STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	09/27/2019

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ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

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E 000	Initial Comments An unannounced Recertification survey was conducted on 9/23/19 through 09/27/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #HZ1Y11.	E 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she	F 578		10/20/19

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

Electronically Signed | 10/21/2019

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F 578	Continued From page 1 has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to clarify code status on one of one residents (Resident #42) reviewed for Advanced Directives. Findings include: Resident #42 was admitted to the facility on 1/25/14 with diagnoses that included ALS (Amyotrophic Lateral Sclerosis) and anxiety. A review of Resident #42's most recent MDS (Minimum Data Set) dated 7/23/19 and coded as a quarterly assessment revealed the resident was cognitively intact. Active diagnoses included ALS, adult failure to thrive, and anxiety. The MDS coded the resident as receiving hospice. A review of Resident #42's current care plan dated 4/26/19 revealed the resident was care planned as a DNR (Do Not Resuscitate) with interventions that included the staff was to provide maximum comfort for the resident, the staff was to follow facility protocol for identification of code status, and the code status was to be reviewed quarterly.	F 578	Social Worker met with Resident #42 and confirmed she wished to remain a DNR. Audit was completed on 10/4/19 to include all active residents in facility. Audit documented CPR/DNR order, demographics page, DNR Form when applicable and care plan to ensure all were matching for each resident. One other discrepancy was found and corrected immediately. Charts for all new residents are brought to morning Clinical Meeting. Chart will be reviewed to ensure CPR/DNR order is per resident request and matches demographics page, care plan and that the DNR Form is in chart if applicable. This process will also be followed for all readmissions and residents who request Hospice Services. An audit will be completed monthly for the next 3 months to ensure all CPR/DNR documents are properly in place and matching. Audits and chart reviews will be summarized and presented at the monthly	

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F 578	Continued From page 2 A review of Resident #42's medical record revealed an order dated 12/4/14 that read the resident was a full code. It also revealed a DNR (Do Not Resuscitate) form dated 5/22/19 with no expiration date. The review of Resident #42's medical record also revealed order summary reports dated 6/3/19, 7/1/19, and 7/30/19 which read resident was a full code. A review of Resident #42's demographic page revealed the resident was a full code. An interview was conducted on 9/25/19 at 4:40pm with NA #15. She reported with new residents she would ask the nurse what the code status of the resident was, but with the long-term residents she knew them well and knew their code status. She reported Resident #42 was a DNR code status. An interview was conducted with NA #13 on 9/25/19 at 7:45pm. She reported she usually worked the hall where Resident #42 resided. She reported she knew the residents code status by looking at the care plan in the kiosk or she would ask the nurse. An interview was conducted on 9/25/19 at 8:00pm with Medication Aide #5. He reported a resident's code status was on the face page in the electronic record and in the hard chart. He reported he looked at the face page in the electronic record as it was easiest when he was working on the medication cart. He reported Resident #42 was a full code. An interview was conducted with Medication Aide #8 and Nurse #2 on 9/25/19 at 8:05pm. They both reported that residents' code status was documented on the face sheet in the electronic record and in the hard chart. Nurse #2 looked up	F 578	Quality Assurance Meeting for the next 3 months. Any issues or trends identified will be addressed by the committee as they arise and the plan will be revised to ensure continued compliance. The Social Worker is responsible for implementing and maintaining the acceptable plan of correction.	

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F 578	Continued From page 3 Resident #42 and reported she was a full code. An interview was conducted on 9/25/19 at 8:40pm with the DON (Director of Nursing). She reported there should be an order for the resident's updated code status and that Resident #42's medical record should reflect the appropriate code status on all residents.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the minimum data set (MDS) assessment for behaviors for Resident #49 and Resident #31 and for an active diagnsis of cerebral vascular accident for Resident #71. Findings Included: 1. Resident #49 was admitted to the facility on 9/9/19 and diagnoses included end stage renal disease and dialysis dependent. A nursing note dated 9/12/19 for Resident #49 stated he refused to attend dialysis on this shift. A behavior charting note dated 9/12/19 for Resident #49 stated the patient was refusing dialysis treatments. A social service progress note dated 9/12/19 for Resident #49 stated the Social Worker (SW) had spoken with the resident about once again	F 641	Resident #49 had a modification of Section E completed to reflect accurate behavior documentation for Assessment Reference Date 9/18/19. Resident #71 had a modification of Section I completed to reflect accurate medical diagnosis for Assessment Reference Date 9/6/19. Resident #31 had a modification of Section I completed to reflect accurate medical diagnosis for Assessment Reference date 7/10/19. The MDS Coordinator completed an audit of all MDS assessments completed in the last 30 days to verify accurate coding of Sections E and I of the MDS per RAI Manual guidelines. One other inaccuracy was found, corrected and submitted. Education and counseling was completed for the Social Worker responsible for completion of Section E. The Nurse who completed Section I for Resident #71 and	10/20/19

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F 641	Continued From page 4 refusing dialysis. The SW reminded the resident this would be 2 sessions of dialysis in a row that he had missed. A nursing note dated 9/15/19 for Resident #49 stated the nurse had approached the resident twice during the med pass and each time the resident had an excuse not to take his medications. The resident was non-compliant with medication administration. An admission minimum data set (MDS) dated 9/18/19 for Resident #49 identified he had not displayed the behavior of rejection of care during the look-back period. An interview on 9/26/19 at 3:16 pm with the SW revealed she had completed the behavior section (Section E) of the admission MDS dated 9/18/19 for Resident #49. The SW explained she had made a mistake and should have coded the rejection of care on the behavior section. She added she had multiple entries in the resident ' s medical record about him refusing dialysis during the look-back period for that MDS and she coded it incorrectly. An interview on 9/27/19 at 9:29 am with the Director of Nursing (DON) revealed it was her expectation the MDS assessment reflected a true picture of the resident so that individualized care plans would be developed. 2. Resident #71 was admitted to the facility on 8/27/19 and diagnoses included cerebral vascular accident, diabetes, dysphagia, protein calorie malnutrition and metabolic encephalopathy. An admission minimum data set (MDS) for	F 641	#31 is no longer working at the facility. The Director of Nursing provided education to the Interdisciplinary Team members responsible for coding sections of the MDS regarding accuracy of coding according to the RAI Manuel guidelines on 10/16/19. The MDS Coordinator will randomly audit 10 completed MDS assessment weekly for 4 weeks and then 20 MDS assessments monthly for an additional 5 months to verify accruate coding of Sections E and I of the MDS. One to one education and counseling will be provided if opportunities for corrections are identified as a result of these audits. Modifications to the MDS will be completed if necessary. The MDS Coordinator will present results of these audits for 6 months at the Monthly Quality Assurance Meeting. The committee will review results and make any needed recommendations or changes as indicated. The MDS Coordinator is responsible for the plan of correction and ensuring complaince.	

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F 641	Continued From page 5	F 641		

Resident #71 dated 9/6/19 did not identify cerebral vascular accident as an active diagnosis.

An interview on 9/26/19 at 3:21 pm with the MDS nurse revealed cerebral vascular accident was a primary diagnosis for Resident #71 and it should have been coded as a diagnosis on her admission MDS dated 9/6/19.

An interview on 9/27/19 at 9:29 am with the Director of Nursing (DON) revealed it was her expectation the MDS assessment reflected a true picture of the resident so that individualized care plans would be developed.

3. Resident #31 admitted to the facility on 6/23/19 with diagnoses that included dementia, cardiomyopathy, and pneumonia.

A review of Resident #31's most current MDS (Minimum Data Set) assessment coded as a quarterly assessment and dated 7/10/19 revealed the resident was mildly cognitively impaired. Active diagnoses included Non-Alzheimer's dementia, hypertension, and dysphagia. Resident #31's MDS medication look back revealed the resident was on antidepressants 7 out of 7 days.

Resident #31's most current care plan dated 7/10/19 revealed the resident was care planned for use of antidepressant medications with interventions to include administer medications as ordered, monitor and document for side effects and effectiveness, and behavioral health consults as needed.
A review of Resident #31's medical record revealed a physician's order dated 7/7/19 that read Zoloft 25mg (milligram) daily for depression.

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F 641	Continued From page 6 An interview was conducted on 9/26/19 at 3:06pm with the MDS nurse. She reported the MDS nurses were responsible for accurately coding all MDS assessments. She reported the 7/10/19 MDS quarterly assessment for Resident #31 should have been coded with depression as an active diagnosis.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will 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	F 656		10/20/19

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F 656	Continued From page 7 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 observation, record review, resident interview and staff interview the facility failed to develop and implement a person-centered comprehensive care plan to address smoking for 1 of 3 residents (Resident #15) reviewed for safe smoking and the facility failed to develop and implement a person-centered comprehensive care plan to address resident behaviors and the use of an antipsychotic medication for 1 of 5 residents (Resident #59) reviewed for unnecessary medications. Findings included: 1.Resident #15 was admitted to the facility on 7-2-19 with multiple diagnosis that included traumatic subdural hemorrhage, acute kidney infection and acute respiratory failure. The admission Minimum Data Set (MDS) dated 7-9-19 revealed Resident #15 was moderately cognitively impaired. Resident #15's care plan dated 8-28-19 revealed	F 656	The care plan was updated on 10/1/19 for Resident #15 regarding his desire to smoke. Update included interventions and goals based on his need to smoke safely. The care plan for Resident #59 was updated on 10/15/19 with current behaviors, interventions and goals. The antipsychotic medication was discontinued on 9/24/19. Audit was completed reviewing all care plans for all other residents with behaviors and antipsychotic medications and the desire to smoke. All interventions and goals are in place for those residents, no other issues were identified in the audit. Education was provided to the Interdisciplinary Care Team regarding updating care plans whenever there is a change in behavior, antipsychotic medication, change in decision to smoke or any time a resident returns from a hospitalization. Education provided by	

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F 656	Continued From page 8 there were no goals or interventions for the resident to safely smoke. During an interview with Resident #15 on 9-23-19 at 1:46pm, the resident stated he did smoke, and that staff did not supervise him when he smoked. On 9-27-19 at 9:00am, an interview occurred with the Director of Nursing (DON). The DON stated Resident #15 smoked and his family would bring him cigarettes every 2 weeks. She stated she was not aware Resident #15 did not have goals or interventions on his care plan for smoking. The Social Worker was interviewed on 9-27-19 at 10:30am. The Social Worker stated when Resident #15 was admitted his family did not want him smoking but had brought him packs of cigarettes when they came to visit. She also stated she was not sure why Resident #15 did not have goals or interventions on his care plan for smoking. During an interview with the Administrator on 9-27-19 at 11:30am, the Administrator stated she expected resident care plans to reflect the individual resident and their care needs. 2. Resident #59 was admitted to the facility on 10-1-15 then re-admitted on 9-16-19 with multiple diagnosis that included altered mental status, hypothermia, muscle weakness and cerebral vascular disease. The annual Minimum Data Set (MDS) dated 8-16-19 revealed Resident #59 was severely cognitively impaired and was coded for worsening behaviors.	F 656	Director of Nursing on 10/16/19. An audit of care plans for 5 resident per week for 4 weeks will be completed. Care plans for audit will be determined based on behaviors, antipsychotic medications, smoking. After 4 weeks, audits will continue for 5 resident per month for 2 more months to ensure care plans are appropriate and reflect the needs of each resident. Audit results will be summarized and presented at the monthly Quality Assurance meeting for the next 3 months. Any issues or trends identified will be addressed by the committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction.	

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F 656	Continued From page 9 Resident #59's care plan dated 8-31-19 revealed no goals or interventions for behaviors or antipsychotic medication. During an interview with nursing assistant (NA) #1 on 9-24-19 at 2:15pm, NA #1 stated there were no interventions on the resident's care guide related to behaviors the resident may exhibit but that she would speak to Resident #59 and "try to calm him down" or "leave the room for a few minutes and return when he had calmed down." Nurse #1 was interviewed on 9-24-19 at 2:20pm. The nurse stated she was not aware of any goals or interventions for Resident #59's "agitation". She stated she administered the as needed Haldol (antipsychotic medication) 0.3 milliliters intramuscular on 9-23-19 because "he was agitated". Nurse #1 stated she knew Resident #59 was "agitated" because "he kept trying to get out of bed". The Administrator was interviewed on 9-27-19 at 11:30am. The Administrator stated Resident #59 returned to the facility from the hospital on 9-16-19 with the Haldol order and had not realized the medication was not discontinued. She also stated she expected resident care plans to reflect the resident needs and be individualized.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		10/20/19

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F 677	Continued From page 10 by: Based on record review, staff interviews and resident interviews the facility failed to provide bathing for a resident that was dependent for activities of daily living (ADL) care. This was evident in 1 of 3 residents (Resident #28) reviewed for ADL care. Findings included: Resident # 28 was admitted to the facility on 3-21-19 with multiple diagnosis that included muscle weakness, end stage renal disease and congestive heart failure. The quarterly Minimum Data Set (MDS) dated 7-8-19 revealed Resident #28 was cognitively intact and not coded for refusing care. The MDS also revealed Resident #28 needed total assistance with one person for bathing. Resident #28's care plan dated 8-28-19 revealed a goal that the resident would improve his current level of function in ADL's. The interventions for that goal were; supervision to set up and assistance with bathing/showering. During an interview with Resident #28 on 9-24-19 at 9:08am, the resident stated he was not receiving showers or complete bed baths on a regular basis, "I'm supposed to get a shower Tuesday and Fridays and a bed bath the other days but the staff during the day say they are too busy so they leave it to the evening shift and then they say they are too busy and night shift won't give a shower". A review of the bathing task sheet from 8-28-19 to 9-25-19 revealed Resident #28 had received	F 677	Administrator interviewed Resident #28. Discussed his preference for shower days and times. He determined the frequency and days/times he would like to shower and other days he would like a bed bath. Administrator gave information to Unit Nurse to implement. All other alert residents were interviewed for their shower/bathing preferences, including times of day and how often per week they receive a shower. Preferences were documented and information given to Nursing Staff to update shower schedule. Information was recorded in Point Click Care for documentation purposes for Nursing Assistants. Audit completed on 10/16/19. Education was provided to Nursing Staff regarding updates to shower schedule and expectations for showers, bed baths and documentation by the Assistant Director of Nursing. Documentation of showers and baths will be reviewed daily for 4 weeks by the Director of Nursing/Assistant Director of Nursing to ensure showers and baths are being completed. Social worker will also interview 10 resident per week for 4 weeks to confirm showers/baths are being offered and completed. After 4 weeks audits will continue for 5 months to ensure compliance. Audit results will be summarized and presented at the Monthly Quality Assurance meeting for 6 months. Any	

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F 677	Continued From page 11 one shower and 12 bed baths. Nursing assistant (NA) #1 was interviewed on 9-25-19 at 9:55am. NA #1 stated if a resident was not scheduled for a shower than the resident should receive a complete bed bath "but some of the aides here do not do that." She also stated each resident had certain shower days and what time of the day they received their shower. An interview occurred with NA #2 on 9-26-19 at 9:15am. NA #2 stated Resident #28 needed assistance with bathing or showering. He also stated if the resident did not receive a shower than the resident would receive a complete bed bath. NA #2 stated the nursing assistance document the activity in the computer. He also stated he had not known Resident #28 to refuse care and was not able to state the last time Resident #28 received a shower. NA #2 stated Resident #28 was already out of bed today (9-26-19) and did not know if he had a bath or shower prior to getting up for the day. During an interview with the Administrator on 9-27-19 at 11:30am, the Administrator stated Resident #28 liked to get up early and did not always want his bath or shower at that time. She also stated staff should be documenting if the resident refuses care but expected all residents' to receive a shower or full bed bath daily.	F 677	issues or trends will be addressed by the committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction.	
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-	F 686		10/20/19

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F 686	Continued From page 12 (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 observations, record review and staff interviews the facility failed to provide daily wound care as ordered by the physician. This was evident for 1 of 3 residents reviewed for pressure ulcers (Resident #71). Findings Included: Resident #71 was admitted to the facility on 8/27/19 and diagnoses included cerebral vascular accident, protein calorie malnutrition, dysphagia, diabetes and metabolic encephalopathy. An admission minimum data set (MDS) dated 9/6/19 for Resident #71 identified two stage 1, three stage 2 and one stage 4 pressure ulcers. The assessment additionally identified her cognition was severely impaired and required extensive one to two-person assistance with all activities of daily living. A care plan dated 9/9/19 for Resident #71 stated she had pressure ulcers to the back of her head, bilateral ears, bilateral heels and sacrum. Interventions included to administer treatments as ordered and monitor for effectiveness; assess, record and monitor wound healing weekly and	F 686	Resident #71 did not have treatments done on 9/21 and 9/22. Nurse #1, #2 and MDS Nurse all received re-education regarding checking Treatment Records for every resident, every shift they work to ensure all treatments are completed. Education was completed by Assistant Director of Nursing on 10/4/19. Treatment records for all other residents with wound treatments were reviewed on 10/10/19. Any holes in the treatment record were addressed with education and counseling for Nurses responsible. Issues were documented on audit sheet. All other Licensed Nurses received education regarding completing treatments as ordered and reviewing each residents treatment administration record every shift to ensure all treatments are completed. Education was completed on 10/10/19 by the Assistant Director of Nursing. All newly hired Nurses will receive same education by the Assistant Director or Director of Nursing during orientation. Treatment administration	

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F 686	Continued From page 13 monitor dressing daily to ensure it is intact and adhering. Review of wound assessments dated 9/17/19 for Resident #71 revealed the following wounds: · Stage 4 pressure ulcer to sacrum that measured 80 millimeters (mm) length by 50 mm width by 40 mm depth with tunneling at 4:00 to 11:00 o ' clock of 4 centimeters (cm) Unstageable pressure ulcer to occipital (back of head) that measured 50 mm length by 20 mm width with 60% necrotic and 40% fibrotic tissue · Stage 2 pressure ulcer to right ear that measured 20 mm length by 4 mm width · Stage 2 pressure ulcer to left ear that measured 10 mm length by 10 mm width · Deep tissue injury to right heel that measured 10 mm length by 10 mm width · Deep tissue injury to left heel that measured 15 mm length by 3 mm width Review of the September 2019 treatment administration record (TAR) for Resident #71 revealed the following wound treatment orders: · Clean sacral wound with wound cleanser or normal saline. Pack with betadine-soaked gauze. Cover with dry dressing every day shift. There were no initials indicating the treatment was completed for 9/21/19 or 9/22/19. · Cleanse wound to occipital (back of head) superior area with wound cleanser or normal saline. Apply betadine every day shift. There were no initials indicating the treatment was completed for 9/21/19 or 9/22/19. · Clean right ear with normal saline or wound cleanser. Apply skin prep every day shift. There were no initials indicating the treatment	F 686	records will be reviewed daily in morning Clinical Meeting for all residents with wound treatments. Any blanks will be addressed with Nurses responsible. Results of review will be documented on audit sheet daily. Daily review will continue for 12 weeks and results documented. Audits will be summarized and presented in the Monthly Quality Assurance Meeting for the next 3 months. Any issues or trends will be addressed by the committee as they arise and the plan will be revised to ensure continued complaince. The Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction which will be completed by 10/20/19.	

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F 686	Continued From page 14	F 686		

was completed for 9/21/19 or 9/22/19.
· Clean left ear with normal saline or wound cleanser. Apply skin prep every day shift. There were no initials indicating the treatment was completed for 9/21/19 or 9/22/19.
· Clean right heel with normal saline or wound cleanser. Apply skin prep every day shift. There were no initials indicating the treatment was completed for 9/21/19 or 9/22/19.
· Clean left heel with normal saline or wound cleanser. Apply skin prep every day shift. There were no initials indicating the treatment was completed for 9/21/19 or 9/22/19.

An interview on 9/25/19 at 3:01 pm was conducted with Nurse #2 who worked 7:00 am to 7:00 pm on 9/21/19 and 9/22/19. She stated she was the only nurse at the facility over the weekend and had to perform all the wound care on those days. She added she had not worked at the facility for about a month and couldn ' t recall all the residents that required wound care. Nurse #1 explained she did complete the wound care for Resident #71 ' s sacrum on those days because it was soiled and needed to be changed. She stated she did not complete the wound care for the resident ' s head, ears or heels because the current bandages looked pretty clean. Nurse #2 added she did the best she could with completing the wound care but being the only nurse, she wasn ' t able to get all the treatments done.

A phone interview on 9/26/19 at 11:51 am with Nurse #3 revealed he had worked 3:00 pm to 11:00 pm on 9/21/19 and 7:00 am to 12:00 am on 9/22/19. He stated he had not completed any wound care for Resident #71 on those days.

An observation and interview were conducted on

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F 686	Continued From page 15	F 686		

9/26/19 at 12:15 pm with Nursing Assistant (NA) #3 revealed she was a NA 2 and completed the wound care for Resident #71 when she was scheduled. She stated she did not work on 9/21/19 or 9/22/19 and the floor nurse was responsible for completing the wound care when she was off. Observation revealed the wounds to the resident ' s bilateral heels were healed and skin prep was applied. The sacral wound was beefy red with 15% yellow slough in the base of the wound, undermining was noted from 7:00 to 12:00 o ' clock approximately 3cm in depth, wound edges were irregular, and the wound bed was moist. NA #3 cleansed the wound with normal saline, packed betadine-soaked gauze into the wound and covered with adhesive foam. The occipital wound was noted with necrotic tissue in the center with approximately .25 cm pink tissue around the edges. NA #3 cleaned the wound with normal saline, betadine gauze was applied and covered with adhesive gauze dressing. The right ear wound was pink in color with scattered yellow slough noted. NA #1 cleaned the wound with normal saline, triple antibiotic ointment was applied and left open to air. NA #3 used aseptic technique, washed hands before donning gloves and changed gloves between wound care.

An interview on 9/27/19 at 10:15 am with the MDS nurse revealed she had worked on the north unit from 7:00 pm to 7:00 am the weekend of 9/21/19 and 9/22/19. She stated she had re-applied the bandage to Resident #71 ' s sacral wound because it was coming off. She explained she had not done any actual wound care treatments for the resident on either of those days. The MDS nurse added the nurse she took report from did not tell her that all the wound

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F 686	Continued From page 16 treatments had not been completed. An interview on 9/27/19 at 9:33 am with the Director of Nursing (DON) revealed it was her expectation that all wound treatments were completed according the physician ' s orders. She added Resident #71 ' s wound treatments were ordered to be done daily and they should be completed daily.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews the facility failed to complete a smoking assessment on a resident prior to allowing him to smoke independently at the facility. This was evident for 1 of 3 residents (Resident #15) reviewed for smoking. Findings included: Resident #15 was admitted to the facility on 7-2-19 with multiple diagnosis that included traumatic subdural hemorrhage, acute kidney infection and acute respiratory failure. The admission Minimum Data Set (MDS) dated 7-9-19 revealed Resident #15 was moderately	F 689	A smoking assessment was completed for Resident #15 on 9/29/19. Assessment concluded that resident was safe to smoke independently. Smoking assessements were reviewed for all other smokers and all were found to be completed and accurate. Review was completed by the Director of Nursing on 10/10/19. Within 24 hours of admission, smoking assessments will be reviewed for any resident who chooses to smoke. Assessment will also be completed as soon as a resident, who previously did not	10/20/19

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F 689	Continued From page 17 cognitively impaired. During an interview with Resident #15 on 9-23-19 at 1:46pm, the resident stated he did smoke, and that staff did not supervise him when he smoked. Resident #15 also denied a smoking assessment was completed. A review of Resident #15's medical record revealed no smoking assessment. The Director of Nursing (DON) was interviewed on 9-27-19 at 9:00am. The DON stated Resident #15's family brought him a pack of cigarettes every 2 weeks. She also stated a smoking assessment was completed for all residents' that smoked prior to the resident smoking independently to make sure the resident was safe to smoke without supervision. Nurse #3 was interviewed on 9-27-19 at 10:06am. The nurse stated, the admitting nurse was responsible for completing the smoking assessment on new residents', but the facility had "up to 24 hours" to complete the assessment. During an interview with nurse #4 on 9-27-19 at 10:10am, the nurse stated the admitting nurse would need to complete the smoking assessment with the resident and/or family. Nurse #4 stated she did not complete a smoking assessment on Resident #15 "because his family did not want him smoking". She also stated she was aware Resident #15 was smoking "but he is not my resident anymore, so I didn't do one." The Administrator was interviewed on 9-27-19 at 11:30am. The Administrator stated Resident #15 did not smoke very often because his family would bring one pack of cigarettes every 2 weeks	F 689	smoke, decides to start smoking. Assessments will be reviewed in daily Clinical Meeting to confirm completion and to determine independent smoking status or supervision status. All Nurses will be re-educated on the need to determine if a resident chooses to smoke on admission and if so, timely completion of the smoking assessment and determination of independent vs. supervised smoking. Education will also review that assessments need to be completed immediately when a resident who previously did not smoke, decides to start smoking. Education was completed with all Nurses by 10/10/19 by the Assistant Director of Nursing. All smoking assessments will be reviewed and tracked on audit sheet to ensure assessments are completed timely. Audit sheets will be completed weekly and continue for 3 months. Audit results will be summarized and presented at the Monthly Quality Assurance Meeting for the next 3 months. Any issues or trends will be addressed by the committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Plan was completed by 10/20/19.	

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F 689	Continued From page 18 but that she did expect a smoking assessment to be completed on any resident choosing to smoke.	F 689		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to staff Registered Nurse (RN) coverage for 8 consecutive hours daily during 3 out of 3 months reviewed for RN coverage. (6/2019, 7/2019 and 8/2019). Finding included: Record review revealed the facility does not have an approved waiver for staffing. Review of the Daily Posting of Health Care Center Staffing (DPHCCS) and staff time cards revealed: On 6/02/19 the facility census was 71 residents and there were no consecutive RN hours for the entire day.	F 727	Days there was no confirmed RN coverage can not be corrected retroactively. Schedule is being reviewed daily by Director of Nursing and Administrator to ensure at least 8 consecutive hours of RN coverage a day, 7 days per week. Facility has recruited an Assistant Director of Nursing, RN who will assist with coverage when needed and with recruitment. Director of Nursing and Administrator continue to work with recruiters to increase RN staffing overall. The Nursing Scheduler will give Human Resources the daily schedule. Human	10/20/19

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F 727	Continued From page 19 On 6/16/19 the facility census was 71 residents and there were no consecutive RN hours for the entire day. On 6/29/19 the facility census was 69 residents and there were no consecutive RN hours for the entire day. On 6/30/19 the facility census was 70 residents and there were no consecutive RN hours for the entire day. On 7/13/19 the facility census was 77 residents and there were no consecutive RN hours for the entire day. On 7/14/19 the facility census was 76 residents and there were no consecutive RN hours for the entire day. On 7/27/19 the facility census was 77 residents and there were only 7.5 consecutive RN hours for the entire day. On 7/28/19 the facility census was 78 residents and there were 3.75 consecutive RN hours for the entire day. On 8/17/19 the facility census was 77 residents and there were no consecutive RN hours for the entire day. On 8/18/19 the facility census was 78 residents and there were no consecutive RN hours for the entire day. Interview on 09/27/19 10:19 AM with the Administrator and Director of Nurses was conducted. Both indicated the facility was constantly recruiting nurses, in competition with hospital recruitment and the nurse agency. The Administrator stated she expected a RN in the building no less than 8 consecutive hours each day.	F 727	Resources will print time sheet for RN working 8 consecutive hours and give to the Director of Nursing and/or Administrator to ensure coverage scheduled was worked for 8 consecutive hours. Process will continue with no end date. Results of RN staffing confirmation process will be summarized and presented at the Monthly Quality Assurance meeting by the Director of Nursing for the next 3 months. Any issues identified will be addressed by the committee as they arise. The Director of of Nursing is responsible for implementing and maintaining the acceptable plan of correction.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		10/20/19

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F 756	Continued From page 20 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756		

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F 756	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on record review, pharmacy consultant and staff interview the facility failed to maintain documentation of the pharmacist ' s monthly medication regimen review (MRR) within the facility and readily available for 5 of 5 residents reviewed for unnecessary medications (Resident #30, Resident #45, Resident #61, Resident #64 and Resident #43). Findings Included: 1. Resident #30 was admitted to the facility 6/16/17 and diagnoses included depressive disorder, chronic pain syndrome, diabetes, congestive heart failure and chronic kidney disease. A quarterly minimum data set (MDS) dated 7/10/19 for Resident #30 identified he received an opioid, antidepressant and diuretic for 7 days of the look-back period, insulin injections for 6 days of the look-back period, a hypnotic for 4 days of the look-back period and an antibiotic for 1 day of the look-back period. A review of the electronic and paper medical record for Resident #30 revealed no monthly medication review (MRR) was available for June 2019, July 2019 and August 2019. A phone interview on 9/25/19 at 1:06 pm with the Pharmacy Consultant (PC) revealed she had started at the facility about 3 months ago. She stated the MRR ' s for the residents were currently available on the pharmacies website and she was not currently documenting any information in the resident ' s medical record	F 756	Pharmacy Consultant documentation is in charts of Residents #30, 45, 61, 64 and 43. Documentation notes that she had no recommendations for these residents during the month in review. All medical records were audited for Pharmacy recommendations for month of September. Pharmacy Consultant has provided documentation for medical records of any resident that was reviewed and had no recommendations. Pharmacy Consultant was educated regarding need for resident specific documentation when medications are reviewed and no recommendations are made by Administrator on 10/10/19. Consultant will provide documentation monthly. Medical Records will be audited monthly to ensure each record has evidence of a Pharmacy review either through recommendations that are made or a note stating review indicates no recommendations at this time. Audit will be completed monthly for the next 3 months to ensure documentation is in place. Audits will be summarized and presented at the monthly Quality Assurance meeting for the next 3 months. Any issues or trends identified will be addressed by the committee as they arise and the plan will be revised to ensure continued compliance.	

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F 756	Continued From page 22 when she completed her monthly MRR ' s. The PC explained the facility monthly reports, resident recommendations and a list of residents she reviewed but did not have recommendations for were located on the pharmacy website. She stated this information was provided to the facility Director of Nursing (DON) via the website. The PC indicated the pharmacy had received mixed messages from the facilities corporate office regarding whether the MRR ' s should be documented in the individual resident ' s medical record. An interview on 9/25/19 at 2:43 pm with Nurse #2 revealed she recalled the facility changed pharmacies around February 2019. She stated they had received some training on how to re-order medications from the pharmacy website, but she did not know how to access any pharmacy reports from the website. An interview on 9/26/19 at 11:43 am with Nurse #4 revealed she was able to access the pharmacy website to re-order medications, but she did not know how to access the pharmacy notes or recommendations. Nurse #4 explained the pharmacy recommendations were usually faxed or given to them and the nurses followed-up with the physicians. An interview on 9/27/19 at 9:26am with the DON revealed the PC recommendations and reports were on the pharmacy website. She stated the PC printed the pharmacy recommendations for her monthly and she would distribute these to the nurses for follow-up. She added the PC did not document anything in the medical record monthly for each resident, but there was a list of residents that she reviewed each month with her report on	F 756	The Medical Records Coordinator is responsible for implementing and maintaining the acceptable plan of correction by 10/20/19.	

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the website. The DON explained all the facility nurses were trained on how to access the pharmacy website to re-order medications and they should also be able to access the pharmacy reports.

2. Resident #45 was admitted to the facility on 4/18/19 with diagnoses that included diabetes, Non-Alzheimer's disease, anxiety, psychotic disorder, and epileptic seizures.

A review of Resident #45's quarterly Minimum Data Set assessment dated 7/26/19 revealed the resident received insulin 7 out of 7 days, antipsychotics 7 out of 7 days, antianxiety medications 7 out of 7 days, and antidepressants 7 out of 7 days in the medication look back period.

A review of Resident #45's medical record, electronic and paper, revealed no monthly medication review documentation was available for June, July, and August 2019.

3. Resident #61 was admitted to the facility on 10/18/18 with diagnoses that included Parkinson's, dementia, depression, psychosis, and mood affective disorder.

A review of Resident #61's quarterly Minimum Data Set assessment dated 8/16/19 revealed the resident received antidepressants 7 out of 7 days, antipsychotics 7 out of 7 days, and diuretics 7 out of 7 days.

A review of Resident #61's medical record,

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F 756	Continued From page 24	F 756		

electronic and paper, revealed no monthly medication review documentation was available for July and August 2019.

An interview was conducted on 9/25/19 at 2:00pm with the DON (Director of Nursing). The DON reported the pharmacist came to the facility once a month. She reported any recommendation by the pharmacist was given to the physician for review. The DON reported the pharmacist also brought the list of residents she reviewed for the month. She reported all the nurses were in serviced on the pharmacy website and should be able to access the list of residents reviewed. She reported if a resident or responsible person requested medical records, she would show the pharmacy resident list and block out the other names. She reported there was no documentation in the resident's charts unless the pharmacist made a recommendation to the physician.

4. Resident #-64 was admitted to the facility on 1/16/19 with diagnoses that included bipolar disorder and stroke.

A review of Resident #64's quarterly Minimum Data Set assessment dated 5/14/19 revealed the resident received antidepressants 6 out of 7 days, anticoagulant 6 out of 7 days, opioid 7 out of 7 days
and antibiotics 7 out of 7 days.

A review of Resident #64's electronic and paper medical record revealed no monthly medication review documentation was available for July 2019 and August 2019.

An interview was conducted on 9/25/19 at

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2:00pm with the DON (Director of Nursing). The DON reported the pharmacist came to the facility once a month. She reported any recommendation by the pharmacist was given to the physician for review. The DON reported the pharmacist also brought the list of residents she reviewed for the month. She reported all the nurses were in serviced on the pharmacy website and should be able to access the list of residents reviewed. She reported if a resident or responsible person requested medical records, she would show the pharmacy resident list and block out the other names. She reported there was no documentation in the resident's charts unless the pharmacist made a recommendation to the physician.

5. Resident #43 was admitted to the facility on 4-19-16 with multiple diagnosis that included dementia, unspecified psychosis, peripheral vascular disease, major depression and anxiety disorder.

The quarterly Minimum Data Set (MDS) dated 7-25-19 revealed Resident #43 was severely cognitively impaired and received antianxiety, antidepressant, opioid and antipsychotic medication 7 out of 7 days during the look back period.

A review of Resident #43's electronic and paper medical record revealed no documentation from the pharmacy consultant of a medication regimen review being completed from October 2018 to 9-1-19.

The Administrator was interviewed on 9-27-19 at 11:30am. The Administrator stated there had been some confusion related to the pharmacy consult's medication recommendations needing to be placed in the residents' medical record. The Administrator stated she would follow up with the corporate office.

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §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: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §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 in the clinical record; §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; §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 §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	F 758		10/20/19

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F 758	Continued From page 27 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §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. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interview the facility failed to document monitoring of the use and side effects for psychotropic medications for 2 of 5 sampled residents (Resident #59 and #43) reviewed for unnecessary medications. Findings included: 1.Resident #59 was admitted to the facility on 10-1-15 then re-admitted on 9-16-19 with multiple diagnosis that included altered mental status, hypothermia, muscle weakness and cerebral vascular disease. The annual Minimum Data Set (MDS) dated 8-16-19 revealed Resident #59 was severely cognitively impaired and was coded for worsening behaviors. Resident #59's care plan dated 8-31-19 revealed no goals or interventions for behaviors or antipsychotic medication. Review of the physician orders dated 9-16-19 revealed an order for behavior monitoring for the use of antipsychotic medications and monitoring for side effects every shift.	F 758	The psychotropic medication for Resident #59 was discontinued on 9/24/19. The nurse that administered the medication is no longer employed. Resident #43 has a straight order for psychotropic medication due to multiple behavior issues. Nurses and Nursing Assistants were re-edcuated to document all behaviors every shift for this resident on 10/10/19 by Assistant Director of Nursing. New hires will complete education during orientation with Assistant Director or Director of Nursing. Both resident care plans have been reviewed to ensure they reflect any current behaviors and appropriate interventions. Care plans and behavior documentation has been reviewed for all other residents who receive psychotropic medications. All care plans were accurate with behaviors listed, interventions and goals. Behavior documentation is being recorded for these residents also. Reviews were documented on an audit sheet by Director of Nursing on 10/14/19. Education will be provided to all Nursing	

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F 758	Continued From page 28 A physician order dated 9-16-19 revealed Haldol (antipsychotic medication) 0.3 milliliters (ML) by mouth every 4 hours as needed for agitation or delirium. Resident #59's medication administration record (MAR) for the month of September revealed Haldol 0.3ML was given to the resident on 9-23-19. A review of Resident #59's progress notes dated 9-16-19 to 9-25-19 revealed no documentation of the resident's behaviors or if there were or were not any side effects from Resident #59's antipsychotic medication. During an interview with Nurse #1 on 9-24-19 at 2:20pm, the nurse stated she provided Resident #59 Haldol 0.3ML's on 9-23-19 "because he was agitated". She stated the resident "kept trying to get out of bed". The nurse denied Resident #59 was yelling, cursing or trying to strike anyone. She stated she did not document the resident's behaviors or if there were any side effects noted after administering the medication "I should have written a note, but I got busy and forgot." The Administrator was interviewed on 9-24-19 at 2:55pm. The Administrator stated the nurses were to utilize the behavior codes in the MAR to document each shift the behavior of a resident on an antipsychotic medication and if there were any side effects from the medication. She stated staff were putting a check in the box instead of utilizing the codes and not writing a progress note describing the resident's behaviors each shift. The Administrator stated she expected the staff to document significant behavioral issues in the	F 758	staff regarding documentation, every shift, of any behaviors and use of psychotropic medications. Education will be completed on 10/10/19. Audits will be completed for residents with behaviors and/or use of psychotropic medications weekly for 4 weeks. Audits will ensure behaviors and use of medications is being documented. After 4 weeks audits will continue monthly for the following 2 months. Audit results will be summaried and presented at the Monthly Quality Assurance meeting for the next 3 months. Any issues or trends identified will be addressed by the committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction on 10/20/19.	

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resident medical record.

During an interview with the physician on 9-27-19 at 1:32pm, the physician stated he would not expect an as needed psychotropic medication to be used unless the resident was aggressive towards others or themselves and other interventions did not work. He also stated he would expect documentation in the medical record to reflect the need for the medication and if there were any side effects.

2. Resident #43 was admitted to the facility on 4-19-16 with multiple diagnosis that included dementia, unspecified psychosis, peripheral vascular disease, major depression and anxiety disorder.
The quarterly Minimum Data Set (MDS) dated 7-25-19 revealed Resident #43 was severely cognitively impaired and was not coded for any behaviors.

Resident #43's care plan dated 8-15-19 revealed a goal that she would have fewer psychotic symptoms and be free of psychotropic drug related complications. The interventions for that goal included; administering antipsychotic medication as ordered by the physician, review behaviors, interventions and alternate therapies attempted and their effectiveness, observe, document and report any adverse reactions of psychotropic medications.

A review of the physician orders dated 11-9-18 revealed an order for staff to observe and document Resident #43's behaviors and side effects of her psychotropic medications in the progress notes.

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During an interview with nursing assistant (NA) #4 on 9-26-19 at 5:00pm, NA #4 stated Resident #43 would become anxious when care was being provided, such as yelling out, pushing the NA's away and striking out. The NA stated she would speak with the resident and try to calm the resident down and report the behaviors to the nurse. She denied there was an area in the NA's documentation to document resident behaviors.

Nurse #3 was interviewed on 9-26-19 at 5:10pm. The nurse stated Resident #43 would yell and the resident's behaviors would continue to "escalate." Nurse #3 also stated Resident #43's behaviors did not occur everyday but did occur "several" times a week. The nurse stated that specific behaviors and any side effects of medication would be documented in the progress notes but that he did not always remember to document.

Resident #43's progress notes were reviewed from 9-1-19 to 9-25-19 and revealed no documentation of the resident's behaviors or any side effects from her psychotropic medications.

The Administrator was interviewed on 9-24-19 at 2:55pm. The Administrator stated staff were to write any behaviors or side effects of their medication in the residents' progress notes but that was not occurring. She also stated she expected the staff to document significant behavioral issues in the resident medical record.

During an interview with the physician on 9-27-19 at 1:32pm, the physician stated he would expect documentation in the medical record to reflect the need for the medication and if there were any side effects from the psychotropic medication.

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F 761	Continued From page 31	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to discard expired medications located in 1 of 1 medication room and failed to date opened medications in 2 of 2 medication carts that were observed. (South unit and North unit) Findings Included:	F 761	The basaglar insulin pen and lantus insulin pen on cart #2 were properly discarded. The Pneumovax 23, Engerix B and Lorazepam found outdated in the North Hall medication refrigerator were all removed and placed in a locked cabinet for disposal by the Director of Nursing. The bottle of Milk Thistle found on South hall medication cart was removed and	10/20/19

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F 761	Continued From page 32 An observation on 9/27/19 at 10:35 am of the north unit medication cart #2 revealed an opened, undated Basaglar insulin pen that had sticker with a dispense date of 9/23/19 and an opened, undated Lantus insulin pen that had a sticker with a dispense date of 9/23/19. Nurse #4 was present during the observation and stated both insulin pens should have been dated when they were opened. An observation on 9/27/19 at 10:45 am of the north medication room revealed 1 vial of Pneumovax 23 had an expiration date of 6/17/19, 1 vial of Engerix B had an expiration date of 5/7/19 and 10 vials of Lorazepam had expiration dates of 7/26/19. There were all stored in the refrigerator located in the medication room. Nurse #4 was present during the observation and stated these expired medications had come from their previous pharmacy provider. She explained when she tried to send them back to that pharmacy, they refused to take them because the facility had switched to a new pharmacy provider. Nurse #4 added she didn ' t know what to do with them because neither pharmacy would take them back and medications can ' t be disposed of at the facility. An observation on 9/27/19 at 11:05 pm of the south unit medication cart #1 revealed a bottle of 200 caps of milk thistle that was opened, but not dated. Nurse #3 was present during the observation and stated he believed he had opened the milk thistle sometime last week and he should have dated the bottle when he opened it.	F 761	properly discarded. All 4 medication carts were check by the Director of Nursing to ensure no other undated pens or open undated medications were on any of the medications carts. None were found. South and North Hall medication refrigerators were checked for outdated medications by the Director of Nursing and no others were found. Education will be provided to all Nurses regarding proper dating of all new bottles of medication and insulin pens, by the Assistant Director of Nursing. Education was completed by 10/10/19. The process for removal of expired medication will also be provided. All 4 medication carts and the medication refrigerators will be inspected weekly for 4 weeks for any open, undated or expired medications. After 4 weeks medication carts will be inspected every 2 weeks for 2 more months. Inspections will be recorded on an audit sheet, documenting any issues found. Issues will be address with Nurses responsible. Education will also be provided to all newly hired Nurses during orientation by the Director of Nursing or Assistant Director of Nursing. Audits will be summarized and presented in the Monthly Quality Assurance meeting for the next 3 months. Any issues or trends identified will be addressed by the committee as they arise and the plan will be revised to ensure continued complaince.	

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F 761	Continued From page 33 An interview on 9/27/19 at 11:20 am with the Director of Nursing (DON) revealed it was her expectation that all medications be dated when they are opened. She explained the facility had changed pharmacy providers on 5/1/19 and originally both pharmacies said they would take back any expired medications. She added when they attempted to return expired medications to the new pharmacy provider, they rejected them. The DON stated she received a notice from the new pharmacy provider that instructed them to stop trying to return any expired medications from their previous pharmacy as they would not take them back. The DON explained she was working with their corporate office on how they should dispose of expired medications. She added the expired medications should have been taken out of the refrigerator and placed away in a locked cabinet so no one would accidently administer to a resident.	F 761	The Director of Nursing is responsible for implemting and maintaining the acceptable plan of correction. Completion date is 10/20/19.	
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 observations, record review, and staff interviews the facility ' s Quality Assessment and Performance Improvement Committee (QAPI) failed to maintain implemented procedures and monitor the interventions that were put in place following the annual recertification of 11/16/18.	F 867	The Quality Assurance Committee met on 10/17/19 to address the plan of correction for recent survey and repeat deficiencies for F641 and F677. Root cause for F641 was determined to be that the Interdisciplinary Team Members	10/20/19

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F 867	Continued From page 34 This was for recited deficiencies in the areas of provision of activities of daily living for dependent residents (F-677) and assessment accuracy (F-641). These deficiencies were re-cited during the annual recertification survey on 9/27/19. The continued failure of the facility during 2 federal surveys of record showed a pattern of the facility ' s inability to sustain and effective QAPI program. Findings included: This tag is cross referenced to: 1. F 677 - Based on record review, staff interviews and resident interviews the facility failed to provide bathing for a resident that was dependent for activities of daily living (ADL) care. This was evident in 1 of 3 residents (Resident #28) reviewed for ADL care. During the recertification survey on 11/16/18 the facility was cited at F 677 for failure to provide a bath for a resident that was dependent for Activities of Daily Living (ADL ' s). This was evident for 1 of 3 residents that were reviewed for ADL ' s (Resident #6). 2. F 641 - Based on record review and staff interview the facility failed to accurately code the minimum data set (MDS) assessment for behaviors for Resident #49 and Resident #31 and for an active diagnosis of cerebral vascular accident for Resident #71. During the recertification survey on 11/16/18 the facility was cited at F 641 for failure to accurately code the MDS (Minimum Data Set) for 1 out of 5 residents (Resident #58) reviewed for unnecessary medications and 1 out of 6 residents (Resident #26) reviewed for nutrition.	F 867	responsible for Sections E and I did not validate for accuracy the actual behavior documentation (Resident #49 and #31) and diagnosis of a resident (Resident #71) during the observation period resulting in an inaccurate Minimum Data Set being closed and transmitted. Root cause for F677 was determined to be that the documentation book for showers was inadvertently discarded, loosing documentation of showers for some months and the Nursing Assistans were not regularly documenting in Point Click Care that showers were given or refused. The Committee determined that random audits of MDS accuracy will be completed for 6 months. If accuracy is not achieved, Interdisciplinary Team members responsible will be addressed individually and audits will be extended beyond the 6 months until accuracy is achieved. 10 MDS will be audited a week for first 2 months, then 20 MDS audits a month for the next 4 months will be completed. Any inaccurate MDS will be corrected and transmitted following the modification process. Documentation of showers and/or refusals will be completed daily and turned in to the Nurse on unit for review and validation that shower was given and/or refused. The Director of Nursing and/or Assistant Director of Nursing will confirm that showers was given or offered by reviewing documentation daily. Any documentation that is not completed or shower not given will be addressed with	

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	345014	A. BUILDING _____ B. WING _____	09/27/2019

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F 867	Continued From page 35 An interview on 9/27/19 at 12:44 pm with the Administrator revealed the facility quality assurance team met monthly and was attended by herself, the Director of Nursing (DON), Medical Director, Pharmacy Consultant and department managers. She added the Pharmacy Consultant tried to come monthly but attended quarterly at a minimum. She stated the facility had been working on quality assurance plans in the areas of documentation, assessments and baseline care plans. The Administrator explained the facility was not currently completing any monitoring of MDS accuracy or ADL ' s as related to bathing. She added the facility had monitored these areas for about 6 months after being cited for these areas last year. The Administrator indicated going forward they would expand the number of MDS ' s they review for accuracy and complete daily monitoring to ensure residents are bathed. She added shower sheets that documented if a shower was completed or not would go directly to the DON for daily follow-up.	F 867	the individual Nursing Assistant responsible. Audits will be brought to the monthly Quality Assurance Meeting for review and recommendations if necessary. Any inaccuracy that is found will be immediately addressed with the Team Member responsible and correction made. The Regional Clinical Reimbursement Specialist will review the facility Quality Assurance Committee meeting audits (for F641) for 6 months to ensure accuracy is achieved and make further recommendations if necessary The Regional Nurse Consultant will review the facility Quality Assurance Committee meeting documentation (for F677) for 6 months to ensure showers have been given and documented and to make further recommendations if necessary. The Administrator is responsible for implementing the plan of correction, Chairing the Quality Assurance Committee and ensuring the plan of correction is complete so that compliance is achieved.	
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, pest activity voiced by 2	F 925	Rooms 127 and 133 were thoroughly	10/20/19

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F 925	Continued From page 36 of 4 alert and oriented Residents who attended Resident Council meeting, staff interviews, interview with pest control representative and review of pest service reports, the facility failed to maintain an effective pest control program. (Room #127 and hallway between Room #123 and Room #127. The findings included: A Resident Council Meeting was held on 9/24/19 at 3:15 PM with a total of 4 alert and oriented in attendance. During the meeting, 2 Residents expressed concerns related to pest activity. One stated a problem with flies and gnats, and one stated a crawling insect similar to a water bug on 9/23/19 had crawled on the bed beside the pillow. Both residents stated they had reported this to staff (could not remember exact names). Review of the Pest Control service report revealed on 9/12/19 a room #155 was treated for flies due to debris and sticky stuff on the floor creating flies. Observation on 9/24/19 at 4:50 PM of Room #127 with the Director of Nurses (DON), Housekeeping supervisor (HK supervisor), and HK floor technician was conducted. HK floor technician moved the bedside cabinet. Behind this bedside cabinet located next to the bed were multiple pieces of trash, debris and an accumulation of dust. Under the trash were small particles of a black colored substance which resembled mouse droppings. The dresser closet was pulled away from the wall and on the floor was an accumulation of dust and a dead insect that resembled a water bug. A second bedside cabinet located near the room entrance was pulled away from the wall. Flying insects similar	F 925	cleaned, all furniture was moved for cleaning, all items on the floor moved or put away so floor and baseboard could be cleaned. There was no further evidence of pests in either room. All resident rooms in facility were thoroughly cleaned, all furniture was moved for cleaning, all items on the floor were put away so floor could be cleaned. The Housekeeping schedule for detailed deep cleaning of residents rooms was revised so that each room will be addressed once per month. The current Housekeeping vendor was changed to another service schedule to begin services on 10/26/19. Environmental rounds are made daily by the Administrator , documenting 5 rooms per day. Audit will document any evidence of pests and cleanliness of room, including behind furniture. Any issues will be addressed immediately by Housekeeping or Pest Control. Audits will continue for 3 months to ensure cleanliness is sustained and pest issues are not found. Education was provided for Nursing staff regarding open containers of food which attract pests and removal of these items. Education was completed by Assistant Director of Nursing on 10/10/19. Audits will be summarized and presented at the monthly Quality Assurance meeting for the next 3 months. Any issues or trends identified will be addressed by the committee as they arise and the plan will	

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F 925	Continued From page 37 to gnats appeared. The floor was sticky and had 2 plastic bags stuck to the floor. HK floor technician removed the plastic bags and a live insect crawled across the floor into the cove molding and small particles of a black colored substance which resembled mouse droppings were noted. Under the sink in the floor corners and near a rodent trap box were black particles that resembled mouse droppings were noted. Observation on 9/24/19 after exiting Room #127 revealed clusters of flying insects similar to gnats. Interview on 9/24/19 at 5:11 PM with the HK supervisor stated she started on September 16, 2019 as the supervisor and stated her expectation was to have HK staff mop and swept the floor, moving the furniture as necessary. Interview on 09/25/19 12:24 PM with HK #1 (who worked at the facility for 13 years and assigned to Room #127) was conducted. HK #1 stated she cleaned Room #127 and pulled the bedside table near the door every Tuesday and have observed gnats on the unit and in Room #133 as recently as 9/25/19. Continued interview revealed residents kept foods uncovered in their rooms and the previous HK supervisor and nurses on the unit (could not recall the names or dates) were told. Interview on 09/25/19 at 2:05 PM with the contracted Pest control company representative (PCR) stated no facility staff made me aware of mouse droppings, gnats or crawling insects until 9/24/19. dropping. Usually do an inspection monthly in the facility stated by PCR and any slips with pest citing are kept in the maintenance office. The maintenance director was not available during the survey.	F 925	be revised to ensure continued complaince. The Administrator is responsible for implementing and maintaining the acceptable plan of correction by 10/20/19.	

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F 925	Continued From page 38 Interview on 9/27/19 at 10:44 AM with the administrator revealed she expected housekeeping to thoroughly clean resident rooms and report any evidence of pest. The administrator also indicated the previous HK manager was replaced to address housekeeping issues.	F 925		