On 4/26/19 the MDS nurses audited all residents with fall care plans to ensure	

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F 656	Continued From page 39 Coordinator stated the resident's MDS was not coded for tracheostomy care, so the care plan was not developed. An interview was conducted on 4/4/19 at 4:00 pm with the Director of Nursing (DON) who stated that she expected staff to develop a comprehensive care plan to meet the needs and preferences of each individual resident. 2a. Resident #51 was admitted to the facility on 1/20/11 with the diagnoses of dysphagia, dementia, restlessness, and agitation. A review of Resident #51's quarterly MDS dated 2/1/19 revealed the resident had a severely impaired cognition with no speech and was rarely understood or understands. The resident required total dependence for all ADLs. The active diagnoses were contractures of hips and knees, restless leg syndrome, and extrapyramidal and movement disorder. A review of Resident #51's care plan updated 2/6/19 did not reveal documentation which addressed a focus, goal or intervention for range of motion and prevention of further contractures. On 3/31/19 at 4:30 pm Resident #51 was observed to have moderate contractures to her both knees and hips. The resident was also noted to have involuntary movement of her extremities. On 3/31/19 at 4:35 pm an interview was conducted with Nursing Assistant (NA) #5 who stated that the resident had involuntary movements of her extremities and was not	F 656	interventions in place. No negative findings were noted. Systemic Change On 4/14/19 the corporate reimbursement auditor in-serviced the MDS nurses on development of care plans and revision to meet resident current status. This in-service will be provided to any new MDS nurses. On 4/18/19 the director of nursing and staff facilitator in-serviced nursing staff (licensed nurses, and Certified Nursing Assistants) on following the residents care plan/care guide and ensuring interventions are in place. This in-service was added to the orientation for newly hired nursing staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator, director of nursing, staff facilitator, or unit manager will audit 10 resident care plans weekly x 12 weeks to ensure care plan(s) are present tracheostomy care, and decreased range of motion (as appropriate) and that care plan interventions are in place for nail care, meal assistance, suicide prevention, and falls by observation. This audit will be documented on the intervention audit tool. The monthly Quality Assurance/Performance Improvement committee will review the results of the intervention audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring,	

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F 656	Continued From page 40 currently receiving restorative nursing for passive range of motion (PROM) and it was a long time since the resident had therapy services. On 4/3/19 at 12:30 pm an interview was conducted with NA #1 who stated that Resident #51 was not currently receiving PROM or restorative nursing services by the NAs. On 4/3/19 at 2:40 pm an interview was conducted with the Therapy Manager who stated that Resident #51 has not had therapy services for a long time (several months) and was not currently receiving preventative contracture prevention. The resident had a new wheel chair that was padded to accommodate the extremity movement and jerking and to prevent injury. The resident was not receiving restorative NA for PROM contracture care. The Therapy Manager did not know if there was a plan in place by nursing for restorative nursing. Restorative nursing services was provided by the NA staff with two NAs being the champion for resources. An interview was conducted on 4/4/19 at 4:00 pm with the Director of Nursing (DON) who stated that she expected staff to develop a comprehensive care plan to meet the needs and preferences of each individual resident. b. Resident #51 was admitted to the facility on 1/20/11 with the diagnoses of dysphagia, dementia, restlessness, and agitation. A review of Resident #51's quarterly MDS dated 2/1/19 revealed the resident had severely impaired cognition with no speech and was rarely understood or understands. The resident	F 656	and make recommendations for monitoring for continued compliance. The administrator and/or director of nursing will present the findings and recommendations of the monthly Quality Assurance/Performance Improvement committee to the quarterly executive Quality Assurance/Performance Improvement committee for further recommendations and oversight. Completion date May 9, 2019	

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required total dependence for all ADLs. The active diagnoses were protein mal-nutrition and dysphagia. The resident received a therapeutic diet.

A review of Resident #51's care plan updated 2/6/19 revealed a focus for nutrition with pureed, double portion diet and nutritional supplement for each meal.

A review of Resident #51's diet order meal ticket provided by the Dietary Manager (DM) revealed the resident was to receive pureed, double portion enriched meal.

On 4/2/19 at 8:30 am an observation was done of the resident in her bed and her breakfast tray was served. The breakfast was a single portion. NA #5 verified that the meal portion was single and the DM verified that the meal portion was single.

On 4/2/19 at 8:30 am an interview was conducted with NA #2 who stated she was regularly scheduled to feed Resident #51 and had not observed the resident receive double portion meals. NA #2 commented that if she felt the resident was still hungry she would order a second meal.

On 4/4/19 at 8:35 am an interview was conducted with the DM who stated Resident #51's meal was a single portion and does not know why the resident did not receive a double portion this morning or in the past.

On 4/4/19 at 12:30 pm an interview was conducted with Dietary Aide #1 who stated the cook would announce the ordered meal for pureed and DA #1 served the food onto the plate.

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DA #1 commented that the cook did not announce "double" this morning and the resident received a single portion. DA #1 stated that she believed this was a miss due to mis-communication.

An interview was conducted on 4/4/19 at 4:00 pm with the DON who stated that she expected staff to implement the resident's care plan.

c. Resident #51 was admitted to the facility on 1/20/11 with the diagnoses of dysphagia, dementia, restlessness, and agitation.

A review of Resident #51's quarterly MDS dated 2/1/19 revealed the resident had a severely impaired cognition with no speech and was rarely understood or understands. The resident required total dependence for all ADLs. The active diagnoses were involuntary movements of the extremities.

A review of Resident #51's care plan updated 2/6/19 revealed the resident was dependent and received total daily care which included cleaning and cutting finger nails.

On 3/31/19 at 4:00 pm an observation was done of Resident #51 in her bed. Her family was at the bedside visiting and commented that the resident's nails were long. A family member commented that he was aware that the resident could resist and offered to hold the resident's hand. The family member stated he would inform staff about the nails.

On 4/4/19 at 8:30 am an interview was conducted with NA #5 who stated she was regularly

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scheduled to care for Resident #51. NA #5 and commented that the resident's nails were long and the resident would not allow staff to cut her nails. NA #5 further commented that the nails were not pressing on the resident's palms when her hands were closed. NA #5 stated she was not aware the resident had a care plan intervention to cut her nails to prevent accidental scratching.

On 4/4/19 at 8:30 am an observation was done of Resident #51's nails which remained long and were now dirty.

An interview was conducted on 4/4/19 at 4:00 pm with the DON who stated that she expected staff to implement the resident's care plan.

3. Resident #24 was admitted on 9/10/12 with diagnoses of adult failure to thrive, dementia with behavioral disturbance, and bipolar disorder.

Resident #24 signed an agreement with the facility to contract for safety and agreement to participate in outpatient treatment dated 5/18/18 after her suicide attempt.

A review of Resident #24's annual MDS dated 1/9/19 revealed the resident was understood and understands and her cognition was intact. The resident required supervision for dressing and personal care and was independent with all other ADLs. Active diagnoses were non-Alzheimer's dementia, bipolar disorder, psychotic disorder, and suicide attempt.

A review of Resident #24's care plan updated on 1/22/19 revealed ineffective coping with suicidal

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behavior. Intervention was for a "dig bell" and not a corded call bell to prevent inappropriate suicide attempt usage.

A review of Resident #24's nurses' notes from last recertification to 4/4/19 revealed the resident has regular behaviors and the staff had assessed for suicidal risk and ideation. Resident has periodically had 1:1 supervision. The resident contracted for safety.

On 4/3/19 at 5:00 pm an observation was done of Resident #24 who was resting in bed and did not want to have visitors. The resident had a corded call light in her bed.

On 4/3/19 at 5:05 pm an interview was conducted with NA #11 who stated that Resident #24 was calm today but can have verbal and physical behaviors. The resident was observed for and had precautions for suicidal ideation or attempts. NA #11 was not aware that the resident should not have access to a corded call light according to her care plan.

On 4/3/19 at 5:15 pm an interview was conducted with Nurse #13 assigned to Resident #24 who stated that the resident was observed for suicidal ideation or attempts. Nurse #13 was not aware that the resident ' s care plan had an intervention for a "dig bell" and not a corded call light.
On 4/4/19 at 9:00 am an observation was done of Resident #24 in her bed. The resident's breakfast tray was in the room and had plastic ware. The resident had a corded call light. A ding bell was not observed.

On 4/4/19 at 9:00 am an interview was conducted with NA #11 who stated that Resident #24 had

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prior history of suicidal attempt and was supervised for suicidal ideation and attempt. The resident had no sharp objects in her room and plastic ware for her meals. NA #11 stated and observed that the resident had a corded call light. NA #11 was not aware that the resident was to have a ding bell in lieu of the corded call light for her care plan. NA #11 stated that she had access to the resident's care plan.

On 4/4/19 at 9:30 am an interview was conducted with the MDS Coordinator who stated she was responsible for Resident #24's care plan. The Coordinator stated the resident's current care plan had the intervention of a ding bell and not a corded call bell for suicidal prevention/safety. The Coordinator was not informed of any changes to this care plan intervention.

An interview was conducted on 4/4/19 at 4:00 pm with the DON who stated that she expected staff to implement the resident ' s care plan.
4. Resident #28 was admitted to the facility on 12/21/17 with diagnoses that included Alzheimer' s, schizophrenia, unsteadiness on feet, and repeated falls. The quarterly Minimum Data Set (MDS) assessment dated 12/26/18 indicated Resident #28's cognition was severely impaired. Resident #28's care plan included the focus area of the risk for falls characterized by a history of falls and injury. This area was initiated on 12/22/17. The interventions included anti-rollbacks to Resident #28's wheelchair (initiated on 4/30/18 and last revised 7/27/18). An incident report dated 10/20/18 completed by Nurse #7 indicated Resident #28 had unwitnessed fall on 10/20/18 at 10:50 AM that resulted in small bump to the left side of her forehead.

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The fall investigation checklist form dated 10/20/18 completed by Nurse #7 indicated the new intervention that was put into place to prevent a repeat fall was to add anti-rollbacks to Resident #28's wheelchair. This checklist was signed as complete by Unit Manager (UM) #1.
The investigation follow up form, undated and unsigned, indicated Resident #28 had a fall on 10/20/18 at 10:50 AM and that anti-rollbacks were going to be put into place on Resident #28's wheelchair to stabilize it for her.
Resident #28's care plan related to falls was updated on 10/23/18 with the repeat intervention of anti-rollbacks on wheelchair.
A work order dated 10/24/18 completed by UM #1 indicated anti-rollbacks were to be added to Resident #28's wheelchair. This work order indicated the anti-rollbacks were added on 10/25/18.
A phone interview was conducted with Nurse #7 on 4/3/19 at 2:43 PM. Nurse #7 stated that the nurse assigned to the resident at the time of the fall completed an incident report and initiated the fall investigation checklist form. She explained that this form had a question on it about what new interventions were going to be implemented to prevent repeated falls. Nurse #7 further explained that sometimes she was unable to think of an appropriate intervention, so she left this question blank and let one of UMs determine what new intervention was appropriate. The incident report, investigation checklist, and investigation follow up form that indicated anti-rollbacks were to be implemented for Resident #28 after the 10/20/18 fall were reviewed with Nurse #7. The care plan that indicated that the intervention of anti-rollbacks was already in place on Resident #28's care plan (initiated on 4/30/18 and last revised 7/27/18) was

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reviewed with Nurse #7. Nurse #7 stated she believed one of the UMs had wrote the intervention of anti-rollbacks on the fall investigation checklist. She was unable to recall with certainty if Resident #28's wheelchair had anti-rollbacks at the time of the 10/20/18. She indicated that if it was noted as a new intervention that the anti-rollbacks were probably not in place on Resident #28's wheelchair at the time of 10/20/18 fall.

An interview was conducted with UM #1 on 4/2/19 at 2:40 PM. The incident report, investigation checklist, and investigation follow up form that indicated anti-rollbacks were to be implemented for Resident #28 after the 10/20/18 were reviewed with UM #1. The work order that indicated anti-rollbacks were added to Resident #28's wheelchair on 10/25/18 was reviewed with UM #1. The care plan that indicated the intervention of anti-rollbacks was already in place on Resident #28's care plan (initiated on 4/30/18 and last revised 7/27/18) at the time of her 10/20/18 fall was reviewed with UM #1. UM #1 confirmed she had completed the work order on 10/24/18 for anti-rollbacks to Resident #28's wheelchair. She was unable to explain why Resident #28's anti-rollbacks were not in place at the time of her 10/20/18 fall when this intervention was on her care plan.

An interview was conducted with the Director of Nursing on 4/4/19 at 3:15 PM. She indicated she expected care plan interventions to be implemented.

5. Resident #60 was admitted to the facility on 7/1/18 and readmitted on 2/11/19 with diagnoses that included dementia.

A physician ' s order dated 2/6/19 indicated

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Resident #60 was to eat community style in the dining room to encourage intake.
Resident #60 ' s care plan, initiated on 7/2/18, included the focus area of assistance for eating related to cognitive deficit and dysphagia. The interventions, initiated on 7/2/18 and revised 2/6/19, indicated Resident #60 was to eat her meals in the dining room to encourage intake.
The quarterly Minimum Data Set (MDS) assessment dated 2/14/19 indicated Resident #60 had short-term and long-term memory problems and severely impaired decision making. She required the extensive assistance of 1 for eating.
An observation was conducted of the dinner meal on 3/31/19 at 6:05 PM. Resident #60 was eating in her room with assistance provided by Nursing Assistant #10.
An observation was conducted of the dinner meal on 4/3/19 at 6:10 PM. Resident #60 was eating in her room with assistance provided by NA #11.
An interview was conducted with NA #10 on 4/3/19 at 5:30 PM. She revealed she was unaware that Resident #60 had a physician ' s order to eat all of her meals in the dining room. She stated that she was the only NA working on Resident #60 ' s unit on 3/31/19 during the 2nd shift and she had difficulty getting all of the residents out of bed and into the dining room on her own. She indicated this was why she served and fed Resident #60 dinner in her room on 3/31/19.
An interview was conducted with NA #11 on 4/4/19 at 2:55 PM. She stated she was aware that Resident #60 was supposed to eat all meals in the dining room. She revealed that normally there were 2 NAs and the nurse on the unit, but one of the NAs had called off on 4/3/19 for the 2nd shift. She further revealed that because she

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F 656	Continued From page 49 was the only NA on Resident #60 ' s unit that she was unable to get her out of bed for dinner due to time limitations. An interview was conducted with the Director of Nursing on 4/4/19 at 3:15 PM. She indicated she expected care plan interventions to be implemented.	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	F 657		5/1/19

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by:
Based on record review, observation, and staff interviews, the facility failed to revise the resident's care plan for padded side rails (Resident #51) for 1 of 22 residents reviewed.

Findings included:

Resident #51 was admitted to the facility on 1/20/11 with the diagnoses of dysphagia, dementia, restlessness, and agitation.

A review of Resident #51's quarterly Minimum Data Set dated 2/1/19 revealed the resident had severely impaired cognition with no speech and was rarely understood or understands. The resident required total dependence for all activities of daily living (ADLs). The active diagnoses were history of falls and involuntary movement.

A review of Resident #51's care plan updated on 2/6/19 revealed a focus falls prevention and actual fall and an intervention for padded side rails.

On 4/2/19 at 8:30 am an observation was done of the resident in her bed. The resident had a scoop mattress with a low bed and fall mat in place. The resident did not have side rails and/or pads.

On 4/3/19 at 8:30 am Nursing Assistant (NA) #1 stated that the resident had not had side rails since December 2018.

An interview was conducted on 4/4/19 at 4:00 pm with the Director of Nursing who stated that she expected staff to review and update the resident's care plan accordingly.

F657
The plan of correcting the specific deficiency
On 4/24/19 the facility consultant updated resident #51's care plan to remove inaccurate intervention of padded side rails.
The procedure for implementing the acceptable plan of correction for the specific deficiency cited
Audit completed of all residents with intervention of padded side rails by facility consultant on 4/25/19. No negative findings noted.
Systemic change
On 4/18/19 the director of nursing and staff facilitator in-serviced nursing staff, certified nursing assistants and licensed nurses, on ensuring interventions on the care plan and/or care guide are in place and if the intervention is no longer accurate the licensed nurse will update the care plan. This in-service was completed on 4/29/18. This in-service was added to the orientation for newly hired nursing staff.
The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements
The director of nursing, assistant director of nursing, unit manager, and/or staff facilitator will audit 5 residents (on random halls, on random shifts to include all 3 shifts, and on random days to include weekends) weekly x 12 weeks, to review and revise care plan intervention as

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F 657	Continued From page 51	F 657	needed. This audit will be documented on the care plan audit tool. The monthly Quality Assurance/Performance Improvement committee will review the results of the care plan audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or director of nursing will present the findings and recommendations of the monthly Quality Assurance/Performance Improvement committee to the quarterly executive Quality Assurance/Performance Improvement committee for further recommendations and oversight Date of compliance May 1, 2019.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to accurately transcribe physician orders for an antianxiety medication ordered by the physician for 1 of 6 residents whose medications were reviewed (Resident #53). The findings included:	F 658	F658 The plan of correcting the specific deficiency The facility nurse clarified resident # 53's Buspar order with the prescribing nurse practioner and the medication continues at the twice daily dose. The procedure for implementing the acceptable plan of correction for the	5/1/19

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F 658	Continued From page 52 Resident #53 was admitted to the facility on 10/8/18. Her diagnoses included depression and anxiety. A review of the medical record revealed an order dated 12/19/18 for Buspar 10 milligrams (mg) three times a day for anxiety. A review of the resident's monthly Physician Orders for January 2019 included Buspar 10mg by mouth three times a day for anxiety (as initiated on 12/19/18). The January 2019 Medication Administration Record (MAR) revealed she received 10mg of Buspar three times a day as prescribed from 1/1/19 to 1/31/19. The Buspar was scheduled to be given at 8:30am, 12:00pm and 8:30pm. A review of the most recent Minimum Data Set (MDS) coded as a quarterly assessment and dated 2/5/19 revealed the resident had moderate cognitive deficits. She required setup assistance with meals and extensive to total assistance from staff members for all other Activities of Daily Living (ADL's). A review of the monthly Physician Orders for February 2019 included Buspar 10mg by mouth twice daily (not as initiated on 12/19/18). The February 2019 MAR revealed she received 10mg Buspar only twice daily at 8:30am and 8:30pm from 2/1/19 to 2/28/19. A review of the monthly Physician Orders for March 2019 included Buspar 10mg by mouth twice daily for anxiety (not as initiated on 12/19/18).	F 658	specific deficiency cited On 4/24/19 the unit managers audited all new orders for the past 7 days to ensure transcription to the medication administration record was accurate. No additional negative findings noted. Systemic change On 4/18/19 the director of nursing (DON) and the staff facilitator (SF) began an in-service with licensed nurses on correct transcription of orders. This in-service was completed on 4/29/19. This in-service was added to the orientation for newly hired licensed nurses. When a new order is received the nurse will transcribe the order to the medication administration record accurately. The unit manager, DON, or SF will review the new order to ensure transcription was completed accurately within 72 hours or the order being obtained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, SF, and/or unit manager will audit 5 residents (on random halls to include all residents) daily 3x per week (on random days to include all 7 days per week) x 12 weeks, to ensure any new orders were transcribed to the medication administration record accurately. This audit will be documented on the activities of daily living audit tool. The monthly quality improvement/performance improvement (QAPI) committee will review the results of the activities of daily living audit tools	

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F 658	Continued From page 53 The March 2019 MAR revealed she received 10mg Buspar twice daily at 8:30am and 8:30pm from 3/1/19 to 3/31/19. On 4/1/19 at 3:54pm an interview occurred with the Unit Manager #1. She identified her signature dated 2/8/19 for the check on Resident #53's February physician orders. She reviewed the orders and February MAR stating that it was an oversight and normally such an error should have been caught and corrected. The Unit Manager #1 further stated she would complete a medication error report related to the situation and obtain a clarification order from the physician. On 4/1/19 at 430pm an interview was conducted with the Director of Nursing (DON). She stated it appeared there was an error during the February 2019 month end changeover resulting in Resident #53's Buspar being given twice daily instead of three times a day as ordered. During a phone interview with Nurse #5 on 4/3/19 at 11:30am she explained when she completed MAR checks for the end of the month changeover, she looked at the current MAR and orders for the past month. She added that she would not have looked back to the January MAR or December orders when she completed change over from Feb to March2019. During an interview with the DON on 4/4/19 at 3:20 she stated it was her expectation for orders to be transcribed correctly.	F 658	for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QAPI committee to the quarterly executive QAPI committee for further recommendations and oversight Date of compliance May 1, 2019.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		5/9/19

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F 677	Continued From page 54 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility failed to provide assistance to residents who required extensive to total care with eating, bathing, showers, personal hygiene, and/or nail care for 4 of 6 residents reviewed for the provision of activity of daily living (ADL) care (Residents #9, #51, #74, and #80). The findings included: 1. Resident #9 was admitted to the facility on 8/12/09 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) assessment dated 1/2/19 indicated Resident #9' s cognition was severely impaired. Resident #9 was dependent on 1 for eating. Resident #9 ' s active care plan included the focus area of assistance with eating. The interventions included total assist with eating. An observation was conducted of the dinner meal on the memory care unit where Resident #9 resided on 3/31/19. The meal trays arrived on the unit at 6:00 PM. There was one Nursing Assistant (NA), NA #10, assigned to the memory care unit. Resident #9 was observed to be laying in her room with her eyes closed on 3/31/19 at 6:05 PM when her meal tray was placed on her portable over the bed table by NA #10. This table was positioned next to the bed, outside of the resident ' s reach, and the cover remained on the	F 677	F677 The plan of correcting the specific deficiency On 4/23/19 resident #9 was observed by facility consultant being provided with meal assistance by facility certified nursing assistant (CNA) at the same time as resident #9's table mates. On 4/23/19 resident #51 was observed by facility consultant with all nails trimmed and without sharp edges. Nail care was provided by facility CNA and/or licensed nurse by observation on 4/23/19. Resident #74 was discharged from facility on 4/23/19. Resident # 80 refused shower on 4/22/19. Resident observed without facial hair on 4/24/19 by facility consultant. Resident # 8- was shaved by facility CNA on 4/24/19 prior to observation. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/24/219 the unit manager observed all residents for nail care. Any negative findings were addressed by unit manager during audit. On 4/24/2019 the unit manager observed the meal for all residents in the memory care unit to ensure residents were provided with assistance needed. No negative findings noted. On 4/22/2019 the unit manager audited all	

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F 677	Continued From page 55 tray. A continuous observation revealed that Resident #9 was not assisted with eating until 6:45 PM when NA #10 entered the room and began to provide total eating assistance for the resident. An interview was conducted with NA #10 on 4/3/19 at 5:30 PM. She stated that she was the only NA working on Resident #9 ' s unit on 3/31/19 during the 2nd shift. She indicated that there were 5 residents on that unit who required eating assistance and they were all eating in their rooms for dinner on 3/31/19. She stated that Medication Aide #2 was also on this unit during the dinner meal on 3/31/19, but that she had to stay in the memory care unit ' s dining room to provide supervision to the residents who ate in there. NA #10 revealed it was difficult to feed all of the residents who needed assistance with eating when she was the only NA. She further revealed that it took 40 minutes to provide Resident #9 with eating assistance on 3/31/19 because she was the only NA on Resident #9 ' s unit. An interview was conducted with the Director of Nursing (DON) on 4/4/19 at 3:15 PM. She indicated that she expected dependent residents to be assisted with Activity of Daily Living (ADL) care. She acknowledged that 40 minutes from the time a meal tray was served to the time the resident was assisted with eating was too long as it allowed opportunity for the meal to get cold which could be unappetizing to the resident causing them to eat less. The DON revealed that there were a few staff who had called off on 3/31/19 due to illness and/or other emergencies which left the facility with less staff than originally scheduled.	F 677	resident showers to ensure showers provided per schedule. Any negative findings were addressed by date by the resident being showered or refusal documented. On 4/24/2019 the unit manager audited all facial hair with no negative findings. On 4/18/19 the director of nursing began an in-service with nursing staff on providing assistance with activities of daily living including nail care, shaving, and showers. This in-service was completed on date. This in-service was added to the orientation for new nursing staff on 4/18/19 by the staff facilitator. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The unit manager will monitor 5 residents, 5 random days per week, to include weekend days and all meal times, for 12 weeks using the activities of daily living audit tool. Monitoring on the floors will include the shower schedule, shaving, nail care, a meal tray pass to ensure assistance is provided for eating. The Unit Managers will report continuing issues or concerns to the Director of Nursing if residents of not received the care. The Unit Managers and/or Director of Nursing will report to the Quality Assurance/Performance Improvement committee the effectiveness of the monitoring and identify any continuing issues. The monthly quality improvement (QI)	

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F 677	Continued From page 56 2. Resident #74 was admitted to the facility on 10/3/18 with diagnoses that included chronic obstructive pulmonary disease, spinal stenosis, muscle weakness, and unsteadiness on feet. The quarterly Minimum Data Set (MDS) assessment dated 1/10/19 indicated Resident #74 ' s cognition was intact. She had no behaviors and no rejection of care. Resident #74 was assessed as extensive assistance of 2 or more for transfers, extensive assistance of 1 with personal hygiene and dressing, and dependent on 1 for bathing. Resident #74 ' s active care plan included the focus areas of bathing, dressing, and personal hygiene. The interventions indicated Resident #74 was dependent on 1 for assistance with bathing and she required physical assistance with personal hygiene/grooming and dressing. An interview was conducted with Resident #74 on 3/31/19 at 4:35 PM. Resident #74 was dressed in a hospital gown. She reported that she normally was provided with her morning personal care which included a bed bath and changing her clothing once per day during the first shift. She stated that she had not received her morning care today (3/31/19) and she believed this was because the facility didn ' t have enough staff. Resident #74 indicated that she preferred to remain in the hospital gown, but she wanted to change into a clean gown as she had slept in the one she was wearing. A review was conducted on 4/4/19 of the Nursing	F 677	committee will review the results of the activities of daily living audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance performance improvement (QAPI) committee for further recommendations and oversight. Corrective action compliance date: May 9, 2019	

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Assistant (NA) bathing documentation for Resident #74 for 3/31/19. The documentation confirmed Resident #74 had not received any type of bathing (partial bed bath, full bed bath, shower) on 3/31/19.

An interview was conducted with NA #2 on 4/4/19 at 12:10 PM. She stated that she worked the 1st shift on 3/31/19 and was assigned to Resident #74. NA #2 indicated that she normally provided all of her residents with a full bed bath when she provided morning personal care when she worked the 1st shift. She reported that she had 22 assigned residents on 3/31/19 due to an NA calling off. She stated that she was not able to provide Resident #74 with any type of bathing and she had not changed Resident #74 ' s gown on 3/31/19 because of time limitations. NA #2 stated that NA #5 worked the 2nd shift on 3/31/19 and that she informed her that she had been unable to bath Resident #74.

An interview was conducted with NA #5 on 4/4/19 at 2:50 PM. NA #5 stated that she always provided her residents with a full bed bath during their morning personal care when she worked the 1st shift. She stated that she worked the 2nd shift on 3/31/19 and was assigned to Resident #74. She stated that she had not known Resident #74 was not provided with any type of bathing on 3/31/19 during the 1st. She denied that NA #2 reported this information to her. She stated that she had changed Resident #74 ' s gown during the 2nd shift on 3/31/19.

An interview was conducted with the Director of Nursing (DON) on 4/4/19 at 3:15 PM. She indicated she expected all residents to received assistance with Activity of Daily Living (ADL) care

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as required. The DON revealed that there were a few staff who had called off on 3/31/19 due to illness and/or other emergencies which left the facility with less staff than originally scheduled.

3a. Resident #80 was admitted to the facility on 12/7/17 with multiple diagnoses including dementia. The admission Minimum Data Set (MDS) assessment dated 2/28/19 indicated that Resident #80 had impaired cognition and needed extensive assistance with personal hygiene.

Resident #80's care plan dated 3/5/19 revealed that he required assistance with personal hygiene and bathing. The goal was for him to be neat, clean and odor free. The approaches included to offer showers and personal hygiene. The resident required 2 person assist at times and if he refused to offer bed bath.

On 3/31/19 at 3:59 PM, Resident #80 was observed in bed and he was unshaven. Another observation was conducted on 4/1/19 at 9:33 AM and at 1:50 PM and he was still unshaven.

On 4/1/19 at 1:55 PM, NA (Nursing Aide) #7, assigned to Resident #80, was interviewed. She stated that she didn't try to shave him because he always refused to be shaved and he only allowed NA #12 (shower aide) to shave him during his shower days every Tuesday and Friday. NA #7 had agreed that Resident #80 needed to be shaved.

On 4/1/19 at 1:56 PM, NA #12 was interviewed.

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She stated that the facility had a shower team consisting of 2 NAs and she was one of them. She stated that Resident #80's beard had grown fast and he needed to be shaved in between his shower days at least every 2 days. She reported that Resident #80 was scheduled to have a shower every Tuesday and Friday, however he was not provided a shower last Friday because she was pulled to work on the floor as NA and so the resident was not shaved that day. NA #12 also stated that Resident #80 did not refuse shower or personal hygiene but he would be cussing during the care. She reported that she had seen Resident #80 the morning of 4/1/19 and stated "he really needed to be shaved". At 3:05 PM, NA #12 reported that Resident #80 was already been shaved and he did not refuse but was cussing.

On 4/1/19 at 2:01 PM, Unit Manager (UM) #1 was interviewed. The UM reported that she had seen Resident #80 the morning of 4/1/19 and agreed that the resident needed to be shaved. She stated that she expected the NA assigned to shave the resident in between his shower days and if he refused to get another NA to shave him.

Interview with the Director of Nursing (DON) was conducted on 4/4/19 at 11:00 AM. The DON stated that she expected the staff to provide showers as scheduled and to provide personal hygiene as needed. The DON verified that the shower team was assigned to work on the floor lately but she expected the NA assigned to the resident to provide showers and personal hygiene to the resident.

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3b. Resident #80 was admitted to the facility on 12/7/17 with multiple diagnoses including dementia. The admission Minimum Data Set (MDS) assessment dated 2/28/19 indicated that Resident #80 had impaired cognition and was totally dependent with bathing.

Resident #80's care plan dated 3/5/19 revealed that he required assistance with personal hygiene and bathing and the goal was for him to be neat, clean and odor free. The approaches included to offer showers and personal hygiene. The resident required 2 person assist at times and if he refused to offer bed bath. The resident was scheduled to receive shower every Tuesday and Friday.

Review of the shower documentation revealed that Resident #80 did not receive a shower on 3/29/19 (Friday) and 4/2/19 (Tuesday).

On 4/1/19 at 1:56 PM, NA #12 was interviewed. She stated that the facility had a shower team consisting of 2 NAs and she was one of them. She reported that Resident #80 was scheduled to have a shower every Tuesday and Friday, however he was not provided a shower last Friday because she was pulled to work on the floor as NA. NA #12 also stated that Resident #80 did not refuse shower or personal hygiene but he would be cussing during the care.

On 4/4/19 at 11:00 AM, interview with the Director of Nursing (DON) was conducted. The DON stated that she expected the staff to provide showers as scheduled. The DON verified that the shower team was assigned to work on the floor lately but she expected the NA assigned to the resident to provide showers and personal hygiene

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to the resident.

On 4/4/19 at 1:55 PM, Unit Manager (UM) #2 was interviewed. The UM reported that last week, the shower team was assigned to work on the floor due to high staff turnover. He expected the NA assigned to the resident to provide shower as scheduled.

On 4/4/19 at 2:38 PM, NA #13 was interviewed. She stated that she was a member of the shower team. The shower team worked Monday through Friday except Wednesday (day off) from 5 AM to 3 PM to provide showers. Residents on A beds were provided showers every Monday and Thursday and B beds were provided showers every Tuesday and Friday. NA #13 reported that shower was not provided on Wednesday, Saturday or Sunday and after 3 PM. She revealed that starting last week, the shower team was pulled to work on the floor. She was assigned to Resident #80 on Tuesday (4/2/19) and she provided him a full bed bath and not a shower. She indicated that Resident #80 did not refuse shower that day. She further stated that shower was provided when there was time.

4. Resident #51 was admitted to the facility on 1/20/11 with the diagnoses of dementia, restlessness, and agitation.

A review of Resident #51's quarterly Minimum Data Set (MDS) dated 2/1/19 revealed the resident had severely impaired cognition with no speech and was rarely understood or understands. The resident required total dependence for all activities of daily living (ADLs). The active diagnosis was dementia.

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A review of Resident #51's care plan updated 2/6/19 revealed the resident was dependent and received total daily care which included cleaning and cutting her finger nails.

On 3/31/19 at 4:00 pm an observation revealed Resident #51 was in her bed. Her family was at the bedside visiting and commented that the resident's finger nails were long. The resident's finger nails were observed to be long on both hands. A family member commented that he was aware that the resident could resist and offered to hold the resident's hand (family member had not offered in the past). The family member stated he would inform staff about the long finger nails.

On 4/1/19 at 1:30 pm an interview was conducted with the Staff Development Coordinator (SDC) who stated she was aware and informed by the NAs that the resident had refused her personal and nail care. The family was made aware. The SDC was not aware that the family had offered to assist the staff so the resident could receive care. The SDC provided no other interventions for nail care at this time.

On 4/4/19 at 8:30 am an interview was conducted with NA #5 who stated she was regularly scheduled to care for Resident #51. NA #5 commented that the resident's nails were long and would not allow staff to cut her nails. NA #5 further commented that the nails were not pressing on the resident's palms when her hands were closed. NA #5 stated she was not aware the resident had a care plan intervention to cut her nails to prevent accidental scratching. NA #5 stated she would inform the nurse of the resident's refusal and no further action was taken.

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F 677	Continued From page 63 On 4/4/19 at 8:30 am an observation was done of Resident #51's finger nails on both hands which remained long and were now dirty. An interview was conducted on 4/4/19 at 4:00 pm with the Director of Nursing (DON) who commented that Resident #51 could be resistive to care and that was the resident ' s right to refuse. The DON provided nurses' notes dated February 2019 that the resident declined nail care. The DON agreed that the resident needed additional intervention to provide nail care and to allow the continued refusal without additional intervention was not appropriate. The DON stated that she expected staff to provide ADL care for dependent residents.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff, resident, Family Nurse Practitioner, and physician interview, the facility failed to follow the physician order for orthopedic consultation and sling placement until orthopedic consultation (Resident #22) for 1 of 1 resident reviewed. Findings included:	F 684	F684 For residents affected by the issue: On 4/1/19 the facility Medical Director discontinued the sling order and ordered an x-ray of the affected arm. Also, the resident was scheduled for a routine orthopedic appointment. The resident had follow up appointment on 4/10/19 with the	5/1/19

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F 684	Continued From page 64 Resident #22 was admitted to the facility on 5/15/18 with diagnoses of unspecified abnormalities of gait and age-related osteoporosis. A review of Resident #22's annual Minimum Data Set (MDS) dated 1/8/18 revealed the resident had a severely impaired cognition. The resident required extensive assistance of 1 staff for transfers, dressing, and toileting. The active diagnoses were arthritis, osteoporosis, and difficulty walking. A review of Resident #22's care plan updated on 12/24/18 revealed a focus and interventions for potential for and history of falls. Resident #22's nurses note dated 12/18/2018 at 1:42 pm documented that the resident was found lying on the floor crying out for help. The resident was assessed for injuries and none were noted. Pain medication was administered with effective results. Resident #22 nurses' note dated 12/21/2018 at 11:00 am documented the resident was assessed and noted right shoulder to be asymmetrical with her left shoulder. The resident could not lift her right arm without pain. The Family Nurse Practitioner (FNP) assessed the resident and determined she should be seen in the Emergency Room (ER). The Family Nurse Practitioner (FNP) progress note dated 12/21/18 documented Resident #22 had deformity and limited range of motion (ROM) of the left shoulder noted, send to ER. The diagnosis was recent fall with significant injury.	F 684	orthopedic physician. The resident was given an injection for osteoarthritis on 4/10/19. Other potentially affected residents: : The unit managers, staff facilitator, and director of nursing audited orders for the past 30 days to assure orders or referrals for resident care were implemented. Audit completed 4/29/19 with no negative findings. Measures implemented: Upon a resident returning to the facility from an outside appointment or emergency room visit, the paperwork for the visit and potential orders will be given to a nurse on-duty. The receiving nurse will review the paperwork/orders for any new or changed recommendations and contact the resident physician to obtain a telephone order. Once the order is obtained from the resident's physician the nurse will transcribe the orders appropriately. Licensed nurses will in-serviced by April 29, 2019 on the process by the director of nursing and staff facilitator. This in-service will be added to new employee orientation for nurses. Monitoring to maintain compliance: The night shift nurses implemented a 24 hour chart audit to assure that new orders are implemented and placed on appropriate record such as the treatment record. A new nightly 24 hour chart check audit tool that was implemented will be reviewed each morning by the Director of Nursing. The audit tool will be compared with the previous day's resident's appointments in the morning stand-up meeting to identify residents that may have new orders. The	

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F 684	Continued From page 65 A review of Resident #22's ER note dated 12/21/19 revealed she fell three days ago at the facility transferring. There was a history of osteoporosis. The resident was noted not using her right arm today as usual. X-ray report revealed fracture of right humerus with non-union that was subacute and chronic appearing. The physician recommended orthopedic consultation. Resident #22 had a physician order dated 12/21/18 for the resident to wear a right arm sling for humerus fracture. No discontinuance of order was identified. The FNP follow up noted dated 12/27/18 revealed the resident had a sling and swathe to the right shoulder. The diagnoses were displaced fracture of right humerus and shoulder pain caused by fall with significant injury. A review of Resident #22's X-ray report dated 4/1/19 findings were a proximal humerus fracture with soft tissue swelling, displacement and angulation. No erosions were demonstrated. Observation of Resident #22 on 3/31/19 and 4/1/19 revealed the resident was not wearing the right arm sling. On 4/1/19 at 4:00 pm an interview was conducted with Nurse #2 who was unaware of the resident's history because "I have not had her for a while" and received no information regarding the resident's right arm fracture or sling in report. Nurse #2 observed the resident who was not wearing the right arm sling. On 4/2/19 at 9:45 am an interview was conducted with Resident #22's physician who stated that the resident had osteoporosis with history of	F 684	Director of Nursing will review the 24 hour chart checks daily (5 days a week) for 12 weeks. Identified missing orders will be corrected when found. Ongoing issues with transcription will be identified and plan put into place to correct. The Director of Nursing will report to the Quality Assurance/Performance Improvement committee the effectiveness of the monitoring and identify any continuing issues. Corrective action compliance date: May 1, 2019	

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pathological fractures of the spine and had been seen by an orthopedist in the past. In December 2018 the resident fell (12/18/18), was sent to the ER due to pain (12/21/18), and the radiograph report indicated that the resident sustained a right humerus displaced fracture. The physician stated he ordered for a sling and expected his FNP to order an orthopedic consultation to evaluate the right humerus fracture. The physician stated that he was informed by the facility yesterday (after surveyor asked for orthopedic progress notes) that the orthopedic consult was not completed in December 2018 when requested, and the resident had not seen an orthopedist as ordered to date 4/2/19. The physician stated that he ordered an x-ray of the resident's right humerus 4/1/19 and the radiograph reading was chronic fracture. The physician stated that he expected staff to ensure that the resident wore her right arm sling as ordered for 4 to 6 weeks until the resident saw the orthopedist for recommended treatment. The physician stated that the care provided to Resident #22's right arm fracture was a drop in the standard of care and that the failure to have treatment by the orthopedist could have caused the chronic fracture, but it was hard to tell due to the osteoporosis and prior history of pathological fracture. The right arm humerus fracture was not pathological. There would need to be an orthopedic consultation to determine if the fracture could be reduced. The physician commented that at this late date with the right arm humerus chronic fracture, prior history of pathological fracture, and osteoporosis, he was not sure that anything could be done and if it would have changed the outcome. The physician stated that the resident would have an orthopedic consultation order today.

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An interview was conducted on 4/2/19 at 10:00 am with the Director of Nursing (DON) who stated that there have been transcription errors in the facility and an audit was underway. Resident #22's sling placement/documentation on the MAR was not transcribed from December 2018 to January 2019 and the resident did not have her sling placed. The resident's orthopedic consult was not transcribed and subsequently not done.

An interview was conducted on 4/2/19 at 10:45 am with Resident #22's family member who stated the resident had fallen in the past and fractured the right arm about 2 years ago before admission to the facility. The resident had limited use of the right arm before the fall and was now barely using the right arm. The family member commented that the resident continued to try and get up on her own after family and staff have asked her not to.

On 4/2/19 at 1:00 pm an interview was conducted with the FNP who stated she wrote a plan in her progress note for Resident #22 to have an orthopedic consultation for the right arm on 12/21/18 and the resident had a recommendation in her ER discharge summary that the resident required orthopedic follow up. The FNP expected the staff to obtain an orthopedic consultation from her notes and the ER discharge summary when the resident returned from the hospital.

On 4/2/19 at 12:36 pm an interview was attempted with the nurse present when Resident #22 fell on 12/18/18 (no longer employed at the facility) with no success.

An interview was conducted on 4/2/19 at 12:30

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pm with the Radiologist who read the 4/1/19 x-ray for Resident #22's right arm. The right arm fracture was chronic and old. The radiograph from 12/21/18 that read subacute and chronic was defined as not a new fracture. The resident probably reinjured or aggravated an existing fracture, had osteoporosis and had history of pathological fractures.

On 4/2/19 at 12:45 pm an interview was conducted with Nurse #3 who stated she had assessed Resident #22 on 12/19/18 the day after her fall and the resident's body was assessed and no bruising was found, and the resident had not complained of pain. Nurse #3 did not document if range of motion (ROM) was assessed. The resident was not guarding her arm. The resident had a history of right shoulder surgery and did not appear to be using the right arm any different. Nurse #3 stated that on 12/21/18 the resident's right arm was noted by a Nursing Assistant (NA) to have a deformity and the FNP was notified. The resident was sent to the ER and a subacute, chronic fracture of the right humerus was reported. The resident's January 2019 MAR did not have the sling order transcribed and there was no documentation that the staff placed the sling. If there was no documentation, the sling was not placed. Nurse #3 was aware there was a physician order for the resident to wear a right arm sling after her fall due to fracture/pain.

An interview was conducted on 4/2/19 at 10:00 am with the DON who stated that there were multiple transcription errors contributing to omissions of the physician order and an audit was in place. The DON further stated that she expected staff to follow the physician order.

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F 688	Continued From page 69	F 688		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and family interview, the facility failed to provide care and services to prevent further contracture (Resident #51) for 1 of 5 residents reviewed for position and mobility. Findings included: Resident #51 was admitted to the facility on 1/20/11 with the diagnoses of dementia, contractures of both hips and knees and involuntary movement of the extremities. A review of Resident #51's therapy notes revealed the last treatment was 10/31/18 for wheel chair evaluation and post fall.	F 688	F688 For residents affected by the issue: A therapy referral was placed and on 4/7/18 an occupational therapy assessment was completed on the resident. The occupational therapist and created a plan of care to develop a restorative program specific for the resident for upper extremities. On 4/22/19 the physical therapist completed an evaluation and found no contractures were present in the hips and lower extremities. The resident was freely moving the lower extremities. Other potentially affected residents: The licensed nurses are auditing the other residents for contractures or risk of a	5/9/19

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F 688	Continued From page 70 A review of Resident #51's quarterly Minimum Data Set (MDS) dated 2/1/19 revealed the resident had severely impaired cognition with no speech and was rarely understood or understands. The resident required total dependence for all activities of daily living (ADLs). The active diagnoses were contractures of hips and knees, restless leg syndrome, and extrapyramidal and movement disorder (involuntary movement of the extremities). A review of Resident #51's care plan updated 2/6/19 did not reveal documentation which addressed a focus, goal or intervention for range of motion and prevention of further contractures. There was a focus for total dependence on staff for ADLs. On 3/31/19 at 4:30 pm Resident #51 was observed to have moderate contractures to her both knees and hips. The resident was also noted to have involuntary and purposeful movement of all her extremities. On 3/31/19 at 4:30 pm an interview was conducted with the family who stated the resident "was not moving." She was frequently in the bed and getting stiffer. On 3/31/19 at 4:35 pm an interview was conducted with Nursing Assistant (NA) #5 who stated that Resident #51 had involuntary movements of her extremities and was not currently receiving restorative nursing for passive range of motion (PROM) and had been a long time since the resident had physical therapy services (several months). NA #5 thought the resident ' s contractures were "about the same."	F 688	contracture. Audit revealed one other resident with potential risk. Referral to therapy of at risk resident was be completed on 4/29/19. Measures implemented: The Director of Nursing on 4/18/19 in-serviced the nursing staff that changes in resident range of motion is communicated to the nurse on their floor and a therapy referral made. Additionally, residents currently on a restorative program must be documented following resident care. Monitoring to maintain compliance: Monitoring to maintain compliance: The Minimum Data Set (MDS) nurse, unit manager, staff facilitator, and/or director of nursing will review and observe 5 residents 5 times per week on random days (to include weekends) and random times (to include all shifts) to monitor documentation by nursing staff for restorative care, including splints/braces applied as ordered. Residents on a restorative program that are not being documented on will be identified and nursing staff follow up to assure care is completed and documented. This audit will be documented on the activities of daily living audit tool. Weekly audit of 2 residents by the unit manager will be completed for 12 weeks to identify other residents at risk for contractures. Potential at risk residents will be identified by the unit manger audit and discussed in morning meeting and referral given to the therapy department during the morning meeting. The audit tool used will be the activities of daily living audit tool. The Director of Nursing will report to the	

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F 688	Continued From page 71 On 4/3/19 at 12:30 pm an interview was conducted with NA #1 who stated that Resident #51 was not currently receiving PROM or restorative nursing services by the NAs. The process for a resident to receive restorative nursing was NAs were now responsible for PROM after therapy services were completed. The NAs had received education and two NAs were champions for the service. A Physical Therapist would make the recommendation. On 4/3/19 at 2:40 pm an interview was conducted with the Therapy Manager who stated that Resident #51 has not had therapy services for a long time (several months) and was not currently receiving preventative contracture prevention by therapy services. The Therapy Manager agreed that a resident's contractures could worsening without PROM. The resident had a new wheel chair that was padded to accommodate the extremity movement and jerking and to prevent injury. The resident was currently not receiving restorative NA for PROM contracture care. The Therapy Manager did not know if there was a plan in place by nursing for restorative nursing. The process was for restorative nursing services to be provided by the NA staff after physical or occupation therapy services were completed. The Therapy Manager suggested checking with the NAs. An interview was conducted on 4/4/19 at 4:00 pm with the Director of Nursing (DON) who stated that she expected staff to provide care and services to prevent the start of or worsening contractures.	F 688	Quality Assurance/Performance Improvement committee the effectiveness of the monitoring and identify any continuing issues. Corrective action compliance date: May 9, 2019	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		5/9/19

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F 689	Continued From page 72 §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 staff interview, the facility failed to implement fall prevention interventions, and also failed to thoroughly investigate and analyze falls to determine causative factors and implement appropriate interventions to reduce the risk of further falls for 1 of 5 residents reviewed for falls. Resident #28 sustained 10 falls in 5 months with 2 of these falls resulting in multiple staples to her head. The findings included: Resident #28 was admitted to the facility on 12/21/17 with diagnoses that included Alzheimer's, schizophrenia, unsteadiness on feet, and repeated falls. The quarterly Minimum Data Set (MDS) assessment dated 12/26/18 indicated Resident #28's cognition was severely impaired. Resident #28 required the extensive assistance of 2 or more for bed mobility, dressing, toileting, and personal hygiene and the extensive assist of 1 for transfers. She was assessed as requiring supervision of 1 for walking in room and locomotion on the unit and supervision with set up help only for walking in corridor. Resident #28 was not steady on her feet, but she was able to stabilize without staff assistance.	F 689	F689 The plan of correcting the specific deficiency Resident # 28 was reviewed by the falls committee which included nursing, administrator, and therapy on 4/29/2019. The review included root cause analysis of falls, and care plan implementation (interventions in place and accurate for resident status). Plan of care was not changed at that time. The procedure for implementing the acceptable plan of correction for the specific deficiency cited Residents with falls in the past 7 days were reviewed by the facility consultant for trends, causative factors, interventions, and care plan updates or reviews on 4/24/19 with no negative trends noted. Systemic change The facility will begin a weekly falls committee meeting 4/29/19 to identify the root cause and complete an analysis of resident patterns of falls, interventions, injuries and needs. Residents that present with multiple falls will be added to the fall committee weekly review. On 4/18/19 the director of nursing	

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F 689	Continued From page 73 Resident #28 ' s care plan included the focus area of the risk for falls characterized by a history of falls and injury. This area was initiated on 12/22/17 and the interventions included: - Bed in lowest position (initiated 12/22/17) - Encourage resident to take rest periods as needed when ambulating (initiated 4/2/18) - Rehabilitation therapy referral as needed (initiated 6/5/18) - Evaluate effectiveness and side effects of psychotropic drugs and other medications with physician for possible decrease in dosage/elimination of medication (initiated 12/22/17 and revised 6/7/18) - Resident to wear proper non-slip footwear (initiated 6/7/18) - Provide diversional activities (initiated 6/7/18) - Have commonly used items within reach (initiated 6/18/18) - Encourage resident to participate in activities that promote exercise and physical activity for strengthening and improved mobility (initiated 6/21/18) - Toilet resident frequently as needed and prior to going to bed at night (initiated 6/22/18 and revised 6/25/18) - Encourage resident to take rest periods as needed when resident was pacing a lot. Offer resident snacks and pain medication as needed. (initiated 4/30/18 and revised 6/25/18) - Assist during transfer and mobility. Anticipate needs and intervene when resident was bending, stooping and/or reaching (initiated 6/25/18) - Keep wheelchair within reach of the resident with anti-rollbacks (initiated 4/30/18 and revised 7/27/18) - Observe for potential medication side effects	F 689	in-serviced the nursing staff on fall investigation including scene evaluation, contributing factors, and root cause. This in-service was added to the orientation of new nursing staff on 4/18/19 by the staff facilitator. On 4/11/2019 Leadership staff and nursing leadership were in-serviced on root cause analysis by the administrator. Staff were given the root cause analysis matrix for use in identifying resident patterns or other root cause analysis focus areas. In the daily morning meetings, the administrator has lead discussion on root cause analysis discussion using varying topics. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The facility will implement a weekly falls committee meeting to review residents with multiple falls and identify root cause and potential implementations. The facility will continue the weekly falls committee meeting for at least 12 weeks and potentially longer. If deemed appropriate, the falls committee may reduce to a monthly meeting after the 12 weeks. The unit manager and/or director of nursing will review all falls weekly x 12 weeks to ensure fall interventions were in place based on the care plan at the time of the fall, and a fall investigation has been completed. This audit will be documented on the falls audit tool. The Director of Nursing will report to the Quality Assurance/Performance	

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F 689	Continued From page 74 that may increase risk for falls (initiated 9/4/18) - Provide frequent staff observation of resident (initiated 9/10/18) - Ensure environment free of clutter (initiated 9/10/18) - Encourage resident to use handrails or assistive devices properly (initiated 10/8/18) - Keep call light within reach and answer timely (initiated 10/15/18) An incident report dated 10/20/18 completed by Nurse #7 indicated Resident #28 had unwitnessed fall on 10/20/18 at 10:50 AM that resulted in small bump to the left side of her forehead. Resident #28 was found lying on her left side in front of her wheelchair on the floor in the hallway of the memory care unit. The fall investigation checklist form dated 10/20/18 completed by Nurse #7 indicated the new intervention that was put into place to prevent a repeat fall was to add anti-rollbacks to Resident #28's wheelchair. This checklist indicated that the 10/20/18 fall for Resident #28 was reviewed on 10/22/18 during the morning meeting and the fall investigation was signed as complete by Unit Manager (UM) #1. The investigation follow up form, undated and unsigned, indicated Resident #28 had a fall on 10/20/18 at 10:50 AM. Resident #28 used a wheelchair with no pedals and was able to self-propel the wheelchair and to ambulate independently. She was noted with no safety awareness related to Alzheimer's. The interventions to prevent reoccurrence indicated that Resident #28 was to be encouraged to take frequent rest periods and to sit in wheelchair.	F 689	Improvement committee the effectiveness of the monitoring and identify any continuing issues. The monthly QI committee will review the results of the fall intervention audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight Corrective action compliance date: May 9, 2019	

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Anti-rollbacks were to be put into place on Resident #28's wheelchair to stabilize it for her.

Resident #28's care plan related to falls was updated on 10/23/18 with the intervention of anti-rollbacks on wheelchair. This was a repeat intervention as it was initiated on Resident #28's care plan on 4/30/18.

A fall risk assessment dated 10/23/18 indicated Resident #28 was at high risk for falls.

A work order dated 10/24/18 completed by UM #1 indicated anti-rollbacks were to be added to Resident #28's wheelchair. This work order indicated the anti-rollbacks were added on 10/25/18.

A phone interview was conducted with Nurse #7 on 4/3/19 at 2:43 PM. Nurse #7 stated that the nurse assigned to the resident at the time of the fall completed an incident report and initiated the fall investigation checklist form. She explained that this form had a question on it about what new interventions were going to be implemented to prevent repeated falls. Nurse #7 further explained that sometimes she had a tough time answering this question if it was related to a resident who already had multiple interventions in place. She reported that if she was unable to think of an appropriate intervention that she left this question blank and let one of UMs determine what new intervention was appropriate. The incident report, investigation checklist, and investigation follow up form that indicated anti-rollbacks were to be implemented for Resident #28 after the 10/20/18 fall were reviewed with Nurse #7. The care plan that

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indicated that the intervention of anti-rollbacks was already in place on Resident #28's care plan (initiated on 4/30/18 and last revised 7/27/18) was reviewed with Nurse #7. Nurse #7 stated she believed one of the UMs had added that intervention onto the investigation checklist. She was unable to recall with certainty if Resident #28's wheelchair had anti-rollbacks at the time of the 10/20/18. She indicated that if it was noted as a new intervention that the anti-rollbacks were probably not in place on Resident #28's wheelchair.

An interview was conducted with UM #1 on 4/2/19 at 2:40 PM. UM #1 stated the nurse assigned to the resident at the time of the fall completed an incident report and initiated the fall investigation checklist form. She reported this nurse was supposed to identify a new fall prevention intervention that related to the fall. She stated that during the morning meetings on Mondays through Fridays all falls were reviewed with management staff and she and UM #2 were responsible for ensuring the investigation checklist was completed and that a new fall prevention intervention was identified. UM #1 was asked if the investigation into the fall included a review of the current fall prevention interventions to ensure they were in place. She stated that the investigation should include a review of this information. The incident report, investigation checklist, and investigation follow up form that indicated anti-rollbacks were to be implemented for Resident #28 after the 10/20/18 were reviewed with UM #1. The work order that indicated anti-rollbacks were added to Resident #28's wheelchair on 10/25/18 was reviewed with UM #1. The care plan that indicated the intervention of anti-rollbacks was already in place

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on Resident #28 ' s care plan (initiated on 4/30/18 and last revised 7/27/18) at the time of her 10/20/18 fall was reviewed with UM #1. UM #1 was unable to explain why Resident #28's anti-rollbacks were not in place at the time of her 10/20/18 fall when this intervention was already on her care plan. She was also unable to explain why the investigation failed to identify that this care planned intervention had not been implemented.

An incident report dated 11/5/18 completed by Nurse #8 indicated Resident #28 had a witnessed fall on 11/5/18 at 10:10 AM that resulted in a "knot" to the right back of her head. Resident #28's Nursing Assistant (NA) reported that while she was giving Resident #28 a bed bath the resident stood up and fell. The NA was noted as NA #8.

The fall investigation checklist form dated 11/5/18 completed by Nurse #8 indicated the new intervention that was put into place to prevent a repeat fall for Resident #28 was to "watch during bathing". The section on this checklist that provided a date the fall was reviewed during the morning meeting was blank and there was no signature by UM #1 or UM #2 to indicate the investigation was complete.

A phone interview was attempted on 4/3/19 at 9:04 AM with Nurse #8 but she was unable to be reached.

A phone interview was attempted on 4/3/19 at 9:05 AM with NA #8 but she was unable to be reached.

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An interview was conducted with UM #1 on 4/2/19 at 2:40 PM. The incident report and the fall investigation checklist form that was partially completed for Resident #28's 11/5/18 fall were reviewed with UM #1. The new intervention identified on the fall investigation checklist that stated "watch during bathing" was reviewed with UM #1. UM #1 verified that this investigation checklist was incomplete, but she was unable to provide an explanation as to why. She revealed that NA #8 should not have turned her back on Resident #28 while she was giving her a bed bath. She further revealed that "watch during bathing" was not a new intervention as this should have been normal protocol for the NA while bathing Resident #28. UM #1 was unable to recall if any re-education had been provided to NA #8 after this incident. She stated that NA #8 was no longer employed at the facility.

A physician's note dated 11/19/18 indicated Resident #28 was a fall risk related to mobility impairment. He reported that because of Resident #28's dementia there was a slow physical decline which required frequent monitoring as well as preventative measures to prevent falls with potential injuries or fractures. The physician wrote that Resident #28's had multiple comorbid factors that created poor activity endurance while performing essential activities of daily living without assistance which made safety a priority for Resident #28.

An incident report dated 12/2/18 completed by Nurse #9 indicated Resident #28 had an unwitnessed fall on 12/2/18 at 10:39 PM. Resident #28 was found on the floor, sitting on her buttocks, with bleeding noted to the back of

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her head. She was sent to the Emergency Room (ER) for evaluation.

An ER note dated 12/2/18 indicated Resident #28 had laceration to her scalp 2 centimeters (cm) in length and 3 millimeters (mm) in depth. The laceration was repaired with 4 staples.

The fall investigation checklist form dated 12/2/18 completed by Nurse #9 indicated the new intervention that was put into place to prevent a repeat fall for Resident #28 was "observe and intervene for causative factors". This checklist indicated that the 12/2/18 fall for Resident #28 was reviewed on 12/3/18 during the morning meeting and the fall investigation was signed as complete by UM #2.

The care plan for Resident #28 related to falls was revised on 12/4/18 with the new intervention to "observe and intervene for factors causing falls ...".

A phone interview was conducted with Nurse #9 on 4/3/19 at 8:49 AM. Nurse #9 stated that the nurse assigned to the resident at the time of the fall completed an incident report and initiated the fall investigation checklist form. She stated that she never completed the question that asked about new interventions on the Investigation checklist. She reported she left this question blank and that UM #1 or UM #2 answered the question. The incident report for Resident #28's 12/2/18 fall was reviewed with Nurse #9. The fall investigation checklist that indicated the new intervention that was implemented was "observe and intervene for causative factors" was reviewed with Nurse #9. Nurse #9 stated that this intervention was already in place as the staff were

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supposed to be observing Resident #28 and trying to figure out the cause of every fall.

An interview was conducted with UM #2 on 4/2/19 at 3:08 PM. The incident report and the fall investigation checklist form for Resident #28's 12/2/18 fall were reviewed with UM #2. The new intervention identified on the fall investigation checklist that stated "observe and intervene for causative factors" was reviewed with UM #2. UM #2 acknowledged that the intervention of observing Resident #28 and trying to figure out the cause of her falls was not a new intervention as this was normal procedure for all resident falls. He revealed that he was aware the interventions noted on the investigation checklists were not always related to the fall that occurred. He indicated it was an ongoing process to educate the nurses on how to properly fill out the investigation checklist form.

An incident report dated 1/13/19 completed by Nurse #14 indicated Resident #28 had an unwitnessed fall on 1/13/19 at 10:13 PM. Resident #28 was found in the hallway, seated on her buttocks, with bleeding noted to the right side of her scalp. She was sent to the ER for evaluation.

An ER note dated 1/13/19 indicated Resident #28 had a laceration to her scalp 2 cm in length. The laceration was repaired with 5 staples.

The fall investigation checklist form dated 1/13/19 completed by Nurse #14 indicated the new intervention that was put into place to prevent a repeat fall was to assist Resident #28 with ambulation when in the hallway and to direct to an activity. This checklist indicated that the

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1/13/19 fall for Resident #28 was reviewed on 1/14/19 during the morning meeting and the fall investigation was signed as complete by UM #1.

A phone interview was attempted on 4/3/19 at 9:08 AM with Nurse #14 but she was unable to be reached.

An incident report dated 1/17/19 completed by Nurse #7 indicated Resident #28 had an unwitnessed fall with no injury in the dining room of the memory care unit on 1/17/19 at 8:40 AM. Resident #28 was found lying on the floor on her back in the dining room on the memory care unit.

The fall investigation checklist form dated 1/17/19 completed by Nurse #7 indicated the new intervention that was put into place to prevent a repeat fall for Resident #28 was to observe routinely for needs. This checklist indicated that the 1/17/19 fall for Resident #28 was reviewed on 1/18/19 during the morning meeting and the fall investigation was signed as complete by UM #2 on 1/21/19.

A phone interview was conducted with Nurse #7 on 4/3/19 at 2:43 PM. The incident report related to the 1/17/19 fall for Resident #28 was reviewed with Nurse #7. The investigation checklist form that identified the new intervention of observing Resident #28 routinely for needs was reviewed with Nurse #7. Nurse #7 reported that this was not a new intervention as staff had to frequently monitor Resident #28 at all times.

An interview was conducted with UM #2 on 4/2/19 at 3:08 PM. The incident report and the fall investigation checklist form for Resident #28 ' s 1/17/19 fall were reviewed with UM #2. The new

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intervention identified on the fall investigation checklist that stated "observe routinely for needs" was reviewed with UM #2. UM #2 acknowledged that the intervention of observing Resident #28 routinely for needs was not a new intervention as staff were expected to observe all residents routinely for needs.

An incident report dated 1/20/19 completed by Nurse #10 indicated Resident #28 had an unwitnessed fall with no injury in the television room on the memory care unit on 1/20/19 at 11:44 AM.

The fall investigation checklist form dated 1/20/19 completed by Nurse #10 indicated Resident #28 was reaching for a cup when she fell. The new intervention that was put into place to prevent a repeat fall was to transfer and change position slowly. This checklist indicated the 1/20/19 fall for Resident #28 was reviewed on 1/21/19 during the morning meeting and the fall investigation was signed as complete by UM #1.

The care plan related to falls for Resident #28 was updated on 1/21/19 with the interventions of "transfer and change position slowly" and "observe resident routinely for needs".

The care plan related to falls for Resident #28 was updated on 1/22/19 with the intervention of "assist to ambulate when in hallway and direct to an activity".

A phone interview was conducted with Nurse #10 on 4/3/19 at 9:15 AM. Nurse #10 stated that the nurse assigned to the resident at the time of the fall completed an incident report and initiated the fall investigation checklist form. She revealed

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that she had just received education on 4/2/19 from UM #1 on how to properly fill out the fall investigation checklist form and how to develop new interventions that correlated with the cause of the fall in an effort to prevent a repeat fall. She further revealed that prior to 4/2/19 she had not understood how to fill out the fall investigation checklist form correctly. The incident report related to the 1/20/19 fall for Resident #28 was reviewed with Nurse #10. The investigation checklist form that identified the new intervention of transferring and changing positions slowly was reviewed with Nurse #10. Nurse #10 stated that this new intervention about transferring and changing positions was not related to the 1/20/19 fall for Resident #28. She reported that Resident #28 had dropped her cup on the floor and fell when she was reaching for it.

An interview was conducted with UM #1 on 4/2/19 at 2:40 PM. The incident report and the fall investigation checklist form for Resident #28 ' s 1/20/19 fall were reviewed with UM #1. The new intervention to transfer and change position slowly that was identified on the fall investigation checklist was reviewed with UM #1. UM #1 was unable to explain how this intervention correlated to Resident #28's 1/20/19 fall.

An incident report dated 2/5/19 completed by Nurse #9 indicated Resident #28 had an unwitnessed fall in her room with no injury on 2/5/19 at 6:01 AM. Resident #28 was found lying on her right near her bed.

The fall investigation checklist form dated 2/5/19 completed by Nurse #9 indicated the new intervention that was put into place to prevent a repeat fall for Resident #28 was adequate lighting

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and leaving the bathroom light on. This checklist indicated that the 2/5/19 fall for Resident #28 was reviewed on 2/6/19 during the morning meeting and the fall investigation was signed as complete by UM #1.

The care plan related to falls for Resident #28 was updated on 2/6/19 with the new intervention of adequate environmental lighting in resident's room and bathroom.

A phone interview was conducted with Nurse #9 on 4/3/19 at 8:49 AM. The incident report for Resident #28's 2/5/19 fall was reviewed with Nurse #9. The fall investigation checklist that indicated the new interventions implemented for adequate lighting and keeping Resident #28's bathroom light on were reviewed with Nurse #9. Nurse #9 stated that she had not written that intervention. She indicated that it would've been dark in Resident #28's room at the time of the 2/5/19 fall (6:01 AM) and maybe the resident couldn't see what she was doing. She added that Resident #28 was able to get up from bed independently, but that she never went to the bathroom on her own.

An incident report dated 2/10/19 completed by Nurse #14 indicated Resident #28 had an unwitnessed fall on 2/10/19 at 6:00 AM. Resident #28 was found lying on the floor beside her bathroom door. Her right eye was noted to be purple with bruising noted to the face and right deltoid. Resident #28 was sent to the ER for evaluation.

An ER note dated 2/10/19 indicated the evaluation of Resident #28 resulted in no treatment changes and required no surgical

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interventions.

The fall investigation checklist form dated 2/10/19 completed by Nurse #14 for the 6:00 AM fall left the question about new interventions blank. This checklist indicated that the 2/10/19 fall for Resident #28 was reviewed on 2/11/19 during the morning meeting and the fall investigation was signed as complete by UM #1.

A phone interview was attempted on 4/3/19 at 9:08 AM with Nurse #14 but she was unable to be reached.

An incident report dated 2/10/19 completed by Nurse #11 indicated Resident #28 had an unwitnessed fall with no injury on 2/10/19 at 6:37 PM in the dining room of the memory care unit. Resident #28 was in her wheelchair in the dining room as Nurse #11 was preparing trays. A "thump" was heard and Nurse #11 then saw Resident #28 on the floor in front of her wheelchair.

The fall investigation checklist form dated 2/10/19 completed by Nurse #11 for the 6:37 PM indicated the new interventions that were put into place to prevent a repeat fall were for Resident #28's wheelchair to be locked when she attempted to ambulate, toilet as needed, and monitor closely. This checklist indicated that this 2/10/19 fall for Resident #28 was reviewed on 2/11/19 during the morning meeting and the fall investigation was signed as complete by UM #1.

A phone interview was conducted with Nurse #11 on 4/3/19 at 9:11 AM. The incident report related to the 2/10/19 fall at 6:37 PM for Resident #28 was reviewed with Nurse #11. The investigation

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checklist form that identified the new interventions of Resident #28's wheelchair to be locked when she attempted to ambulate, toilet as needed, and monitor closely were reviewed with Nurse #11. Nurse #11 stated that she had written these interventions on the checklist. She indicated she was still learning how to fill out the form properly at that time. She revealed that after this checklist was turned in, she received re-education from the Director of Nursing (DON) and UM #1 on how to develop an intervention that related to the fall.

An incident report dated 2/21/19 completed by Nurse #7 indicated Resident #28 had a witnessed fall with no injuries on 2/21/19 at 10:50 AM. Resident #28 was observed walking in the hall while another resident was in her pathway and she slowly fell to the floor.

The fall investigation checklist form dated 2/21/19 completed by Nurse #7 indicated the new intervention that was put into place to prevent a repeat fall was to "make sure environment is free of clutter including other residents". This checklist indicated that this 2/21/19 fall for Resident #28 was reviewed on 2/22/19 during the morning meeting and the fall investigation was signed as complete by UM #1.

The care plan related to falls for Resident #28 was revised on 3/6/19. The previous intervention, initiated on 9/10/18, of ensuring Resident #28's environment was free of clutter was updated to include the environment also being free of people in her path.

A phone interview was conducted with Nurse #7 on 4/3/19 at 2:43 PM. The incident report related to the 2/21/19 fall for Resident #28 was reviewed

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with Nurse #7. The investigation checklist form that identified the new intervention of ensuring the environment was free of clutter and people was reviewed with Nurse #7. Nurse #7 stated that she believed this fall happened at the time other residents were returning from an activity so there were a lot of people in the hallway. She explained that the intent of the intervention was to keep Resident #28 clear of the hallway when it was known there was going to be a lot of people moving about.

An observation was conducted of Resident #28 on 4/3/19 at 3:40 PM. Resident #28 was self-propelling in her wheelchair throughout the hallway of the memory care unit. She independently propelled her wheelchair from one end of the unit to the other, maneuvered her wheelchair to face the opposite direction, and then propelled back to the other end of the unit. The care planned fall prevention interventions were observed to be in place at the time of this observation.

An interview was conducted with the DON on 4/2/19 at 3:10 PM. She acknowledged that the facility's fall investigation process had not included analyzing the pattern of falls as a whole in an attempt to drill down to the root cause. She additionally acknowledged that the interventions noted on the investigation checklist were not always related to that specific fall.

On 4/3/19 at 8:30 AM the DON stated she reviewed each of Resident #28's falls from 10/20/18 through present on the evening of 4/2/19. She reported she was looking for a possible pattern for days of the week, time, staffing, and other factors that could correlate to

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F 689	Continued From page 88 the falls. The DON revealed that the facility had not been analyzing these details for residents with multiple falls to determine if any patterns were evident. She additionally revealed that although she felt it was impossible to prevent all falls for Resident #28, that it was possible to reduce the risk of falls by drilling down to the root cause and implementing interventions that addressed the root cause. A final interview was conducted with the DON on 4/3/19 at 3:15 PM. She stated she expected fall prevention interventions to be implemented. She indicated that she expected falls to be thoroughly investigated and analyzed to determine causative factors and to implement interventions based on the causative factors in an effort to reduce the risk of further falls.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		5/1/19

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F 692	Continued From page 89 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff and family interview, the facility failed to provide physician ordered interventions to prevent weight loss (Residents #51 and #60) for 2 of 3 residents reviewed for nutrition and hydration. Findings included: 1. Resident #51 was admitted to the facility on 1/20/11 with the diagnoses of dysphagia, restlessness, and agitation. Resident #51 had a physician monthly order dated 12/2018 for a nutritional supplement four times a day and meal pureed with thin liquids, magic cup, and double portion meals. A review of Resident #51's quarterly Minimum Data Set dated 2/1/19 revealed the resident had severely impaired cognition with no speech and was rarely understood or understands. The resident required total dependence for all ADLs. The active diagnoses were protein mal-nutrition and dysphagia. The resident received a therapeutic diet. A review of Resident #51's care plan updated 2/6/19 revealed a focus for nutrition with pureed, double portion diet and nutritional supplement for each meal. A review of Resident #51's diet order meal ticket provided by the Dietary Manager (DM) revealed the resident was to receive pureed, double	F 692	F692 The plan of correcting the specific deficiency Resident #51 was observed with double portions on 4/24/19 breakfast meal by facility consultant. Resident #60 was observed eating breakfast in the community dining are on 4/24/19 by facility consultant. During this observation resident was receiving assistance from facility certified nursing assistance. The plan for identifying of potential residents affected On 4/23/19 the facility consultant observed residents at lunch to ensure they received diets as ordered with no negative findings. On 4/23/19 the facility consultant observed lunch meal to ensure residents were receiving meal at location of choice and/or order with no negative findings. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/18/19 the director of nursing in-serviced nursing staff on providing supplements, and diets as ordered, and proving eating assistance in the appropriate location as designated by care plan or order. This in-service was added to the orientation of new nursing	

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F 692	Continued From page 90 portion enriched meal. On 4/2/19 at 8:30 am an observation was done of the resident in her bed and her breakfast tray was served. The breakfast was a single portion. Nursing Assistant (NA) #5 verified that the meal portion was single and the DM verified that the meal portion was single. On 4/2/19 at 8:30 am an interview was conducted with NA #2 who stated she was regularly scheduled to feed Resident #51 and had not observed the resident receive double portion meals. NA #2 commented that if she felt the resident was still hungry she would order a second meal, and the resident always ate 100% of her meal. On 4/3/19 at 8:55 am an observation of Resident #51 fed her breakfast meal by NA #1 a double portion. It was noted that the resident was calm during feeding and when she was full with no independent extremity movement. On 4/4/19 at 8:35 am an interview was conducted with the DM who stated Resident #51's meal was a single portion on 4/2/19 and does not know why the resident did not receive a double portion that morning or in the past. The DM was aware that the resident had been eating 100% of her meals (single portion). On 4/4/19 at 12:30 pm an interview was conducted with Dietary Aide (DA) #1 who stated the cook would announce the ordered meal for pureed and DA #1 served the food onto the plate accordingly during the tray line. DA #1 commented that the cook did not announce "double" this morning and the resident received a	F 692	staff on 4/18/19 by the staff facilitator. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, unit manager, minimum data set nurse, and/or staff facilitator will observe 5 residents 3 times (at random meals to include all meals on random days to include weekends) weekly x 12 weeks to ensure diet, including supplements, is provided, and that resident is eating in location of choice and/or as designated on the care plan. This audit will be documented on the ADL audit tool. The results of the ADL Audit Tool will be compiled by the Administrator and/or Director of Nursing and presented to the Quality Improvement Committee monthly x 3months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring. Corrective action compliance date: May 1, 2019	

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single portion. DA #1 stated that she believed this was a miss due to mis-communication and could have occurred in the past.

An interview was conducted on 4/4/19 at 4:00 pm with the Director of Nursing who stated that she expected staff to follow the physician order for diet and nutritional supplement.

2. Resident #60 was admitted to the facility on 7/1/18 and readmitted on 2/11/19 with diagnoses that included dementia.

A Registered Dietician (RD) note dated 2/1/19 recommended that Resident #60 eat community style in the dining room to encourage intake.

A physician's order dated 2/6/19 indicated Resident #60 was to eat community style in the dining room to encourage intake.

A review of Resident #60's weight record indicated a weight of 119 pounds on 2/6/19.

Resident #60's care plan, initiated on 7/2/18, included the focus area of assistance for eating related to cognitive deficit and dysphagia. The interventions, initiated on 7/2/18 and revised 2/6/19, indicated Resident #60 was to eat her meals in the dining room to encourage intake.

The quarterly Minimum Data Set (MDS) assessment dated 2/14/19 indicated Resident #60 had short-term and long-term memory problems and severely impaired decision making. She required the extensive assistance of 1 for eating.

A review of Resident #60's weight record

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indicated a weight of 114 pounds on 3/22/19. This was a loss of 5 pounds since 2/6/19.

An observation was conducted of the dinner meal on 3/31/19 at 6:05 PM. Resident #60 was eating in her room with assistance provided by Nursing Assistant (NA) #10.

An observation was conducted of the dinner meal on 4/3/19 at 6:10 PM. Resident #60 was eating in her room with assistance provided by NA #11.

An interview was conducted with NA #10 on 4/3/19 at 5:30 PM. She revealed she was unaware that Resident #60 had a physician's order to eat all of her meals in the dining room. She stated that she was the only NA working on Resident #60's unit on 3/31/19 during the 2nd shift and she had difficulty getting all of the residents out of bed and into the dining room on her own. She indicated this was why she served and fed Resident #60 dinner in her room on 3/31/19.

An interview was conducted with NA #11 on 4/4/19 at 2:55 PM. She stated she was aware that Resident #60 was supposed to eat all meals in the dining room to encourage her nutritional intake. She revealed that normally there were 2 NAs and a nurse on Resident #60's unit, but one of the NAs had called off on 4/3/19 for the 2nd shift. NA #11 further revealed that because she was the only NA on Resident #60's unit on 4/3/19 that she was unable to get her out of bed for dinner due to time limitations.

A phone interview was conducted with the RD on 4/4/19 at 10:15 AM. She indicated she was familiar with Resident #60. She stated that she

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F 692	Continued From page 93 recommended community dining for Resident #60. She explained that staff had shared with her that they thought Resident #60 would have better intake eating in the dining room with her peers. The RD stated that she expected interventions related to nutrition to be followed. An interview was conducted with the Director of Nursing on 4/4/19 at 3:15 PM. She indicated she expected nutritional interventions recommended by the RD and ordered by the physician to be consistently implemented.	F 692		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		5/1/19

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F 725	Continued From page 94 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility failed to provide sufficient nursing staff to ensure a resident ' s bathing preferences were honored (Resident #74), to provide activity of daily living (ADL) assistance to residents who required extensive to total care with eating, bathing, showers, personal hygiene, and/or nail care (Residents #9, #51, #74, and #80), and to ensure a resident ate community style in the dining room as ordered by the physician (Resident #60). This affected 5 of 22 sampled residents. The findings included: This tag is cross-referred to: 1. F561: Based on record review, resident interview, and staff interview, the facility failed to provide showers as scheduled for 1 of 2 residents (Resident #74) reviewed for choices. 2. F677: Based on record review, observation, resident interview, and staff interview, the facility failed to provide assistance to residents who required extensive to total care with eating, bathing, showers, personal hygiene, and/or nail care for 4 of 6 residents reviewed for the provision of activity of daily living (ADL) care (Residents #9, #51, #74, and #80). 3. F692: Based on record review, observation,	F 725	F725 For residents affected by the issue: The facility has added a certified nursing assistant position in the dementia unit to meet resident needs on 4/24/2019. The facility has added a unit manager position to increase oversite on the dementia unit on 4/8/2019. The facility has implemented staff increases and sign on program to fill open positions and maintain current staff on 4/24/2019. Showers and resident care are being monitored daily and audited at the end of the day shift. The unit managers identify each resident scheduled for a shower for the day and audit and review documentation that a shower and cares were given or were declined. Showers or cares not completed are passed along to the evening shift verbally and via the added nurse communication book for completion. Other potentially affected residents: Daily audits identify residents not receiving showers and care. Added staff increase oversite and man power to monitor resident cares. Measures implemented: Measures have been taken to reduce staff turnover with pay incentives on 4/24/2019. Increased unit manager is for improving oversite and completion of showers and care on	

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F 725	Continued From page 95 and staff and family interview, the facility failed to provide physician ordered interventions to prevent weight loss (Residents #51 and #60) for 2 of 3 residents reviewed for nutrition and hydration. A resident council meeting was conducted on 4/2/19 at 10:30 AM with 16 alert and oriented residents (Residents #2, #3, #4, #6, #7, #30, #33, #40, #45, #53, #57, #67, #68, #69, #72, and #87). The residents reported that the facility had not had enough Nursing Assistants (NAs) to provide showers as scheduled and to provide bed baths and personal hygiene care on the weekends. The residents stated that the facility had been working on this staffing issue and there was a period of time when it had improved, but that recently it had reappeared as a problem. An interview was conducted with the Director of Nursing (DON) on 4/4/19 at 3:15 PM. She indicated that it was her expectation that the facility have a sufficient number of nursing staff to meet the needs of the residents. She reported that this included having enough staff to honor a resident ' s bathing preferences, to provide Activity of Daily Living care, and to ensure physician ordered weight loss prevention interventions were implemented.	F 725	4/8/2019. Auditing with the activities of daily living audit tool will identify residents that have not been given showers or cares. Shift to shift communication book will alert evening shift residents requiring care. On 4/18/19 the director of nursing began an in-service with nursing staff on providing proving assistance with activities of daily living including showers, nail care, eating, personal hygiene, and bathing. This in-service was added to the orientation of new nursing staff on 4/18/19 by the staff facilitator on 4/18/19. Monitoring to maintain compliance: The unit manager, director of nursing, minimum data set nurse, or staff facilitator will audit (by observation and documentation review) using the ADL audit tool 5 residents weekly (on random shifts to include all shifts on random days to include all days) to ensure showers have been provided per schedule, assistance is being provided for eating, nail care has been provided, shaving, and personal hygiene has been provided. Issues will be reported to the director of nursing. The Director of Nursing will report to the Quality Assurance/Performance Improvement committee the effectiveness of the monitoring and identify any continuing issues. Corrective action compliance date: May 1, 2019	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		5/1/19

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F 755	Continued From page 96 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to administer medication as ordered (Resident #24) for 1 of 5 residents reviewed for unnecessary medication. Findings included:	F 755	F755 For residents affected by the issue: The residents medication has been refilled and is currently receiving the medication as prescribed. The resident has not been without the proper dose since being refilled.	

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F 755	Continued From page 97 Resident #24 was admitted on 9/10/12 with diagnoses of dementia with behavioral disturbance, and bipolar disorder. A review of Resident #24's annual Minimum Data Set dated 1/9/19 revealed the resident was understood and understands and her cognition was intact. Active diagnoses were non-Alzheimer's dementia, bipolar disorder, and psychotic disorder. Resident #24 had a physician order dated 2/12/19 for Restoril (sleep aid) 30 milligrams at bedtime. A review of Resident #24's March 2019 Medication Administration Record (MAR) revealed documentation that the resident was not administered her ordered Restoril 15 mg 2 tablets at bedtime on March 16 - 20, 2019 (5 days). The documented comments for omitted doses were "out, reordered, on order, and not available" respectively. On 4/3/19 at 5:15 pm an interview was conducted with Nurse #13 who was assigned to Resident #24. Nurse #13 indicated that all the resident's medications have a reminder to reorder when there were 3 tablets left. The facility does not stock Restoril. If the resident was out of Restoril at 9:00 pm there would be no resource to obtain the medication for that night. Each nurse who administered medication was expected to reorder that medication when the count was low and the written reminder on the fourth to last dose was visible. The local pharmacy provided backup medication that were not controlled substances, but they closed by 9:00 pm. On 4/4/19 at 9:50 am an interview was conducted	F 755	Other potentially affected residents: A complete audit of all residents medication availability was completed on two occasions since the issue, the latest audit was 4/25/19. No other issues were found with the audit. On 4/18/19 the director of nursing initiated an in-service for nursing staff on providing medications as ordered, and obtaining medications after hours and on weekends. This in-service was added to orientation of new nursing staff on 4/18/19 by the staff facilitator. Measures implemented: The unit managers are completing activities of daily living audit tool 3 times a week to assure no other resident medication has not been refilled. Monitoring to maintain compliance: The unit managers will be monitoring 5 times a week for adequate amount of medication for 5 residents, for 12 weeks and monthly for an additional 3 months. The Director of Nursing will report to the Quality Assurance/Performance Improvement committee the effectiveness of the monitoring and identify any continuing issues. Corrective action compliance date: May 1, 2019	

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F 755	Continued From page 98	F 755		

with Nurse #1 who stated she was assigned evening shift to Resident #24 on 3/16/19 and 3/17/19 and there was no Restoril to administer. The nurse scheduled on 3/15/19 documented on the MAR that the Restoril was reordered (first missed dose) and Nurse #1 did not check to see if the medication was reordered. She checked for the medication in the medication cart and there was none. The resident was informed that the Restoril was out but was ordered. The resident voiced no concern and had no behavior 3/16/19 and 3/17/19. The process for medication reorder was to remove the medication sticker with the refill information housed in the medication box before you could access the next medication dose when there are three doses remaining. The sticker would be placed on the reorder sheet and faxed to the pharmacy at the end of the shift. The medication was usually received by the next day. Nurse #1 did not further check for the delivery of Restoril because the MAR documented that it was ordered.

On 4/4/19 at 2:50 pm an interview was conducted with Medication Aide (MA) #2 who stated she was assigned to provide medication to Resident #24 on 3/13/19 through 3/15/19. MA #2 stated she noted the Restoril was finished and informed the nurse (does not recall who) and was told that the Restoril was ordered. MA #2 stated she was not able to administer the Restoril for 3 doses/3days due to the medication being unavailable and commented that staff wrote on the MAR each day of the Restoril missed dose that the medication was ordered. MA #2 stated she had not placed the medication renewal sticker on the reorder form; she was required to inform the nurse. MA #2 was not aware that she should have asked about obtaining the medication if it was not

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F 755	Continued From page 99 available repeatedly.	F 755		
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 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	F 756		5/1/19

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F 756	Continued From page 100 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 staff, resident, family, Consultant Pharmacist, and physician interview, the pharmacist failed to notify the physician of irregular medication (Resident #22) for 1 of 5 residents reviewed for unnecessary medication. Findings included: Resident #22 was admitted to the facility on 5/15/18 with diagnoses of unspecified abnormalities of gait, age-related osteoporosis, and history of breast cancer. A review of Anastrozole manufacturer information revealed the medication was prescribed to post-menopausal women with hormone receptor positive breast cancer by an oncologist. The typical timeframe for administration was 5 years unless the cancer was of a certain type and would be determined by an oncologist to continue to 10 years. Anastrozole can cause osteoporosis and is contraindicated when pathological fracture is present and would require an annual bone density test. Resident #22 had a physician order for Anastrozole 1 mg each day dated 5/15/18 (hormone receptor blocker used as a chemotherapy). A review of Resident #22 ' s annual Minimum Data Set (MDS) dated 1/8/18 revealed the resident had a severely impaired cognition. The resident required extensive assistance of 1 staff	F 756	F756 For residents affected by the issue: Resident was scheduled for an appointment with the oncologist for May 6, 2019 to evaluate the continuation of the medication or the discontinuing of the medication. Other potentially affected residents: No other resident is on this medication. If a resident were to be admitted with this medication the facility will refer the resident to their oncologist for clarification on continuance of the medication. The facilities pharmacist reviewed all current residents' charts to assure no other resident is on an irregular medication. No other residents were found to be on any of these medications. Measures implemented: On 4/18/19 the staff nurses were in-serviced by the director of nursing that residents on chemotherapy medications, including estrogen blockers, are to be referred to the physician for continued use. This in-service was added to the orientation for new staff nurses on 4/18/19 by the staff facilitator. Monitoring to maintain compliance: The facility pharmacy consultant will complete monthly audit to ensure appropriately follow up for irregular medications. The pharmacy consultant will report any findings of this type of medication to the director of nursing and to the Quality	

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F 756	Continued From page 101	F 756		

for transfers, dressing, and toileting. There was no scheduled or prn pain medication.

An interview was conducted on 4/2/19 at 10:45 am with the Resident ' s family member who provided the breast cancer history. Surgery was 10 to 12 years ago and Anastrozole was started immediately afterwards.

On 4/4/19 at 12:00 pm an interview was conducted with the Pharmacy Consultant who stated she had reviewed Resident #22's medication and did not inform the physician of the Anastrozole as an irregular medication. The Consultant commented that she was not familiar with Anastrozole but was aware a stop date was required and was normally followed by an oncologist. The Consultant stated that the Anastrozole did not have a stop date and she did not know when the medication was started. The Consultant stated that if she knew the resident was on the Anastrozole for 10 to 12 years she would have recommended the physician discontinue the medication. The consultant commented that she was not aware the resident had severe osteoporosis and pathological fractures, including a fracture of the arm in the facility, which would make Anastrozole not recommended. The consultant stated that she was not aware of the risk versus benefits for this class of drug but was aware that the medication was ordered by an oncologist.

On 4/1/19 at 11:00 am an interview was conducted with the resident who remembered she has breast cancer several years ago and had surgery of her right breast. The resident stated that it was more than 5 years ago but could not remember the date. The resident was not aware

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F 756	Continued From page 102 she was taking medication for breast cancer. On 4/2/19 at 9:45 am an interview was conducted with Resident #22 ' s physician who stated that the resident had osteoporosis with history of pathological fractures of the spine and had been seen by an orthopedist. The physician was not familiar with Anastrozole and expected the pharmacist to guide him with the administration. The physician commented after Anastrozole information was obtained that because of the timeframe administered (10-12 years) and the history of pathological fractures, the medication was not appropriate for this resident and would discontinue. An interview was conducted on 4/2/19 at 10:00 am with the Director of Nursing who stated that she expected the pharmacist to monthly review the resident ' s medication and notify the physician and facility of irregular medication.	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		5/1/19

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F 757	Continued From page 103 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and resident, family, Consultant Pharmacist, and physician interview, the facility failed to ensure the resident did not receive unnecessary medication (Resident #22) for 1 of 5 residents reviewed for unnecessary medication. Findings included: Resident #22 was admitted to the facility on 5/15/18 with diagnoses of unspecified abnormalities of gait, age-related osteoporosis, and history of breast cancer. Resident #22 had a physician order for Anastrozole 1 mg each day dated 5/15/18 (hormone receptor blocker used as a chemotherapy). A review of Anastrozole manufacturer information revealed the medication was prescribed to post-menopausal women with hormone receptor positive breast cancer by an oncologist. The typical timeframe for administration was 5 years unless the cancer was of a certain type and would be determined by an oncologist to continue to 10 years. Anastrozole can cause osteoporosis and is contraindicated when pathological fracture is present and would require an annual bone	F 757	F757 For residents affected by the issue: The resident is scheduled for an appointment with their oncologist for May 6, 2019 to review whether to continue the medication. Other potentially affected residents: The facility pharmacist completed 100% audit to identify other potentially unnecessary medications. The audit was completed 4/22/16. No other residents are on chemotherapeutic/ estrogen blocking medications. Measures implemented: The facility pharmacist will complete monthly audits to identify unnecessary medications. Monitoring to maintain compliance: The pharmacy consultant will report to the administrator and director of nursing any findings of unnecessary medications. Director of Nursing will communicate with physician and discuss discontinuance of identified medications. Director of nursing and pharmacy consultant will review auditing with the Quality Assurance/Performance Improvement committee. Corrective action compliance date: May 1, 2019	

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RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

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F 757	Continued From page 104	F 757		

density test.

A review of Resident #22's annual Minimum Data Set dated 1/8/19 revealed the resident had a severely impaired cognition. The active diagnoses were arthritis, osteoporosis, and breast cancer.

On 4/1/19 at 11:00 am an interview was conducted with the resident who remembered she had breast cancer several years ago and had surgery of her right breast. The resident stated that it was more than 5 years ago but could not remember the date. The resident was not aware she was taking medication for breast cancer.

An interview was conducted on 4/2/19 at 10:45 am with the Resident's family member who provided Resident #22's breast cancer history. Surgery was 10 to 12 years ago and Anastrozole was started immediately afterwards. The resident had history of pathological fractures of the spine. The family believed the resident was to remain on the Anastrozole because the physician ordered the medication.

On 4/2/19 at 9:45 am an interview was conducted with Resident #22's physician who stated that the resident had osteoporosis with history of pathological fractures of the spine and had been seen by an orthopedist. The physician was not familiar with Anastrozole and ordered all the medication the resident was taking at home on admission to the facility. The physician expected the pharmacist to guide him with the Anastrozole administration. The physician commented after Anastrozole information was obtained that because of the timeframe administered (10-12 years) and the history of pathological fractures,

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F 757	Continued From page 105 the medication was not appropriate for this resident and would discontinue. Anastrozole was routinely given for 5 years. On 4/4/19 at 12:00 pm an interview was conducted with the Pharmacy Consultant who stated she had reviewed Resident #22's medication and did not inform the physician of the Anastrozole as an irregular medication. The Consultant commented that she was not familiar with Anastrozole but was aware a stop date was required and was normally ordered, administered for 5 years, and followed by an oncologist. The Consultant stated that the Anastrozole did not have a stop date and she did not know when the medication was started. The Consultant stated that if she knew the resident was on the Anastrozole for 10 to 12 years she would have recommended the physician discontinue the medication. The consultant commented that she was not aware the resident had severe osteoporosis and pathological fractures, including a fracture of the arm while in the facility.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		5/9/19

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F 761	Continued From page 106 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to date multi dose medications (inhalers and Prostat) for 3 of 4 medication carts reviewed for medication storage (100, 200 and 400 halls). The findings included: A review of the facility policy titled Medication Expiration Dates and dated 11/1/17, read in part manufacturer's expiration dates shall be observed when provided, for any and all medications. Please see the appendix for a summary of common medications with specific discard/expiration guidelines. The appendix summary from Neil Medical Group indicated Advair (an inhaler used to treat asthma and chronic obstructive pulmonary disease-COPD) should be discarded 30 days after opening, Incruse Ellipta (an inhaler used to treat COPD) should be discarded 6 weeks after opening the foil tray, Anoro Ellipta (an inhaler used to treat COPD) should be discarded 6 weeks after opening the foil tray and Prostat (a nutritional	F 761	F761 For residents affected by the issue: On 4/4/2019 the undated inhalers and prostat were discard based on pharmacy policy by the unit manager. Other potentially affected residents: The licensed nurses, unit managers, and staff facilitator completed a 100% audit of the medication carts for expired medications 4/4/2019. No other medication was found to be expired. All medications were reviewed for appropriate dating after opening and that they were not expired. Measures implemented: Staff nurses were in-serviced on 4/18/19 through 4/29/19 on medication storage policy including dating and labeling multi-dose vials by the director of nursing. This in-service was added to the orientation of new staff nurses on 4/18/19 by the staff facilitator. Monitoring to maintain compliance: Weekly the unit managers will complete a medication storage audit for 12 weeks	

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F 761	Continued From page 107 supplement) should be discarded 3 months after opening. 1) On 4/3/19 at 2:25pm, an observation of the medication cart for 200 hall was conducted with Unit Manager #2. Items discovered included: *Incruse Ellipta 62.5 milligrams (mg) for Resident #70 was opened and undated. A label was present on the box that read to discard 6 weeks after opening. *Advair 250/50mg for Resident #70 was opened and undated. *Incruse Ellipta 62.5mg for Resident #87 was opened and undated. A label was present on the box that read to discard 6 weeks after opening. In an interview on 4/3/19 at 2:25pm, Unit Manager #2 stated the inhalers should have been dated when opened and were removed from the cart. The Unit Manager referred to the label on the box stating it should be discarded after 6 weeks after being opened. He stated that it was the responsibility of the nurse that opened the medication to date the medication. During an interview on 4/4/19 at 1:40pm with the Unit Manager #2, he stated third shift checks the medication carts nightly for any expired and undated medications, however the expectation is for all nurses to date medications as appropriate when opening and discard per the manufacturer guidelines. The Director of Nursing was interviewed on 4/4/19 at 3:20pm and stated it was her expectation for inhalers to be dated when	F 761	using the medication cart/medication room audit tool and report adverse findings to the director of nursing. The director of nursing will report compliance to the Quality Assurance/Performance Improvement committee. Corrective action compliance date: May 9, 2019	

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F 761	Continued From page 108	F 761		

opened. She explained that the nurse that opened the medication was responsible for dating and anyone who found the medication undated should contact the pharmacy and discard.
2. On 4/3/19 at 2:58 PM, the 400 hall medication cart was observed. There was a used Anoro Ellipta inhaler observed in one of the medication drawers with no date of opening. The label on the box of the Anoro Ellipta read "discard 6 weeks after opening foil tray".

An interview was conducted with the Medication Aide (Med Aide) #1 on 4/3/19 at 3:00 PM. The Med Aide stated that Anoro Ellipta inhaler should have been dated by the nurse who opened the foil tray. The Med Aide had verified that the used inhaler was not dated when opened.

An interview with the Director of Nursing (DON) was conducted on 4/4/19 at 11:30 AM. The DON stated that the Assistant Director of Nursing (ADON) and the night shift nurses were supposed to be checking the medication carts for expired and undated multi dose medication. The DON also indicated that she expected the multi dose medications including the inhalers to be dated when opened and to follow the facility's policy and the manufacturer's specification on expiration dates.

3. On 4/3/19 at 2:49 PM, the 100 hall medication cart was observed. There was an opened bottle of Pro-Stat (protein supplement), 1/4 full, with no date of opening. The label on the bottle of Pro-Stat read to discard 3 months after opening.

An interview with Nurse #4 was conducted on 4/3/19 at 2:52 PM. Nurse #4 stated that Pro-Stat

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F 761	Continued From page 109 should have been dated by the nurse who opened the bottle. Nurse #4 had verified that the opened bottle of Pro-Stat was undated. An interview with the Director of Nursing (DON) was conducted on 4/4/19 at 11:30 AM. The DON stated that the Assistant Director of Nursing (ADON) and the night shift nurses were supposed to be checking the medication carts for expired and undated multi dose medication. The DON also indicated that she expected the multi dose medication including Pro-Stat to be dated when opened and to follow the facility's policy and the manufacturer's specification on expiration dates.	F 761		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced	F 825		5/9/19

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F 825	Continued From page 110 by: Based on record review, observation, and staff interview, the facility failed to follow the physician's order for an Occupational Therapy evaluation for 1 of 4 residents (Resident #9) reviewed for position/mobility. The findings included: Resident #9 was admitted to the facility on 8/12/09 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) assessment dated 1/2/19 indicated Resident #9's cognition was severely impaired. She was dependent on 2 or more for assistance with transfers, dressing, and personal hygiene. Resident #9 was dependent on 1 for locomotion on the unit, eating, toileting and she required the extensive assistance of 2 or more for bed mobility. A physician's order dated 3/7/19 received by Nurse #7 indicated an Occupational Therapy (OT) evaluation for Resident #9 to address the clenching of her fists. An observation was conducted of Resident #9 on 3/31/19 at 6:05 PM. She was lying in bed and she was observed with clenched fists on both hands. An interview was conducted with the Therapy Manager on 4/3/19 at 12:15 PM. She reported that when a physician's order was written for an OT evaluation the nurse who received the order needed to complete a referral form in the Electronic Medical Record (EMR) to alert the rehabilitation staff of the new evaluation order.	F 825	F825 For residents affected by the issue: The affected resident was referred to occupational therapy for an evaluation on 4/3/2019. The therapist assessed the resident and did not recommend any splinting due to the residents ability to open and close hands fully on 4/3/2019. Other potentially affected residents: The facility is auditing for the past 30 days to assure orders or referrals for resident care were implemented, Including therapy on 4/25/2019 by the unit managers. No negative findings were noted. Measures implemented: The facility completed 100% audit for the past 14 days for therapy referral screenings. No other issues were identified. Monitoring to maintain compliance: Daily orders are reviewed by the unit managers for appropriate transcription and implementation on 5 residents for 5 times a week for 12 weeks using the 24 hour chart audit tool. Any inaccurate transcription will be corrected and reported to the director of nursing. The director of nursing will report compliance to the Quality Assurance/Performance Improvement committee. Corrective action compliance date: May 9, 2019	

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F 825	Continued From page 111 The physician's order dated 3/7/19 for an OT evaluation for Resident #9 was reviewed with the Rehabilitation Director. The Therapy Manager then reviewed the EMR for Resident #9 and revealed a referral form had not been completed by the nurse. She stated that she had no record to indicate an OT evaluation had been conducted for Resident #9 after the 3/7/19 physician's order. A follow up interview was conducted with the Therapy Manager on 4/3/19 at 2:15 PM. She verified an OT evaluation had not been conducted for Resident #9 after the 3/7/19 physician's order. She reported she evaluated Resident #9 today (4/3/19) and indicated that she believed the hand clenching was a behavior and had not required OT intervention. A phone interview was conducted with Nurse #7 on 4/3/19 at 2:43 PM. Nurse #7 confirmed the Therapy Manager's interview that the nurse who received the physician's order for an OT evaluation was supposed to enter a referral form in the EMR to alert the rehabilitation staff of the new evaluation order. The physician's order dated 3/7/19 for an OT evaluation for Resident #9 was reviewed with Nurse #7. Nurse #7 was informed that no referral was present in the EMR related to this 3/7/19 order for Resident #9. Nurse #7 was unable to explain why she had not completed a referral form in the EMR for Resident #9 after she received the 3/7/19 order for an OT evaluation. An interview was conducted with the Director of Nursing on 4/4/19 at 3:15 PM. She indicated she expected physician's orders for therapy evaluations to be followed.	F 825		
F 842	Resident Records - Identifiable Information	F 842		5/1/19

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F 842 SS=B	Continued From page 112 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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F 842	Continued From page 113 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate medical records for 4 of 22 residents reviewed (Residents #11, #71, #80 and #67). 1) Resident #11 was admitted to the facility on 8/29/08 with diagnoses that included stroke with paralysis, aphasia (partial or total loss of the ability to communicate verbally or using written words) and contracture to the right elbow/hand.	F 842	F842 The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/1/2019 the splint for resident # 11 was discontinued by director of nursing and removed from the medication administration record. On 4/1/2019 the splint for resident #71	

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F 842	Continued From page 114 The most recent Minimum Data Set (MDS) coded as an annual assessment and dated 1/8/19 assessed the resident with severe cognitive deficits. He was noted to have limited range of motion (ROM) to one upper extremity and required total assistance from staff for all Activities of Daily Living (ADL's). Review of the Rehab Communication to Nursing, dated 3/13/19 indicated the resident was to receive Restorative Nursing for passive ROM (PROM) exercises to his right shoulder, elbow and fingers and splint application to the right elbow and hand for 4 hours a day, beginning on 3/15/19. A review of the current care plan showed a care plan for positioning assistance and risk for further contractures. Interventions included PROM 7 times a week to the right arm and hand, apply right elbow and hand splint on for 4 hours per day in the splint/brace program as well as monitor the skin integrity under the splints daily. Review of the restorative nursing flow record dated 3/18/19 to 4/2/19 revealed documentation present for 7 out of the 16 days for passive ROM, splint application and skin monitoring (3/20/19, 3/21/19, 3/22/19, 3/26/19, 3/27/19, 3/29/19 and 4/1/19). On 3/31/19 at 3:05pm Resident #11 was observed resting in his bed. He was not wearing any splints to his right arm or hand and no splints were observed in his room. On 4/2/19 at 8:45am the resident was observed lying in his bed with no splints present to his right	F 842	was discontinued by director of nursing and removed from the medication administration record. From 4/1/2019 through 4/4/2019 the director of nursing (DON), staff facilitator, and unit managers searched resident charts, nurse's station and medical records and were unable to locate the missing page of the medication administration record. On 4/4/2019 the director of nursing notified the medical director of the medical record error, with no new orders received. On 4/3/2019 resident #28's minimum data set (MDS) assessment was modified and submitted to the national repository by the MDS nurse on 4/3/2019. From 4/25/19 through 4/29/19 the facility consultant completed an audit of MDS assessments completed in last 30 days to ensure coding accurate for medications including injections with no negative findings. From 4/25/19 through 5/1/19 the unit managers completed an audit of medication administration records to ensure present with no negative findings. On 4/5/2019 through 4/9/2019 the unit managers audited residents with splint orders to ensure the device was present and documented as ordered. No negative findings. On 4/18/19 the director of nursing initiated an in-service with nursing staff on following physician orders including splints, medications as ordered, medical records must be complete including medication administration. This in-service was added to the orientation for new	

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F 842	Continued From page 115 arm or hand. On 4/2/19 at 9:50am Resident #11 was observed lying in his bed with no splints present to his right arm or hand. An interview occurred with Nurse Aide #6 on 4/2/19 at 9:50am. She indicated that she was Resident #11's usual aide and normally applied his splints after his bath. She stated that she was aware of how to do the passive ROM exercises and the splint was to be worn for 4 hours a day but didn't document the passive ROM or the application of the splint because she didn't have access to that section in the Electronic Medical Record System (EMR). On 4/2/19 at 10:15am an interview was conducted with the Director of Nursing (DON). She stated in February 2019 she began to transition the application and removal of splints to the floor aides. She further explained that on 2/21/19 she had in-service with all the aides regarding the expectations for splints. The DON added that not all the aides had access to the charting for the splints in the EMR system and agreed that she could not verify splints were being applied as ordered unless they were documented. On 4/2/19 at 10:30am an interview was conducted with the Therapy Manager. She explained Resident #11 was evaluated and treated by Occupational Therapy from 2/12/19 to 3/14/19 for contracture of the right elbow and hand. He was released to the nursing restorative program on 3/15/19. She further stated she provided training to the staff on how to correctly perform the PROM exercises and apply the	F 842	nursing staff by the staff facilitator on 4/18/19. On 4/17/19 and 4/18/19 the MDS nurses were in-services by the corporate reimbursement auditor on correct coding of the MDS assessment based in the resident assessment instrument (RAI) manual. This in-service will be provided to any new MDS nurse by the DON. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements Auditing will be completed 5 times per week on 5 residents by the minimum data set nurse, the director of nursing, the staff facilitator and/or unit manager using the activities of daily living audit tool, minimum data set audit tool and intervention audit tool weekly for 12 weeks to assure correctness of the medical record, including MDS accuracy, presence of medication administration record, and splint application. The director of nursing will report compliance to the Quality Assurance/Performance Improvement committee. The monthly QI committee will review the results of the F842 audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly	

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F 842	Continued From page 116 splints and monitored them for a few days to ensure the techniques were performed correctly. Nurse Aide #6 was observed performing PROM exercises and application of splints to Resident #11's right elbow and hand on 4/2/19 at 10:40am. An interview occurred with Nurse Aide #7 on 4/4/19 at 2:00pm. She indicated she was the first shift restorative champion for staff to come to with any questions regarding the restorative nursing program. She stated the floor aides were responsible for applying the splints and they all had access to the section on the EMR for documentation. On 4/4/19 at 2:15pm Resident #11 was observed resting in his bed with right arm and hand splint on. On 4/4/19 at 3:20pm during an interview with the DON, she stated her expectation was for the staff to document when splints were applied. 2) Resident #71 was admitted to the facility on 10/10/18 with diagnoses that included intracranial injury, traumatic hemorrhage of cerebrum, diabetes mellitus and gout. The most recent MDS coded as a quarterly assessment and dated 3/1/19 assessed Resident #71 with severe cognitive deficits and he required extensive to total assistance with all ADL's. He was noted with limited ROM to one lower extremity. Review of the active care plan did not indicate the use of bilateral foot drop splints or contractures.	F 842	executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction. Corrective action compliance date: May 1, 2019	

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Review of the monthly Medication Administration Records (MAR) for January 2019, February 2019 and March 2019 revealed, to remove bilateral foot drop splints on 3-11 shift.

A review of the March 2019 physician orders indicated to remove bilateral foot drop splints on 3-11 shift- nurse to sign off on MAR.

On 4/2/19 at 9:40am the resident was observed lying in bed without foot drop splints present.

On 4/2/19 at 4:30pm an interview was conducted with Nurse #6. She stated that she was familiar with the resident and has never taken foot drop splints off.

On 4/2/19 at 4:30pm an interview occurred with Unit Manager #1. She explained that the resident was part of the evacuees taken in from the Hurricane in September 2018 and did not recall him having foot drop splints.

An interview was conducted with the Unit Manager #2 on 4/3/19 at 10:25am. He explained Resident #71 was part of the evacuees taken in from the Hurricane in September 2018 and did not recall him having foot drop splints. He was unable to locate any information or orders stating the resident wore foot drop splints.

On 4/3/19 at 10:40am Resident #71 was observed lying in his bed, watching TV without foot drop splints on.

On 4/3/19 at 10:45am an interview occurred with Nurse Aide #7. She indicated she has not applied or seen the resident wearing bilateral foot drop

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splints.

An interview occurred with the therapy manager on 4/3/19 at 11:15am. She stated the resident had been screened and evaluated by physical therapy after admission, but foot drop splints were not recommended or ordered.

Nurse #5 was identified as the nurse that initiated the bilateral foot drop splint on the MARs and was interviewed via phone on 4/3/19 at 11:20am. She indicated that she normally worked the 3rd shift and was familiar with the resident both at his previous and current facility. She explained that she knew he had some type of device on his feet when at the previous facility and thought they were heel protectors.
She further stated that when the resident was evacuated to this facility (due to flooding related to the hurricane in September 2018) he did not have his full medical record and she added the foot drop splint because she knew he wore some type of device to his feet. She was unable to clarify whether they were splints or heel protectors. Nurse #5 stated that she kept carrying over the removal of the foot drop splints from MAR to MAR at the end of the month but never questioned whether he used any splints or why there was no mention of applying the foot drop splints. Nurse #5 stated that the foot drop splints should not have been placed on the MAR without an order or recommendation.

During an interview with the Director of Nursing on 4/3/19 at 11:30 she stated it was an error and the removal of the bilateral foot drop splints on the 3-11 shift should have been questioned or clarified during the end of the month reviews.

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On 4/4/19 at 8:05am an interview was conducted with the Staff Development Coordinator (SDC) who was the nurse that completed the first check on the January 2019 MAR. She stated that when she completed the MAR check on 12/26/18 she wrote in to remove the bilateral foot drop splints on the 3-11 shift as it was on the December MAR. She further explained that she had started working at the facility on 11/26/18 and was feeling a bit overwhelmed at the time of the MAR check. The SDC stated that she should have questioned why there was no mention of applying the splints and investigated further for an order or to see if they resident wore them.

On 4/4/19 at 3:20pm the DON stated it was her expectation for the medical record to be accurate.
3. Resident #80 was admitted to the facility on 12/7/17 and was readmitted on 2/21/19 with multiple diagnoses including dementia. The admission Minimum Data Set (MDS) assessment dated 2/28/19 indicated that Resident #80 had impaired cognition and had received antianxiety, antidepressant and hypnotic medication for 7 days during the assessment period.

Review of Resident #80's doctor's orders revealed that on 12/4/18, Resident #80 had an order for Risperdal (antipsychotic drug) 2 milligrams (mgs) by mouth twice a day and Risperdal 25 mgs subcutaneously (SQ) every 2 weeks for dementia with behaviors. On 2/13/19, there was an order to decrease the Risperdal to 12.5 mgs SQ every 2 weeks.

Review of Resident #80's nurse's notes revealed that he was discharged to the hospital on 2/18/19 and was readmitted to the facility on 2/21/19.

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Resident #80's Medication Administration Records (MARs) for February 2019 were reviewed. The MARs did not indicate that Risperdal was administered to Resident #80 from February 1-18, 2019.

An interview with the Medical Records staff was conducted on 4/2/19 at 4:31 PM. The Medical Records staff stated that 2-3 pages of the February 2019 MARs for Resident #80 were missing and she could not find them. She indicated that at the end of each month, the MARs were left in a book for the pharmacist to review. After the pharmacist review, the book with the MARs was given to her by the unit managers to be filed in the resident's medical record. The Medical Record staff reported that at times the book was not given to her timely and so she was behind with her filing. She also added that she didn't know how and why those MARs were missing.

Interview with the Unit Manager (UM) #1 was conducted on 4/2/19 at 4:33 PM, The UM stated that Risperdal was administered to Resident #80 prior to his discharge to the hospital on 2/18/19. The UM was unable to find the MARs to indicate that Risperdal was administered to Resident #80 from February 1-18, 2019.

Interview with the Director of Nursing (DON) on 4/3/19 at 8:50 AM was conducted. The DON stated that Resident #80 was receiving his Risperdal prior to his discharge to the hospital on 2/18/19. The DON stated that some pages of Resident 80's February 2019 MARs were missing and the Medical Records staff member was unable to find them. She stated that she expected the resident's medical records to be complete and

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accurate.
4. Resident #67 was admitted to the facility on 10/1/18 with diagnoses that included Diabetes Mellitus (DM).

A physician's order dated 12/13/18 indicated the discontinuation of Trulicity (DM medication) for Resident #67.

A physician's order dated 1/24/19 indicated the discontinuation Levemir (insulin), Novolog (insulin), and Glucotrol (DM medication) for Resident #67.

The quarterly Minimum Data Set (MDS) assessment dated 2/22/19 indicated Resident #67's cognition was intact. He was coded with the active diagnosis of DM.

A nursing note dated 2/22/19 completed by MDS Nurse #1 indicated Resident #28 received the following medications related to DM: Levemir, Novolog, Glucotrol, and Trulicity.

An interview was conducted with MDS Nurse #1 on 4/1/19 at 4:00 PM. The 2/22/19 nursing note that indicated Resident #67 received Levemir, Novolog, Glucotrol, and Trulicity was reviewed with MDS Nurse #1. The physician s orders that indicated Trulicity was discontinued on 12/13/18 and Levemir, Novolog, and Glucotrol were discontinued on 1/24/19 were reviewed with MDS Nurse #1. She indicated she needed to review her records to see why she wrote the 2/22/19 note.

A follow up interview was conducted with MDS Nurse #1 on 4/1/19 at 4:20 PM. She revealed she reviewed her records and the 2/22/19 note

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F 842	Continued From page 122 for Resident #67 was inaccurate. She reported she had copied and pasted the information from a previous note into her 2/22/19 note without verifying its accuracy. An interview was conducted with the Director of Nursing on 4/4/19 at 3:15 PM. She indicated she expected medical records to be complete and accurate.	F 842		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, resident interviews and record reviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the recertification survey	F 865	F 865 Quality Assurance/Performance Improvement Program/Plan The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/29/19 the facility Quality	5/1/19

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F 865	Continued From page 123 dated 10/18/18. This was for six recited deficiencies in the areas of Self Determination at F561- not providing showers as scheduled; Accuracy of Assessments at F641- not coding the Minimum Data Set (MDS) accurately; Services Provided Meet Professional Standards at F658- not administering psychotropic medications as ordered; Activities of Daily Living (ADL) Care Provided for Dependent Residents at F677- not providing nail care to a dependent resident; Nutrition/Hydration Status Maintenance at F692- not implementing interventions to prevent weight loss and Label/Store Drugs & Biologicals at F761- not dating multi- dose medications which were previously cited on 10/18/18. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. The findings included: This citation is cross referenced to: 1a. F561- Based on record review, resident interview, and staff interview, the facility failed to provide showers as scheduled for 1 of 2 residents (Resident #74) reviewed for choices. During the recertification survey of 10/18/18 the facility was cited for failing to provide showers as scheduled for 1 of 2 residents reviewed for choices (Resident #54). 1b. F641- Based on record review, observation, resident interview, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medications (Residents #28, #67, and #75), falls (Resident #28), activities of daily living (Resident	F 865	Assurance/Performance Improvement (QAPI) Committee held a meeting to review the purpose and function of the QAPI committee and review on-going compliance issues. The Medical Director, Administrator, Director of Nursing, Minimum Data Set (MDS) nurse, Dietary Manager, maintenance director, medical records, and housekeeping supervisor will attend QAPI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 4/29/19 the corporate facility consultant in-serviced the facility administrator, director of nursing, MDS nurse, admissions, activities director, maintenance director, dietary manager, medical records, therapy director, and housekeeping supervisor related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related F561, F641, F658, F677, F692, and F761. As of 4/29/19 after the facility consultant in-service, the facility QAPI Committee will begin identifying other areas of quality concern through the QAPI review process, for example: review of rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), review of resident council minutes, review of resident concern logs, review of pharmacy reports, review of audits related to the plan of correction and review of regional facility consultant recommendations. The Facility QAPI Committee will meet at a minimum of monthly and Executive	

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F 865	Continued From page 124 #28), tracheostomy care (Resident #34), active diagnoses (Resident #22), tube feeding (Resident #52), and pain (Resident #51) for 7 of 22 sampled residents. During the recertification survey of 10/18/18 the facility was cited for failing to code the Minimum Data Set (MDS) assessments accurately in the areas of hospice care (Resident #44), medications (Resident # 280), diagnoses (Residents #280 & #11) and nutrition (Resident #30) for 4 of 20 sampled residents whose MDS assessments were reviewed. 1c. F658- Based on record reviews, observations and staff interviews, the facility failed to accurately transcribe physician orders for an antianxiety medication ordered by the physician for 1 of 6 residents whose medications were reviewed (Resident #53). During the recertification survey of 10/18/18 the facility was cited for failing facility to administer antipsychotic medication as ordered for 1 of 5 residents reviewed for unnecessary medications (Resident #8). 1d. F677- Based on record review, observation, resident interview, and staff interview, the facility failed to provide assistance to residents who required extensive to total care with eating, bathing, showers, personal hygiene, and/or nail care for 4 of 6 residents reviewed for the provision of activity of daily living (ADL) care (Residents #9, #51, #74, and #80). During the recertification survey of 10/18/18 the facility was cited for failing to provide fingernail	F 865	QAPI committee meeting a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiencies.	

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care for one of two dependent residents reviewed for Activities of Daily Living (ADLs) (Resident #5).

1e. F692- Based on record review, observation, and staff and family interview, the facility failed to provide physician ordered interventions to prevent weight loss (Residents #51 and #60) for 2 of 3 residents reviewed for nutrition and hydration.

During the recertification survey of 10/18/18 the facility was cited for failing to implement the interventions as ordered to prevent further weight loss for 1 of 3 sampled residents reviewed for nutrition (Resident # 75).

1f. F761- Based on observations and staff interviews, the facility failed to date multi dose medications (inhalers and Prostat) for 3 of 4 medication carts reviewed for medication storage (100, 200 and 400 halls).

During the recertification survey of 10/18/18 the facility was cited for failing to discard expired medications and to date multi dose medications in 2 of 2 medications rooms observed (main medication room and dementia care unit).

The repeat six citations were reviewed with the Administrator on 4/4/19 at 2:55pm. He stated that the repeat citations could be related to the facility trying to change and implement new procedures too fast as well as the rapid turnover in the staff. He added that as of recently, the Medical Director has been more involved with the monthly Quality Assurance meetings.