| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **STANLY MANOR** | **625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001** |

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| E 000 | Initial Comments<br><br>An unannounced Recertification survey was conducted on 7/8/19 through 7/11/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #NPMH11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint survey was conducted from 7/8/19 to 7/11/19. There were 18 total complaint allegations with 8 of those allegations substantiated. See Event #NPMH11. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>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.<br><br>§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.<br><br>§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. | F 550 | | 8/8/19 |

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

Electronically Signed | 07/25/2019

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| F 550 | Continued From page 1<br>§483.10(b) Exercise of Rights.<br>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.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff interview, the facility failed to provide dignity by not serving meals to all residents at a table at the same time for 5 of 5 sampled residents observed (Residents # 28, #61, #62, #121 & # 6).<br><br>Findings included:<br><br>1. Resident # 61 was admitted to the facility on 10/20/18 with multiple diagnoses including Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 6/4/19 indicated that Resident #61 had memory and decision making problems and was dependent on the staff with eating.<br><br>On 7/8/19 at 12:05 PM, a lunch meal observation was conducted in the main dining room (DR). The meal cart arrived in the main DR at 12:05 PM. Five staff members including NA (Nurse Aide) #1 and NA #2 were observed passing the | F 550 | DISCLAIMER:<br>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.<br><br>On 8/7/19, Resident Liaison will review with Resident #28, #61, #62, #121, #6 and/or Resident Representatives, the expectation for nurses and nurse aides assisting with meal service, to serve meals to each resident per table to assure a dignified dining experience.<br><br>On 7/31/19, Service Line Educator will educate NA #1, #2, #3, #4, and #5, to | |

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| F 550 | Continued From page 2<br>trays to the residents. After passing the trays, 2 staff members (NA #1 and NA #2) were left in the main DR.<br><br>On 7/8/19 at 12:15 PM, Resident #61 was observed sitting at a table with 2 other residents. The 2 other residents had their trays in front of them and they were already eating. Resident #61 did not have a tray in front of her. At 12:30 PM, NA #2 was observed to serve Resident #61's tray and started feeding the resident.<br><br>On 7/8/19 at 2:45 PM, NA #2 was interviewed. NA #2 stated there were 3 residents in the main DR who needed to be fed. The staff members had to pass the trays of those residents who could feed themselves first. It would take 10-15 minutes to pass the trays and after passing the trays, they would start feeding the residents who needed to be fed. NA #2 verified that Resident #61 had to wait at least 15 minutes to be fed after other residents on the table were served.<br><br>On 7/11/19 at 2:10 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to serve the trays of all residents on the table at the same time however she didn't have enough staff to feed the residents at the same time. The DON further indicated that she would start splitting the dining times of residents who needed to be fed.<br><br>2. Resident # 121 was readmitted to the facility on 6/3/19 with multiple diagnoses including vascular dementia. The admission Minimum Data Set (MDS) assessment dated 6/10/19 indicated that Resident #121 had moderate cognitive impairment and needed supervision with 1 person | F 550 | serve meals to each resident per table to assure a dignified dining experience. The Director of Nursing (DON) noted in this deficiency is no longer employed at the facility.<br><br>Beginning 7/31/19, the Administrator, Director of Nursing, and Service Line Educator will educate nurses and nurse aides assisting with meal service, to serve meals to each resident per table to assure a dignified dining experience. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new nurses and nurse aides assisting with meal service, to serve meals to each resident per table to assure a dignified dining experience, will be provided by the Service Line Educator.<br><br>Beginning 7/31/19, Administrative Stand Up Team will observe nurses and nurse aides assisting with lunch, to serve meals to each resident per table to assure a dignified dining experience. The Administrative Stand Up Team includes the Administrator, Director of Nursing, Dietary Manager, Minimum Data Set (MDS) Coordinator, Admissions Coordinator, Medical Records Coordinator, Environmental Services Manager, Resident Liaison, and Activity Director.<br><br>Interdisciplinary Team (IDT) members will conduct weekly observations 3 days per | |

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| F 550 | Continued From page 3<br>physical assist with eating.<br><br>On 7/8/19 at 12:05 PM, a lunch meal observation was conducted in the main dining room (DR). The meal cart arrived in the main DR at 12:05 PM. Five staff members including NA #1 and NA #2 were observed passing the trays to the residents. After passing the trays, 2 staff members (NA #1 and NA #2) were left in the main DR.<br><br>On 7/8/19 at 12:15 PM, Resident # 121 was observed sitting at a table with 2 other residents. The 2 other residents had their trays in front of them and they were already eating. Resident #121 did not have a tray in front of him. At 12:45 PM, NA #3 was observed entering the main DR with Resident #121's tray and served it to the resident.<br><br>Attempted to interview Resident #121 but he was not available.<br><br>On 7/8/19 at 12:46 PM, NA # 3 was interviewed. NA #3 stated that Resident #121 was able to feed himself and at times he ate in his room and at times he ate in the main DR. The NA reported that Resident #121's tray was delivered in 500 hall meal cart and the cart just arrived on the hall. NA #3 further reported that when Resident #121 decided to eat in the DR he had to wait for his tray.<br><br>On 7/11/19 at 2:10 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to serve the trays of all residents on the table at the same time. | F 550 | week, to ensure nurses and nurse aides assisting with lunch, serve meals to each resident per table to assure a dignified dining experience. IDT members include the MDS Coordinator, Dietary Manager, Resident Liaison, and Activity Director.Weekend Manager on Duty will conduct weekend observation, 1 day per weekend, to ensure nurses and nurse aides assisting with lunch, serve meals to each resident per table to assure a dignified dining experience. Any identified issues will be corrected at that time. Results of the monitoring will be shared by Activity Director with the Administrator and Director of Nursing on a weekly basis and will be shared by Activity Director with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |

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| F 550 | Continued From page 4 | F 550 | | |

3. Resident #28 was admitted to the facility on 9/12/18 with multiple diagnoses including anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 5/7/19 indicated that Resident #28's cognition was severely impaired and she needed extensive assistance with eating.

On 7/8/19 at 12:05 PM, a lunch meal observation was conducted in the main dining room (DR). The meal cart arrived in the main DR at 12:05 PM. Five staff members including NA (Nurse Aide) #1 and NA #2 were observed passing the trays to the residents. After passing the trays, 2 staff members (NA #1 and NA #2) were left in the main DR.

On 7/8/19 at 12:15 PM, Resident #28 was observed sitting at a table with 1 other resident. The other resident had his tray in front of him and was already eating. Resident #28 did not have a tray in front of him. At 12:45 PM, NA #4 came to the main DR and she was observed to serve Resident #28's tray and started feeding the resident.

On 7/8/19 at 2:45 PM, NA #2 was interviewed. NA #2 stated there were 3 residents in the main DR who needed to be fed. The staff members had to pass the trays of those residents who could feed themselves first. It would take 10-15 minutes to pass the trays and after passing the trays, they would start feeding the residents who needed to be fed.

On 7/8/19 at 2:48 PM, NA #4 was interviewed. She stated that she was assigned on 300 hall. The NA reported that she was informed that the NA assigned to help in the main DR had left and she was informed to help feed residents in the

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| F 550 | Continued From page 5 | F 550 | | |

main DR.

On 7/11/19 at 2:10 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to serve the trays of all residents on the table at the same time however she didn't have enough staff to feed the residents at the same time. The DON further indicated that she would start splitting the dining times of residents who needed to be fed.

4. Resident #6 was admitted to the facility on 6/5/15 with multiple diagnoses including Alzheimer's disease. The significant change in status Minimum Data Set (MDS) assessment dated 4/11/19 indicated that Resident #6 had severe cognitive impairment and she was totally dependent on the staff with eating.

On 7/10/19 at 8:00 AM, a breakfast meal observation was conducted on 600 hall dining room (DR). The meal cart was observed on the 600 hall hallway and 2 Nurse Aides (NA #3 & NA # 5) were observed passing the trays.

On 7/10/19 at 8:01 AM, Resident #6 was observed sitting at a table with 4 other residents. One of the 4 residents had a tray in front of her and she was already eating. Resident #6 did not have a tray in front of her. At 8:12 AM, NA #3 was observed to serve Resident #6's tray and started feeding the resident.

On 7/10/19 at 8:35 AM, NA #3 and NA #5 were interviewed. NA #5 stated that currently, there were 3 residents on the 600 hall who needed to be fed and Resident #6 was one of them. They stated that breakfast cart arrived on the 600 hall

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| F 550 | Continued From page 6 | F 550 | | |

between 7:45 and 7:50 AM and they would start passing the trays on the hall and then in the dining room. NA #3 and NA #5 verified that one resident in the DR was already served her tray because she was able to feed herself and the other 3 residents needed to be fed.

On 7/11/19 at 2:10 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to serve the trays of all residents on the table at the same time however she didn't have enough staff to feed the residents at the same time. The DON further indicated that she would start splitting the dining times of residents who needed to be fed.

5. Resident # 62 was admitted to the facility on 2/5/18 with multiple diagnoses including Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 6/4/19 indicated that Resident #62 had severe cognitive impairment and she was totally dependent on the staff with eating.

On 7/10/19 at 8:00 AM, a breakfast meal observation was conducted on 600 hall dining room (DR). The meal cart was observed on the 600 hall hallway and 2 Nurse Aides (NA #3 & NA # 5) were observed passing the trays.

On 7/10/19 at 8:01 AM, Resident #62 was observed sitting at a table with 4 other residents. One of the 4 residents had a tray in front of her and she was already eating. Resident #62 did not have a tray in front of her. At 8:30 AM, NA #3 was observed to serve Resident #62's tray and started feeding the resident.

On 7/10/19 at 8:35 AM, NA #3 and NA #5 were

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| F 550 | Continued From page 7<br>interviewed. NA #5 stated that currently, there were 3 residents on the 600 hall who needed to be fed and Resident #62 was one of them. They stated that breakfast cart arrived on the 600 hall between 7:45 and 7:50 AM and they would start passing the trays on the hall and then in the dining room. NA #3 and NA #5 verified that one resident in the DR was already served her tray because she was able to feed herself and the other 3 residents needed to be fed.<br><br>On 7/11/19 at 2:10 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to serve the trays of all residents on the table at the same time however she didn't have enough staff to feed the residents at the same time. The DON further indicated that she would start splitting the dining times of residents who needed to be fed. | F 550 | | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>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.<br><br>§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.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the | F 561 | | 8/8/19 |

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| F 561 | Continued From page 8<br>facility that are significant to the resident.<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident, Responsible Party (RP) and staff interviews and record review, the facility failed to honor resident preference for showers for 2 (Resident #11 and Resident #36) of 2 residents reviewed for bathing preferences. The findings included:<br><br>1. Resident #11 was admitted on 3/10/18 with a diagnosis of Dementia.<br><br>Resident #11's annual Minimum Data Set (MDS) dated 1/23/19 indicated she had moderate cognitive impairment with no behaviors. Section F titled Preferences for Customary Routine and Activities read choosing bed bath, showers and sponge bath were somewhat important to her.<br><br>Resident #11's quarterly MDS dated 4/16/19 indicated she had moderate cognitive impairment with no behaviors. She was coded for physical help with transfers with bathing.<br><br>Review of a facility grievance dated 5/1/19 submitted by Resident #11's RP read she wanted the staff to assist her with bathing. The grievance | F 561 | Resident #11 was discharged on 6/14/19. On 7/11/19, Resident #36 was offered a shower and received it based on her preference.<br><br>Service Line Educator will educate NA #12, #13, and #8, to assure resident□s shower/bath schedule is implemented in accordance with resident/resident representative preference. Education was completed on 8-1-2019 for NA #12,# 13 and #8 .<br><br>On Admission and Quarterly, Interdisciplinary Team (IDT) members will review shower/bath preferences with resident/resident representatives during the admission assessment/care plan meeting and the shower/bath schedule will be updated accordingly. IDT members include the MDS Coordinator, Dietary Manager, Resident Liaison, and Activity Director.<br><br>Beginning 7/31/19, the Administrator, | |

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| F 561 | Continued From page 9<br>findings/conclusions read that the staff was educated on assisting Resident #11 with care and hygiene.<br><br>Review of Resident #11's care plan for Activities of Daily Living (ADLs) initiated 2/12/19 and last revised on 5/1/19 read she was assigned and to be assisted with a shower or tub bath weekly and partial baths on non bath days at her or the RP discretion. There was no evidence of a care plan for any refusals of care.<br><br>Review of an undated facility shower schedule read she was to receive showers on Tuesdays and Fridays on first shift.<br><br>Review of Resident #11's electronic and hard copy medical record indicated she was on isolation from 3/15/19 to 4/10/19 due to influenza and pneumonia.<br><br>Review of Resident #11's shower roster for the week of 4/14/19 through 4/20/19, she received one shower.<br><br>Review of Resident #11's shower roster for the week of 4/21/19 through 4/27/19, she received one shower.<br><br>Review of Resident #11's shower roster for the week of 4/28/19 through 5/4/19, she received no showers.<br><br>Review of Resident #11's shower roster for the week of 5/5/19 through 5/11/19, she received no showers.<br><br>Review of Resident #11's shower roster for the week of 5/12/19 through 5/18/19, she received | F 561 | Director of Nursing, and Service Line Educator will educate all nursing staff to assure resident□s shower/bath schedule is implemented in accordance with resident/resident representative preference. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new nursing staff to assure resident□s shower/bath schedule is implemented in accordance with resident/resident representative preference, will be provided by the Service Line Educator.<br><br>Beginning 7/22/19, the Activity Director, Activity Assistant, and Resident Liaison, will conduct a facility wide Resident Choice Survey with residents/resident representatives to evaluate shower/bath frequency preferences. Shower/bath schedules will be updated in accordance with each resident's frequency preference.<br><br>Admissions Coordinator or designee, will conduct weekly shower/bath audits for 5 residents to ensure compliance. Weekend Manager on Duty will conduct weekend shower/bath audits for 2 residents to ensure compliance. Audits will consist of reviewing residents shower/bath schedules and documentation of when staff provided the shower/bath. Any identified issues will be corrected at that time. Results of the monitoring will be shared by Admission Coordinator with the Administrator and Director of Nursing on a | |

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| F 561 | Continued From page 10<br>one shower.<br><br>Review of Resident #11's shower roster for the week of 5/26/19 through 6/1/19, she received no showers.<br><br>Review of Resident #11's shower roster for the week of 6/2/19 through 6/8/19, she received one shower.<br><br>Review of Resident #11's shower roster for the week of 6/9/19 through 6/14/19, she received one shower.<br><br>During a telephone interview on 7/9/19 at 9:48 AM, Resident #11's RP stated while she was sick, she did not want her to be given showers and she assisted her with bathing during that time. The RP stated after her isolation ended, the staff only showered Resident #11 on occasion. The RP confirmed she completed a grievance about the lack of staff assistance with her bathing and hygiene. She stated Resident #11's did not refuse showers and it was important to her to receive showers as scheduled. She stated if Resident #11 refused showers, bathing or hygiene assistance, the facility should have contacted her, so she could speak with Resident #11.<br><br>During an interview on 7/10/19 at 3:35 PM, Nursing Assistant (NA) #12 stated she recalled that while Resident #11 was on isolation for the flu, the RP did not want her to be showered. NA #12 stated Resident #11 was not scheduled showers of 2nd shift but she was not aware of any refusals of bathing or hygiene assistance.<br><br>During an interview on 7/11/19 at 8:50 AM, NA #13 recalled working first shift with Resident #11. | F 561 | weekly basis and will be shared by Admissions Coordinator with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |

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She stated she was not aware of any refusals with hygiene or bathing. She also recalled the RP not wanting Resident #11 to have showers for a few weeks due to the flu. NA #13 stated she looked at the shower schedule to know what showers were due on her shift. She was unable to recall why Resident #11 did not receive her showers as scheduled. She stated if a resident refused their shower, she reported it to the nurse.

During an interview on 7/11/19 at 2:03 PM, the Administrator and the Director of Nursing stated it was their expectation that refusals of showers and hygiene be documented and expected preference for showers to be honored.

2. Resident #36 was admitted to the facility on 10/3/18 with diagnoses that included cancer and muscle weakness.

The significant change Minimum Data Set (MDS) assessment dated 2/26/19 indicated Resident #36 ' s cognition was intact. She was assessed with no behaviors and no rejection of care. Resident #36 indicated that it was somewhat important to her to choose between a tub bath, shower, bed bath, or sponge bath. She was assessed as requiring physical assistance with part of bathing activity.

Resident #36 ' s care plan included the focus area of staff assistance for all Activities of Daily Living (ADLs) due to impaired mobility, muscle weakness, and cancer. This area was initiated on 3/4/19 and last revised on 6/5/19 and included the intervention of resident being assisted with showers.

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An interview was conducted with Resident #36 on 7/8/19 at 10:12 AM. She reported that her preferred method of bathing was a shower and that her showers were scheduled for Mondays and Thursdays. She revealed that she had not consistently been receiving her showers as scheduled and that her last shower was a week ago (7/1/19).

A review was conducted of the Nursing Assistant (NA) bathing/shower documentation for Resident #36 from 6/10/19 through 7/9/19. Resident #36 was scheduled to receive showers on Mondays and Thursdays. The documentation indicated that she received showers on 5 of 9 scheduled shower days (6/10/19, 6/13/19, 6/17/19, 6/27/19, and 7/1/19). Resident #36 was provided with a full bed bath instead of a shower on 4 of 9 scheduled shower days (6/20/19, 6/24/19, 7/4/19, and 7/8/19). There were no refusals noted for Resident #36 during this timeframe (6/9/19 through 7/9/19).

An interview was conducted with NA #8 on 7/11/19 at 10:30 AM. She stated that showers were documented in the electronic medical record. She reported that if a resident refused a shower that they were to document this refusal and report this to the nurse. NA #8 indicated that she was familiar with Resident #36 and that her cognition was intact, and her statements were reliable. The NA bathing/shower documentation that indicated NA #8 documented a bed bath for Resident #36 on her scheduled shower day of 6/20/19 was reviewed with NA #8. NA #8 was unable to recall working with Resident #36 on 6/20/19 and also unable to recall documenting a bed bath for this resident. NA #8 reported that

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| F 561 | Continued From page 13<br>she had not usually been assigned to Resident #36 on her shower days.<br><br>An interview was conducted with the Director of Nursing (DON) on 7/11/19 at 2:03 PM. The DON 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. She reported that if a resident refused a shower that the NA was to offer a shower again later in their shift. The DON indicated if the resident continued to refuse a shower that the NA was to document this refusal in the electronic medical record and report this information to the nurse. | F 561 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff and resident interviews and record review, the facility failed to code the Minimum Data Set (MDS) correctly in the areas of tracheostomy (Resident #10), bowel continence (Resident #16), falls (Resident #30 ) cognation (Resident #66) and mood (Resident #66). This was for 4 of 18 residents reviewed for MDS accuracy. The findings included:<br><br>1. Resident #10 was admitted 8/6/18 with cumulative diagnoses of Chronic Respiratory Failure and a tracheostomy (a surgically created hole in the windpipe to allow air to enter the lungs). | F 641 | Resident #66 Minimum Data Set (MDS) Assessment section of Cognitive Patterns and Mood was reviewed and analyzed by the MDS Coordinator. On 7/30/19, MDS Coordinator and Resident Liaison modified the assessment related to Cognition and Mood and resubmitted for accuracy of the resident□s assessment.<br><br>Resident #30 Minimum Data Set (MDS) Assessment section of Health Conditions was reviewed and analyzed by the MDS Coordinator. On 7/18/19, MDS Coordinator modified the assessment related to Falls and resubmitted for | 8/8/19 |

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| F 641 | Continued From page 14<br><br>Review of Resident #10 annual Minimum Data Set (MDS) dated 4/19/19 indicated he was cognitively intact and exhibited no behaviors. He was coded for supervision with his activities of daily living. He not coded as having a tracheostomy.<br><br>Review of Resident #10's care plan revised 5/1/19 read staff were to assist with his tracheostomy care as needed.<br><br>During an interview with Resident #10 on 7/10/19 at 3:00 PM, he stated he was very comfortable caring for his tracheostomy.<br><br>During an interview on 7/11/19 at 12:50 PM, the MDS Coordinator stated she missed coding the tracheostomy on Resident #10's annual MDS dated 4/19/19. She stated it was an oversight and she submitted a correction to the annual MDS on 7/10/19.<br><br>During an interview on 7/11/19 at 2:03 PM, the Administrator stated it was her expectation that the MDS be coded correctly and include the tracheostomy for Resident #10.<br><br>2. Resident #16 was admitted 3/2/18 with a diagnosis of Alzheimer's Disease.<br><br>Resident #16's quarterly Minimum Data Set (MDS) dated 4/23/19 indicated severe cognitive impairments and she exhibited no behaviors. Section H under bowel continence was checked as not rated due to appliances or no stool during the 7 day look back period. | F 641 | accuracy of the resident□s assessment.<br><br>Resident #10 Minimum Data Set (MDS) Assessment section of Special Treatment, Procedures, and Programs was reviewed and analyzed by the MDS Coordinator. On 7/10/19, MDS Coordinator modified the assessment related to Tracheostomy and resubmitted for accuracy of the resident□s assessment.<br><br>Resident #16 Minimum Data Set (MDS) Assessment section of Bowel and Bladder was reviewed and analyzed by the MDS Coordinator. MDS Coordinator reviewed the look back period for the Quarterly MDS assessment and determined the documentation didn□t support that the resident had a bowel movement and therefore, the MDS coding was accurate. MDS Coordinator interviewed NA # 1 and determined NA #1 did not regularly provide care for Resident #16 and wasn□t familiar with resident□s bowel continence status.<br><br>On 7/11/19, MDS Coordinator was provided education by the Director of Case Mix & Compliance regarding Federal and State regulation to ensure MDS Assessment accuracy in the sections of Health Conditions, Special Treatment, Procedures, and Programs, and Bowel and Bladder. On 7/8/19, Resident Liaison was provided education by the Director of Case Mix & Compliance regarding Federal and State regulation to ensure MDS Assessment accuracy in the sections of Cognitive Patterns and Mood. | |

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| F 641 | Continued From page 15<br><br>Review of Resident #16's care plan last revised 5/15/19 indicated a problem with bowel incontinence and constipation. Interventions included documenting elimination.<br><br>Review of Resident #16 elimination record for April 2019 indicated documented evidence of stools.<br><br>During an interview on 7/10/19 at 3:35 PM, Nursing Assistant (NA) #12 stated Resident #16 was occasionally incontinent of bowel. NA #12 stated she required staff assistance with toileting and if she had a bowel movement during toileting, it would be documented in the electronic record. NA #12 stated it was possible that Resident #16 toileted herself and had a bowel movement and staff were not aware.<br><br>During an interview on 7/1/19 at 1:47 PM, the MDS Nurse stated she reviewed a 7 day look back from 4/17/19 through 4/23/19 and there was documented stool for that 7 days. The MDS Nurse stated she could not recall if she interviewed any of the staff to determine if the look back period was accurate with Resident #16 not having a stool for 7 days. She stated she also could not recall if she informed a nurse that Resident #16's documentation from 4/17/19 to 4/23/19 did not include any documented evidence of a stool. The MDS Nurse confirmed that interviewing and observations should be part of the process when completing the MDS and not to rely solely on the documentation. | F 641 | On 8/6/19, the Service Line Educator will conduct an audit of MDS Assessments, for the period of 7/1/19 through 7/30/19, to ensure MDS Assessment accuracy in the sections of Cognitive Patterns, Mood, Health Conditions, Special Treatment, Procedures, and Programs, and Bowel and Bladder.<br><br>On 7/15/19, Director of Case Mix & Compliance reviewed MDS Assessments for the period of 5/1/19 through 7/19/19, to ensure MDS Assessment accuracy for Cognition, Mood, Falls, Tracheostomy, and Bowel Continence. Initial results of the audit included, modifications were not made correctly, and the Director of Case Mix & Compliance educated MDS Coordinator on accurate modifications. The results of the second audit completed on 7/23/19 included, four assessments not modified correctly, and the Director of Case Mix & Compliance educated the Resident Liaison and re-educated the MDS Coordinator.<br><br>During weekday morning meeting, the Administrative Stand Up Team will utilize the 24 hour report and review new orders. The Administrative Stand Up Team includes the Administrator, Director of Nursing, Dietary Manager, Minimum Data Set (MDS) Coordinator, Admissions Coordinator, Medical Records Coordinator, Environmental Services Manager, Resident Liaison, and Activity Director. Interdisciplinary Team (IDT) members will utilize this information to | |

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| F 641 | Continued From page 16<br><br>During an interview on 7/11/19 at 2:03 PM, the Administrator stated it was her expectation that the MDS be coded correctly, include interviews and observations. She further stated it was her expectation that if there was no documentation of Resident #16 not having a stool for the look back period of 4/17/19 to 4/23/19, it should have prompted the MDS Nurse to notify the nurse.<br><br>3. Resident # 30 was readmitted to the facility on 5/10/17 with multiple diagnoses including Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 5/13/19 indicated that Resident #30 had severe cognitive impairment and she had no falls since admission or prior assessment. The prior MDS assessment was dated 2/19/19.<br><br>Review of the accident/incident reports revealed that Resident #30 had a fall on 3/5/19 at 1:30 PM with no injury.<br><br>Resident #30's nurse's notes were reviewed. The note dated 3/5/19 at 8:15 PM (created on 7/9/19) revealed that the nurse was called to resident's room at 1:30 PM. The resident was noted sitting on the floor in the bathroom between the toilet and the trash can. The resident stated that she missed the toilet when she sat down. There was no injury noted.<br><br>On 7/10/19 at 5:11 PM, the MDS Nurse was interviewed. The MDS Nurse claimed that she had a note on her calendar that Resident had a fall on 3/5/19 with no injury. She reviewed the | F 641 | assure Cognition, Mood, Falls, Tracheostomy, and Bowel Continence will be correctly coded on the MDS. IDT members include the MDS Coordinator, Dietary Manager, Resident Liaison, and Activity Director. Review of acute clinical areas/changes listed on the 24 hour report and changes in care via review of orders daily will prompt MDS Coordinator to make sure needed documentation is present in the record to facilitate accurate coding and update care plans. On 7/31/19, communication form will be developed to facilitate communication between nursing and MDS Coordinator. On 7/31/19, the Service Line Educator will educate nurses on communication form protocol. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new nursing staff on communication form protocol, will be provided by the Service Line Educator.<br><br>Director of Nursing (DON) or designee, will conduct weekly audits of 5 MDS Assessments to ensure compliance. Any identified issues will be corrected by MDS Coordinator at that time. Results of the monitoring will be shared by DON with the Administrator and Director of Nursing on a weekly basis and by DON with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |

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quarterly MDS assessment dated 5/13/19 and stated that she coded the fall incorrectly.

On 7/11/19 at 2:10 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the MDS assessment to be coded accurately. The DON verified that Resident #30 had a fall on 3/5/19.

4. Resident #66 was admitted to the facility on 6/3/19 with diagnoses that included aphasia (loss of ability to understand or express speech) following cerebral infarction, hip fracture, and dementia.

A nursing note dated 6/6/19 indicated Resident #66 was alert and able to verbalize needs. She was noted with mumbled speech at times.

On 7/8/19 at 3:30 PM the admission Minimum Data Set (MDS) assessment dated 6/10/19 was reviewed. This MDS indicated Resident #66 was not in a persistent vegetative state. Section C (Cognitive Patterns section) and Section D (Mood section), were coded to indicate Resident #66 was rarely/never understood and that the Brief Interview for Mental Status (BIMS) and the resident mood interview were not conducted. Sections C and D were completed by the Social Worker (SW).

An interview was conducted with Resident #66 on 7/8/19 at 4:10 PM. Resident #66 was alert and oriented to self. She was able to answer closed ended questions with logical answers but was unable to answer open ended questions due to confusion. Resident #66 ' s speech was mumbled at times.

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On 7/9/19 at 10:20 AM Resident #66 ' s admission MDS assessment dated 6/10/19 was reviewed on the facility ' s Electronic Medical Records (EMR) system. This review revealed the 6/10/19 MDS for Resident #66 had been changed to indicate the resident interviews on Section C and Section D had been conducted and the resident was coded as severely impaired (score of 99 on the BIMS). A modification assessment for the 6/10/19 MDS for Resident #66 had not been initiated.

On 7/9/19 at 10:25 AM the admission MDS assessment dated 6/10/19 was reviewed on the Aspen Central Office (ACO) MDS database. This reviewed confirmed the 6/10/19 MDS assessment for Resident #66 that was transmitted to the National Database (NDB) had coded Resident #66 as rarely/never understood on Section C and Section D and the resident interviews (BIMS and mood interview) were not conducted.

An interview was conducted with the SW on 7/9/19 at 10:45 AM. The ACO MDS database that had Section C and Section D of the 6/10/19 MDS for Resident #66 coded as rarely/never understood was reviewed with the SW. The facility ' s EMR system that had Resident #66 ' s 6/10/19 MDS coded to indicate the resident interviews on Sections C and D had been completed was reviewed with the SW. The SW was asked why the facility ' s EMR system had the 6/10/19 MDS coded differently from the assessment that was submitted to the NDB. The SW stated that on the afternoon of 7/8/19 the facility ' s MDS consultant provided her with education on the proper coding of the resident

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interviews on Section C and Section D. She stated that she was unaware of the instructions from the Resident Assessment Instrument (RAI) manual on how to code Section C and D accurately. She reported that based on the RAI manual, Sections C and D of Resident #66 ' s 6/10/19 MDS that was submitted to the NDB had been inaccurate. The SW revealed that the 6/10/19 MDS had been re-opened and she changed her previous answers on this assessment for Resident #66 on 7/8/19. She reported that she had not known why a modification assessment was not initiated for Resident #66 ' s 6/10/19 MDS. She stated that she simply followed her instructions to change her answers.

An interview was conducted with the facility ' s MDS consultant on 7/9/19 at 11:05 AM. She stated that she pulled a report on 7/8/19 of all residents that had been coded as rarely/never understood on the MDS assessments completed during the second quarter of 2019. She revealed that 8 residents had been identified, including Resident #66, on this report. She indicated she provided education to the SW on the instructions in the RAI manual on accurate coding of Sections C and D. The MDS consultant revealed that the SW had been conducting the resident interviews, but she had been coding Sections C ad D to indicate that the interviews were not conducted if the resident was unable to complete the interview in its entirety. She explained that this resulted in the MDS assessments being coded inaccurately. The MDS Consultant was asked why the 6/10/19 MDS for Resident #66 was changed on 7/8/19 without a modification assessment being initiated. She revealed that she had instructed staff to complete modification assessments for the

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| F 641 | Continued From page 20<br>affected MDS assessments. The MDS consultant stated that she was going to provide additional education to the SW and MDS Coordinator on this date (7/9/19) related to modifying MDS assessments and that modification assessments would be initiated for the affected residents, including Resident #66.<br><br>An interview was conducted with the Director of Nursing (DON) on 7/11/19 at 2:03 PM. She indicated she expected the MDS to be coded accurately. | F 641 | | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline | F 655 | | 8/8/19 |

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| **STANLY MANOR** | **625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001** |

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| F 655 | Continued From page 21<br>care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to complete an initial baseline care plan within 48 hours of admission and failed to provide a copy of the baseline care plan to the resident's responsible party. The facility also failed to include oxygen therapy on the baseline care plan for 1 of 1 newly admitted sampled residents (Resident #270).<br><br>The findings included:<br><br>Resident admitted to the facility on 6/30/19 with diagnoses that included chronic obstructive pulmonary disease (COPD) and hypertension.<br><br>An admission Minimum Data Set (MDS) was in progress. | F 655 | On 7/4/19, the initial baseline care plan was completed for Resident #270. On 7/22/19, the initial baseline care plan was reviewed and a copy was provided to the resident□s representative.<br><br>Service Line Educator will educate Nurse #1 the process for ensuring the initial baseline care plan will be completed within 48 hours of admission and a copy provided to the resident/resident representative. Nurse #1 was educated 7-31-19<br><br>Beginning 7/31/19, the Service Line Educator will educate all nurses on the process for ensuring the initial baseline care plan will be completed within 48 | |

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| F 655 | Continued From page 22<br>A review of the physician orders dated 6/30/19 revealed oxygen at 2 liters (L) continuously.<br><br>A review of the baseline care plan dated 7/4/19 revealed no mention of oxygen therapy or that a copy of the care plan was provided to the resident, resident representative or both.<br><br>During an interview on 7/11/19 at 10:53am, Resident #270's responsible party indicated he was not provided a copy of the baseline care plan.<br><br>On 7/11/19 at 11:00am a phone interview occurred with Nurse #1 who was the admitting nurse for Resident #270. She indicated the admitting nurse was to initiate the baseline care plan however Resident #270's baseline care plan was not started until 7/4/19. She stated it was an oversight not to include oxygen therapy on the care plan and she had not provided a copy to the resident's responsible party.<br><br>The administrator indicated on 7/11/19 at 11:08am, the facility had identified incomplete baseline care plans as a current problem and they had a Performance Improvement Plan (PIP) in place. She reported the PIP was initiated on 7/5/19. The Administrator provided this PIP dated 7/5/19 for review. The PIP indicated that the correction action was to be fully implemented by 7/12/19 and included education, audits and ongoing monitoring. The Administrator acknowledged the baseline care plan was completed greater than 48 hours of admission.<br><br>On 7/11/19 at 11:40am the Director of Nursing reviewed the baseline care plan and acknowledged it was initiated greater than 48 | F 655 | hours of admission and a copy provided to the resident/resident representative. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new nurses on the process for ensuring the initial baseline care plan will be completed within 48 hours of admission and a copy provided to the resident/resident representative, will be provided by the Service Line Educator.<br><br>On 8/6/19, the Medical Records Coordinator will conduct an audit of baseline care plans, for the period of 7/1/19 through 7/30/19, to ensure initial baseline care plans were completed within 48 hours of admission and a copy was provided to the resident/resident representative.<br><br>During weekday morning meeting, the Administrative Stand Up Team will utilize the 24 hour report to review admissions. The Administrative Stand Up Team includes the Administrator, Director of Nursing, Dietary Manager, Minimum Data Set (MDS) Coordinator, Admissions Coordinator, Medical Records Coordinator, Environmental Services Manager, Resident Liaison, and Activity Director. Interdisciplinary Team (IDT) members will utilize this information to ensure initial baseline care plans will be completed within 48 hours of admission and resident/resident representative provided a copy. IDT members include | |

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| F 655 | Continued From page 23<br>hours after admission and a copy was not provided to the responsible party.<br><br>On 7/11/19 at 12:51pm an interview occurred with the Nurse Educator Consultant who stated an audit of new admission assessments was conducted in June 2019 and several charts were noted to have no baseline care plans completed. Nursing staff began completion of missing documents on 7/4/19 and education on initiating the baseline care plan within a 24 to 48 hour period began on 7/5/19.<br><br>The Director of Nursing was interviewed on 7/11/19 at 11:15am and stated it was her expectation for the baseline care plan to be completed within 48 hours of admission, the resident and/or responsible party to receive a copy of the baseline care plan and for baseline care plan to be individualized based on the resident's need. | F 655 | the MDS Coordinator, Dietary Manager, Resident Liaison, and Activity Director.<br><br>MDS Coordinator or designee, will conduct weekly 100% audit of Baseline Care Plans, which are completed by the nurses on the unit, to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared by MDS Coordinator with the Administrator and Director of Nursing on a weekly basis and by MDS Coordinator with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as | F 656 | | 8/8/19 |

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| F 656 | Continued From page 24<br>required under §483.24, §483.25 or §483.40; and<br>(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).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to develop an individualized care plan for the use of an indefinite antibiotic for 1 of 5 residents reviewed for unnecessary medications (Resident #12).<br><br>The findings included:<br><br>Resident #12 was admitted to the facility on 7/11/17 with diagnoses that included history of urinary tract infections (UTIs), osteoarthritis and | F 656 | On 7/12/19, MDS Coordinator developed an individualized care plan, addressing prophylaxis antibiotic therapy, for Resident #12.<br><br>On 7/15/19, Director of Case Mix & Compliance educated MDS Coordinator to develop individualized care plans, for residents with prophylaxis antibiotic therapy. | |

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| F 656 | Continued From page 25<br>muscle weakness.<br><br>A review of Resident #12's medical record revealed an order dated 7/13/17 for Cipro 250 milligrams (mg) half a tab to equal 125mg every night for UTI prophylaxis (preventive treatment) indefinitely.<br><br>A review of the quarterly Minimum Data Set (MDS) assessment, dated 4/23/19 revealed the resident to be cognitively intact. She received extensive assistance for Activities of Daily Living (ADL's) except for eating. She had received 7 days of an antibiotic during the 7 day look back period.<br><br>Review of the active care plan dated 5/1/19 revealed the resident was not care planned for the indefinite use of an antibiotic for UTI prophylaxis.<br><br>Review of the June 2019 and July 1 through July 8, 2019 Medication Administration Records (MARs) revealed the resident received Cipro 125mg every day as ordered.<br><br>On 7/11/19 at 9:00am an interview occurred with the MDS nurse. She indicated she should have developed a care plan for the indefinite use of an antibiotic for Resident #12.<br><br>The Director of Nursing was interviewed on 7/11/19 at 11:15am and stated it was her expectation for the care plan to be person centered and should have included the use of an indefinite prophylactic antibiotic. | F 656 | On 7/31/19, Service Line Educator will conduct facility-wide audit of residents on prophylaxis antibiotic therapy to ensure addressed in individualized care plans. The results of the audits revealed 3 residents with current diagnoses that supports long term antibiotic therapy .<br><br>During weekday morning meeting, the Administrative Stand Up Team will utilize the 24 hour report and review new orders. The Administrative Stand Up Team includes the Administrator, Director of Nursing, Dietary Manager, Minimum Data Set (MDS) Coordinator, Admissions Coordinator, Medical Records Coordinator, Environmental Services Manager, Resident Liaison, and Activity Director. IDT members will utilize this information to ensure prophylaxis antibiotic therapy will be addressed in individualized care plans. IDT members include the MDS Coordinator, Dietary Manager, Resident Liaison, and Activity Director.<br><br>Director of Case Mix & Compliance or designee, will conduct monthly 100% audit of individualized care plan of residents on prophylaxis antibiotic therapy to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared by MDS Coordinator with the Administrator and Director of Nursing on a weekly basis and by MDS Coordinator with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |

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| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and interviews with staff, the facility failed to review and revise care plans in the areas of an indwelling catheter (Resident #66) and falls (Resident #17) for 2 of 18 residents reviewed.<br><br>The findings included: | F 657 | On 7/14/19, MDS Coordinator developed an individualized care plan, addressing indwelling catheter, for Resident #66.<br><br>On 7/11/19, MDS Coordinator developed an individualized care plan, addressing falls, for Resident #17. | 8/8/19 |

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| F 657 | Continued From page 27<br>1. Resident #66 was admitted to the facility on 6/3/19 with diagnoses that included urinary retention.<br><br>A physician ' s order dated 6/10/19 for Resident #66 indicated a Foley catheter was to be inserted for urinary retention.<br><br>The admission Minimum Data Set (MDS) assessment dated 6/10/19 indicated Resident #66 had short-term and long-term memory problems and severely impaired decision making. She was coded with an indwelling catheter.<br><br>A physician ' s order dated 6/12/19 for Resident #66 indicated the Foley catheter was to be discontinued.<br><br>A physician ' s order dated 6/14/19 for Resident #66 indicated a Foley catheter was to be inserted for urinary retention.<br><br>The care plan for Resident #66 was reviewed on 7/8/19. This care plan indicated Resident #66 previously had the problem/need area of the risk for Urinary Tract Infection due to an indwelling catheter. This problem/need area was noted to be resolved as a result of the removal of the Foley catheter. This revision was signed by the MDS Coordinator.<br><br>An observation was conducted of Resident #66 on 7/8/19 at 4:10 PM. Resident #66 had a urinary catheter.<br><br>An interview was conducted with the MDS Coordinator on 7/9/19 at 4:20 PM. The active care plan for Resident #66 that indicated the problem/need of an indwelling catheter had been | F 657 | On 7/11/19, Director of Case Mix & Compliance educated MDS Coordinator to review and revise individualized care plans, for residents with indwelling catheter and falls.<br><br>On 8/2/19, Medical Records Coordinator will conduct a facility-wide audit of care plans for residents with indwelling catheter and falls to ensure addressed in individualized care plans.<br><br>During weekday morning meeting, the Administrative Stand Up Team will utilize the 24 hour report and review new orders. The Administrative Stand Up Team includes the Administrator, Director of Nursing, Dietary Manager, Minimum Data Set (MDS) Coordinator, Admissions Coordinator, Medical Records Coordinator, Environmental Services Manager, Resident Liaison, and Activity Director. Interdisciplinary Team (IDT) members will utilize this information to ensure indwelling catheter and falls will be addressed in individualized care plans. IDT members include the MDS Coordinator, Dietary Manager, Resident Liaison, and Activity Director.<br><br>Director of Case Mix & Compliance or designee, will conduct monthly 100% audit of individualized care plan of residents with indwelling catheters and falls to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared by MDS Coordinator with the Administrator and Director of Nursing on a weekly basis | |

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| F 657 | Continued From page 28<br>resolved was reviewed with the MDS Coordinator. The active order for Resident #66 ' s Foley catheter was reviewed with the MDS Coordinator. The MDS Coordinator acknowledged that this care plan was inaccurate as the problem/need of an indwelling catheter should have be revised when the catheter was re-inserted on 6/14/19. She stated that the third shift nurses were supposed to review all orders and then provide the hard copy orders to her, so she could review them and update the care plans accordingly. She revealed that this process was not always followed. The MDS Coordinator stated that she had not known Resident #66 ' s catheter was re-inserted.<br><br>An interview was conducted with the Director of Nursing (DON) on 7/11/19 at 2:03 PM. She indicated she expected care plans to be reviewed and revised to reflect the current status of the residents.<br><br>2) Resident #17 was admitted to the facility on 11/9/18 with diagnoses that included Alzheimer's disease, anxiety disorder and muscle weakness.<br><br>The most recent Minimum Data Set (MDS) coded as a quarterly assessment and dated 4/23/19 revealed the resident to have moderately impaired cognition. She received extensive to total dependence on one to two staff members for all Activities of Daily Living (ADLs). She had no impairment with range of motion and utilized a wheelchair. Resident #17 was frequently incontinent of urine, always incontinent of bowel and had no falls during the look back period.<br><br>A review of the incident report dated 5/21/19 revealed interventions for the fall included "foam | F 657 | and by MDS Coordinator with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |

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| F 657 | Continued From page 29<br>noodles to bed and padding placed to refrigerator, etc.".<br><br>A review of the active care plan revealed a care plan in place for risk of falls due to muscle weakness, impaired mobility, Alzheimer's disease. The goals were reasonable and measurable. The interventions included, in part: out of bed daily, toilet as directed, call bell available and answered promptly, non-skid shoes or socks when out of bed, therapy to treat as indicated, 2 persons assist for transfers, keep personal items within reach and foam noodles to bed (initiated 5/22/19).<br><br>An observation occurred with Resident #17 on 7/10/19 at 3:25pm. She was sitting upright in the wheelchair watching TV in her room. Foam noodles were noted on both sides of the bed and foam padding was present to the edge of the refrigerator and nightstand.<br><br>On 7/11/19 at 8:50am an interview occurred with the MDS nurse. She stated the foam padding was placed to the edges of the refrigerator and nightstand on 5/22/19 but she failed to add them on the care plan.<br><br>The Director of Nursing was interviewed on 7/11/19 at 11:40am and stated it was her expectation for all interventions related to falls to be placed on the care plan. | F 657 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, | F 658 | | 8/8/19 |

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| F 658 | Continued From page 30<br>must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff and Responsible Party (RP) interviews and record review, the facility failed to follow the oral surgeon's orders following an oral biopsy for 1 (Resident #11) of 1 resident reviewed for professional standards of quality. The findings included:<br><br>Resident #11 was admitted on 3/10/18 with a diagnosis of Dementia.<br><br>Review of Resident #11's quarterly Minimum Data Set dated 4/16/19 indicated severe cognitive impairment and exhibited psychosis and wandering behaviors. She was coded for supervision with her activities of daily living.<br><br>Review of Resident #11's care plan revised 5/1/19 included staff monitoring for discomfort or pain and provide interventions as ordered.<br><br>Review of a care plan meeting note dated 5/1/19 read Resident #11 developed a mouth ulcer and was to be seen by the dentist.<br><br>Review of a nursing note dated 5/13/19 at 3:28 PM read Resident #11 was seen by the dentist today.<br><br>Review of the dental consult dated 5/13/19 recommending an oral biopsy to rule out oral cancer.<br><br>Review of the oral surgeon consult dated 5/16/19 read a biopsy was taken of the lesion under her tongue. There was prescription for Peridex | F 658 | Resident #11 was discharged on 6/14/19. Nurse #16 and #17 noted in this deficiency are no longer employed at the facility.<br><br>Beginning 7/31/19, Service Line Educator will educate all nurses on the process for ensuring orders will be initiated following a resident□s consult visit. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new nurses to ensure orders will be initiated following a resident□s consult visit, will be provided by the Service Line Educator.<br><br>On 7/31/19, the Service Line Educator will conduct an audit of consult visits, for the period of 7/1/19 through 7/30/19, to ensure orders were initiated following a resident□s consult visit. The results of the audit revealed no negative findings.<br><br>On 7/31/19, a new sign off tool was developed and initiated for transportation staff, to indicate that orders returned to the facility, following a resident□s consult visit and for nursing to validate orders were initiated. Beginning 7/31/19, Service Line Educator will educate transportation staff and all nurses on the new sign off tool protocol. Any staff member who does | |

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| F 658 | Continued From page 31<br>(prescription antimicrobial oral rinse used to treat gingivitis and promote the healing of inflamed gums) and Motrin (pain reliever) 600 milligrams (mg) every 6 hours for pain dated 5/16/19.<br><br>Review of Resident #11's Physician order revealed the order for Peridex was not carried out until 5/18/19. Review of B.R.'s May 2019 and June 2019 Physician orders included scheduled Ibuprofen (pain reliever) 600 mg every 6 hours for pain.<br><br>Review of B.R.'s nursing notes from 5/1/19 to 6/14/19 included no reports of oral pain.<br><br>Review of B.R. Medication Administration Records for May 2019 and June 2019 revealed she received her Ibuprofen as ordered.<br><br>Review of a grievance form dated 5/23/19 read Resident #11's orders were not carried out, not entered when she returned for the oral surgeon Thursday evening 5/16/19. The orders were not entered until Saturday. The investigation findings read the Director of Nursing (DON) provided education regarding following through with orders timely, The nurse obtained the medication from the hospital on Saturday 5/18/19. The grievance was submitted by Resident #11's RP.<br><br>During a telephone interview on 7/9/19 at 9:48 AM, Resident #11's RP stated she did not receive her ordered mouth rinse until Saturday 5/18/19. She stated Resident #11 returned to the facility sometime the afternoon of 5/16/19 and she left an envelope with a nurse.<br><br>During an interview on 7/10/19 at 8:40 AM, the DON stated it was late in the day when Resident | F 658 | not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new transportation staff and nurses on the new sign off tool protocol, will be provided by the Service Line Educator.<br><br>Medical Records Coordinator or designee, will conduct monthly 100% audit of new sign off tool to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared by Medical Records Coordinator with the Administrator and Director of Nursing on a weekly basis and by Medical Records Coordinator with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |

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| F 658 | Continued From page 32<br>#11 returned from the oral surgeon. She stated apparently Nurse #16 did not take off the orders on 5/16/19. The DON confirmed Resident #11 did not receive her Peridex until Saturday 5/18/19. She stated a nurse went to the hospital to get the Peridex. The DON stated she counseled Nurse #16 and she no longer worked at the facility.<br><br>During a telephone interview on 7/10/19 at 8:30 PM, Nurse #16 stated she came in at 7:00 PM on 5/16/19 and Resident #11 was already back from the oral surgeon. She stated she did not see any new orders. Nurse #16 stated the nurse she relieved did not tell her there were any new orders or orders that needed to be taken off. Nurse #16 stated the DON asked her about the Peridex order, but she reported to the DON that she never saw the order. Nurse #16 stated it should have been done after Resident #11 returned from the oral surgeon or reported to her that she needed to process the order.<br><br>A telephone call and message were left for Nurse #17 assigned Resident #11 on 5/16/19 from 7:00 AM to 7:00 PM. She did not return the surveyors call.<br><br>During an interview on 7/11/19 at 2:03 PM, the Administrator and the DON stated it was their expectation that Resident #11's order for Peridex would have been processed on 5/16/19 and not have waited until 5/18/19. | F 658 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains | F 689 | | 8/8/19 |

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| F 689 | Continued From page 33<br>as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff and Physician interviews and record review, the facility failed to prevent an unsupervised exit of a cognitively impaired resident previously identified with wandering behaviors (Resident #11). Resident #11 sustained no injuries as a result of the unsupervised exit. In addition, the facility failed to investigate and analyze causative factors to prevent further falls (Resident #38 and Resident #17). Resident #38 sustained 4 falls in 6 months one of which resulted in a laceration and one resulted in a right shoulder fracture requiring no surgical intervention. Resident #17 sustained 3 falls in 4 months with 2 of these falls resulting in abrasions and bruising to her head. This was for 3 of 4 residents reviewed for accidents. The findings included:<br><br>1. Resident #11 was admitted on 3/10/18 with a diagnosis of Dementia. Resident #11 was identified on 3/10/18 as an elopement risk and an alarm device was recommended.<br><br>A physician's order dated 4/9/18 read: Roam Alert bracelet (a radio transmitter attached to a resident so that when a resident approaches an exit, the door controller locks the door and transmits an audible alarm) with expiration on 9/14/20. The order read to check placement every shift.<br><br>Resident #11's annual Minimum Data Set dated | F 689 | Following Resident #11□s unsupervised exit, the resident was placed on 30 minute checks to ensure her safety and to monitor her location. Facility-wide observation was conducted and all residents were accounted for in building. Residents with Roam Alert bracelets, a mechanism to reduce the risk of an unsupervised exit, were checked for placement and proper functioning. In addition, assured residents with Roam Alert bracelets had orders in place to check placement and function.<br>Facility-wide elopement assessments were completed for all residents. On 4/13/19, the Roam Alert vendor adjusted the front door alarm for sound volume and range. Beginning 4/16/19, staff were inserviced on elopement protocol. Service Line Educator will educate Nurse #3, NA #6 and #7, and Medication Aide #1 and #2, process to check for placement and proper functioning of Room Alert bracelets.<br><br>On 8/2/19, Service Line Educator will investigate and analyze falls for Resident #38 and Resident #17 and review outcomes with the Interdisciplinary Team (IDT) members. The audit revealed lack of investigation process. IDT members include the MDS Coordinator, Dietary | |

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| F 689 | Continued From page 34<br>1/23/19 indicated she had moderate cognitive impairment with no wandering behaviors in the 7 day look back period. She was coded as independent with ambulation.<br><br>Resident #11's care plan dated 2/12/19 indicated she was a risk for wandering. Interventions included a Roam Alert bracelet to be worn at all times and the nurse was to check placement every shift.<br><br>Resident #11's elopement risk assessment dated 3/5/19 indicated she was an elopement risk and recommended continuation of an alarm device.<br><br>A Roam Alert monthly Preventative Maintenance Form dated 3/21/19 indicated the system was functioning properly.<br><br>The facility layout was as follows: Resident #11 resided on the 200 hall on the first floor. The front entrance to the facility was on the first floor. The first floor housed all residents and the nursing station. There was only one elevator located at the nursing station leading to the ground level. The beauty shop, dining room, therapy room, medical records and kitchen were located on the ground floor.<br><br>A nursing note completed by Nurse #3 dated 4/13/19 at 7:21 AM read as follows: on 4/12/19 at 10:45 PM, Resident #11 was observed outside the door at the end of 200 hall. She was brought inside and assessed for injuries. There were no injuries identified. Resident #11's Roam Alert bracelet was tested and found to be functioning properly. The Physician, Administrator, Director of Nursing (DON) and the Responsible Party (RP) were all notified. Resident #11 was placed on 30 | F 689 | Manager, Resident Liaison, and Activity Director. IDT members will develop individualized care plans for Resident #38 and Resident #17, to reduce the risk of further falls. Nurse #2, #5 and #6 and NA #5, #8, #9, and #11, will be updated on the individualized care plan interventions to address fall risk for Resident #38 and Resident #17. The Director of Nursing (DON) noted in this deficiency is no longer employed at the facility.<br><br>During weekday morning meeting, the Administrative Stand Up Team will utilize the 24 hour report and review new orders. The Administrative Stand Up Team includes the Administrator, Director of Nursing (DON), Dietary Manager, Minimum Data Set (MDS) Coordinator, Admissions Coordinator, Medical Records Coordinator, Environmental Services Manager, Resident Liaison, and Activity Director. The DON will be responsible for conducting a thorough investigation for all elopement and falls. IDT members will utilize this information to ensure wandering behaviors and falls will be addressed in individualized care plans.<br><br>Service Line Educator will educate all facility staff on the Care Event process. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new staff on the Care Event process, will be provided by the Service Line Educator. The Care | |

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| F 689 | Continued From page 35<br>minute visual checks throughout the night and next day. The note read the temperature at the time Resident #11 was discovered was 68 degrees and it had rained earlier in the day but was not raining that evening. She was wearing long sleeves, long pants and bedroom shoes.<br><br>During a telephone interview on 7/8/19 at 8:43 PM, Nurse #3 stated she was working on another hall she heard Medication Aide (MA) #1 call for help because Resident #11 was outside the door on 200 hall. She stated Resident #11 did not appear fearful but confused. She assessed her for injuries and found none. Nurse #3 stated she called the Administrator, the Physician, DON and RP. She stated Resident #11 was last seen at around 9:30 PM and was brought back inside at around 10:45 PM. Nurse #3 stated Nursing Assistant (NA) #6 reported to her that Resident #11 was sitting on the couch in the lobby at 9:30 PM but she did not recall NA #6 reporting anything about her Roam Alert bracelet not working. Nurse #3 stated there had been an ongoing issue with the Roam Alert bracelets not sounding until a resident was at the front door and she had let administration know. She was unable to recall when she informed administration about her concerns related to the alarms. Nurse #3 stated after Resident #11 got outside unsupervised, the facility had the company come and adjust the alert range so now it alarms if resident gets near reception desk but that was only done after Resident #11's unsupervised exit. Nurse #3 confirmed she checked placement of the Roam Alert bracelets on her shift. Nurse #3 stated she discovered after the incident that Resident #11 was found on the ground level by the Dietary Manager earlier on 4/12/19 and apparently, she was brought back up from the | F 689 | Event process provides facility staff an electronic mechanism to report resident Incidents and Accidents. This information is forwarded to Risk Management who distributes it back to the facility with 24 hours, to conduct a thorough investigation and develop interventions. The Interdisciplinary Team (IDT) members will review the outcome of the investigation and update resident□s care plans, accordingly. Service Line Educator will educate nurses on the Incident Reporting function in AHT (American Healthtech □ Electronic Medical Record). The Incident Reporting function in AHT provides nurses electronic access to the Resident Incident Report system for reporting, investigation, follow-up, and tracking and trending. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new nurses on the Incident Reporting function in AHT, will be provided by the Service Line Educator.<br><br>On 7/30/19, the Fall and Safety Committee initiated a new falls log to track falls, validate a thorough investigation was conducted, interventions were developed and addressed in care plans.<br>The Fall and Safety Committee includes the Administrator, DON, Admissions Coordinator, MDS Coordinator, Finance, Activity Director, Resident Liaison, and Therapy.<br><br>On 7/31/19, the facility will implement a | |

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| F 689 | Continued From page 36<br>ground level without letting anyone know. Nurse #3 stated there were several admissions that day with lots of visitors going to the ground level for snacks and drinks. She stated it was possible Resident #11 got on the elevator with them because she did not feel Resident #11 had the cognitive ability to use the elevator "key" to push the down button on the elevator. Nurse #3 stated she did not recall hearing any alarms at the approximate time Resident #11 was suspected of going outside but she thought it would have sounded even if she went out the front door behind visitors.<br><br>The Skilled Nursing Event Investigation and Immediate Action Plan included instructions that the document should be completed by a nursing leader within 24 hours of the incident. The date documented as complete was 4/26/19 and completed by the DON. The form read as follows: Resident #11 was noted outside the facility standing at the 200 hall door waving at staff. Staff immediately went down the hall, entered the code to the locked door and brought Resident #11 inside. She was ambulatory and guided to her room. Resident #11 had been on isolation for approximately 3 weeks related to influenza and pneumonia. She was recently cleared to resume her normal activities. Resident #11 was described as ambulatory, alert, awake but confused. Resident #11 routinely went to the front door and was frequently redirected and had done so on 4/12/19. She had a Roam Alert bracelet in place with orders to check placement every shift and function daily. There were no injuries and no complaints. Neurological checks and visual checks were initiated for every 30 minutes. Her elopement risk was re-evaluated, and her care | F 689 | new Wander Data Collection Tool. This will assist nursing staff with evaluating risks and determining appropriate interventions to address wandering behaviors, on admission, readmission, quarterly, annually, and significant change. The Service Line Educator will educate all nursing staff on the new Wander Data Collection Tool. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new nursing staff on the Wander Data Collection Tool, will be provided by the Service Line Educator.<br><br>DON or designee, will conduct weekly 100% audit of the new Wander Data Collection Tool to ensure nursing staff evaluated risks and determined appropriate interventions to address wandering behaviors, on admission, readmission, quarterly, annually, and significant change. DON or designee, will conduct weekly 100% audit of the Care Event log to ensure Incidents and Accidents are thoroughly investigated, interventions are developed and addressed in care plans. Any identified issues will be corrected at that time. Results of the monitoring will be shared by DON with the Administrator and Director of Nursing on a weekly basis and by DON with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |

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plan was updated 4/13/19. A facility wide head-in-bed check was done, and all residents were identified as present. Residents with Roam Alert bracelets were identified, checked for placement and function. All were functioning properly. Elopement risk assessment were completed on all residents from 4/13/19 to 4/14/19. Door checks were completed to ensure proper function and range. The Roam Alert vendor was contacted to adjust the front door alarm for sound volume and range.

A contractor invoice dated 4/13/19 read as follows: Resident elopement had last night. A request that the system be tested to ensure that the system was not at fault. The system was tested with Administration for 4 hours. The form did not indicate outcome of testing.

Resident #11's wandering care plan was revised on 4/13/19 to include 30 minute checks through the night and next day.

A Physician's order dated 4/16/19 read, check Resident #11's Roam Alert bracelet for function daily.

Review of the The Elopement In-service records provided by the DON read the in-servicing began on 4/16/19 and was completed on 4/29/19. The in-services roster did not include any environmental staff, dietary staff or rehabilitation staff.

Review of a A Roam Alert monthly Preventative Maintenance Form dated 4/17/19 indicated the system was functioning properly and the front door alarm was adjusted if a tagged resident stayed by the door for around 30-45 seconds.

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During an interview on 7/8/19 at 3:20 PM, the Maintenance Supervisor stated he was not involved in investigation but believed Resident #11 walked out the front door with visitors that night. He stated he assessed the door alarms daily for function and the nurses check the bracelets daily for placement and function. He further stated the Roam Alert provider checked the entire system monthly. The Maintenance Supervisor took surveyor to the ground level using the elevator. He stated the beautician, the dietary and therapy departments and medical records were housed on the ground level. The elevator was equipped with a clear plastic covering with a hole drilled in order to use what was described as a "key" to insert into the hole to push the down button on the elevator. Once on the ground level, the Maintenance Supervisor identified a total of 5 exit possibilities. Only 1 of the 5 doors was equipped with the Roam Alert device. It was the door at the loading dock area. He stated 2 doors were in therapy and 1 door was in medical records while the forth door was in the fine dining room. He stated the doors in therapy and medical records were locked at 5:00 PM and the door to the fine dining room was always locked from the outside but always open from inside the room. The Maintenance Supervisor stated he did not feel Resident #11 exited the facility using the elevator and going out any of the doors on the ground level. He did state after Resident #11's unsupervised exit, the "key" that hung at the elevator was moved to behind the nursing station.

During an interview on 7/8/19 at 4:00 PM, MA #1

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stated she was passing medications on another hall around 10:45 PM when she saw Resident #11 standing outside the door at the end of 200 hall. She called for a nurse and they went and let Resident #11 back in. The nurse assessed her for injuries and found none. MA #1 stated Resident #11 was known to wander independently around the facility. She stated Resident #11 had been observed wandering around the facility before and after dinner and had to be redirected on several occasions. MA #1 stated she did not recall hearing any alarms the evening of 4/12/19 and could not recall the last time she saw Resident #11 prior to 10:45 PM. She stated there had been several admissions that day and there were visitors in and out that evening. MA #1 stated she did not feel Resident #11 exited the facility using the elevator and going out one of the doors on the ground level. She stated she did not feel Resident #11's cognition would have been such that she could use the "key" to open the elevator door. She confirmed in-servicing on elopement after the incident.

During an interview on 7/8/19 at 4:14 PM, the Hospital Service Manager stated he was unsure of the date the Administrator notified him of the unsupervised exit but that the Administrator did not give him any sense of urgency. He stated the Administrator requested to know what it would take to put alarms on the elevator and the other doors on the ground level. He stated he put in a request to the hospital "higher ups" on 4/19/19 but that he had not followed up on the request until 7/8/19. He stated a service person was coming 7/12/19 to determine if it was possible to arm the elevator and 4 other doors on the ground level not equipped with the Roam Alert device. He

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stated it was his impression that it was just as extra precaution because the Administrator felt Resident #11 went out front door with visitors. He confirmed the Roam Alert would have sounded if that was how Resident #11 went out, but it was possible that someone at the nursing station reset the alarm without checking to see if a resident was missing.

During an interview on 7/8/19 at 5:10 PM, MA #2 stated she was assigned the 200 hall on 4/12/19 and she last saw Resident #11 at approximately 9:15 PM when she attempted to administer her medications. She stated Resident #11 refused her medications and had been agitated and wandering around the facility over the course of the shift. MA #2 stated she checked Resident #11 placement of her Roam Alert bracelet at the beginning of her shift at around 3:00 PM. She stated function of the bracelet was done on first shift. MA #2 stated she did not recall hearing any alarms the evening of 4/12/19.

During an interview on 7/8/19 at 5:23 PM, NA #6 stated Resident #11 was known to wander around the facility. She stated she was returning from her dinner break with NA #7 at approximately 9:30 PM. She stated they entered the facility through the front door. She recalled seeing Resident #11 sitting on the couch in the lobby and noted it as odd that her Roam Alert bracelet was not setting off the alarm. NA #6 stated she reported it to someone but did not recall who she reported it too. She stated she was in-serviced about the elevator "key" being kept at the nursing station, but she personally did not feel Resident #11 went

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outside the facility using the elevator to go out one of the ground floor doors due to her cognition. NA #6 recalled a family of approximately 4-5 leaving the facility sometime after 9:30 PM and she felt that when they exited, Resident #11 went outside behind them. She stated her Roam Alert should have sounded but she did not recall hearing any alarms during the latter part of her shift.

During a telephone interview on 7/9/19 at 9:41 AM, NA #7 was assigned Resident #11 the evening of 4/12/19. She recalled Resident #11 had been wandering around facility the whole shift. NA #7 recalled coming back from break around 9:30 PM and saw Resident #11 sitting on the couch in the lobby but her alarm was not sounding. NA #7 stated it normally sounded when she was sitting on the couch in the lobby since it was near the front door. NA #7 stated she thought she mentioned it to someone but did not recall who she told. She stated she was not aware that Resident #11 was found on the ground level earlier that day. She stated residents went downstairs for therapy, to get their hair done and sometimes for activities in the fine dining room.

During an interview on 7/9/19 at 10:25 AM, the Dietary Manager (DM) stated she was working the tray line in the kitchen on the ground level when she heard the alarm on 4/12/19. She stated it sounded when a resident wearing a Roam Alert bracelet was near the loading dock door. She stated this was at approximately 5:30 PM. The DM stated she went to see who it was and found Resident #11 standing outside the kitchen door and she appeared frightened because the alarm

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sounded very loud in the hall. She stated she took Resident #11 back up the main level using the elevator and she notified staff at the nursing station. She stated she did not recall who she informed. The DM stated someone gave her the code to enter into the keypad on the ground level to reset the alarm. She stated she went back down the elevator and entered the keypad code to turn off the alarm. The DM stated she and none of her staff were in-serviced about elopements after the incident involving Resident #11.

During an interview on 7/8/19 at 5:30 PM, the DON stated she and the Administrator investigated the incident, but it was her belief that Resident #11 got outside by using the elevator and going out the loading dock door or the door in the fine dining room. The DON stated Resident #11 was a "smart lady" who had a history of going downstairs and setting off the alarm at the loading dock door just outside the kitchen.

During an interview on 7/9/19 at 11:21 AM, the Administrator stated based on the investigation, she felt Resident #11 went out the front door with visitors. She stated as part of the investigation, it was discovered that there were doors on the ground level that were concerning and could contribute to another unsupervised exit.

During an interview on 7/9/19 at 2:50 PM, the Medical Director stated he had recently taken over as the facility's Medical Director and was only recently became familiar with the unsupervised exit of Resident #11. He stated it

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was his expectation that a resident with known cognitive impairment and wandering behaviors not have any unsupervised exits from the facility.

During an interview on 7/11/19 at 2:03 PM, the Administrator stated it was her expectation that a resident with known cognitive impairment and wandering behaviors not have any unsupervised exits from the facility.

2. Resident #38 was admitted 10/31/14 with cumulative diagnoses of Vascular Dementia and Congestive Heart Failure and under the services of hospice.

Review of a facility incident report dated 2/20/19 at 6:15 PM read Resident #38 was noted on the floor in front of the bed on his back. He had attempted to ambulate without assistance from the wheelchair to the bed. There were no injuries. There was a handwritten note with a question mark and it read "after dinner put to bed as soon as possible." The handwritten note was not dated or signed.

Resident #38's care plan for falls was revised on 2/20/19 to read the following: re-educate resident to call for assistance and wait for assistance to arrive. There was no documented evidence of the intervention to assist Resident #38 to bed after dinner. The care plan also read on 2/21/19 the fall was reviewed by the Fall and Safety committee. The intervention to remind resident to call and wait for assistance was continued.

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Resident #38's quarterly Minimum Data Set (MDS) dated 2/27/19 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for extensive staff assistance with bed mobility, toileting and hygiene and limited staff assistance with transfers. He was coded as incontinent of bladder and bowel and not on any toileting program. Resident #38 was coded for one fall with major injury.

A facility incident report dated 4/2/19 at 6:45 AM read Resident #38 walked unassisted to the bathroom and fell. He was lying on his left side with a skin tear to the top of his right hand. Neurological checks were started. There was another handwritten note on the report that read as follows: therapy screen only related to hospice. The handwritten note was not dated or signed.

A nursing note dated 4/2/19 at 6:48 AM read as follows: called to the room by Nursing Assistant (NA). Resident #38 was lying on the bathroom floor on his left side with two small skin tears to the top of his right hand. His skin tears were treated and his Responsible Party (RP) was notified of the fall. Resident #38 complained of left shoulder pain. RP requested an x-ray but did not want him sent to the hospital. The Physician was notified.

The fall care plan was revised on 4/2/19 to include the intervention of a therapy screen. The care plan also read the fall was reviewed by the Fall and Safety committee. Therapy was to screen.

Review of an x-ray report dated 4/2/19 of

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Resident #38's left shoulder read an acute proximal humerus humeral neck fracture.

Review of a nursing note dated 4/2/19 at 2:42 PM read x-ray report received. Resident #38 had a left humerus and left humeral head fracture. The Nurse Practitioner was made aware. Orders were received to stabilize the arm and refer him to Orthopedics as soon as possible. An appointment was made to see Orthopedics on 4/3/19 at 1:45pm. Currently exhibiting no signs of pain.

Review of an Orthopedic Operative/Procedure Report dated 4/3/19 read Resident #38 required closed treatment of a proximal humerus fracture. Treatment was nonoperative management with sling immobilization. Remove the sling twice daily and as needed for skin care. Gentle elbow range of motion. No shoulder range of motion for 4 weeks. Follow up in 4 weeks for repeat x-ray.

Review of a Physician progress note dated 4/4/19 read he was to receive scheduled morphine 5 milligrams three times daily for 3 weeks and continued as needed.

Review of a Physician progress note dated 6/5/19 read Resident #38 last saw Orthopedic on 6/3/19 and noted improvement.

Review of a facility incident report dated 6/11/19 at 11:40 AM read Resident #38 noted to slide out of his wheelchair onto the floor. There were no injuries. There was a handwritten note that read Dycem (non-slip pad) to chair. The handwritten note was not dated or signed.

The fall care plan was revised on 6/12/19 to include the intervention Dycem to the seat of his

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wheelchair due to a fall on 6/11/19. The care plan did not read that this fall was reviewed by the Fall and Safety committee.

Review of a facility incident report dated 7/3/19 at 11:30 AM read Resident #38 was observed lying on the floor resting on his back with his legs crossed. He was smiling as staff entered. There was a handwritten note that read as follows: at the end of the bed with a laceration to the head. Has a scoop/perimeter mattress. Will collaborate with Hospice. Staff are toileting if he shows interest in going. The handwritten note was not dated or signed.

Review of a nursing note dated 7/3/19 at 6:27 PM read as follows: at 11:30 AM, staff called to room to find resident lying on the floor on his back and the foot of the bed with his legs crossed. No apparent injuries noted while on floor. Assisted to bed and noted a skin tear to his right elbow and a laceration to the back of his head. The Physician was in to evaluate and gave new orders to send Resident #38 out to the hospital for an evaluation. He returned to the facility at 4:39 PM after Dermabond (skin adhesive) applied to the laceration and his CT scan ( a series of x-ray images taken from different angles to create cross-sectional images of bones, blood vessels and soft tissues) was negative for injuries.

There was no documented evidence his care plan was revised after the fall on 7/3/19. The care plan did not read this fall was reviewed by the Fall and Safety committee.

During an interview on 7/9/19 at 2:50 PM, the Medical Director stated it was his expectation that all resident falls be analyzed to determine the

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cause and the implementation of effective interventions.

During an interview on 7/10/19 at 11:00 AM, The Director of Nursing (DON) stated she did not conduct fall investigations to determine root cause or patterns. She stated all falls were discussed every morning in stand up and she made personal notes in her calendar. She stated it was her handwriting on the incident reports submitted to the survey team. Regarding the fall on 4/2/19 that resulted in the shoulder fracture for Resident #38, she recalled speaking to his aide who stated she rounded on him 30 minutes before he was found on the floor. The DON offered no additional information related to the process for investigating and implementing effective interventions for resident falls.

During a telephone interview on 7/10/19 at 4:10 PM, Nurse #5 stated she was assigned Resident #38 the night of his fall on 4/2/19. She stated the aide called her to the room and she saw him on the floor in his bathroom. Nurse #5 stated due to Resident #38's history of falls, the aides rounded on him every 2 hours. She stated once they assisted Resident #38 back to bed, he began to complain of left shoulder pain. She stated she contacted his RP and she did not want to send him out to the hospital but rather obtain and x-ray in-house to determine injury. Nurse #5 stated Resident #38 complained of pain at the time, but he declined pain medications when offered. She stated his pain medications was changed to a schedule after the fall.

During a telephone interview on 7/10/19 at 4:17 PM, NA #11 stated she was working with

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Resident #38 the night of 4/2/19. She stated she rounded on him frequently because of his fall history. NA #11 stated she was starting her last round and checked on Resident #38 before she started. She stated he was asleep in bed. NA #11 stated she started her last round at the end of the hall and worked her way up the front. She recalled going into his room and noted he was not in bed. She opened the bathroom door and found him on the bathroom floor. NA #5 stated she called for the nurse and he was complaining of left shoulder pain.

During an interview on 7/11/19 at 11:40 AM, the DON stated every morning all falls were discussed. She confirmed that for a resident with multiple falls, they should be looked at to determine a pattern or a trend. She stated she utilized an intervention calendar to see what has been done and what has worked in the past. The DON stated the hospital was working on something for Long Term Care for post fall evaluation and investigation. She stated all falls were discussed each morning with the Staff Development Coordinator, the Assistant Director of Nursing, the Social Worker, therapy, Clinical Supervisors and the Administrator. The DON confirmed there was no formal method of tracking resident falls at present and nothing was in writing but rather in her "head". She stated it was her practice to start with a therapy screen or a medication review but there was no written follow up after interventions were implemented.

During an interview on 7/9/19 at 11:40 AM, the Administrator stated it was her expectation that resident falls be investigated to determine root cause and that interventions implemented were effective. She further stated it was her

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expectation that there was an effective process of how the facility managed residents' falls.

3) Resident #17 was admitted to the facility on 11/9/18 with diagnoses that included Alzheimer's disease, muscle weakness and osteoarthritis.

Resident #17's care plan included the focus area of risk for falls due to muscle weakness, impaired mobility, and Alzheimer's disease. This area was initiated on 2/5/19 and the interventions included:
" Resident will be out of bed daily (initiated 2/5/19)
" Toilet as directed (initiated 2/5/19)
" Call bell available and answer promptly (initiated 2/5/19)
" Monitor for change in balance (initiated 2/5/19)
" Remind to call for assist when needed (initiated 2/5/19)
" Medications given as ordered (initiated 2/5/19)
" Monitor for side effects from medications and update MD as needed (initiated 2/5/19)
" Therapy to treat as indicated (initiated 2/5/19)
" Non-skid socks/shoes on while out of bed (initiated 2/5/19)
" Assure bed wheels in locked position for transfers (initiated 2/5/19)
" 2-persons for transfers (initiated 2/5/19)
" Personal items within reach (initiated 2/5/19)

The most recent Minimum Data Set (MDS) coded as a quarterly assessment and dated 4/23/19 indicated Resident #17 had moderate cognitive impairment. She had no behaviors or rejection of care. Resident #17 received extensive assistance of 1 staff member for bed mobility and 2 staff members for transfers. She had no impairment

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with range of motion and utilized a wheelchair. Resident #17 was frequently incontinent of urine, always incontinent of bowel and had no falls during the look back period.

a) A review of the nursing progress notes revealed on 2/9/19 at 9:00pm Nurse #6 observed Resident #17 in a sitting position with buttocks on the floor in front of the wheelchair. No injuries were noted.

The facility's "Weekly Event Incidents" report dated 2/10/19 was provided by the Administrator and reviewed as there was not an incident report available for review of the fall on 2/9/19. The report indicated a nurse found the resident sitting on the floor in front of the wheelchair. There was no investigation or analysis of the fall available.

Resident #17's care plan related to falls was reviewed by the MDS nurse on 3/20/19 with no new interventions initiated.

A phone interview was attempted with Nurse #6 on 7/10/19 at 4:10pm. Nurse #6 was unable to be reached for an interview.

b) A review of the nursing progress notes revealed on 5/1/19 at 11:15am Nurse #2 observed the resident on the floor in her room with an abrasion to her forehead. Nursing notes on 5/2/19 and 5/3/19 revealed the resident with purple bruising to both sides of the bridge of her nose and redness to her forehead.

An incident report dated 5/1/19 completed by Nurse #2 indicated Resident #17 had an unwitnessed fall in her room at 11:15am with an abrasion noted. Resident #17 was noted to have

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appeared to be leaning over in the chair and was in no distress. The report was blank in the areas of type of fall, explanation of fall, fall risk and whether the resident was alert and oriented. Handwritten on the incident information form was "therapy screen, stiff?". There was no investigation or analysis of the fall available.

Review of a therapy screen form dated 5/3/19 revealed Resident #17 was screened due to a fall on 5/1/19. No changes and therefore did not require a physical therapy evaluation.

The care plan related to falls was reviewed the MDS nurse on 5/8/19 with no new interventions noted.

On 7/11/19 at 9:40am an interview was conducted with Nurse #2. She could not recall the exact events from the fall that occurred on 5/1/19 but stated Resident #17 tends to lean to the side when up in her wheelchair despite staff correcting her posture. She stated she completed the computerized incident report and only completed the required areas marked with an asterisk, however she could not state which areas those were.

c) A review of the nursing progress notes revealed on 5/21/19 Nurse #5 observed the resident lying on her right side on the floor. The resident stated she rolled off her bed and hit her forehead on the refrigerator. A small abrasion was noted to her forehead and a skin tear was present to her right elbow.

An incident report dated 5/21/19 completed by Nurse #5 indicated Resident #17 has an unwitnessed fall in her room at 11:15am with an

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abrasion noted. The description of the fall read in part, "Resident was changing position and rolled off the bed unto the floor". The report was blank in the areas of type of fall, explanation of fall, fall risks and whether the resident was alert and oriented. Handwritten on the incident information form was "padded frig etc and foam noodles" as well as "on forehead and skin tear on elbow". There was no investigation or analysis of the fall available.

The care plan for Resident #17 related to falls was revised on 5/22/19 with the new intervention of foam noodles to bed.

A phone interview was conducted with Nurse #5 on 7/10/19 at 4:13pm. She confirmed she was the nurse assigned to Resident #17 at the time of the fall on 5/21/19. She stated the resident appeared to have rolled off her bed and believed she hit her head on the wooden crate that the personal refrigerator sat upon, causing an abrasion to her forehead as well as a skin tear to the elbow. Nurse #5 added the bed was in the lowest position and denied the resident attempting unassisted transfers. She stated she completed the computerized incident report and only completed the required areas marked with an asterisk, however she could not state which areas those were.

An observation and interview were conducted with Resident #17 on 7/10/19 at 3:25pm. Resident #17 was sitting upright in her wheelchair watching TV. Foam padding was present to the edge of Resident #17's personal refrigerator as well as the nightstand and foam noodles were present to both sides of the bed. She was unable to recall the details of her falls.

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On 7/10/19 at 3:30pm an interview occurred with Nurse Aide (NA) #8 who was familiar with the resident. She stated Resident #17 did not attempt unassisted transfers and required one to two staff member assistance with bed mobility and transfers. She added that foam noodles were in place to both sides of the resident's bed after her last fall. She added staff provided frequent monitoring for safety, ensured the bed was in the lowest position when she was placed to bed and call light was within reach.

On 7/10/19 at 3:35pm an interview was conducted with NA #9 who cared for Resident #17 in the evening. She stated the resident did not attempt unassisted transfers and readily accepted care. One to two staff members provided assistance with transfers and bed mobility. She added that foam noodles were in place to both sides of the bed after her last fall. She added staff provided frequent monitoring for safety, assisted with toileting every 2 to 3 hours and as needed, ensured the bed was in the lowest position when she was placed to bed, and call light was within reach.

An interview occurred with the Director of Nursing (DON) on 7/11/19 at 11:40am. She acknowledged the facility's fall investigation process had not included analyzing the pattern of the falls to find the root cause. She additionally acknowledged that she was not tracking the falls for trends or patterns.

The Administrator was interviewed 7/11/19 at 2:15pm and stated she expected falls to be thoroughly investigated and analyzed to determine causative factors in an effort to reduce

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| F 689 | Continued From page 54<br>the risk for further falls and to have appropriate interventions in place. | F 689 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§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-<br><br>§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;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and interviews with family and staff, the facility failed to provide a nutritional supplement as recommended by the Registered Dietician and as ordered by the physician for a resident who experienced significant weight loss for 1 of 4 residents (Resident #54) reviewed for nutrition.<br><br>The findings included: | F 692 | On 7/10/19, an order was written by physician for Resident #54 to receive Ensure with breakfast and dinner. In addition, on 7/10/19, order was initiated for Resident #54 to receive Magic Cup with lunch and dinner. On 7/10/19, resident received the Ensure and Magic Cup and continues to receive these nutritional supplements, as ordered. On 7/11/19, the Registered Dietician | 8/8/19 |

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| F 692 | Continued From page 55<br>Resident #54 was admitted to the facility on 12/10/18 and most recently readmitted on 5/6/19 with diagnoses that included heart failure, anxiety, and depression.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 5/30/19 indicated Resident #54 ' s cognition was severely impaired. She required supervision of 1 for eating and she had significant weight loss with a weight of 117 pounds.<br><br>The care plan for Resident #54 was updated on 5/30/19 with the new problem/need of rapid/gradual weight loss related to inadequate nutrient intake. The interventions included referral to the Registered Dietician (RD) for evaluation and recommendations.<br><br>An RD note dated 5/30/19 indicated Resident #54 weighed 138 pounds on 12/21/18 and her current weight was 118 pounds. This was noted to be a 15% weight loss in 5 months. The RD wrote that this was an unintended weight loss and she recommended the addition of magic cup twice daily with lunch and dinner.<br><br>An RD Recommendation form dated 5/30/19 indicated the problem of continued weight loss of 15% in 5 months for Resident #54. The recommendation was for magic cup twice daily with lunch and dinner. The physician signed this recommendation with his approval on 5/31/19.<br><br>A physician ' s order dated 6/1/19 entered into the electronic record by Nurse #7 indicated magic cup (nutritional supplement) twice daily with lunch and dinner for Resident #54. | F 692 | assessed Resident #54 and didn□t recommend any further changes to address the resident□s nutritional needs.<br><br>On 7/31/19, the Service Line Educator will conduct an audit of orders received for nutritional supplements, for the period of 7/1/19 through 7/30/19, to ensure nutritional supplements are provided as ordered. The results of the audit revealed no negative findings.<br><br>During weekday morning meeting, the Administrative Stand Up Team will utilize the 24 hour report and review new orders. The Administrative Stand Up Team includes the Administrator, Director of Nursing, Dietary Manager, Minimum Data Set (MDS) Coordinator, Admissions Coordinator, Medical Records Coordinator, Environmental Services Manager, Resident Liaison, and Activity Director. Interdisciplinary Team (IDT) members will utilize this information to ensure nutritional supplements were provided as ordered. IDT members include the MDS Coordinator, Dietary Manager, Resident Liaison, and Activity Director.<br><br>Registered Dietitian will provide the Dietary Manager the physician recommendations, for follow-up that orders were initiated and nutritional supplements were provided as ordered. On 7/30/19, the Service Line Educator provided education to the Registered Dietician and Dietary Manager on this new protocol. | |

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| F 692 | Continued From page 56<br>An observation was conducted of Resident #54 on 7/10/19 at 12:37 PM during her lunch meal. Resident #54 was eating lunch in her room. Her meal tray had not included a magic cup. Her dietary tray card had not indicated that a magic cup was to be included on her tray. Resident #54 was accompanied by a family member during this lunch meal. An interview was conducted with the family member on 7/10/19 at 12:38 PM. She reported that she visited with Resident #54 several times per week during her lunch meal. She indicated she had not recalled Resident #54 receiving a magic cup on her lunch tray at any time in the past several weeks.<br><br>An interview was conducted with Nursing Assistant (NA) #10 on 7/10/19 at 12:30 PM. She stated that if a resident was to receive a magic cup that it would have been listed on the dietary tray card. She confirmed Resident #54 had no magic cup on her tray card and that she had not received a magic cup with her lunch.<br><br>An interview was conducted with the Dietary Manager (DM) on 7/10/19 at 3:50 PM. The DM reviewed the process for implementation of dietary orders. She reported that the RD wrote her recommendations on the hard copy RD recommendation form and this form was reviewed by the physician. She stated that if the physician agreed to the recommendation he signed the RD ' s hard copy recommendation form and then the nurse on duty entered an electronic order into the Electronic Medical Record (EMR). The DM stated that the nurse who entered the order was then to print out a hard copy of the electronic order and take it to the dietary department. She reported that once this hard copy order was received by the dietary | F 692 | Dietary Manager or designee, will conduct weekly 100% audit of nutritional supplement orders to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared by Dietary Manager with the Administrator and Director of Nursing on a weekly basis and by Dietary Manager with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |

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| F 692 | Continued From page 57 | F 692 | | |

department it was entered into dietary ' s electronic record to be included on the resident ' s tray card. The DM provided a hard copy print out of the electronic order that was entered into the EMR by Nurse #7 on 6/1/19 for magic cup twice daily for Resident #54. This hard copy print out was signed by Nurse #9 on 7/10/19. The DM revealed that the dietary department had not received a print out of this hard copy order and it had not been added to Resident #54 ' s dietary tray card. She stated that she asked Nurse #9 to print out the order and provide her with a copy (on 7/10/19). The DM confirmed that Resident #54 had not received the magic cup supplement as ordered. She stated that the order for the magic cup was entered onto Resident #54 ' s dietary tray card as of this afternoon (7/10/19) and that the resident was to receive this supplement as ordered for the first time at her dinner meal on 7/10/19.

An interview was conducted with Nurse #9 on 7/10/19 at 4:00 PM. Nurse #9 confirmed that she printed out the electronic order dated 6/1/19 for Resident #54 ' s magic cup twice daily on 7/10/19, she signed the order, and she provided the order to the DM. She explained that the order had been entered into the electronic record by Nurse #7 on 6/1/19, but the DM had not received a printed out copy that was signed by a Nurse.

An interview was conducted with Nurse #7 on 7/10/19 at 4:50 PM. The electronic order dated 6/1/19 for Resident #54 ' s magic cup twice daily was reviewed with Nurse #7. She confirmed she entered this order into the EMR. She stated that after she entered the order, the normal process was for her to give a hard copy of the order to

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| F 692 | Continued From page 58<br>one of he dietary staff. Nurse #7 revealed she was unable to recall if she gave a hard copy of this 6/1/19 order for Resident #54 to the dietary staff.<br><br>An interview was conducted with the RD on 7/10/19 at 1:00 PM. The 5/30/19 RD recommendation for magic cup twice daily for Resident #54 was reviewed with the RD. She reported that Resident #54 had significant weight loss and she recommended the magic cup twice daily to avoid any further weight loss. The RD revealed she was unaware Resident #54 had not received the magic cup twice daily. She stated she expected her recommendations to be reviewed by the physician and to be provided as ordered if the physician agreed with her recommendations. The RD reported that Resident #54 had not had an updated weight since May 2019 as she had refused to be weighed from June 2019 through present.<br><br>An interview was conducted with the Director of Nursing (DON) on 7/11/19 at 2:03 PM. She stated that she expected nutritional supplements recommended by the RD and ordered by the physician to be provided to the resident. | F 692 | | |
| F 695 SS=E | Respiratory/Tracheostomy Care and Suctioning<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, | F 695 | | 8/8/19 |

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| F 695 | Continued From page 59<br>and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident, staff and Physician interviews and record review, the facility failed to assess the skin around a tracheostomy and observe tracheostomy care (Resident #10), failed to administer continuous oxygen at the Physician ordered rate, change the oxygen tubing, change a nebulizer mask and humidification as ordered by the Physician and failed to store a nebulizer mask in a protective bag while not in use (Resident #169). The facility also failed to obtain a Physician order prior to the initiation of oxygen (Resident #37) and failed to date and label oxygen tubing and humidification (Resident #270). This was for 4 of 5 residents reviewed for respiratory care. The findings included:<br><br>1. Resident #10 was admitted 8/6/18 with cumulative diagnoses of Chronic Respiratory Failure and a tracheostomy (a surgically created hole in the windpipe to allow air to enter the lungs).<br><br>Review of the Body Assessment Schedule dated 1/3/17 read Resident #10 was to have a full skin assessment every Sunday on the 7:00 AM to 7:00 PM shift.<br><br>Review of Resident #10 Physician order dated 4/12/19 read the nurse was to assist him with self care of his tracheostomy daily.<br><br>Review of Resident #10 annual Minimum Data Set (MDS) dated 4/19/19 indicated he was cognitive intact and exhibited no behaviors. He was coded for supervision with his activities of | F 695 | On 7/18/19, nurse assisted with Resident #10□s tracheostomy care. On 7/24/19, nurse assessed Resident #10□s skin around tracheostomy and observed tracheostomy care. Nurse documented that the area around the tracheostomy was clean and dry with no redness or drainage or signs of infection, at this time. Service Line Educator will educate Nurse #7, #13, and #15, to assess Resident #10□s skin around tracheostomy and observe tracheostomy care by 8/8/19.<br><br>On 7/12/19, nurse administered Resident #169□s continuous oxygen at the Physician ordered rate, changed the oxygen tubing, changed a nebulizer mask and humidification bottle as ordered by the Physician and stored nebulizer mask in a protective bag while not in use. Service Line Educator will educate Nurse #7 and Treatment Aide #1,by 8/8/19 to administered Resident #169□s continuous oxygen at the Physician ordered rate, change the oxygen tubing, change nebulizer mask and humidification bottle as ordered by the Physician and store nebulizer mask in a protective bag while not in use.<br><br>On 7/10/19, physician ordered O2 saturations for Resident #37. Based on the results, determined that the resident didn□t require oxygen. Physician wrote an order to discontinue oxygen on 7/11/19. Service Line Educator will educate Nurse | |

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| F 695 | Continued From page 60<br>daily living. He not coded as having a tracheostomy.<br><br>Review of Resident #10's care plan last revised on 5/1/19 read he was at risk for skin breakdown due to his chronic tracheostomy. Interventions included a full skin assessment weekly.<br><br>Review of a skin assessment dated 5/5/19 read no signs of skin breakdown noted.<br><br>Review of a skin assessment dated 5/12/19 read no open wound noted.<br><br>The facility provided no evidence of a skin assessment for the weeks of 5/19/19 or 5/26/19.<br><br>The facility provided no evidence of a skin assessment for the weeks of 6/2/19, 6/9/19, 6/16/19 and 6/23/19.<br><br>Review of a nursing note dated 6/12/19 at 5:48 AM read Resident #10 was started on an antibiotic due to an abscess on the back of his neck. Also ordered was warm compresses to the area while awake. The abscess appeared slightly red and swollen.<br><br>Review of a skin assessment dated 6/30/19 read no skin breakdown. Skin intact.<br><br>Review of a skin assessment dated 7/7/19 read scabbed are to back of neck, no skin breakdown noted.<br><br>During an interview on 7/10/19 at 12:13 PM, Nurse #7 stated Resident #10 did his own tracheostomy care and she only changed his tracheostomy tie and equipment if it showed up | F 695 | #7, #8, and #9 to obtain a physician□s order prior to the initiation of oxygen.<br><br>On 7/10/19, nurse dated and labeled Resident #270□s oxygen tubing and humidification bottle. Service Line Educator will educate Nurse #1 and #13 to date and label Resident #270□s oxygen tubing and humidification bottle.<br><br>Beginning 7/31/19, Nurse Aide II and nurses will conduct facility-wide observation of residents receiving oxygen, to ensure oxygen tubing and humidification bottles are labeled and dated, oxygen is administered at the physician ordered rate, oxygen tubing is changed per protocol, nebulizer mask and humidification bottle is changed as ordered, and nebulizer mask stored in a protective bag while not in use.<br><br>During weekly Administrative Rounds, staff will observe residents receiving oxygen services, to ensure oxygen tubing and humidification bottles are labeled and dated, oxygen is administered at the physician ordered rate, oxygen tubing is changed per protocol, nebulizer mask and humidification bottle is changed as ordered, and nebulizer mask stored in a protective bag while not in use. Administrative Rounds team includes the Administrator, Director of Nursing, Admissions Coordinator, Resident Liaison, Activity Director, and Activity Assistant. Weekend Manager on Duty will conduct weekend observation, to observe residents receiving oxygen services, to | |

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| F 695 | Continued From page 61<br>on his TAR. She stated she did not routinely assess the skin around his tracheostomy because the weekend nurse did it.<br><br>During an interview on 7/10/19 at 3:00 PM, Resident #10 stated he completed his tracheostomy care in the evenings before he went to bed. He stated seldom was a nurse present during his tracheostomy care unless it was to change his tie. Resident #10 stated this was his third tracheostomy and he very comfortable with caring for it. He stated he had taught the staff "a thing or two" about tracheostomies.<br><br>During a telephone interview on 7/10/19 at 4:37 PM, Nurse #13 confirmed she was assigned Resident #10 on 6/2/19, 6/9/19 and 6/23/19. She stated Resident #10 was independent with his tracheostomy care and she was not aware that he was scheduled to a weekly skin assessment every Sunday. Nurse #13 stated if it did not alert her on his TAR, she would not have known to complete it. Nurse #13 stated she was aware of the skin assessment schedule, but most have overlooked it on 6/2/19, 6/9/19 and 6/23/19.<br><br>During a telephone call on 7/11/19 at 12:20 PM, Nurse #15 confirmed she completed the skin assessment on Resident #10 the weeks of 5/5/19, 5/12/19, 6/30/19 and 7/7/19. She stated she worked at the facility as needed on the weekends. Nurse #15 recalled Resident #10 was recently treated for an abscess to the back of his neck. She stated when she did her weekly skin assessments, she would "scan" his tracheostomy.<br><br>During an interview on 7/11/19 at 12:45 PM, | F 695 | ensure oxygen tubing and humidification bottles are labeled and dated, oxygen is administered at the physician ordered rate, oxygen tubing is changed per protocol, nebulizer mask and humidification bottle is changed as ordered, and nebulizer mask stored in a protective bag while not in use.<br><br>Administrator or designee, will conduct weekly 100% audit of Administrative Rounds Forms to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared by Administrator with the Administrator and Director of Nursing on a weekly basis and by Administrator with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |

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Nurse #7 confirmed she worked with Resident #10 on 5/19/19. She stated she did not complete a skin assessment of his tracheostomy because she was under the impression that the nurse who watched him perform tracheostomy care did it.

During another interview on 7/11/19 at 12:50 PM, Resident #10 stated he found "a knot" on the back of his neck and told the nurse. He stated the Physician came in and assessed it and ordered antibiotics. He stated the abscess was gone.

During an interview on 7/11/19 at 2:03 PM, the Administrator and the Director of Nursing (DON) stated it was their expectation that a nurse observed Resident #10 perform his tracheostomy care and assess the skin around his tracheostomy while observing his care. The DON stated it was her expectation that Resident #10 receive a full skin assessment weekly.

2. Resident #169 was admitted 5/20/16 with cumulative diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Respiratory Failure, Congestive Heart Failure (CHF) and Chronic Kidney Disease.

Review of Resident #169's quarterly Minimum Data Set (MDS) dated 6/6/19 indicated she was cognitively intact and exhibited psychosis. She was coded for the use of oxygen.

Review of Resident #169's care plan revised on 6/19/19 read she was at risk for shortness of breath due to COPD. Interventions included administering her oxygen as ordered by the Physician.

Review of Resident #169's electronic medical

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| F 695 | Continued From page 63 | F 695 | | |

record indicated she was sent to the hospital on 7/1/19 and readmitted back to the facility on 7/7/19.

Review of Resident #169's readmission orders dated 7/7/19 read the following: continuous oxygen at 2.5 liters, change the nebulizer tubing every 7 days as needed, change the oxygen tubing and humidifier bottle every 5 days when oxygen in use.

During an observation on 7/8/19 at 11:32 AM, Resident #169 was sitting up in bed, She was wearing a nebulizer mask receiving a breathing treatment. The oxygen concentrator was running at 1.5 liters. The date on the oxygen tubing read 6/29/19. The date on the nebulizer mask read 6/20/19. The humidifier water bottle was dated 6/29/19.

During an interview on 7/9/19 at 3:00 PM, the Physician stated it was his expectation that Resident #169 receive her continuous oxygen at the ordered rate, oxygen tubing, nebulizer tubing, nebulizer mask and humidified water be changed as ordered. He further stated the nebulizer mask should be stored in a bag when it was not in use for infection control purposes.

During an observation on 7/9/19 at 3:05 PM, Resident #169 was sitting up in bed wearing her oxygen with the oxygen concentrator running at 1.5 litters. The oxygen tubing was still dated 6/29/19. Her nebulizer mask was lying on the nightstand next to her bed not secured in a bag. The mask was still dated 6/20/19. The humified water bottle was still dated 6/29/19.

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During an interview on 7/9/19 at 4:55 PM, Nurse #7 stated the oxygen tubing, humidified water bottle was not changed when she returned from the hospital on 7/7/19. Nurse #7 stated Resident #169's nebulizer mask should have been changed 6/27/19 but apparently was not. Nurse #7 also observed Resident #169's nebulizer mask lying on her nightstand and confirmed not only should have it been changed on her readmission 7/7/19 but it should be stored in a bag when it was not in use. Nurse #7 verified Resident #169's continuous oxygen was running at 1.5 litters but ordered at the rate of 2.5 litters. Nurse #7 stated she was unsure why Resident #169's oxygen was not running at the ordered rate except to say one has to be down at eye level to ensure the ordered rate. Nurse #7 corrected the oxygen rate to 2.5 litter and stated she would ensure the oxygen tubing, nebulizer tubing and mask, the humidifier water bottle were changed immediately.

During an observation on 7/10/19 at 8:45 AM, Resident #169 oxygen was running at the ordered rate of 2.5 litters, the oxygen tubing and humidified water bottle was dated changed 7/9/19. The nebulizer mask was observed inside a bag but still dated 6/20/19.

During an interview on 7/10/19 at 4:40 PM, Nurse #7 stated she instructed the Treatment Aide (TA) to change out all the tubing, water and mask yesterday but apparently, she neglected to change the nebulizer mask and she had not noticed the error. Nurse #7 changed the nebulizer mask on 7/10/19 at this time.

During an interview on 7/10/19 at 4:45 PM, TA #1 stated she changed the oxygen tubing and

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humidified water bottle on 7/9/19. She stated she also observed the nebulizer mask lying on Resident #169's nightstand but did not change it but rather returned it to the bag. She stated it was an oversight.

During an interview on 7/11/19 at 2:03 PM, the Administrator and the Director of Nursing (DON) stated it was their expectation that Resident #169's oxygen be administer as ordered and tubing, mask and humified water be changed as ordered. Both also stated the expectation that the nebulizer mask be stored in a bag when it was not in use.

3. Resident # 37 was originally admitted to the facility on 12/7/18 and was readmitted on 4/30/19 with multiple diagnoses including congestive heart failure (CHF). The quarterly Minimum Data Set (MDS) assessment dated 5/21/19 indicated that Resident #37's cognition was intact.

Resident #37's nurse's notes were reviewed. The note dated 5/4/19 at 9:45 AM (written by Nurse # 8) revealed that Resident #37 was complaining of left sided chest pain and her oxygen saturation was 80%. Oxygen was started at 3 Liters (L) per minute and her oxygen saturation went up to 99%. The Nurse Practitioner (NP) was notified and she ordered to send the resident to the emergency room (ER) for evaluation. The note did not indicate whether the resident was admitted to the hospital or not. The note dated 5/6/19 at 1:38 PM (written by Nurse #9) revealed that Resident #37 was on oxygen and the oxygen saturation was 98%.

On 7/9/19 at 8:10 AM and at 4:47 PM, Resident #37 was observed in bed with oxygen between 2 ½ - 3 Liter (L) per minute via nasal cannula.

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On 7/9/19 at 4:48 PM, Resident #37 was interviewed. She stated that she was using oxygen since she was readmitted from the hospital. Resident #37 was not able to remember the date of readmission.

Review of Resident #37's medical records (electronic and hard copy chart) revealed no order for oxygen.

On 7/9/19 at 4:49 PM, Nurse #7, assigned to Resident #37, was interviewed. The Nurse stated that Resident #37 was on oxygen since she was readmitted from the hospital.

On 7/9/19 at 4:50 PM, Nurse #7 observed Resident #37's oxygen and verified that the resident was receiving oxygen between 2 ½ - 3 L per minute via nasal cannula. Nurse #7 reviewed Resident #37's medical records and she reported that the resident had no doctor's order for oxygen. The Nurse indicated that the admitting Nurse should have written the order for then oxygen.

On 7/11/19 at 10:20 AM, Nurse #8 was interviewed. The Nurse remembered that Resident #37 had complained of chest pain and her oxygen saturation was low. She started the resident on oxygen at 3 L per minute via nasal cannula and she notified the NP who gave her an order to send the resident to the ER. Nurse #8 indicated that she could not remember whether Resident #37 was admitted or not. The nurse also stated that if the resident was not admitted to the hospital and she came back to the facility with oxygen, an order for oxygen should have been written.

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On 7/11/19 at 11:01 AM, Nurse # 9 was interviewed. The Nurse verified that she was assigned to Resident #37 on 5/6/19 and the resident was on oxygen. The Nurse stated that she didn't check if Resident #37 had a doctor's order for oxygen. Nurse #9 verified that there was no note to indicate the date and time Resident #37 came back from the ER. The Nurse also indicated that the Nurse who received the resident from ER should have written the order for the oxygen.

On 7/11/19 at 2:10 PM, the Director of Nursing (DON) was interviewed. The DON expected that all residents on oxygen should have an order for the oxygen. The DON added that the admitting Nurse was responsible to verify with the doctor the need for the oxygen and to write an order for the oxygen.

4) Resident #270 was admitted to the facility on 6/30/19 with diagnoses that included chronic obstructive pulmonary disease (COPD), dementia and hypertension.

The Admission Minimum Data Set (MDS) was currently in progress.

A review of the physician orders for July 2019 revealed an order for Oxygen at 2 liters (L) per nasal canula continuously and to change the oxygen tubing and humidifier bottle every 5 days.

A review of the July 2019 Treatment Administration Record (TAR) indicated the oxygen tubing and humidifier bottle was changed on 7/5/19 by Nurse #13.

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On 7/8/19 at 11:45am an observation was made of Resident #270 in her room with oxygen in use and tubing connecting to the humidification bottle on the oxygen concentrator. There was no label with a date on the tubing or the humidification bottle. Resident #270 indicated she did not know when the tubing or humidification bottle was last changed.

An observation was made on 7/9/19 at 11:57am of Resident #270 using the oxygen and the tubing was connected to the humidification bottle on the oxygen concentrator without a label and date. The resident stated she didn't know if the tubing or humidification bottle had been changed.

On 7/9/19 at 3:45pm Resident #270 was observed in her room with the oxygen in use and tubing connected to the humidification bottle and oxygen concentrator. There was no label with a date on the tubing or the humidification bottle.

In an interview with Nurse #1 on 7/9/19 at 3:45pm she indicated the oxygen tubing and humidification bottle were changed every 5 days per the standing orders and were to be labeled with the date and initials of the nurse who completed the task. An observation was made, in the company of Nurse #1, in Resident 270's room, of the oxygen tubing and humidification bottle without a label or date.

A phone interview was completed with Nurse #13 on 7/10/19 at 4:37pm. She stated it was an oversight not to have dated the oxygen tubing and humidification bottle for Resident #270.

On 7/11/19 at 11:15am an interview with the Director of Nursing indicated she expected the

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| F 695 | Continued From page 69<br>oxygen tubing and humidification bottle to be labeled with a date when they are changed as ordered. | F 695 | | |
| F 700 SS=D | Bedrails<br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff and Responsible Party (RP) interviews and record review, the facility failed to assess for the continued need for ½ side rails for 1 (Resident #169) of 1 resident reviewed for side rails. The findings included:<br><br>Resident #169 was admitted 5/20/16 with | F 700 | On 7/10/19, Admissions Coordinator conducted a bed rail evaluation for Resident #169. Evaluation included ensuring an order was in place for bed rails and that the care plan was updated. Result of the evaluation, revealed the rails were used as enablers. | 8/8/19 |

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| F 700 | Continued From page 70<br>cumulative diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Respiratory Failure, Congestive Heart Failure (CHF) and Chronic Kidney Disease.<br><br>Review of Resident #169's quarterly Minimum Data Set (MDS) dated 6/6/19 indicated she was cognitively intact. She was coded for extensive assistance with bed mobility and not coded for the use of bed rails as restraints.<br><br>Review of Resident #169's care plan revised on 6/19/19 read she was at risk for injury or entrapment due to the use of ½ side rails used for mobility, positioning and turning. The interventions included quarterly assessment or as needed for the continued use or elimination of the side rails.<br><br>Review of the facility's Bedrails policy last revised November 2017 read a side rail assessment was to be completed on admission, quarterly and if there was a significant change in a resident's condition.<br><br>During an observation on 7/8/19 at 12:10 PM, Resident #169 was lying in bed. She had bilateral ½ side rails on the upper part of her bed. She was determined as non-interviewable. Her RP was present and stated Resident #169 returned from the hospital on 7/7/19 and had experienced a significant decline and considering hospice. The RP stated Resident #169 used the side rails for turning and repositioning. Resident #169 was able to demonstrate using the left ½ side rail to reposition.<br><br>During an observation on 7/9/19 at 3:05 PM, Residents #169 was sitting up in bed with her | F 700 | On 7/11/19, Admission Coordinator and MDS Coordinator conducted facility-wide bed rail evaluation for each resident. Evaluation including ensuring if bed rails were utilized, that an order was in place and that the care plan was updated. Results of the audit noted that for each resident that required bed rails, that an order was placed and the care plan was updated. Any negative findings of the audits were corrected.<br><br>On 7/31/19, the facility will implement the Bed Rail Evaluation function in AHT (American Healthtech □ Electronic Medical Record) which will provide staff electronic access to conduct bed rail evaluations. Bed Rail Evaluation will be conducted on admission, readmission, quarterly, annually, and significant change. The Service Line Educator will educate all nursing staff on the new Bed Rail Evaluation function in AHT. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new nursing staff on the Bed Rail Evaluation function in AHT, will be provided by the Service Line Educator.<br><br>Director of Nursing (DON) or designee, will conduct weekly 100% audit of the Bed Rail Evaluation report to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared by DON with the | |

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| F 700 | Continued From page 71<br>bilateral ½ side rails engaged.<br><br>During an observation on 7/10/19 at 8:45 AM, Resident #169 was sitting up in bed with her bilateral ½ side rails engaged.<br><br>During an observation on 7/11/19 at 9:00 AM, Resident #169 was sitting up in bed with her bilateral ½ side rails engaged.<br><br>During an interview on 7/11/19 at 9:05 AM, the Social Worker (SW) stated Resident #169 14-Day MDS dated 6/11/19 indicated moderate cognitive impairment and she recently returned from the hospital and has had a significant physical and cognitive decline. The SW stated a significant change MDS was in process and she was admitted to hospice services.<br><br>The facility was unable to provide any evidence of side rails assessment for Resident #169 until 7/11/19.<br><br>During an interview on 7/11/19 at 2:03 PM, the Administrator and the Director of Nursing (DON) stated it was their expectation that a side rail assessment be completed on admission, quarterly or after a significant change in a resident's condition. The Administrator and DON were unable to explain who was responsible for completing a side rails assessment or could they explain why there was no documented evidence of a side rail assessment for Resident #169 until 7/11/19. | F 700 | Administrator and Director of Nursing on a weekly basis and by DON with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review. | F 756 | | 8/8/19 |

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| F 756 | Continued From page 72<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§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.<br>(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.<br>(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.<br>(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.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and Pharmacy | F 756 | The nurse reviewed Resident #37□s | |

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| F 756 | Continued From page 73<br>Consultant and staff interview, the facility failed to act upon the Pharmacy Consultant's recommendation regarding an order for PRN (as needed) psychotropic medication for 1 of 5 sampled residents reviewed (Resident #37).<br><br>Findings included:<br><br>Resident # 37 was originally admitted to the facility on 12/7/18 and was readmitted on 4/30/19 with multiple diagnoses including anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 5/21/19 indicated that Resident #37's cognition was intact.<br><br>Resident #37's doctor's orders were reviewed. The resident had an order dated 4/30/19 for Ativan (anti-anxiety drug) 0.5 milligrams (mgs) every 8 hours PRN (as needed) for anxiety. On 5/3/19, the frequency of the Ativan was changed to 0.5 mgs twice a day PRN for anxiety/agitation.<br><br>Review of Resident #37's monthly drug regimen review (DRR) was conducted. The DRR dated 5/30/19 revealed that the Pharmacy Consultant had addressed the use of the PRN Ativan with no stop date to the Director of Nursing (DON) and the Physician.<br><br>Review of Resident #37's orders revealed that the resident was still on PRN Ativan with no stop date as of 7/10/19.<br><br>On 7/9/19 at 3:26 PM, the Pharmacy Consultant was interviewed. The Pharmacy Consultant stated that she expected the DON to act upon her recommendation at least within 30 days. She expected that nurses to write order for PRN psychotropic medications with a stop date of 14 | F 756 | Pharmacy Consultant recommendation with the physician and the physician wrote an order to discontinue the PRN psychotropic medication on 7/10/19. The Director of Nursing (DON) noted in this deficiency is no longer employed at the facility.<br><br>On 7/31/19, the Service Line Educator will conduct an audit of residents receiving PRN psychotropic medications, for the period of 7/1/19 through 7/30/19, to ensure duration doesn□t exceed 14 days. The results of the audits revealed no negative findings.<br><br>The Interdisciplinary Team (IDT) members will review Pharmacy Consultant Recommendations monthly, to ensure acted upon. IDT members include the MDS Coordinator, Dietary Manager, Resident Liaison, and Activity Director.<br><br>Director of Nursing (DON) or designee, will conduct monthly 100% audit of Pharmacy Consultant Recommendation log to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared by DON with the Administrator and Director of Nursing on a weekly basis and by DON with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |

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| F 756 | Continued From page 74<br>days and for the doctor to reevaluate for continued use after 14 days.<br><br>On 7/10/19 at 10:24 AM, the DON was interviewed. The DON stated that the Pharmacy Consultant was sending the recommendations via e-mail and she was responsible to print the recommendations and gave it to the nurse to call the doctor. The DON verified that she had received the recommendation dated 5/30/19 for the PRN Ativan with no stop date for Resident #37 however she failed to print the recommendation and therefore it was not followed through. The DON added that she had dropped the ball on this recommendation. | F 756 | | |
| F 757 SS=D | Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons | F 757 | | 8/8/19 |

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| F 757 | Continued From page 75<br>stated in paragraphs (d)(1) through (5) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to administer an antibiotic medication as ordered for 1 of 5 sampled residents reviewed (Resident #37). Resident #37 had a doctor's order for an antibiotic eye ointment for 7 days and had received the antibiotic for 21 days.<br><br>Findings included:<br><br>Resident # 37 was originally admitted to the facility on 12/7/18 and was readmitted on 4/30/19 with multiple diagnoses including conjunctivitis. The quarterly Minimum Data Set (MDS) assessment dated 5/21/19 indicated that Resident #37's cognition was intact.<br><br>Resident #37's doctor's orders were reviewed. The resident had an order dated 6/5/19 for Erythromycin (antibiotic) 0.5% eye ointment, apply ribbon into the left lower conjunctival sac of left eye three times day for 7 days for conjunctivitis. The order was received by Nurse # 11 and was transcribed to the Medication Administration Records (MARs) by Nurse #3.<br><br>Resident #37's June 2019 MARs were reviewed. The MARs revealed that Resident #37 had received the Erythromycin eye ointment for 21 days from June 6-28, 2019.<br><br>On 7/10/19 at 3:56 PM, Nurse # 11 was interviewed. The Nurse verified that she had received and had written the order for the Erythromycin for Resident #37 on 6/5/19. The | F 757 | On 6/6/19, Resident #37□s antibiotic eye medication was initiated without a stop date. On 6/25/19, Pharmacy Consultant Recommendation included to clarify the order. On 6/28/19, physician wrote an order to discontinue the antibiotic eye medication. Service Line Educator will educate Nurse #3 to correctly transcribe orders on the Medication Administration Record, to ensure medication was administered as ordered. Nurse #11 noted in this deficiency is no longer employed at the facility.<br><br>On 8/6/19, the Service Line Educator will conduct an audit of residents receiving antibiotics, for the period of 7/1/19 through 7/30/19, to ensure medication was administered as ordered.<br><br>New protocol developed for all new medication orders entered into AHT will be reviewed by a second nurse for accuracy. Protocol will be recorded on the Medication Order log. 2 nurse signatures will be documented on the Medication Order log to validate a review for accuracy. The Service Line Educator will educate all nursing staff on the new protocol developed for all new medication orders entered into AHT. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a | |

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| F 757 | Continued From page 76<br>Nurse reported that the order for the Erythromycin was to administer for 7 days only. She claimed that Nurse # 3 transcribed the order to the MAR.<br><br>Attempted to interview Nurse #3 but was not available.<br><br>On 7/11/19 at 2:10 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the Nurse who transcribed the order on the MAR to indicate the end date and to follow the doctor's order. The DON reported that Nurse #3 failed to indicate the end date on the MAR and therefore the nurses kept on administering the Erythromycin. | F 757 | scheduled shift at the facility upon their return. Orientation for new nursing staff on the new protocol developed for all new medication orders entered into AHT, will be provided by the Service Line Educator.<br><br>Director of Nursing (DON) or designee, will conduct weekly 100% audit of Medication Order log to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared by DON with the Administrator and Director of Nursing on a weekly basis and by DON with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented | F 758 | | 8/8/19 |

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| F 758 | Continued From page 77<br>in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and interviews with resident, staff, Pharmacy Consultant, and physician, the facility failed to provide a clinical indication for the use of antipsychotic medication (Resident #66), failed to complete an Abnormal Involuntary Movement Scale (AIMS) assessment (used to assess for extrapyramidal symptoms for residents receiving antipsychotic medication) prior to the | F 758 | On 7/23/19, physician order was written for Resident #66 to receive a psychological consult to evaluate clinical indication for antipsychotic medication usage. On 8/6/19, Resident #66 is scheduled to be assessed by the Psychologist to define corresponding diagnosis for antipsychotic medication usage. On 7/9/19, Abnormal Involuntary | |

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| F 758 | Continued From page 78<br>administration of an antipsychotic medication (Resident #66), and failed to ensure as needed (PRN) psychotropic medications were time limited in duration (Residents #66 and #37). This was for 2 of 5 residents reviewed for unnecessary medications.<br><br>The findings included:<br><br>1a. Resident #66 was admitted to the facility on 6/3/19 with diagnoses that included dementia without behavioral disturbance, depression, and anxiety.<br><br>A review of the hospital discharge summary dated 6/3/19 for Resident #66 indicated her discharge medication list included Seroquel (antipsychotic medication) 25 milligrams (mg) in the morning and 50 mg at night. There was no corresponding diagnosis for Seroquel on the hospital discharge summary. The hospital discharge active diagnoses were as follows: fracture of left hip, atrial fibrillation, chronic kidney disease, diabetes mellitus Type 2, dyslipidemia, hypertension, gastroesophageal reflux disease, gout, acute respiratory failure with hypoxia, and anemia.<br><br>A physician ' s order dated 6/3/19 indicated Seroquel 25 mg in the morning and 50 mg at night for Resident #66.<br>A physician ' s note dated 6/5/19 indicated Resident #66 was admitted for short term rehabilitation. The resident was noted to be on Seroquel, Cymbalta (antidepressant medication), Depakote (mood stabilizing medication), and Ativan (antianxiety medication) for depression. The physician noted no symptoms of psychosis or behavioral issues for Resident #66. | F 758 | Movement Scale (AIMS) was completed by the Director of Nursing. The nurse reviewed Resident #66□s Pharmacy Consultant Recommendation with physician and the physician discontinued the PRN psychotropic medication on 7/9/19.<br><br>The nurse reviewed Resident #37□s Pharmacy Consultant Recommendation with the physician and the physician discontinued the PRN psychotropic medication was discontinued on 7/10/19.<br><br>On 8/6/19, Service Line Educator will conduct facility-wide audit of residents receiving antipsychotic medications, for the period of 7/1/19 through 7/30/19, to ensure AIMS were completed per protocol, that there is a corresponding diagnosis, and PRN psychotropic medication is administered as ordered.<br><br>New protocol developed for all new antipsychotic medication orders entered into AHT (American Healthtech □ Electronic Medical Record) will be reviewed by a second nurse to ensure AIMS were completed per protocol, that there is a corresponding diagnosis, and PRN psychotropic medication is administered as ordered. Protocol will be recorded on the Medication Order log. 2 nurse signatures will be documented on the Medication Order log to validate review for accuracy. The Service Line Educator will educate all nursing staff on the new protocol developed for all new antipsychotic medication orders entered | |

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| F 758 | Continued From page 79<br><br>The admission Minimum Data Set (MDS) assessment dated 6/10/19 indicated Resident #66 had short-term and long-term memory problems and severely impaired decision making. She was assessed with no symptoms of psychosis, no behaviors, and no rejection of care. Resident #66 had received routine antipsychotic medication on 7 of 7 days.<br><br>The Care Area Assessment (CAA) related to psychotropic drug use for Resident #66 ' s 6/10/19 MDS indicated she received Seroquel for depression.<br><br>A Pharmacy Consultant Medication Regimen Review dated 6/17/19 for Resident #66 indicated a recommendation was made for a corresponding diagnosis to be added for all medication orders.<br><br>A review of the Medication Administration Records (MARs) from 6/3/19 through 7/8/19 indicated Resident #66 had received Seroquel 25 mg in the morning and 50 mg at night as ordered.<br><br>An observation and interview were conducted with Resident #66 on 7/8/19 at 4:10 PM. Resident #66 was alert and oriented to self. She was able to answer closed ended questions with logical answers but was unable to answer open ended questions due to confusion. Resident #66 was noted with no behavioral symptoms.<br><br>An interview was conducted with the Pharmacy Consultant on 7/9/19 at 3:27 PM. The Pharmacy Consultant confirmed she had requested a corresponding diagnosis to be added for all medications prescribed to Resident #66. | F 758 | into AHT. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new nursing staff on the new protocol developed for all new antipsychotic medication orders entered into AHT, will be provided by the Service Line Educator.<br><br>Nurses will be provided AHT access to complete AIMS electronically. Service Line Educator will educate nurses on the AIMS documentation protocol in AHT. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new nurses on the AIMS documentation protocol in AHT, will be provided by the Service Line Educator.<br><br>Director of Nursing (DON) or designee, will conduct weekly 100% audit of Medication Order log to ensure compliance. Medical Records Coordinator or designee, will conduct weekly 100% audit of AIMS to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared by DON with the Administrator and Director of Nursing on a weekly basis and by DON with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |

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An interview was conducted with Resident #66 ' s physician on 7/9/19 at 2:40 PM. The physician was asked to provide a clinical indication for the use of Resident #66 ' s Seroquel. He stated that Resident #66 was prescribed Seroquel by the hospital prior to her admission to the facility. He reported that Resident #66 was admitted for short term rehabilitation and his normal process was not to change any medications for short term rehabilitation residents. He additionally stated that he normally refrained from referring residents who were admitted on a short-term basis to psychiatric services for medication management. The physician indicated that if Resident #66 was admitted as a long-term resident he would have referred her to psychiatric services for medication management to determine the continued need of the Seroquel. The 6/6/19 physician ' s progress note that indicated Resident #66 ' s Seroquel was prescribed for depression was reviewed with the physician. The physician stated that he thought Resident #66 had experienced hallucinations while she was in the hospital, but he was unable to locate any documentation of this information in the medical record.

An interview was conducted with the Director of Nursing (DON) on 7/11/19 at 2:03 PM. She stated she expected all antipsychotics to have a documented clinical indication for use.

1b. Resident #66 was admitted to the facility on 6/3/19 with diagnoses that included dementia without behavioral disturbance, depression, and anxiety.

A physician ' s order dated 6/3/19 indicated

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Seroquel (antipsychotic medication) 25 milligrams (mg) in the morning and 50 mg at night for Resident #66.

The admission Minimum Data Set (MDS) assessment dated 6/10/19 indicated Resident #66 had short-term and long-term memory problems and severely impaired decision making. She was assessed with no symtoms of psychosis, no behaviors, and no rejection of care. Resident #66 had received routine antipsychotic medication on 7 of 7 days.

A Pharmacy Consultant Medication Regimen Review dated 6/17/19 for Resident #66 indicated a recommendation was made for an AIMS assessment to be completed for antipsychotic therapy.

A review of the Medication Administration Records (MARs) from 6/3/19 through 7/9/19 indicated Resident #66 had received Seroquel 25 mg in the morning and 50 mg at night as ordered.

A review of the medical record on 7/9/19 at 12:00 PM revealed there was no AIMS (Abnormal Involuntary Movement Scale) assessment completed for Resident #66.

An AIMS assessment was completed on 7/9/19 at 1:37 PM by the Director of Nursing (DON) for Resident #66.

An interview was conducted with the Director of Nursing (DON) on 7/9/19 at 3:14 PM. She verified that there was no AIMS assessment completed for Resident #66 prior to 7/9/19 at 1:37 PM. She stated that she expected an AIMS assessment to be conducted prior to the initiation

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of an antipsychotic medication and then every 6 months. The DON reported that she believed the admitting nurse was supposed to complete an AIMS assessment if a resident was prescribed antipsychotic medication. She was unable to explain why an AIMS assessment was not completed for Resident #66 by the admitting nurse.

An interview was conducted with the Pharmacy Consultant on 7/9/19 at 3:27 PM. The Pharmacy Consultant reported that it was essential to have an AIMS assessment completed for all residents on antipsychotic medication. She stated that her expectation was for an AIMS assessment to be completed on admission and/or upon initiation of an antipsychotic medication and then every 6 months thereafter. She confirmed that she had requested an AIMS assessment to be completed for Resident #66 on her 6/17/19 Medication Regimen Review.

1c. Resident #66 was admitted to the facility on 6/3/19 with diagnoses that included dementia without behavioral disturbance, depression, and anxiety.

A physician ' s order dated 6/3/19 indicated Ativan (antianxiety medication) 0.5 milligrams (mg) twice daily as needed (PRN) for Resident #66. There was not stop date for this PRN Ativan order.

The admission Minimum Data Set (MDS) assessment dated 6/10/19 indicated Resident #66 had short-term and long-term memory problems and severely impaired decision making. She was assessed with no behaviors and no

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rejection of care. Resident #66 had not received antianxiety medication during the MDS review period.

A Pharmacy Consultant Medication Regimen Review for Resident #66 dated 6/17/19 indicated PRN orders for Ativan were limited to 14 days unless the prescriber clearly identified a different duration for the order and also clearly documented the rationale for this duration in the resident ' s medical record. Resident #66 was noted to have a PRN order for Ativan that was started on admission (6/3/19). The Pharmacy Consultant indicated that this PRN Ativan order should be stopped unless a new order with a specific duration was received and clinical rationale was documented in the chart.

A physician ' s order dated 7/9/19 indicated a discontinuation of Ativan 0.5 mg PRN for Resident #66.

A review of the Medication Administration Records (MARs) from 6/3/19 through 7/9/19 indicated Resident #66 had received PRN Ativan one time only (6/20/19).

An interview was conducted with the Pharmacy Consultant on 7/9/19 at 3:27 PM. She confirmed she had written a Pharmacy Recommendation on 6/17/19 related to Resident #66 ' s PRN Ativan order that was in place since admission (6/3/19) for greater than 14 days without a documented rationale in the medical record.

An interview was conducted with Resident #66 ' s physician on 7/9/19 at 2:40 PM. The physician

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indicated he was aware of the regulation related to PRN psychotropic medications. He stated that PRN psychotropics were to be ordered for 14 days and then re-evaluated after the 14-day period to determine their continued need. He indicated if the PRN psychotropic was assessed with a continued need that he would write a new order with a duration of 14 days. He reported that it was an error if a stop date was not included in the physician ' s order for a PRN psychotropic medication.

An interview was conducted with the Director of Nursing (DON) on 7/11/19 at 2:03 PM. The DON indicated that orders for PRN psychotropic medications were to be time limited in duration to 14 days and then re-evaluated by the physician after the 14-day period to determine if there was continued need for the PRN order. She stated that if the PRN psychotropic was assessed with a continued need then the physician was to write a new order with a duration of 14 days. The DON reported that she was unsure if nurses had been trained on the regulations related to PRN psychotropic medications.

2. Resident # 37 was originally admitted to the facility on 12/7/18 and was readmitted on 4/30/19 with multiple diagnoses including anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 5/21/19 indicated that Resident #37's cognition was intact.

Resident #37's doctor's orders were reviewed. The resident had an order dated 4/30/19 for Ativan (anti-anxiety drug) 0.5 milligrams (mgs) every 8 hours PRN (as needed) for anxiety. On 5/3/19, the frequency of the Ativan was changed to 0.5 mgs twice a day PRN for anxiety/agitation.

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| F 758 | Continued From page 85<br><br>On 7/9/19 at 2:25 PM, Resident #37's doctor was interviewed. He stated that PRN Ativan should only be ordered for 14 days and then reevaluate after 14 days for continued use. He indicated that he just came back from a vacation and he was not aware and he was not informed that Resident #37 was on PRN Ativan.<br><br>On 7/9/19 at 3:26 PM, the Pharmacy Consultant was interviewed. The Pharmacy Consultant stated that she expected the nurses to write order for PRN psychotropic medications with a stop date of 14 days and for the doctor to reevaluate for continued use after 14 days.<br><br>On 7/11/19 at 11:05 AM, Nurse #1 was interviewed. The nurse verified that she had received order for PRN Ativan on 4/30/19 for Resident #37. The nurse reported that she started working at the facility end of March 2019 and she didn't know at that time that order for PRN psychotropic medication should have a stop date of 14 days.<br><br>Nurse #10 was no longer employed at the facility.<br><br>On 7/11/19 at 2:10 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to write order for PRN psychotropic medications with a stop date of 14 days and to notify the doctor to reevaluate the resident for continued need after 14 days. The DON reported that she didn't think nurses were trained on PRN psychotropic medications and the need for a stop date. | F 758 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) | F 842 | | 8/8/19 |

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| F 842 | Continued From page 86<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(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.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§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-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(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 a serious threat to health or safety as permitted | F 842 | | |

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| F 842 | Continued From page 87<br>by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff and resident interviews and record review the facility failed to maintain complete and accurate medical records for 5 (Resident #11-dental and oral surgeon consults), (Resident #10-Treatment Administration Records and oxygen saturation), (Resident #169-urinalysis), (Resident #270-oxygen saturation) and (Resident #66-consults and Treatment Administration Record). This was for 5 of 21 residents reviewed for accurate medical records. The findings included: | F 842 | On 7/11/19, facility obtained Resident #11□s dental and oral surgeon consults.<br><br>Service Line Educator will educate Nurse #7 and #13,Nurese will be educated by 8/8/19 to document Resident #10□s tracheostomy care on the Treatment Administration Record (TAR).<br><br>On 7/11/19, facility obtained the results of Resident #169□s urinalysis. | |

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| F 842 | Continued From page 88<br><br>1. Resident #11 was admitted on 3/10/18 with a diagnosis of Dementia.<br><br>Review of Resident #11's quarterly Minimum Data Set dated 4/16/19 indicated severe cognitive impairment and exhibited psychosis and wandering behaviors.<br><br>Review of a care plan meeting note dated 5/1/19 read Resident #11 developed a mouth ulcer and was to be seen by the dentist.<br><br>Review of a nursing note dated 5/13/19 at 3:28 PM read Resident #11 was seen by the dentist today.<br><br>Review of Resident #11's electronic and hard chart did not include any documentation from the dentist visit on 5/13/19.<br><br>During an interview on 7/10/19 at 9:00 AM, the Medical Record (MR) staff person stated she reviewed Resident #11's electronic and closed hard chart and she was unable to find the dental consult dated 5/13/19. She stated normally when a resident saw the in-house dentist, a copy of the dental consult was placed in the hard chart, but she was unable to explain why it was not part of Resident #11's medical record.<br><br>During an interview on 7/11/19 at 9:40 AM, the Administrator provided a copy of the dental consult dated 5/13/19 recommending an oral biopsy to rule out oral cancer. She stated she had to contact the dental provider to obtain the consult.<br><br>Review of the Complaint Intake Report registered | F 842 | Service Line Educator will educate Nurse #4 and #14, to document Resident #270□s oxygen saturations on the Treatment Administration Record (TAR).<br><br>On 7/9/19, facility obtained Resident #66□s orthopedic consult note.<br><br>Service Line Educator will educate nurses providing Resident #66□s catheter care, to document on the Treatment Administration Record (TAR).<br><br>On 8/6/19, Service Line Educator will conduct facility-wide audit of TARs, for the period of 7/1/19 through 7/30/19, to ensure complete and accurate documentation.<br><br>Beginning 7/31/19, Service Line Educator will educate nurses on the process for ensuring urinalysis results are obtained and included in resident□s Electronic Medical Record (EMR) and orders will be initiated following a resident□s consult visit. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new nurses on the process for ensuring urinalysis results are obtained and included in resident□s Electronic Medical Record (EMR) and orders will be initiated following a resident□s consult visit, will be provided by the Service Line Educator. | |

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| F 842 | Continued From page 89<br>with the state read Resident #11 was seen by an oral surgeon on 5/16/19 and again on 6/6/19 but there was no documented evidence of these two consults in the electronic or hard copy medical record.<br><br>During an interview on 7/10/19 at 9:00 AM, the Medical Record (MR) staff person stated she reviewed Resident #11's electronic and hard chart and she was unable to find the oral surgeon consults dated 5/16/19 and 6/6/19. She stated normally when a resident had an outside consult, a copy of the consult was placed in the hard chart, but she was unable to explain why it was not part of Resident #11's medical record.<br><br>During an interview on 7/11/19 at 9:40 AM, the Administrator provided a copy of the oral surgeon consult dated 5/16/19 which read a biopsy was taken of the lesion under her tongue. She stated she had to contact the oral surgeon's office to obtain the consult. She also provided a copy of the oral surgeon consult dated 6/6/19 which read the biopsy came back positive for cancer. The Administrator stated she had to contact the oral surgeon's office to obtain the consults.<br><br>During an interview on 7/11/19 at 2:03 PM, the Administrator and the Director of Nursing stated it was their expectation that all resident's medical records be complete and accurate and that Resident #11's dental and oral surgeon consults would have been in her hard chart. The Administrator also stated that the facility was going all electronic with medical records later in July 2019 and hoped that would remedy the problem with incomplete and inaccurate medical records. | F 842 | On 7/31/19, a new diagnostic order log was developed and initiated for nursing staff, to document urinalysis, labs, and x-rays. Nursing documentation will include the receipt of order, completion of order, receipt of results, and Physician/Advanced Practice Practitioner (APP) notification. Beginning 7/31/19, Service Line Educator will educate nurses on the new diagnostic order log. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new nurses on the new diagnostic order log will be provided by the Service Line Educator.<br><br>Director of Nursing (DON) or designee, will conduct weekly 100% audit of Medication Order log to ensure compliance. DON or designee, will conduct weekly 100% audit of TARs for completeness and for urinalysis to be located in resident□s EMR to ensure compliance. DON or designee, will conduct monthly 100% audit of new diagnostic order log to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared by DON with the Administrator and Director of Nursing on a weekly basis and by DON with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |

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2. Resident #10 was admitted 8/6/18 with cumulative diagnoses of Chronic Respiratory Failure and a tracheostomy (a surgically created hole in the windpipe to allow air to enter the lungs).

Review of Resident #10's annual Minimum Data Set dated 4/19/19 indicated he was cognitively intact and exhibited no behaviors. He was coded for supervision with his activities of daily living. He not coded as having a tracheostomy.

Review of Resident #10's June and July 2019 Physician orders indicated the following: Nurse to assist Resident #10 with self care of tracheostomy daily, change the corrugated tubing for the tracheostomy humidifier weekly, change his tracheostomy tie and mask weekly, change his tracheostomy set up weekly and check his oxygen saturation levels every shift.

Review of Resident #10's Treatment Administration Record (TAR) for June 2019 revealed 10 days a nurse did not initial as assisting him with self care of his tracheostomy. The June 2019 TAR revealed 3 weeks a nurse did not initial as changing Resident #10's corrugated tubing and 3 weeks a nurse did not initial as changing his tracheostomy tie and mask. The June 2019 TAR revealed 2 weeks a nurse did not initial as changing his tracheostomy set up and 15 shifts a nurse did not initial or document Resident #10's oxygen saturation level.

Review of Resident #10's July TAR from 7/1/19 through 7/10/19 revealed 5 days a nurse did not initial as assisting him with self care of his tracheostomy and the July 2019 TAR revealed 9 shifts a nurse did not initial or document Resident

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#10's oxygen saturation level.

During an interview on 7/9/19 at 3:57 PM, the Administrator stated the facility had identified incomplete documentation as a current problem and they had Performance Improvement Plan (PIP) in place initiated on 7/5/19.

During an interview on 7/10/19 at 12:13 PM, Nurse #7 stated Resident #10 did his own tracheostomy care and she only changed his tracheostomy tie and equipment if it showed up on his TAR. She stated she checked his oxygen saturation levels daily but sometimes forgot to document it.

During an interview on 7/10/19 at 3:00 PM, Resident #10 stated he completed his tracheostomy care in the evenings before he went to bed. He stated staff changed his tracheostomy tie, mask, corrugated tubing and tracheostomy set up every week. He stated he "stayed on top of it." He also stated staff checked his oxygen saturation levels a couple times a day.

During a telephone interview on 7/10/19 at 4:37 PM, Nurse #13 stated Resident #10 was independent with his tracheostomy care and he completed it at bedtime. She stated if she was present during his tracheostomy care, she should have documented it on the TAR. Nurse #13 stated sometimes she forgot to document it.

During an interview on 7/11/19 at 2:03 PM, the Administrator and Director of Nursing stated it was their expectation that all medical records to be complete and accurate.

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3. Resident #169 was admitted 5/20/16 with cumulative diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Respiratory Failure, Congestive Heart Failure (CHF) and Chronic Kidney Disease.

Review of Resident #169's quarterly Minimum Data Set (MDS) dated 6/6/19 indicated she was cognitively intact.

Review of a Physician order dated 4/5/19 read Resident #169 was to have urinalysis with culture and sensitivity to rule out a urinary tract infection. She was placed on an antibiotic empirically.

Review of Resident #160's electronic and hard chart revealed no evidence of the results from the urinalysis ordered 4/5/19.

During an interview on 7/11/19 at 10:35 AM, the Administrator provided a copy of the urinalysis results from 4/5/19 and stated it was not in Resident #169's medical record and was requested from the laboratory on 7/11/19.

During an interview on 7/11/19 at 2:03 PM, the Administrator and the Director of Nursing stated it was their expectation that all resident's medical records be complete and accurate. The Administrator also stated that the facility was going all electronic with medical records later in July 2019 and hoped that would remedy the problem with incomplete and inaccurate medical records.

4) Resident #270 was admitted to the facility on 6/30/19 with diagnoses that included chronic obstructive pulmonary disease (COPD), dementia and hypertension.

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The Admission Minimum Data Set (MDS) was currently in progress.

A review of the July 2019 physician orders revealed an order for Oxygen at 2 liters (L) per nasal canula continuously and oxygen saturations to be checked every shift (7am to 3pm, 3pm to 11pm and 11pm to 7am).

Review of the July 2019 Treatment Administration Record (TAR) revealed oxygen saturations were not documented as obtained by the nurse or refused by the resident for 6 out of 8 days (7/3/19, 7/4/19, 7/5/19, 7/6/19, 7/7/19 and 7/8/19).

A review of the staff schedule indicated Nurse #4 was assigned to Resident #270 on 7/1/19, 7/5/19 and 7/8/19. A phone interview was conducted 7/11/19 at 10:06am. She recalled obtaining the oxygen saturations as ordered but stated she failed to document on the TAR.

Review of the staff schedule revealed Nurse #14 was assigned to Resident #270 on 7/6/19 and 7/7/19. A phone interview was attempted with Nurse #14 on 7/11/19 at 10:22am. She was unable to be reached for interview.

On 7/11/19 at 11:08am an interview occurred with the Administrator. The incomplete TAR documentation for Resident #270 was reviewed by the Administrator, who revealed the facility had identified incomplete documentation as a current problem and had a Performance Improvement Plan (PIP) in place. She reported the PIP was initiated on 7/5/19. The Administrator provided the PIP dated 7/5/19 for review. The PIP indicated the corrective action was to be fully implemented

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by 7/12/19 and included education, audits and ongoing monitoring. The Administrator acknowledged the problem of incomplete documentation had not been resolved as evidenced by the incomplete documentation on Resident #270's TAR occurring most recently as 7/8/19.

The Director of Nursing was interviewed on 7/11/19 11:15am and indicated she expected the medical records to be complete and accurate.

5a. Resident #66 was admitted to the facility on 6/3/19 with diagnoses that included a hip fracture.

The hospital discharge summary dated 6/3/19 indicated Resident #66 was to follow up with the orthopedist in 1.5 to 2 weeks.

The admission Minimum Data Set (MDS) assessment dated 6/10/19 indicated Resident #66 had short-term and long-term memory problems and severely impaired decision making. Resident #66 had an active diagnosis of a hip fracture.

A Nurse Practitioner (NP) note dated 6/26/19 indicated Resident #66 had an order in her medical record to be seen by her orthopedist in 1.5 to 2 weeks after hospital discharge. The NP wrote that there was no report in the medical record of this orthopedic visit.

A physician ' s order completed by the NP indicated that Resident #66 was discharged from the hospital on 6/3/19 and was to follow up with orthopedist in 1.5 to 2 weeks. The NP wrote that

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an appointment needed to be made for Resident #66 if she had not been seen.

A review of Resident #66 ' s hard copy and electronic medical record was conducted on 7/8/19 and revealed no orthopedic notes.

On 7/9/19 an orthopedic visit note dated 6/19/19 was added to Resident #66 ' s hard copy medical record.

An interview was conducted with the Director of Nursing (DON) on 7/11/19 at 2:03 PM. She indicated she expected consultation visit notes to be in the medical record. The DON acknowledged it was pertinent to obtain documentation from all consultations as this documentation could affect decisions with the resident ' s plan of care.

5b. Resident #66 was admitted to the facility on 6/3/19 with diagnoses that included urinary retention.

The admission Minimum Data Set (MDS) assessment dated 6/10/19 indicated Resident #66 had short-term and long-term memory problems and severely impaired decision making.

A physician's order dated 6/14/19 for Resident #66 indicated a Foley catheter was to be inserted for urinary retention.

A physician's order dated 6/14/19 for Resident #66 indicated catheter care every shift and as needed (7:00 AM, 3:00 PM, and 11:00 PM).

A physician's order dated 6/14/19 for Resident

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#66 indicated a catheter bag cover was to be in place at all times and to check placement every shift (7:00 AM, 3:00 PM, and 11:00 PM).

A physician's order dated 6/14/19 for Resident #66 indicated to empty catheter bag every shift and as needed (7:00 AM, 3:00 PM, and 11:00 PM).

A review of the Treatment Administration Record (TAR) from 6/14/19 through 6/30/19 revealed the following incomplete documentation related to Resident #66 ' s catheter care orders:
- Catheter care every shift was not documented as completed on 19 of 51 shifts.
- Catheter bag cover in place and checked each shift for placement was not documented as completed on 19 of 51 shifts.
- Empty catheter bag every shift was not documented as completed on 25 of 51 shifts.

A review of the TAR from 7/1/19 through 7/8/19 revealed the following incomplete documentation related to Resident #66 ' s catheter care orders:
- Catheter care every shift was not documented as completed on 14 of 24 shifts with the most recent incomplete documentation on 7/8/19 for the third shift.
- Catheter bag cover in place and checked each shift for placement was not documented as completed on 14 of 24 shifts with the most recent incomplete documentation on 7/8/19 for the third shift.
- Empty catheter bag every shift was not documented as completed on 19 of 24 shifts with the most recent incomplete documentation on 7/8/19 for the third shift.

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| F 842 | Continued From page 97<br>An interview was conducted with the Administrator on 7/9/19 at 3:57 PM. The incomplete TAR documentation for Resident #66 was reviewed with the Administrator. The Administrator revealed that the facility had identified incomplete documentation as a current problem and they had Performance Improvement Plan (PIP) in place. She reported that this PIP was initiated on 7/5/19. The Administrator provided this PIP dated 7/5/19 for review. The PIP indicated that the corrective action was to be fully implemented by 7/12/19 and included education, audits, and ongoing monitoring. The Administrator acknowledged that the problem of incomplete documentation had not been resolved as evidenced by the incomplete documentation on Resident #66 ' s TARs occurring most recently on 7/8/19.<br><br>An interview was conducted with the Director of Nursing (DON) on 7/11/19 at 2:03 PM. She indicated that she expected medical records to be complete and accurate. | F 842 | | |
| F 881 SS=E | Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3)<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff, pharmacy | F 881 | On 7/23/19, physician order was written | 8/8/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345281 | A. BUILDING _____ B. WING _____ | C 07/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| STANLY MANOR | 625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001 |

| (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 |
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| F 881 | Continued From page 98<br>consultant and physician interview the facility failed to initiate the facility wide antibiotic stewardship program. This was evidenced by 1 of 5 sampled residents reviewed for unnecessary medication use (Resident #12).<br><br>The findings included:<br><br>Review of the "Infection Prevention Plan" (IPP) revised January 2019 indicated the Antibiotic Stewardship Program (ASP) was to improve the use of antibiotics to protect the residents and reduce antibiotic resistance which was crucial to the IPP. The goal of the ASP was to optimize the treatment of infections while reducing adverse events associated with antibiotic use through improving antibiotic prescribing practices and reducing inappropriate use. The components of the program included in part:<br>1. Leadership commitment<br>2. Accountability<br>3. Action<br>4. Tracking<br>5. Education<br><br>Resident #12 was admitted to the facility on 7/11/17 with diagnoses that included history of urinary tract infections (UTIs). Physician progress notes from 7/12/17 to present revealed "history of UTI's. Continue Cipro prophylaxis". A record review revealed an order dated 7/13/17 for Cipro 250 milligrams (mg) give half tab (125mg) every night for UTI prophylaxis indefinitely. A urinalysis dated 3/31/19 was negative. There was no record of a urology consultation since her admission date.<br><br>On 7/9/19 at 2:47pm an interview occurred with the physician. The physician was familiar with the | F 881 | for Resident #12 to obtain urology consult. The Director of Nursing (DON) noted in this deficiency is no longer employed at the facility.<br><br>Beginning 7/31/19, Service Line Educator will educate all nurses on the Infection Prevention Plan which includes Antibiotic Stewardship. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new nurses on the Infection Prevention Plan which includes Antibiotic Stewardship, will be provided by the Service Line Educator. On 7/31/19, Service Line Educator will conduct facility-wide audit of residents on prophylaxis antibiotic therapy to ensure compliance. The results of the audits revealed 3 residents with current diagnoses that supports long term antibiotic therapy .<br><br>During weekday morning meeting, the Administrative Stand Up Team will utilize the 24 hour report to review resident receiving antibiotics. The Administrative Stand Up Team includes the Administrator, Director of Nursing (DON), Dietary Manager, Minimum Data Set (MDS) Coordinator, Admissions Coordinator, Medical Records Coordinator, Environmental Services Manager, Resident Liaison, and Activity Director. Residents receiving antibiotics will be added to the new diagnostic order | |

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| F 881 | Continued From page 99<br>Antibiotic Stewardship Program and stated, "every patient has individual needs" when it came to the use of antibiotics, however he would be researching further as to why Resident #12 was on an indefinite antibiotic.<br><br>An interview with the Director of Nursing occurred on 7/9/19 at 3:14pm. The Director of Nursing (DON) stated she had been the infection control nurse since being hired in January 2019 and that she was familiar with the antibiotic stewardship program but could not produce any antibiotic logs or protocols for the antibiotic stewardship program. The DON reviewed the antibiotic order for Resident #12 and stated, "I don't see anything wrong with it. If there is an order for indefinite use I just continue it".<br><br>On 7/9/19 at 3:26pm an interview occurred with the pharmacy consultant. She reviewed for unnecessary antibiotics each month and communicated with the physician and facility when an indefinite antibiotic was being used. The pharmacy consultant provided a recommendation to the physician dated 6/26/19 to review the use of indefinite antibiotic for Resident #12.<br><br>The Director of Nursing and Administrator were interviewed on 7/11/19 at 11:15am. They both were aware the facility did not utilize an antibiotic stewardship program but expected to implement and follow an infection control program per regulatory guidelines. | F 881 | log. This log will include a section for nursing staff to document, that appropriate consults were being associated with the antibiotic usage, in accordance with Antibiotic Stewardship. Service Line Educator will educate all nurses on the new diagnostic order log, including the section for nursing staff to document, that appropriate consults were being associated with the antibiotic usage, in accordance with Antibiotic Stewardship. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new nurses on the new diagnostic order log, including the section for nursing staff to document, that appropriate consults were being associated with the antibiotic usage, in accordance with Antibiotic Stewardship, will be provided by the Service Line Educator.<br><br>On 7/31/19, the facility will implement the Antibiotic Stewardship function in AHT (American Healthtech □ Electronic Medical Record) which will provide nurses electronic access to implement the protocol. Service Line Educator will educate nurses on the Antibiotic Stewardship documentation protocol in AHT. Any staff member who does not receive the training by the specified date, 8/8/19, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. Orientation for new | |

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| F 881 | Continued From page 100 | F 881 | nurses on the Antibiotic Stewardship function in AHT, will be provided by the Service Line Educator.<br><br>Director of Nursing (DON) or designee, will conduct weekly 100% audit of the Antibiotic Utilization Report to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared by DON with the Administrator and Director of Nursing on a weekly basis and by DON with QAA monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAA Committee. | |