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E 000	Initial Comments An unannounced Recertification survey was conducted in conjunction with a complaint investigation on 09/16/19 through 09/19/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID#27GN11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification survey was conducted in conjunction with a complaint investigation on 09/16/19 through 09/19/19. A total of four allegations were investigated. One of the allegations was substantiated and three of the allegations were unsubstantiated.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		10/17/19

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

Electronically Signed | 10/10/2019

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F 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement Care Plan interventions for 4 of 4 residents (Resident #31, Resident #38, Resident #32, and Resident #19) whose Care Plans were reviewed for falls. Findings included: 1. Resident #31 was re-admitted to the facility on 03/31/19 and had diagnoses of dementia without behaviors and a history of falls. The Minimum Data Set (MDS) dated 08/01/19 revealed Resident #31 had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. Resident #31's Care Plan dated 09/13/19	F 656	1. All residents identified thru the survey process had a fall assessment completed by 9/18/19. 2. All residents have the potential to be affected by this deficient practice. A chart audit was conducted and a fall assessment was completed on every resident not in compliance. All care plans were reviewed and updated. These audits were completed on 9/18/19. 3. The facility fall policy was reviewed and updated. The nursing staff was in-serviced on completing fall assessments. The charge nurse/designee will now be responsible for completing the quarterly fall assessments. A schedule of	

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F 656	Continued From page 2 revealed a risk for falls with an intervention of "Please complete a fall risk assessment on me quarterly." In an interview on 09/19/19 at 10:37 AM the Charge Nurse stated that at one time there had been a nurse assigned to complete quarterly fall assessments. She indicated that the nurse had been unassigned from that duty and that another nurse had not been assigned to do the task. She expressed that the fall assessments had not been getting done because no one had been assigned to complete them and they had fallen through the cracks. In an interview on 09/19/19 at 4:56 PM the Director of Nursing (DON) verified that the fall assessments were not being completed because the assigned nurse had been pulled to work the floor and no one else had been assigned to do them. The DON expressed that the assessments were important so that interventions could be put in place to try to prevent falls from happening. 2. Resident #38 was re-admitted to the facility on 06/10/19 with diagnoses of atrial fibrillation, Parkinson's disease, and a new right femur fracture. The quarterly Minimum Data Set (MDS) dated 09/10/19 revealed Resident #38 was severely cognitively impaired and did not reject care. Resident #38 had impairments on both lower extremities but had no falls since the prior assessment or last re-entry period. The Care Plan dated 04/25/19 revealed that Resident #38 was at risk for falls related to weakness and a diagnosis of Parkinson's	F 656	assessments will be developed by the MDSC and maintained at the nurses' station. 4. The DON/designee will conduct an audit of fall assessments weekly x4, then monthly. The results of these audits will be reviewed in the monthly QAPI meetings to ensure compliance. 5. All above actions will be completed by 11/29/19.	

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F 656	Continued From page 3	F 656		

disease. Interventions included "Please complete a fall risk assessment on me quarterly."

In an interview on 09/17/19 at 2:45 PM the MDS Nurse verified that no quarterly fall assessments had been completed on Resident #38 since her admission on 10/29/18. She indicated that she input the information into the Care Plan but that she was not responsible for making sure that the assessments had been completed.

In an interview on 09/19/19 at 10:37 AM the Charge Nurse stated that at one time there had been a nurse assigned to complete quarterly fall assessments. She indicated that the nurse had been unassigned from that duty and that another nurse had not been assigned to do the task. She expressed that the fall assessments had not been getting done because no one had been assigned to complete them and they had fallen through the cracks.

In an interview on 09/19/19 at 4:56 PM the Director of Nursing (DON) verified that fall assessments were not being completed because the assigned nurse had been pulled to work the floor and no one else had been assigned to do them. The DON expressed that the assessments were important so that interventions could be put in place to try to prevent falls from happening.

3. Resident #32 was admitted to the facility on 4/10/18 with diagnoses that included a history of falling, a displaced femur fracture, fractures of the nasal bones, an orbital floor fracture on the right side, a traumatic cerebral hemorrhage, hearing loss, atrial fibrillation and chronic obstructive pulmonary disease.

The Minimum Data Set comprehensive

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F 656	Continued From page 4	F 656		

assessment dated 8/7/19 documented Resident #32 had one fall with no injury during the assessment reference period.

The care plan for Resident #32 dated 9/17/19 included a problem that read: "I am at risk for falls related to a history of falls with fractures." The goal was for the resident to remain free from injury for 90 days. One of the interventions in place was to complete a fall risk assessment for the resident quarterly.

Resident #32 had a fall risk assessment completed on 06/22/18 as part of a Nursing Admission Assessment and again on 09/18/19 (after the survey team had alerted the facility that fall risk assessments had not been completed for the resident as care planned).

Nursing progress notes documented on 07/23/19 at 6:15 AM Resident #32 fell with no injuries reported. The fall involved a broken toilet paper rack. An observation of the toilet paper rack was made on 09/19/19 at 12:05 PM. The rack was found to be fully functional with a roll of toilet paper in place. During an interview with the Plant Operations Manager at the time of the observation he stated if a resident had an incident that involved a needed repair by maintenance it was done immediately without the generation of paperwork.

In an interview conducted with the Nurse Supervisor on 09/19/19 at 10:37 AM she stated there had been a nurse assigned to complete quarterly fall assessments, that nurse was unassigned from the duty and another nurse had not been assigned. The fall assessments had not been getting done because no one had been

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F 656	Continued From page 5	F 656		

assigned to complete them. She commented the fall risk assessments had fallen through the cracks. Since it had come to the attention of the facility during the survey, they had reassigned the original nurse who had been doing the assessments to do them again.

In an interview with the Director of Nursing on 09/19/19 at 4:55 PM she stated there had been a nurse assigned to complete the quarterly fall assessments. When that nurse was assigned to a different duty the facility failed to assign another nurse to complete the fall assessments. She concluded the fall risk assessments were not being completed as planned. She stated going forward she herself would be completing the fall risk assessments for residents as care planned.

4. Resident #19 was admitted to the facility on 11/28/18. Her documented diagnoses included right femur fracture, Alzheimer dementia, vertigo, and hypertension.

Record review revealed a fall risk assessment was completed for Resident #19 on 11/28/18.

A 12/02/18 incident report documented Resident #19 told staff that she had experienced a fall.

On 12/05/18 Resident #19's care plan documented the resident was a risk for falls due to having poor balance, dizziness and a history of falls. Interventions to this care plan problem included, "Please complete a fall risk assessment on me quarterly."

Record review revealed a fall risk assessment

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was completed for Resident #19 on 12/05/18.

Record review revealed another fall risk assessment was not completed for Resident #19 until 06/17/19 following a fall on 06/10/19 which resulted in the resident having a fracture of the right hip.

During an interview with the Charge Nurse on 09/19/19 at 10:37 AM she stated previously there had been a nurse assigned to complete quarterly fall risk assessments, but that duty was removed from the nurse, and was not reassigned to anyone else. She reported as a result fall risk assessments were not getting completed.

During an interview with the Minimum Data Set (MDS) Nurse on 09/19/19 at 2:57 PM she stated she expected care plan interventions to be implemented. She reported the care plan interventions were communicated verbally to direct care staff by herself, the Director of Nursing (DON), or the Nurse Supervisor. She commented the care plan interventions were also documented on the care plan which all direct care staff had access to. According to the MDS Nurse, a new electronic alerts feature in the e-charting system also alerted staff when new care plan interventions were put in place.

During an interview with the acting DON on 09/19/19 at 4:55 PM she stated care plan interventions should be implemented. She reported staff should be aware of these interventions because they were passed on verbally, were documented on 24-hour reports, and were sent to staff via alerts in electronic charting.

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F 686	Continued From page 7	F 686		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff, therapist, and physician interviews, the facility failed to prevent a right ankle, Deep Tissue Injury (DTI) caused by a knee brace not being positioned on the knee which allowed the brace to press against the resident's ankle for 1 of 3 residents (Resident #38) whose pressure wounds were reviewed. Findings included: Resident #38 was readmitted to the facility on 06/10/19 and had diagnoses of a fractured right femur, Parkinson's disease, and dementia without behaviors. The Medication Administration Record (MAR) revealed that on 06/26/19 an order had been placed to monitor the knee brace and to perform skin checks every two hours to Resident #38's right lower extremity.	F 686	1. Resident #38 was identified thru the survey process with a deep tissue injury caused by a knee brace. 2. The facility pressure ulcer policy was reviewed and updated. The nursing staff was in-serviced on facility skin care protocols. 3. Residents with braces will have a skin check every two hours and as needed. Skin checks will be documented in the EMR. 4. The DON/designee will conduct an audit of skin assessments weekly x4 and then monthly. The results of these audits will be reviewed in the monthly QAPI to ensure compliance. 5. All the above actions will be completed by 11/29/19	10/17/19

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F 686	Continued From page 8	F 686		

Resident #38's Care Plan initiated on 06/26/19 revealed under activities of daily living (ADL), interventions of: Right Leg precautions - No leg bending, no abduction, no bending of the hip more than 90 degrees. Knee immobilizer as ordered - T scope (hinged knee brace). Check skin every two hours and as needed.

The quarterly Minimum Data Set (MDS) dated 09/10/19 revealed that Resident #38 was severely cognitively impaired and did not reject care. Resident #38 required the extensive assistance of one person for bed mobility, dressing, and hygiene, and was dependent on one person for transfers, toilet use, and bathing. Resident #38 was at risk for but had no pressure ulcers.

In an interview on 09/18/19 at 7:07 AM Nurse #1 stated that Resident #38's knee brace should be loosened, and the skin checked every two hours. He stated that the last time he had checked Resident #38's knee brace was at 2:00 AM that morning.

In an interview on 09/18/19 at 8:30 AM Nurse #2 stated she had last checked the skin on Resident #38's right leg at 7:45 AM and would check it again at 10:00 AM.

In an observation of Resident #38's knee brace and the skin beneath it on 09/18/19 at 9:59 AM and an interview with Nurse #2 at the same time, she stated the knee brace was not in the right position. The brace was positioned so that the bottom of the knee brace was on the right ankle. Nurse #2 loosened the straps on the brace to check the skin on Resident #38's leg. A dark red area, approximately the size of ½ of a dime, with

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a dark purple center was noted on Resident #38's right medial ankle. The area was not open. The skin around the wound was also red. Nurse #2 stated she had discovered the area when she checked Resident #38's skin at 7:45 AM. She indicated that she had not documented the wound, notified the physician or notified the Responsible Party when the wound was discovered. She indicated she had not provided any treatment or protection to the wound on discovery. She indicated she would go and bring a therapist back to the room to correctly position Resident #38's brace. Resident #38 did not appear to be in any pain from the pressure wound.

In an observation and interview with Physical Therapist (PT) #1 on 09/18/19 at 10:06 AM he adjusted Resident #38's knee brace approximately 6 inches up the leg to the correct position. He stated that the pressure injury on the ankle was caused by the knee brace pressing against the ankle.

In a telephone interview on 09/18/19 at 3:46 PM Resident #38's physician stated that Resident #38 should not have developed a pressure injury on the ankle from a knee brace. He indicated that the brace should have been monitored for its position and the skin should have been monitored to prevent this type of injury. He stated that the pressure injury was avoidable and should not have happened.

The Skin Evaluation Form dated 09/18/19 revealed the wound was reddish/purple in color, was non-blanchable, and measured 0.8 by 0.4 cm (centimeters). The surrounding skin was red, and the wound was staged as a DTI.

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F 686	Continued From page 10 In an interview on 09/19/19 at 10:37 AM the Charge Nurse stated that she had assessed Resident #38's ankle wound and that she had classified it as a DTI. In an interview on 09/19/19 at 2:00 PM Nursing Assistant (NA) #1 stated she had been instructed on the proper positioning of Resident #38's knee brace. She indicated she observed the pressure area on Resident #38's right ankle on 09/16/19 but did not tell the nurse because she thought it was an old wound. In an interview on 09/19/19 at 4:56 PM the acting Director of Nursing (DON) stated that all orders should be followed. She indicated that interventions were put in place for a reason and in this case, they were put in place to prevent injury. She stated that the skin and knee brace checks needed to be done as ordered to maintain Resident #38's skin integrity. She indicated that Resident #38 should not have developed an ankle pressure injury from a knee brace that was improperly positioned. The DON stated that the Nursing Assistants should always report any skin injury to the nurse even if they think it is an old injury because it might not have been reported.	F 686		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		10/17/19

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F 692	Continued From page 11 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and Registered Dietician interviews, the facility failed to provide a nutritional supplement in the amount ordered by the physician for a resident with continued weight loss for 1 of 4 residents (Resident #31) whose nutrition was reviewed. Findings included: The March 2019 paper Medication Administration Record (MAR) revealed an order to administer Medpass 2.0 (a nutritional supplement) 120 mls (milliliters) by mouth three times daily. Resident #31 was readmitted to the facility on 03/31/19 and had diagnoses of hypertension, dementia without behaviors, and pain. The 04/01/19-09/17/19 electronic MARs revealed orders to administer Medpass 2.0 by mouth three times daily for nutritional supplementation. The orders did not contain an amount of the supplement to be provided.	F 692	1. Medication record audits were completed to identify all residents who had the potential to be affected by this deficient practice. A chart audit was conducted. This audit was completed on 9/17/19. All care plans were reviewed and updated. 2. The DON/designee will conduct an audit of Medpass orders weekly x4. Thereafter, all new orders will be reviewed each month by nursing staff to ensure that each order contains all the needed elements. All nurses will be in-serviced on the 5 rights of medication administration and reminded that each of the elements must be defined within the MD order for the medication. 3. The results of these audits will be reviewed in the monthly QAPI meetings to ensure compliance. 4.All above actions will be completed by 11/29/19.	

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Resident #31's weights were recorded as follows:

03/01/19 112.20 pounds
04/01/19 108.40 pounds
05/02/19 106.80 pounds
06/03/19 105.00 pounds
07/02/19 100.20 pounds
08/01/19 101.40 pounds
08/07/19 101.80 pounds
08/21/19 98.60 pounds
08/29/19 98.20 pounds
09/03/19 98.10 pounds
09/12/19 97.60 pounds

The annual Minimum Data Set (MDS) dated 08/01/19 revealed Resident #31 had short-term and long-term memory problems and was severely impaired in cognitive skills for daily decision making. Resident #31 needed the extensive assistance of one person for eating. Resident #31 weighed 101 pounds and had a weight loss of 5% or more in the last month or a weight loss of 10% or more in the last six months.

The Registered Dietician (RD) note dated 09/10/19 revealed that Resident #31 had a significant weight loss trend in place. Resident #31's intake had been good over the last seven days with an average intake amount of 71%. Multiple therapeutic supplements were in place to aid with needs including Medpass 2.0 120 ml three times daily. According to the note Resident #31's weight loss may be unavoidable due to disease progression.

Resident #31's Nutrition Care Plan updated 9/13/19, listed interventions of diet as ordered and to monitor weights as ordered.

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F 692	Continued From page 13	F 692		

In an observation on 09/17/19 at 5:06 PM Resident #31 was up in the dining room eating a peanut butter and jelly sandwich. Approximately 90% of the sandwich had been eaten.

In an interview on 09/18/19 at 9:08 AM Nurse #4 stated she worked with Resident #31 4-5 days per week. She reviewed the order in the computer for the Medpass 2.0 and stated that there was no dosage amount listed, but that she usually administered 60 ml of the Medpass 2.0 to Resident #31. Nurse #4 indicated that it was a problem that no dosage amount was listed on the order and that she should have clarified the order. Nurse #4 explained that Resident #31 received the Medpass 2.0 because the resident did not eat well.

In an observation on 09/18/19 at 11:38 AM Resident #31 was up in the dining room and was served macaroni and cheese, greens, chicken, and corn bread. Approximately 25% of the meal was eaten.

In an interview on 09/18/19 at 5:05 PM Nurse #5, who worked with Resident #31 on the 3PM-11PM shift, stated she had been administering 60 ml of Medpass 2.0 to Resident #31 on her shift.

In an interview on 09/19/19 at 11:07 AM the MDS Nurse clarified that "diet as ordered" on the Care Plan consisted of anything related to nutrition including supplements, meals, and snacks.

In a telephone interview on 09/19/19 at 12:05 PM Nurse #6 stated that the facility had begun using electronic charting for medication administration on 04/01/19. She indicated that she transferred the order for the Medpass 2.0 from the paper

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F 692	Continued From page 14 MAR to the electronic MAR and did not check to see that the order had transferred with all the needed information which would have included the amount to be given. In a telephone interview on 09/19/19 at 2:23 PM the RD stated that generally she looked at a resident's MAR each time she assessed them. She indicated that she must have missed that there was no amount listed for the dispensing of the Medpass 2.0 on the May, July, August and September 2019 MARs when she assessed Resident #31 during those months. She verified that she expected nutritional interventions to be followed and would expect orders to be entered into the electronic record correctly when the facility changed from paper to electronic charting. The RD indicated that although Resident #31 only received one half the Medpass 2.0 that was ordered, other interventions were in place and she did not feel this contributed heavily to the continued weight loss. In an interview on 09/19/19 at 4:56 PM the Director of Nursing (DON) stated that interventions were put in place for a reason and that she expected them to be followed. She indicated that she expected orders to be followed and that when the MAR went from paper to electronic the orders should have been checked to make sure they were input correctly. The DON expressed that it was important to provide nutritional supplements as ordered to prevent continued weight loss. The DON clarified that it was also the responsibility of the RD to look at the MAR to make sure supplements were given as ordered.	F 692		
F 760	Residents are Free of Significant Med Errors	F 760		10/17/19

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F 760 SS=D	Continued From page 15 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on physician assistant interview, staff interview, and record review the facility failed to provide anticoagulation coverage for seven days after a sub-therapeutic lab value was obtained for 1 of 2 sampled residents (Resident #45) receiving anticoagulant medication (Coumadin). The facility also failed to hold the administration of an anticoagulant (medication used to treat/prevent the formation of blood clots) as ordered by the physician for 1 of 2 sampled residents (Resident #45) who was on Coumadin. Findings included: 1. a. Resident #45 was admitted to the facility of 07/12/19. The resident's documented diagnoses included atrial fibrillation (irregular heart rhythm) and cerebrovascular accident (CVA) or stroke with left sided weakness. Resident #45's 07/19/19 admission minimum data set (MDS) assessment documented her cognition was moderately impaired and she was receiving anticoagulant medication daily. On 07/23/19 "Risk for unexplained bruising or bleeding r/t (due to) taking anticoagulant medication" was identified as a problem in Resident #45's care plan. Interventions to this problem included "Please give me anticoagulant med as ordered." On 08/13/19 Physician Assistant (PA) #1 wrote an order to discontinue Resident #45's Coumadin	F 760	1. All residents identified thru the survey process had the potential to be affected by this deficient practice and were audited. The audits were completed on 9/20/19. All care plans were updated as needed. 2. The Coumadin policy was reviewed and updated. The nursing staff was in-serviced ion monitoring labs and notifications of MD promptly when labs are received. 3. The DON/designee will conduct a weekly audit of PT/INR x4 and then monthly. PT/INR labs will be reviewed 5x/week in the ITM (interdisciplinary team meeting). The results of these audits will be reviewed in the monthly QAPI meeting to ensure compliance. 4. All above actions will be completed by 11/29/19.	

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F 760	Continued From page 16	F 760		

once her international normalized ratio (INR) was below 2, and at that point, to start the resident on Eliquis 2 milligrams (mg) twice a day (BID).

08/26/19 lab results documented Resident #45's prothrombin time (PT) was 40.5 and her INR was 4.3 (these lab values were calculated based on the time it took the resident's blood to clot). In response to these lab results PA #1 ordered for the Coumadin to be temporarily discontinued with a repeat PT/INR to be drawn on 08/29/19.

08/29/19 lab results documented Resident #45's PT was 34.8 and her INR was 3.7. In response to these lab results PA #1 ordered the Coumadin to remain on hold with a repeat PT/INR to be drawn on 09/05/19.

09/04/19 lab results documented Resident #45's PT was 15.3 and her INR was 1.5. There was no documentation on the lab results to indicate that they were called in to the PA or primary physician.

Review of Resident #45's August 2019 and September 2019 electronic medication administration record (e-MAR) revealed the resident did not receive any more Coumadin after 08/25/19, and the resident did not receive Eliquis on 09/04/19 after her INR fell below 2 as ordered by the PA.

On 09/10/19 PA #1 wrote an order to start Resident #45 on Eliquis 2 mg every 12 hours.

Review of Resident #45's September 2019 e-MAR revealed the resident received her first dose of Eliquis on 09/12/19. The resident did not receive any anticoagulant medication for seven days.

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Review of Resident #45's electronic medical record revealed she did not experience any signs and symptoms of a stroke or heart problems between 09/04/19 and 09/12/19.

During an interview with the Charge Nurse on 09/19/19 at 3:40 PM she stated she could not explain why Resident #45 went without anticoagulant medications between 09/04/19 and 09/11/19. She commented maybe the PA wanted to assess the resident in person before making a decision on how to best continue the resident's anticoagulant therapy. The Charge Nurse explained because of an in-coming hurricane the Medical Director gave permission for labs scheduled on 09/05/19 to be drawn early on 09/04/19.

During a telephone interview with PA #1 on 09/19/19 at 4:30 PM he stated Resident #45 should have been transitioned from Coumadin to Eliquis before 09/12/19. He reported he could not recall if the facility made him aware of Resident #45's 09/04/19 lab results, but remarked that he ordered Resident #45 to be transitioned to Eliquis again on 09/10/19 since the facility had not done so yet per his 08/13/19 order to make the change after the resident's INR fell below 2. The PA explained Resident #45 was receiving anticoagulation therapy for control of her atrial fibrillation, and the resident's heart rate was currently under very good control so the Coumadin was being used for preventative measures. Thus, he commented there was a lower risk that Resident #45 could have experienced any harm from going without anticoagulant therapy for seven days.

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During an interview with the acting Director of Nursing (DON) on 09/19/19 at 4:55 PM she stated Resident #45 should not have gone from 09/04/19 through 09/11/19 without anticoagulant medication. She reported a nurse should have documented a PA or physician response if they were contacted with lab results on 09/04/19 and clarified whether or not the resident was still to be transitioned to Eliquis after the INR was below 2 as ordered back on 08/13/19. She commented the resident going seven days without anticoagulant therapy increased the chance the resident could have experienced a stroke.

1. b. Resident #45 was admitted to the facility of 07/12/19. The resident's documented diagnoses included atrial fibrillation (irregular heart rhythm) and cerebrovascular accident (CVA) or stroke with left sided weakness.

Resident #45's 07/19/19 admission minimum data set (MDS) assessment documented her cognition was moderately impaired and she was receiving anticoagulant medication daily.

On 07/23/19 "Risk for unexplained bruising or bleeding r/t (due to) taking anticoagulant medication" was identified as a problem in Resident #45's care plan. Interventions to this problem included "Please give me anticoagulant med as ordered."

A 08/16/19 hospital discharge summary documented Resident #45's Coumadin was to be resumed at 1.5 milligrams (mg) daily (QD) starting on 08/19/19.

08/22/19 lab results documented Resident #45's prothrombin time (PT) was 31.5 and her

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international normalized ratio (INR) was 3.3 (these lab values were calculated based on the time it took the resident's blood to clot) . It was documented on these lab results that Physician Assistant (PA) #1 wanted Resident #45's Coumadin to be held on 08/22/19 and 08/23/19 with Coumadin 1 mg QD to start on 08/24/19 and a PT/INR to be drawn on 08/26/19.

Review of Resident #45's August 2019 electronic medication administration record (e-MAR) revealed the resident's Coumadin was held on 08/22/19, but the resident received Coumadin 1.5 mg on 08/23/19. The resident received Coumadin 1 mg on 08/24/19 and 08/25/19.

08/26/19 lab results documented Resident #45's PT was 40.5 and her INR was 4.3. In response to these lab results PA #1 ordered for the Coumadin to be temporarily discontinued with a repeat PT/INR to be drawn on 08/29/19.

08/29/19 lab results documented Resident #45's PT was 34.8 and her INR was 3.7. In response to these lab results PA #1 ordered the Coumadin to remain on hold.

Review of Resident #45's electronic medical record revealed the resident did not experience any episodes of bleeding between 08/23/19 and 08/29/19.

During an interview with Nurse #2 on 09/19/19 at 2:57 PM she stated if the PA conveyed he wanted Coumadin held, the nurse receiving this communication put the medication on hold in the e-MAR. She also commented that it was her general routine to pull the medication card out of the cart and leave it in the locked medication

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room with a note on the card documenting the medication was being held.

During an interview with the Charge Nurse on 09/19/19 at 3:40 PM she stated the nurse who received communication from the PA to hold medications placed them on hold in the e-MAR so the medications were flagged with a red 'H" in the administration section on the affected dates . She explained a nurse, although it could not be determined which one, forgot to document in the e-MAR that Resident #45's Coumadin was placed on hold on 08/23/19. She commented that because Resident #45's Coumadin was not held on 08/23/19 it increased the risk the resident could have experienced bleeding.

During a telephone interview with PA #1 on 09/19/19 at 4:30 PM he stated if he gave orders to hold Coumadin on certain dates then he would expect the facility to follow through and make sure the residents did not receive the medication. He explained the treatment goal for Resident #45 was to transition the resident from Coumadin to Eliquis, and in order to do so the resident's INR needed to be below 2. Therefore, he commented not holding the Coumadin on 08/23/19 slowed down Resident #45's progress toward attaining her INR goal and transitioning off Coumadin. The PA stated Resident #45 received Coumadin to manage her atrial fibrillation.

During a 09/19/19 4:12 PM interview with Nurse #2, who did not hold Resident #45's Coumadin on 08/23/19, she stated she administered Coumadin to the resident on 08/23/19 because there was no red H (designating a hold) in the e-MAR on that date and there was no note on the resident's Coumadin bubble pack to hold the medication on

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F 760	Continued From page 21 08/23/19. During an interview with the acting Director of Nursing (DON) on 09/19/19 at 4:55 PM she stated it was the responsibility of the staff nurses to make sure medications that the PA wanted held were placed on hold in the e-MAR and did not get administered to the residents. She reported not holding Coumadin as ordered by the PA increased the chances that Resident #45 could have experienced bleeding and delayed the goal of getting the resident's INR below 2.	F 760		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to establish a Quality Assurance/ Performance Improvement Program (QA/PIP) for an issue identified in May 2019 (falls) to include a root cause analysis, monitoring, and review of audit results. Findings included: The facility Quality Assessment Performance Improvement Plan Policy (Effective Date November 30, 2017) defines the responsibilities of the Governing Body of the facility, (the Executive Director/Administrator, Director of Nursing Services, Assistant Director of Nursing Services and the Medical Director), as responsible for the development and	F 867	1. The facility QAPI program was identified during the survey for failure to identify an individual plan for structured monitoring, auditing, staff education or evaluations pertaining to falls. 2. The facility's QAPI policy was reviewed and updated. The team members were in-serviced on developing and implementing appropriate plans of action to correct identified quality deficiencies and regularly reviewing and analyzing the data collected. Analyzing the QAPI program performance to identify and follow up on areas of concern or opportunities for improvement.	10/17/19

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F 867	Continued From page 22 implementation of the QAPI program. The Governing Body is responsible for: 1. Identifying and prioritizing problems based on performance indicator data. 2. Incorporating resident and staff input that reflects organizational processes, functions, and services provided to residents. 3. Ensuring that corrective actions address gaps in the system and are evaluated for effectiveness. 4. Setting clear expectations for safety, quality, rights, choice, and respect. 5. Ensuring adequate resources exist to conduct QAPI efforts. The Quality Assurance Performance Improvement (QAPI) Committee reports to the executive leadership and Governing Body and is responsible for: 1. Meeting, at a minimum, on a quarterly basis; more frequently, if necessary 2. Coordinating and evaluating QAPI program activities 3. Developing and implementing appropriate plans of action to correct identified quality deficiencies 4. Regularly reviewing and analyzing data collected under the QAPI program and data resulting from drug regiment review and acting on available data to make improvements. 5. Determining areas for PIPs and Plan-Do-Study-Act (PDSA) rapid cycle improvement projects. 6. Analyzing the QAPI program performance to identify and follow up on areas of concern and/or opportunities for improvement. The facility Monthly QAPI Reports and Event	F 867	3. LCS corporate Nurse consultant will provide an in-depth overview of the QAPI program in the last week of October 2019 for all team members. 4. All above actions will be completed and in place by the October QAPI meeting on 10/29/19.	

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F 867	Continued From page 23 Logs for May, June and July 2019 were reviewed. A brief summary of the number of falls that occurred was reported. The documentation did not include an individual plan for structured monitoring, auditing, staff education or evaluations pertaining to falls. In an interview conducted with the Director of Nursing on 09/19/19 at 4:55 PM she stated she had been looking at the high incidence of falls in the facility. She commented she had not developed a PIP (Performance Improvement Plan), monitoring or measuring tools or tangible auditing tools. She acknowledged the facility had a Quality Assurance policy she had not been following to establish and monitor Quality Assurance issues. She stated she had never been taught how to formally develop Quality Assurance PIP's after issues had been identified. She reported when she took over quality assurance in 2016, she had no examples to refer to because the previous nurse who was in charge of Quality Assurance had been let go promptly and did not have a QA process in place.	F 867		