

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345051</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/07/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>ANSON HEALTH AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 SOUTH GREENE STREET WADESBORO, NC 28170</b>	
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F 637 SS=D	<p>Comprehensive Assessment After Significant Chg CFR(s): 483.20(b)(2)(ii)</p> <p>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to complete a significant change Minimum Data Set (MDS) for a resident with 3 areas of decline. This was for 1 (Resident #83) of 1 residents reviewed for a significant functional and medical decline. The findings included:  Resident #83 was admitted 12/15/08 with cumulative diagnoses of Alzheimer's Disease and muscle weakness.  Review of July 2018 physician orders indicated Resident #83 had a diet downgrade from mechanical soft to a pureed diet on 7/26/18 due to Dysphagia (difficult swallowing).  Review of a Wound Assessment dated 7/27/18 indicated Resident #83's developed an unstageable pressure ulcer to her sacrum.  Review of Resident #83's monthly weights</p>	F 637	<p>Minimum Data Set (MDS) Nurse/Interdisciplinary Team(ITD)consisting of Director of Nursing, Dietary Manager, Social Worker, Therapy, failed to conduct a significant change in status assessment as an oversight, on resident # 83 to address change in diet texture, significant weight loss and new unstageable pressure ulcer. A significant change assessment has been completed on resident #83 by facility MDS Nurse for assessment reference date of 9/5/18.</p> <p>An audit of residents to determine significant change in status relating to significant weight loss, diet texture down grades and new stage 3, 4 or unstageable pressure ulcers will be completed on all resident with census date of 9/7/18 by the Director of Nursing (DON),Assistant Director of Nursing (ADON) and nursing</p>	10/5/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/27/2018

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 637	<p>Continued From page 1</p> <p>indicated an approximate 15-pound weight loss since 1/9/18. January 9,2018 weight was recorded as 118.6 pounds and as of August 1, 2018 her weight was recorded as 103.8 pounds.</p> <p>Review of Resident #83's quarterly Minimum Data Set (MDS) dated 8/15/18 indicated moderate cognitive impairment and she exhibited no behaviors. She was coded for total assistance with her activities of daily living (ADLs) except for supervision eating. Resident #83 was coded as incontinent of bladder and bowel, coded for one unstageable pressure ulcer and no weight loss.</p> <p>There was no evidence of a care plan for actual weight loss or an actual pressure ulcer.</p> <p>In an observation on 9/6/18 at 8:45 AM, Nursing Assistant (NA) #3 stated Resident #83 was not eating well but was able to feed herself after tray set-up.</p> <p>In a wound care observation on 9/6/18 at 11:25 AM, the Treatment Nurse and Director of Nursing (DON) stated since Resident #83's diet was downgraded to pureed, she has not been eating well. Observation of the sacrum revealed a pen-point site and the upper part of the sacrum. There were no concerns with technique or healing.</p> <p>In an interview on 9/7/18 at 12:40 PM, NA #4 stated Resident #83 had no appetite. Observation of NA #4 set up Resident #83's lunch meal. Resident #83 stated she was starving. She was observed feeding herself without difficulty and ate 75% of the meal.</p> <p>In an interview on 9/7/18 at 2:15 PM, the MDS</p>	F 637	<p>supervisor by 10/5/18. Any areas of non-compliance addressed at this time. The MDS Nurse/IDT team was in-serviced by the Regional MDS/Reimbursement Manager on 9/25/18 regarding conducting a significant change in status and what constitutes a significant change in status.</p> <p>DON/ADON and Nursing supervisors as well as MDS Nurse will review 5 Omnibus Budget Reconciliation Act (OBRA) assessments weekly for 4 weeks, then bi-weekly x 8 weeks, then monthly x 3 months to determine if a significant change in status is present.</p> <p>Data obtained during weekly MDS audits will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement(QAPI) by the DON monthly for 3 months, and then The QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. MDS Nurse/DON responsible for implementing plan of correction Compliance Date 10/5/2018</p>		

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F 637	Continued From page 2 Nurse stated instead of a quarterly MDS done on 8/15/18, she should have completed a significant change MDS. She stated she completed significant change MDS on 9/6/18 for Resident #83.  In an interview on 9/7/18 at 3:20 PM, the Administrator stated it was her expectation that a significant change MDS would have been completed on 8/15/18 due to Resident #83's decline in weight, skin and diet.	F 637			
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 interview the facility failed to accurately code the minimum data set for active diagnoses (Resident #53 and #79) for 2 of 5 residents reviewed for medications and for dental (Resident #83) for 1 of 1 resident reviewed for dental.  Findings included:  1.  Resident #53 was admitted to the facility on 5/31/17 and the documented diagnoses were acute coronary thrombosis not resulting in a heart attack, diabetes mellitus type 2, repeated falls, fracture of the thoracic vertebra, ankylosing spondylitis of thoracic and lumbar spine, coronary artery disease, localized edema, peripheral vascular disease, hypertension, and vascular	F 641	MDS Nurse failed to accurately Code the MDS for sections O, L and I for resident Number 53, 83 and 79. MDS nurse stated the omissions were oversight.  The most recent MDS for Resident # 79 and Resident #83 and Resident #53 were corrected Facility MDS Nurse on 9/13/2018.  The most recent MDS for all current residents for census date of 9/7/18 will be audited for accuracy by the Regional MDS/Reimbursement manager, DON, ADON by 10/5/2018 with any areas of non-compliance corrected at this time. MDS staff will be re-educated on the importance of accurately coding the MDS specifically section I, L and O by the	10/5/18	

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F 641	<p>Continued From page 3 dementia.</p> <p>A physician order dated 5/31/17 (on admission) revealed Estradiol 1 mg each day for peri-menopause.</p> <p>The care plan updated 6/19/18 had goals and interventions for altered mobility, therapeutic diet, impaired vision, potential for skin breakdown, activities of daily living self-care deficit, potential for falls, potential for urinary tract infection, pain, communication deficit, diabetes, hypertension, respiratory deficit, and occasional smoker,</p> <p>The quarterly Minimum Data Set (MDS) dated 9/6/18 revealed Resident #53 had adequate hearing, clear speech, and was understood and understands. The cognition was moderately impaired. The resident required one-person physical assistance for activities of daily living except transfers was extensive assistance of one and meal was set up. Active diagnoses were hypertension, diabetes, chronic obstructive pulmonary disease, unsteadiness on her feet, generalized muscle weakness, and chronic pain syndrome. The resident received scheduled and as needed pain medication.</p> <p>The physician progress note dated 7/27/18 revealed the resident had the diagnosis of menopausal syndrome.</p> <p>A review of Resident #53 ' s record revealed the care plan had no goal or intervention documented for menopausal syndrome/hot flashes and risk for hormone replacement therapy, and the MDS did not reflect the diagnoses of menopausal syndrome.</p>	F 641	<p>Regional MDS/Reimbursement manager on 9/25/18.</p> <p>The DON and ADON will audit 5 completed OBRA assessments every week for 4 weeks, then bi-weekly x 4 weeks, then monthly x 3 months for accuracy.</p> <p>Results of the audit will be brought to QAPI monthly meeting by the DON to be analyzed for patterns and trends monthly for 3 months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.</p> <p>Compliance date 10/5/2018</p>		

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F 641	<p>Continued From page 4</p> <p>On 9/7/18 at 3:15 pm an interview was conducted with the MDS nurse who stated the menopausal syndrome diagnosis should have been reflected in the MDS dated 9/6/18 with corresponding care plan.</p> <p>On 9/7/18 at 3:45 pm an interview was conducted with the Director of Nursing (DON) who stated she expected the MDS to be coded accurately.</p> <p>2.</p> <p>Resident #79 was readmitted to the facility on 4/28/18 and the diagnoses were acute on chronic congestive heart failure, Alzheimer's disease, pneumonia, urinary tract infection, hypertension, depression, chronic atrial fibrillation, and osteoarthritis.</p> <p>Physician order dated 4/28/18 was for Anastrozole 1 mg each day for breast cancer.</p> <p>Physician progress note dated 4/28/18 revealed the resident had a breast cancer diagnosis.</p> <p>The significant change Minimum Data Set dated 8/11/18 revealed the resident had adequate hearing, clear speech, sometimes understands and sometimes understood. The cognition was unable to be assessed due to the inability to answer the questions. The resident required extensive assistance of 2 staff for bed mobility and all transfers including toileting. The resident also had total dependence for locomotion and extensive assistance of 2 staff for personal care, bathing, and dressing. One-person assistance was needed for meals. The active diagnoses were Alzheimer's disease, pneumonia, urinary tract infection, hypertension, depression, chronic</p>	F 641			

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F 641	<p>Continued From page 5</p> <p>atrial fibrillation, and osteoarthritis. Hospice services were in place.</p> <p>The care plan dated 8/11/18 was updated and revealed goals and interventions for impaired thought process and memory loss, regular diet, potential for skin breakdown, potential for falls, pain, communication deficit, diuretic, in-room socialization, Hospice services, at risk for pneumonia, cardiac, and at risk for urinary tract infection.</p> <p>A review of Resident #79 ' s record revealed the care plan had no goal or intervention documented for breast cancer nor risk and timeframe for chemotherapy treatment, and the MDS did not reflect the diagnoses of breast cancer.</p> <p>On 9/7/18 at 3:15 pm an interview was conducted with the MDS nurse who stated the breast cancer diagnosis should have been reflected in the MDS dated 9/6/18 with corresponding care plan.</p> <p>On 9/7/18 at 3:45 pm an interview was conducted with the DON who stated she expected the MDS to be coded accurately.</p> <p>3.</p> <p>Resident #9 was admitted 3/11/16 with cumulative diagnoses of Cerebral Vascular Accident and contractures.</p> <p>Resident #9's annual Minimum Data Set (MDS) dated 1/6/18 7/4/18 indicated he was cognitively intact and exhibited no behaviors. He was coded with no dental concerns.</p>	F 641			

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F 641	Continued From page 6  Review of a physician order dated 5/2/18 read Resident #9 was to be referred for a full mouth extraction.  Review of a dental consult dated 7/10/18 read a comprehensive evaluation with Resident #9's but noted refusal for any dental intervention.  In an interview and observation on 9/5/18 at 3:00 PM, Resident #9 stated he was experiencing no dental or oral discomfort. He stated he went to a dentist about his teeth awhile back and they wanted to pull all his teeth. He stated he declined having all his remaining teeth extracted. Resident #9's oral civility was observed with multiple missing, broken and decaying teeth.  In an interview on 9/6/18 at 8:30 AM, Nursing Assistant (NA) #2 stated Resident #9 often refused oral care and voiced no oral discomfort.  In an interview on 9/7/18 at 2:15 PM, the MDS Nurse stated she completed the section L (Oral and Dental Status) for the annual MDS dated 1/6/18. She stated she was aware Resident #9 was missing teeth, but she coded the MDS inaccurately.  In an interview on 9/7/18 at 3:20 PM, the Administrator stated it was her expectation that section L for oral/dental status of Resident #9 would have been coded accurately on the annual MDS dated 1/6/18.	F 641			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans	F 656		10/5/18	

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F 656	Continued From page 7 §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 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	F 656			

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F 656	<p>Continued From page 8 section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, staff and resident interviews and record review, the facility failed to complete a comprehensive care plan for actual weight loss and pressure ulcer for 1 (Resident #83) of 3 residents reviewed for weight loss. The facility also failed to complete a comprehensive care plan for restorative nursing and refusal for 1 (Resident #9) of 2 residents reviewed for range on motion. The findings included:</p> <p>1. Resident #83 was admitted 12/15/08 with cumulative diagnoses of Alzheimer's Disease and muscle weakness.</p> <p>Review of July 2018 physician orders indicated Resident #83 had a diet downgrade from mechanical soft to a pureed diet on 7/26/18 due to Dysphagia (difficult swallowing).</p> <p>Review of a Wound Assessment dated 7/27/18 indicated Resident #83's developed an unstageable pressure ulcer to her sacrum.</p> <p>Review of Resident #83's monthly weights indicated an approximate 15-pound weight loss since 1/9/18. January 9, 2018 weight was recorded as 118.6 pounds and as of August 1, 2018 her weight was recorded as 103.8 pounds.</p> <p>Review of Resident #83's quarterly Minimum Data Set (MDS) dated 8/15/18 indicated moderate cognitive impairment and she exhibited no behaviors. She was coded for total assistance with her activities of daily living (ADLs) except for supervision eating. Resident #83 was coded as</p>	F 656	<p>The MDS Nurse failed to develop a care plan to address actual weight loss and pressure ulcer for resident #83. Also failed to develop a comprehensive care plan for refusal of Restorative Nursing program comprised of Passive range of motion and splinting for resident #9. This failure was an oversight.</p> <p>The care plan for resident #9 was updated/corrected on 9/7/2018 by the MDS Nurse/DON to reflect refusal of restorative nursing program. The care plan for resident #83 to address actual weight loss and new pressure ulcer was updated/corrected on 9/7/2018 by the MDS nurse and DON.</p> <p>An audit of comprehensive care plans for census date of 9/7/18 was completed by the Regional MDS/Reimbursement Manager on 9/24/18, 9/25/18, 9/27/18 and 9/28/18. Any areas of non-compliance corrected at this time.</p> <p>IDT/Care plan/MDS team was in-serviced on 9/25/18 by the Regional MDS/Reimbursement Manager regarding the importance of developing a comprehensive care plan addressing problem be it actual or at risk of. Regional MDS/Reimbursement Manager will audit 5 comprehensive care plans weekly for 12 weeks for accuracy. Data obtained from the weekly audits will be reported to the QAPI Committee by the</p>		

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F 656	<p>Continued From page 9</p> <p>incontinent of bladder and bowel, coded for one unstageable pressure ulcer and no weight loss.</p> <p>There was no evidence of a care plan for actual weight loss or an actual pressure ulcer.</p> <p>In an observation on 9/6/18 at 8:45 AM, Nursing Assistant (NA) #3 stated Resident #83 was not eating well but was able to feed herself after tray set-up.</p> <p>In a wound care observation on 9/6/18 at 11:25 AM, the Treatment Nurse and Director of Nursing (DON) stated since Resident #83's diet was downgraded to pureed, she has not been eating well. Observation of the sacrum revealed a pen-point site and the upper part of the sacrum. There were no concerns with technique or healing.</p> <p>In an interview on 9/7/18 at 12:40 PM, NA #4 stated Resident #83 had no appetite. Observation of NA #4 set up Resident #83's lunch meal. Resident #83 stated she was starving. She was observed feeding herself without difficulty and ate 75% of the meal.</p> <p>In an interview on 9/7/18 at 2:15 PM, the MDS Nurse stated she did not care plan Resident #83 for the actual pressure ulcer with interventions and for actual weight loss with interventions. She stated she only added the presence of the unstageable pressure ulcer to Resident #83's sacrum to the interventions listed for the potential of pressure ulcers. The MDS Nurse stated it was the responsibility of the Dietary Manager (DM) to complete the care plan for actual weight loss.</p> <p>In an interview on 9/7/18 at 2:48 PM, the DM</p>	F 656	<p>DON monthly for 3 months. Data obtained during the audit process will be analyzed for patterns and trends. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine continued auditing is necessary to maintain compliance.</p> <p>Compliance dtae 10/5/2018</p>		

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F 656	<p>Continued From page 10</p> <p>stated she was not aware that Resident #83 had lost weight and noted she was only care planned for the potential for weight loss. The DM stated she should have completed a care plan for actual weight loss when she reviewed the quarterly MDS completed on 8/15/18.</p> <p>In an interview on 9/7/18 at 3:20 PM, the Administrator and DON stated it was their expectation that Resident #83's care plan be comprehensive and include the presence of an actual pressure ulcer with interventions. Both stated the comprehensive care plan should have also included a care plan for Resident #83's actual weight loss.</p> <p>2. Resident #9 was admitted 3/11/16 with cumulative diagnoses of Cerebral Vascular Accident and contractures.</p> <p>Resident #9's quarterly Minimum Data Set (MDS) dated 7/4/18 indicated he was cognitively intact and exhibited no behaviors. He was coded for impairments to both lower extremities and one upper extremity.</p> <p>Review of a Therapy Screen dated 7/24/18 read Resident #9 refused to wear his elbow and wrist splint and had a history of noncompliance.</p> <p>Review of Resident #9's September 2018 physician orders indicated he was to receive restorative nursing for passive range of motion (ROM and splinting 3-6 times weekly.</p> <p>In an interview and observation on 9/5/18 at 3:00 PM, Resident #9 stated the restorative aides ask him if he would wear his left wrist splint, but he refused because it was painful. He was observed</p>	F 656			

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F 656	<p>Continued From page 11</p> <p>wearing an elbow splint to his left arm. He stated he sometimes wore splints to his bilateral lower extremities, but the splints impede is mobility when he wanted to out to smoke.</p> <p>In an interview on 9/6/18 at 8:30 AM, Nursing Assistant (NA) #2 stated Resident #9 Nursing Assistant (NA) #2 stated the restorative aides did his does splinting and ROM but she knew he usually refused to wear his splints.</p> <p>In an interview on 9/6/18 at 9:40 AM, the Rehabilitation Director stated Resident #9 was screened quarterly for worsening of his contractures or for a change in his compliance and wiliness to participate in therapy.</p> <p>In an observation on 9/6 at 11:20 AM, Resident #9 was sitting up in his wheelchair wearing his left elbow splint and his bilateral lower extremity splints.</p> <p>In an interview on 9/6/18 at 2:35 PM, the Restorative Aide (RA) stated she performed passive ROM to Resident #9's bilateral lower extremities, left elbow and left wrist. The RA stated Resident #9 often refused splinting and would never allow her to place the left wrist splint on. The RA stated Resident #9 also refused his bilateral lower extremities because the splints limit his mobility to go smoke.</p> <p>Review of Restorative Nursing Notes from 8/1/18 to present included multiple refusals for splinting.</p> <p>In an interview on 9/7/18 at 2:15 PM, the MDS Nurse stated she was aware that Resident #9 was receiving passive ROM and splinting. She also stated she was aware of his refusal of his</p>	F 656			

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F 656	Continued From page 12 splints on occasion. She was unable to offer an explanation why the restorative nursing and refusal were not care planned.	F 656			
F 686 SS=D	In an interview on 9/7/18 at 3:20 PM, the Administrator and Director of Nursing stated it was their expectation that Resident #9's care plan be comprehensive and include the restorative nursing and his refusal of splinting.  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 interviews with staff, the physician, and the Nurse Practitioner, the facility failed to monitor an identified "lesion" on Resident #39 ' s right great toe that progressed to a stage 2 pressure ulcer and failed to provide treatment to the pressure ulcer for 1 of 3 residents reviewed for pressure ulcers.  The findings included:	F 686	1. Nurse Practitioner (NP) identified and documented in a progress note a purpuric bullous lesion to resident # 39 right great toe without an order to treat on 8/30/2018. On 9/10/18 order received to paint right great toe with skin prep daily and leave open to air per wound care nurse.  2. 100% skin assessment audit to identify non-intact skin areas, completed by DON	10/5/18	

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F 686	<p>Continued From page 13</p> <p>Resident #39 was initially admitted to the facility on 8/3/17 and most recently readmitted on 1/16/18 with diagnoses that included diabetes mellitus type 2, hemiplegia (paralysis of one side of the body) following a cerebral infarction affecting the right dominant side, hypertension, aphasia, atrial fibrillation, and hypothyroidism.</p> <p>A physician ' s order dated 1/16/18 indicated a heel inspection every night at bed time for Resident #39.</p> <p>Resident #39 ' s plan of care included the problem/need of the potential for skin breakdown secondary to incontinence of bowel and impaired mobility. This area was initiated on 8/16/17 and most recently updated on 7/18/18 to include the problem of an unstageable pressure ulcer to Resident #39 ' s sacrum. The goal was for Resident #39 to not present with any evidence of pressure induced skin impairment for the next review on 10/20/18. The interventions included, in part, to provide routine skin assessments to monitor for any evidence of skin breakdown, report and record any red or open areas, provide treatment accordingly if impairments were noted, and heel inspections every night at bedtime.</p> <p>The annual Minimum Data Set (MDS) assessment dated 7/19/18 indicated Resident #39 ' s cognition was severely impaired. He had no behaviors and no rejection of care. Resident #39 required the extensive assistance 2 or more staff with bed mobility and toileting. He required the extensive assistance of 1 staff for transfers, dressing, and personal hygiene. Resident #39 had impairment on 1 side of his upper and lower extremities and had an indwelling urinary</p>	F 686	<p>and Nurse Managers on all active resident to ensure all areas of non-compliance have been addressed. Completed 9/12/2018</p> <p>Nursing assistants will report any skin area of concern noted during ADL care to hall nurse. Hall nurse will assess area and obtain orders as needed and note area on the 24 hour report. Weekend Manager will be notified of any new skin area on weekends, obtain order for treatment and will notify wound care nurse for need of further assessment. Wound care nurse will be notified of any skin area of concern and will notify DON/Unit Manager for need for further assessment. Wound care nurse will report to DON/Unit Manager any reported area in the daily clinical meeting Monday thru Friday, DON/Unit Manager/Weekend Manager will review 24 hour report to ensure appropriate treatment has been obtained.</p> <p>Provider will provide DON/Unit Manager a resident visit list that will indicate the resident evaluated and which resident Provider has written orders on. Resident visit list will be reviewed Mon- Fri in daily clinical meeting.</p> <p>DON/Unit Managers will process all new provider orders, and review each provider assessment note to ensure all areas of concern have been addressed. New orders will be reviewed Monday-Friday in daily clinical meeting. DON will educate all nursing staff(Full-time, Part-time, Weekend) on notification of skin area concerns,</p>		

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F 686	<p>Continued From page 14</p> <p>catheter. He was assessed with 1 pressure ulcer that was identified as a facility acquired unstageable pressure ulcer.</p> <p>A wound assessment note dated 8/28/18 indicated Resident #39 had a facility acquired unstageable pressure ulcer on his sacrum. Resident #39 was identified with no other wounds.</p> <p>A Nurse Practitioner (NP) note dated 8/30/18 indicated Resident #39 ' s reported skin conditions included a "toe ulcer". The NP ' s assessment of Resident #39 ' s "toe ulcer" indicated he had a "[Right] great toe plantar surface with purpuric (purple spots that occur when small blood vessels burst, causing blood to pool under the skin) bullous (fluid filled blisters) lesion 0.8 centimeters (cm) x 1.4 cm no [discharge], pustules (small collection of pus) x 2 noted to the lower portion." This was the first mention in the medical record of an identified skin issue on Resident #39 ' s right great toe.</p> <p>A review was conducted of the physician ' s orders from 8/30/18 through 9/6/18. There were no physician ' s orders for treatment or monitoring of Resident #39 ' s identified "lesion" to his right great toe.</p> <p>A review of the Medication Administration Records (MARs) and Treatment Administration Records (TARs) from 8/30/18 through 9/6/18 indicated a nurse had signed off on Resident #39 ' s heel inspection every night at bedtime. There was no nursing documentation in the medical record related to the "lesion" on Resident #39 ' s right great toe identified by the NP on 8/30/18.</p>	F 686	<p>notification to nursing management, review of provider notes and initiation of orders. Completed 10/5/2018. Any nursing staff not in serviced by 10/5/2018 will not be allowed to work until in-service education is completed.</p> <p>3. DON will present skin assessment audit, 24 hour reports, and resident visit lists to Administrator weekly x 4, bi-weekly x 8, then monthly x 3. Administrator will present results of audits to QAPI Committee x 3 months to ensure compliance and the need for further monitoring. Compliance dtae 10/5/2018</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	<p>Continued From page 15</p> <p>A review of the Nursing Assistant (NA) skin monitoring forms, utilized for the NAs to document skin issues identified during the resident 's shower, from 8/30/18 through 9/6/18 were reviewed. There was no documentation of the identified "lesion" on Resident #39 ' s right great toe.</p> <p>The medical record, both hard copy and electronic, from 8/30/18 through 9/6/18 was reviewed and contained and no mention of the identified "lesion" on Resident #39 ' s right great toe after the NPs note dated 8/30/18.</p> <p>In an observation on 9/6/18 at 9:15 AM the Wound Care (WC) Nurse provided pressure ulcer treatment to Resident #39 ' s sacral ulcer. Treatment was provided as ordered to Resident #39 ' s sacral pressure ulcer. During this observation, Resident #39 was observed with an area on his right great toe that had a dark, almost black, circular area of approximately 2.5 cm with dark red scant drainage.</p> <p>An interview was conducted with the WC Nurse on 9/6/18 at 9:20 AM. The WC Nurse was asked if she had observed the area on Resident #39 ' s right great toe and she indicated she had not observed the area.</p> <p>An interview was conducted with the Director of Nursing (DON) on 9/7/18 at 10:50 AM. The 8/30/18 NP documentation of Resident #39 ' s right great toe, the 9/6/18 observation of Resident #39 ' s right great toe, the interview with the WC Nurse on 9/6/18 that indicated she had not observed his right great toe, and the medical record review that showed no mention of Resident #39 ' s great toe "lesion" after the</p>	F 686			

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F 686	<p>Continued From page 16</p> <p>8/30/18 NP note were all reviewed with the DON. She stated she was going to observe and assess the area on Resident #39 ' s right great toe.</p> <p>A second interview was conducted with the DON on 9/7/18 at 11:20 AM. She revealed she observed Resident #39 ' s right great toe with the WC Nurse on 9/7/18 and the area was assessed as a stage 2 pressure ulcer. She confirmed that the WC Nurse had not previously identified this pressure ulcer, there was no mention of this pressure ulcer in the medical record aside from the NPs 8/30/18 note that assessed the area as a "lesion", and there were no orders for treatment in place.</p> <p>A second interview was conducted with the WC Nurse on 9/7/18 at 11:30 AM. She confirmed she observed Resident #39 ' s right great toe with the DON on 9/7/18. The WC Nurse denied seeing this wound on Resident #39 ' s right great toe previously or having any knowledge of its existence. She stated that when she was completing wound care on a resident she was focused solely on the area where the treatment was ordered. She reported she made every effort to keep any area of the resident ' s body that was not being provided with treatment covered to promote the resident ' s dignity. She indicated this was most likely the reason why she herself had not identified the area on Resident #39 ' s right great toe as his treatment orders were for his sacrum. The WC Nurse stated that normally, any new skin issues would have been reported to her by the physician, NP, or nursing staff verbally, so she would know to assess the area. She confirmed that no information was communicated to her by these parties regarding Resident #39 ' s right great toe. The WC Nurse was unable to</p>	F 686			

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F 686	<p>Continued From page 17</p> <p>explain why she had not observed Resident #39 ' s right great toe on 9/6/18 when the area was brought to her attention during the interview on 9/6/18 at 9:20 AM following the provision of wound care to Resident #39 ' s sacral pressure ulcer. She stated that she was going to write a wound assessment of today ' s observation (9/7/18) of Resident #39 ' s right great toe.</p> <p>The Wound Assessment Report dated 9/7/18 and completed by the WC Nurse indicated Resident #39 ' s right great toe had wound measurements of 0.8 cm x 1.4 cm with no depth noted. The skin around the wound had some edema, the wound bed was dark and scaly in color, and no drainage was noted.</p> <p>A physician ' s order dated 9/7/18 at 11:50 AM indicated to cleanse Resident #39 ' s right great toe area with normal saline and pat dry. Apply Skin Prep (a liquid-film dressing that forms a protective film to help reduce friction) twice daily. This order also indicated the addition of Prostat (protein supplement) 30 milliliters (ml) daily for wounds.</p> <p>The care plan related to Resident #39 ' s skin breakdown and unstageable pressure ulcer to his sacrum was updated on 9/7/18 to include the problem of a stage 2 pressure ulcer to his right great toe. An intervention was also added on 9/7/18 that indicated the administration of treatment to Resident #39 ' s stage 2 pressure ulcer on the right great toe per physician ' s orders.</p> <p>A phone interview was conducted with Nurse #6 on 9/7/18 at 12:35 PM. She confirmed she had worked with Resident #39 on 8/30/18, completed</p>	F 686			

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F 686	<p>Continued From page 18</p> <p>the inspections of his heels that evening, and signed off on the MAR and TAR. She stated that she physically completed the heel inspections via visual observation and denied noticing any skin issues on Resident #39 ' s right great toe.</p> <p>A phone interview was conducted with Nurse #5 on 9/7/18 at 12:40 PM. She confirmed she had worked with Resident #39 on 8/31/18, 9/2/18, 9/3/18, and 9/6/18. She stated she had not physically completed Resident #39 ' s heel inspections with visual observation, but she had signed off on the MAR and TAR. She revealed she depended on the NAs to report any new issues on the resident ' s feet. Nurse #5 denied being informed of and/or noticing any skin issues on Resident #39 ' s right great toe.</p> <p>A phone interview was conducted on 9/7/18 at 1:11 PM with Nurse #4. She confirmed she had worked with Resident #39 on 9/3/18 and 9/4/18. She stated that sometimes she physically completed heel inspections via visual observation, but that sometimes she depended on the NAs to report any new issues on the residents ' feet. She revealed she could not recall if she or the NA had observed Resident #39 ' s heels on 9/3/18 and 9/4/18, but she had signed off on the MAR and TAR. Nurse #4 denied being informed of and/or noticing any skin issues on Resident #39 ' s right great toe.</p> <p>An interview was conducted with the Assistant Director of Nursing (ADON) on 9/7/18 at 12:53 PM. She confirmed she had worked with Resident #39 on 9/5/18, completed the inspections of his heels that evening, and signed off on the MAR and TAR. She stated she physically completed the heel inspections via</p>	F 686			

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F 686	<p>Continued From page 19</p> <p>visual observation and denied noticing any skin issues on Resident #39 ' s right great toe. She explained that she was focused specifically on Resident #39 ' s heels and had probably just not glanced at his toes.</p> <p>A phone interview was conducted with the NP on 9/7/18 at 1:50 PM. She was asked about her note dated 8/30/18 that indicated a "toe ulcer" was reported to her on 8/30/18. She indicated she was unsure about who informed her of Resident #39 ' s toe ulcer. She reported the information was "probably" written in the physician/NPs communication book, a hard copy book where nurses document notes for the physician/NP. The NP was asked about her assessment of Resident #39 ' s right great toe on 8/30/18. She reported that based on her assessment she had not written any orders for treatment, but that she would have expected the area to be monitored by nursing staff and to inform herself and/or the physician of any changes. The NP was asked if she provided a report on her assessment to nursing staff and she revealed that she "probably" told one of the nurses about her assessment and asked them to monitor the area. She indicated she was unable to recall this information with certainty. The NP reported her expectation was for nursing staff to monitor any skin issues as part of their normal nursing routine and report any changes to herself and/or the physician. She indicated she had not observed the area on Resident #39 ' s right great toe since 8/30/18 and she was provided with no nursing updates on the area.</p> <p>A review was conducted of the hard copy physician/NPs communication book on 9/7/18 at 2:00 PM. There was no documentation in this</p>	F 686			

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F 686	<p>Continued From page 20</p> <p>book related to the pressure ulcer and/or "lesion" on Resident #39 ' s right great toe.</p> <p>A phone interview was conducted with Resident #39 ' s physician on 9/7/18 at 1:30 PM. He stated he had reviewed the NPs note dated 8/30/18 and had spoken with the NP and the DON by phone on this date (9/7/18) regarding Resident #39 ' s stage 2 pressure ulcer on his right great toe. He reported he was unaware of this skin issue on Resident #39 ' s right great toe prior to this date (9/7/18). The physician indicated that based on the NPs assessment of Resident #39 ' s right great toe as a "purpuric bullous lesion" he would not necessarily have expected a treatment order to have been put in place or a for a wound consult to have been ordered at that time. He stated his expectation would have been for the NP to notify nursing staff of the assessment, request them to monitor the area, and for nursing staff to keep herself and/or himself informed of any changes. The physician additionally indicated that his expectation was for nursing staff to monitor any skin issues for all residents on a daily basis and to provide himself and/or the NP with notification verbally or through the physician/NPs communication book of any new or worsened areas.</p> <p>A follow up interview was conducted with the DON on 9/7/18 at 2:25 PM. The DON was unable to explain who initially informed the NP of a "toe ulcer" for Resident #39 as there was no documentation in the physician/NP communication book. The DON was asked about her expectations for the NP, WC Nurse, floor nurses, and NAs. She stated that following the NPs assessment of the "lesion" on Resident #39 ' s right great toe on 8/30/18 she expected</p>	F 686			

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F 686	Continued From page 21 the NP to write an order if treatment was indicated and to inform the floor nurse, DON, or WC Nurse verbally of her assessment so the area could be monitored in an attempt to prevent the progression of "lesion" to a stage 2 pressure ulcer. She indicated she expected the WC Nurse to assess any new areas that were reported to her and to communicate with the physician and/or NP to obtain treatment orders if indicated. The DON stated she expected the floor nurses to physically complete a visual observation of a resident ' s heels prior to signing off on the MAR/TAR. She explained that ideally, she would have expected the nurses to also observe the toes of Resident #39 when the heel inspections were completed, but that the nurses could have been focused primarily on his heels based on the physician ' s order. She additionally stated that she expected the floor nurses to complete thorough skin assessments as part of routine nursing care and that she would have expected the stage 2 pressure ulcer on Resident #39 ' s right great toe, initially assessed as a "lesion" on 8/30/18, to have been identified during these routine skin assessments. She revealed that NAs should not be depended upon to complete the heel inspections for the nurses. The DON then spoke about the NA skin monitoring forms and indicated this was a new form for the NAs and was still in the development process for performance improvement. She stated that the form was to provide supplemental information to the nursing staff on a resident ' s current skin issues observed during the shower process. She explained that based on the newness of the form, she was not surprised the NAs had not identified the area on Resident #39 ' s right great toe.	F 686			
F 689	Free of Accident Hazards/Supervision/Devices	F 689		10/5/18	

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F 689 SS=D	<p>Continued From page 22 CFR(s): 483.25(d)(1)(2)</p> <p>§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</p> <p>§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 and staff interview, the facility failed to prevent a resident from falling during a transfer when one staff provided assistance for a resident who required the extensive assistance of two or more staff for transfers. This fall resulted in no injuries. This was for 1 of 3 residents (Resident #44) reviewed for falls.</p> <p>The findings included:</p> <p>Resident #44 was admitted to the facility on 10/2/13 and most recently readmitted on 2/26/16 with diagnoses that included cerebrovascular disease with hemiplegia (paralysis on one side of the body) affecting right dominant side, abnormal posture, muscle weakness, and dementia.</p> <p>The quarterly Minimum Data Set (MDS) dated 7/20/18 indicated Resident #44 had severe cognitive impairment. He had no behaviors and no rejection of care. Resident #44 required the extensive assistance of 2 or more staff with transfers and the extensive assistance of 1 staff with bed mobility, locomotion on/off the unit, dressing, toileting, and personal hygiene. Resident #44 ' s balance during surface to</p>	F 689	<p>1. Resident # 44 was being assisted with transfer from bed to chair and was lowered to the floor per nursing assistant. Resident plan of care and cardex stated he was a two person assist. The Certified Nursing Assistant(c.n.a) had not reviewed the cardex nor asked the nurse prior to assisting resident # 44 with transfer. On the day of the event c.n.a that was assigned to resident # 44 was educated per the DON to review cardex as well as ask the hall nurse to ensure safe transfer of a resident.</p> <p>2. 100% audit was completed per DON/Unit Manager/ADON of all resident cardex as compared to the care plan to ensure assist with transfers documented correctly. Any change of transfer status corrected at this time. Any area of non-compliance corrected at this time. Completed 10/5/2018.</p> <p>Unit Manager/ADON/Weekend Manager will initiate a cardex for new admissions. The cardex will be reviewed with resident/family per DON/Social Worker</p>		

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F 689	<p>Continued From page 23</p> <p>surface transfers was indicated to be not steady, and only able to stabilize with staff assistance. He had impairment on 1 side of his upper and lower extremities and utilized a wheelchair.</p> <p>Resident #44 ' s plan of care included the problem area of requiring assistance with Activities of Daily Living (ADL) tasks related to right sided hemiplegia. This area was initiated on 10/15/13 and was indicated as reviewed with the most recent MDS assessment dated 7/20/18. The interventions for Resident #44 included staff to provide assistance with transfers daily using two staff members for safety.</p> <p>An incident report dated 8/15/18 indicated Resident #44 had a fall with no injury on 8/15/18 at 7:35 AM. The Nursing Assistant (NA), NA #1, was in the room with the resident and she stated, "He slid to the floor during transfer". Resident #44 was assisted to his wheelchair by 3 staff members. The immediate post incident action was noted as education to the NA for additional assist with transfers.</p> <p>The NA care guide, undated, for Resident #44 was reviewed on 9/6/18. This guide indicated that Resident #44 was at high risk for falls and required assistance with transfers.</p> <p>An interview was conducted with NA #1 on 9/6/18 at 8:40 AM. She stated she had worked at the facility for about 4 months and that she normally worked the first shift. NA #1 was asked how she knew how much assistance a resident required with their ADLs. She indicated she knew just by talking to staff, listening to the report from the previous shift, and getting to know her residents that she normally worked with. She revealed she</p>	F 689	<p>(SW) during 48 hour baseline care plan meeting.</p> <p>Unit Manager/ADON/Weekend Manager will update resident cardex as resident condition changes.</p> <p>DON/Unit Manager/Weekend Supervisor will randomly observe resident transfers on all shifts,to ensure residents are being transferred according to the plan of care. Nursing staff educated on reviewing the cardex□s daily to ensure compliance with assistance with ADL□s including transfer assistance is followed .Completed 10/5/2018.</p> <p>3. The DON/ADON/Unit Manager will audit 25% of cardex□s as compared to care plans weekly x4, bi-weekly x 8, then monthly x 3 to ensure compliance. The DON will present cardex audits to QAPI Committee monthly x 3 months to monitor the need for furthering monitoring and /or staff education. Compliance date 10/5/2018</p>		

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F 689	<p>Continued From page 24</p> <p>had not reviewed resident care plans or their NA care guides. NA #1 indicated she routinely was assigned to Resident #44. She was asked if Resident #44 required 1 person or 2 persons for assistance with transfers. She stated that she always got Resident #44 out of bed and into his wheelchair by herself.</p> <p>This interview with NA #1 continued. The incident report dated 8/15/18 related to Resident #44 's fall during a transfer was reviewed with NA #1. She confirmed she was working with Resident #44 during the time of this incident. She stated that on that specific morning (8/15/18) she had gotten Resident #44 out of bed earlier than usual and he seemed to not have enough strength to assist her with the transfer causing him to slide to the floor. The post-incident action that indicated education was provided to the NA for additional assist with transfers was reviewed with NA #1. She reported she had not recalled receiving any education after this fall. She revealed she continued to transfer Resident #44 by herself.</p> <p>An interview was conducted with the Director of Nursing (DON) on 9/7/18 at 9:20 AM. She was asked how staff knew how much assistance a resident required with their ADLs. She stated that the plan of care, the NA care guide, and an effort to assign consistent staff members to the residents were all utilized to inform staff members of resident needs. The DON stated she expected the care plan interventions to be followed at all times. The care plan for Resident #44 related to ADLs that indicated he required 2 staff persons for assistance with transfers was reviewed with the DON. The incident report dated 8/15/18 that indicated Resident #44 had a fall during a transfer with the assist of one staff member was reviewed</p>	F 689			

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F 689	Continued From page 25 the DON. She indicated that NA #1 was relatively new to the facility at the time of the incident (8/15/18) and that she was provided with re-education after the incident to utilize 2 staff for transfers with Resident #44. The DON was surprised to learn that NA #1 reportedly continued to transfer Resident #44 without an additional staff member. She indicated her expectation was for Resident #44 to be transferred with the assistance of 2 staff members as written in his care plan.	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)  §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.  §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		10/5/18	

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F 690	<p>Continued From page 26</p> <p>prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to collect a urine sample as ordered resulting in a delay in treatment for a urinary tract infection (UTI) for 1 of 2 residents reviewed for a urinary tract infection (Resident #78).</p> <p>Findings included:</p> <p>Resident #78 was admitted to the facility on 7/27/18 with the diagnoses of cerebral vascular accident due to embolism, muscle weakness, hypertension, and peripheral autonomic neuropathy.</p> <p>The care plan dated 8/3/18 had goals and interventions for therapeutic diet, activities of daily living self-care deficit, potential for skin breakdown, potential for falls, pain, and UTI.</p> <p>Resident #78 ' s nurses' note dated 8/12/18 at 5:32 am revealed documentation that the resident was very confused, made odd comments, and that nursing staff would continue to monitor. The 10:29 am nurses ' note documented that the resident made unusual comments and was yelling. A family member informed the staff that there was something wrong with the resident and</p>	F 690	<p>1. On 8/12/18 resident # 78 had an order to collect urine for Culture and Sensitivity (C&amp;S) on 8/13/18 to rule out a Urinary Tract Infection (UTI). Urine was collected and picked up per laboratory (lab) courier on 8/13/18. 8/15/18 lab result had not been obtained. Unit manager called to inquire why facility had not received the results and lab specimen not located per lab. Order was received to re-obtain the urine specimen and preliminary results obtained 8/16/17. Order received 8/17/18 for 1x dose of Rocephin until result of culture obtained. Culture received 8/20/17, results sent to MD and order received 8/21/18 for antibiotic therapy x 3 days.</p> <p>2. Orders for urinalysis in last 30 days audited to ensure results have been obtained from the lab vendor. No other compliance issues noted. DON/Unit Managers will audit/review lab orders daily in clinical meeting to ensure results have been obtained from the lab. Weekend Manager will review all lab orders obtained on the weekend to ensure</p>		

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F 690	<p>Continued From page 27</p> <p>the nurse practitioner (NP) was notified.</p> <p>The physician order dated 8/12/18 revealed an order for a urinalysis and culture and sensitivity for 8/13/18 secondary to increased confusion and urine frequency.</p> <p>Nurses' note dated 8/15/18 and 8/16/18 documented that Resident #78 was noted to be more confused than baseline and the physician was informed and ordered a urinalysis and culture on 8/16/18. The resident ' s representative was notified.</p> <p>Lab urinalysis dated 8/17/18 revealed the urine was collected on 8/16/18 and the result was elevated white cells (showed signs of a UTI).</p> <p>The physician order dated 8/17/18 revealed Ceftriaxone 1 gram intramuscular one-time dose until the resident ' s urine culture was obtained; the diagnoses was abnormal urinalysis.</p> <p>Lab report revealed urine sample was collected and resulted urinalysis dated 8/16/18 was abnormal and was signed by the NP on 8/23/18.</p> <p>Lab report dated 8/20/18 revealed the urine culture result organism was positive for a UTI.</p> <p>The physician order dated 8/21/18 revealed Cipro 250 mg twice a day for three days; diagnoses was UTI.</p> <p>Resident #78 ' s nurses' notes dated 8/21/18 revealed that the resident remained on Cipro. No further notes regarding the resident ' s UTI was identified.</p>	F 690	<p>results have been obtained. In the event the result has not been obtained, the DON/Unit Manager/Weekend Manager will notify lab vendor of need for result and the MD notified that the result has not been received and to obtain further direction. Any lab order received on the weekend will be reviewed per the weekend supervisor.</p> <p>Full time, Part-time,and weekend Licensed Nursing staff educated on ensuring lab results have been obtained from the lab vendor, and to notify provider and DON immediately in the event result not obtained for further directions. Completed 10/5/2018. Licensed staff not educated by 10/5/2018 will not be allowed to work until education received.</p> <p>3. DON will present 30 day urinalysis audit and the daily clinical meeting lab audit to QA monthly to ensure compliance. This is an on-going process change. Compliance date 10/5/2018</p>		

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F 690	<p>Continued From page 28</p> <p>A review of Resident #78 ' s 30-day Minimum Data Set dated 8/24/18 revealed the resident had adequate hearing, clear speech, and was understood and understands. Cognition was moderately impaired. The resident required extensive assistance for two persons for transfers and bed mobility, bathing and personal care, and toileting. Eating required assistance of one. The active diagnoses were hypertension, UTI, cerebral vascular accident, non-Alzheimer's dementia, and idiopathic peripheral autonomic neuropathy.</p> <p>On 9/6/18 at 3:30 pm an interview was conducted with Nurse #1 who stated she was aware that Resident #78 had a UTI but was not aware that the urine collection was not collected on the day it was ordered. The nurse who wrote the order was responsible to place the order for a urine sample in the lab book. Nurse #1 stated the collection of the urine sample was not placed in the lab book until 8/16/18.</p> <p>On 9/6/18 at 3:00 pm an interview was conducted with the Assistant Director of Nursing who stated that Resident #78 was a new admission and her name and demographics were not placed in the lab vendor ' s electronic submission site and staff does not have access to add a new resident. The nurse should have completed paperwork to submit Resident #78 ' s urine sample for urinalysis and culture. The ADON stated that a urine was collected on 8/14/18 but was not found at the lab and there was no follow up until 8/16/18.</p> <p>On 9/6/18 at 3:44 pm an interview was conducted with the Director of Nursing who stated she expected staff to follow the physician order to</p>	F 690			

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F 690	Continued From page 29	F 690			
F 692 SS=D	<p>Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)</p> <p>§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-</p> <p>§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;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§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 observations, staff, Nurse Practitioner (NP), Registered Dietician (RD) and Physician interviews and record review, the facility failed implement interventions to address weight loss and nutritional status for 2 (Resident #83 and Resident #80) of 3 residents reviewed for nutrition. The findings included:</p> <p>1. Resident #83 was admitted 12/15/08 with cumulative diagnoses of Alzheimer's Disease and muscle weakness.</p>	F 692	<p>1. Resident #83 noted with a 15.6lb weight loss without an ordered intervention. On 9/6/18 resident #83 received an order for Medpass 2.0 120ml TID (Three times a day) and prostat 30ml po (By mouth) BID (Twice a day). Weights monitored weekly until stable beginning 9/10/18.</p> <p>Resident #80 was readmitted to facility without a previous order for MedPass to</p>	10/5/18	

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F 692	<p>Continued From page 30</p> <p>Review of July 2018 physician orders indicated Resident #83 had a diet downgrade from mechanical soft to a pureed diet on 7/26/18 due to Dysphagia (difficult swallowing). There were no orders for any prescribed weight or dietary supplements.</p> <p>Review of a Wound Assessment dated 7/27/18 indicated Resident #83's developed an unstageable pressure ulcer to her sacrum.</p> <p>Review of Resident #83's monthly weights indicated an approximate 15-pound weight loss since 1/9/18. January 9, 2018 weight was recorded as 118.6 pounds and as of August 1, 2018 her weight was recorded as 103.8 pounds.</p> <p>Review of a NP note dated 8/2/18 read Resident #83 had a 5.2-pound weight gain and her current weight was 118.2 pounds. There was no evidence of fluid overload and weekly weights were ordered for 4 weeks.</p> <p>Review of Resident #83's August physician orders read an order dated 8/2/18 for weekly weights for weight gain. There were no orders for any prescribed weight or dietary supplements.</p> <p>Review of a RD note dated 8/2/18 read Resident #83 was seen for an unstageable wound to the sacrum. The note read her weight at 118.2 with her Body Mass Index (BMI) of 23 and within normal limits. The note read there was a 7-pound weight gain over the past four months, her lab work was normal, and she was on monthly weight.</p> <p>Review of Resident #83's quarterly Minimum</p>	F 692	<p>restart. Resident noted with a 14lb weight loss on readmission. On 9/6/18 received an order for Med Pass 2.0 90ml with meals.</p> <p>9/13/18 order changed for MedPass 90ml BID (Twice a day)</p> <p>9/17/18 Order changed for MedPass 120ml BID (Twice a day)</p> <p>Resident #83 and resident #80 weights monitored weekly until stable beginning 9/10/18.</p> <p>100% of residents weighed and weights reviewed per DON/Unit Manager/Dietary Manager/Registered Dietician 9/14/18. Interventions for any noted weight loss obtained.</p> <p>2. 100% audit of current weights completed per DON to ensure weight loss captured and interventions in place. Completed 9/14/2018.</p> <p>Admission weight will be obtained within 24 hours of admission per assigned c.n.a. New admissions residents will be weighed weekly per designated c.n.a to establish baseline weight.</p> <p>Monthly weights will be obtained per assigned certified nursing assistant within the first Monday thru Friday of each month. The same person will be assigned to obtain monthly and weekly weights to ensure consistency.</p> <p>Once weights obtained the weights will be entered into the resident's records per the DON and weight loss report generated per the DON. Weight loss to be identified as 5%/30 days, 7.5%/90days,</p>	

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F 692	<p>Continued From page 31</p> <p>Data Set (MDS) dated 8/15/18 indicated moderate cognitive impairment and she exhibited no behaviors. She was coded for total assistance with her activities of daily living (ADLs) except for supervision eating. Resident #83 was coded as incontinent of bladder and bowel, coded for one unstageable pressure ulcer and no weight loss.</p> <p>There was no evidence of a care plan for actual weight loss.</p> <p>Review of a NP note dated 8/15/18 read Resident #83 was malnourished with a low albumin level. The note read her weights were stabilizing and recommend the RD follow up for high protein supplements and the addition of Pro-Stat (protein supplement). There were no new written physician orders on 8/15/18 for malnourishment.</p> <p>Review of a Prealbumin (blood result that help determine protein status) lab test ordered 8/16/18 and obtained on 8/17/18 was 10.1 with normal ranges between 17.0-34. This lab result was initialed as reviewed by the NP on 8/23/18. There were no new orders.</p> <p>Review of a Dietary Manager (DM) note dated 8/17/18 read Resident #83's weight was 118.2 pounds and has remained stable over the past six months. Her diet was recently changed to pureed.</p> <p>Review of Resident #83's weight as of 9/5/18 was documented at 101.0 pounds.</p> <p>Review of a NP note dated 9/5/18 read Resident #83 has had weight loss of 15.6 pounds with a current weight of 103.8. The note read Resident #83's sacral pressure ulcer and weight loss was unavoidable and would continue. The NP note</p>	F 692	<p>10%/180days.</p> <p>Weekly weight meeting will be held with DON/Unit Manager/Dietary Manager to discuss weights and obtain orders for interventions as needed.</p> <p>Registered Dietician (RD) will be given the weight loss report and weight meeting minutes at each visit, to ensure appropriate interventions are in place. RD will provide DON/DM/Administrator with a consultant report upon exit at each visit.</p> <p>3. DON will present weekly weight meeting minutes and weight loss report to the Administrator for review. This will be an ongoing process change. DON/ADON will present weight meeting minutes and weight loss report to QAPI monthly and ongoing.</p> <p>DON/Unit Manager will educate the nursing staff, full-time, part-time, weekend staff on the weight management process changes. Completed 10/5/2018. Any nursing staff not educated by 10/5/2018 will not be allowed to work until education received.</p> <p>Compliance date 10/5/2018</p>		

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F 692	<p>Continued From page 32</p> <p>read Resident #83 was malnourished and she would order the RD to follow up for a high protein supplement and the addition of Pro-Stat.</p> <p>Review of Resident #83's September 2018 order dated 9/5/18 read for the Registered Dietician for follow her on her next round.</p> <p>In an observation on 9/6/18 at 8:45 AM, Nursing Assistant (NA) #3 stated Resident #83 was not eating well but was able to feed herself after tray set-up.</p> <p>In a wound care observation on 9/6/18 at 11:25 AM, the Treatment Nurse and Director of Nursing (DON) stated since Resident #83's diet was downgraded to pureed, she has not been eating well. Observation of the sacrum revealed a pen-point site and the upper part of the sacrum. There were no concerns with technique or healing.</p> <p>In an interview on 9/6/18 at 3:55 PM, the RD and DM both stated they were unaware of Resident #83's weight loss. The RD stated she was not aware of a physician order to see Resident #83 on 9/6/18 but she would evaluate her prior to leaving. The RD stated she received a list monthly of any residents she needed to see for weight loss. The DM was unable to answer why Resident #83 was not of the RD list for evaluation. The RD stated Resident #83's weight loss was likely due the calories she was taking in were being utilized for the healing of her pressure ulcer and left her with a nutritional deficit.</p> <p>Review of a RD note dated 9/6/18 read Resident #83 was seen for weight loss with a current weight of 101.0 pounds. The RD note read her</p>	F 692			

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F 692	<p>Continued From page 33</p> <p>Pre-albumin was low, she was on a pureed diet and had an unstageable pressure ulcer to her sacrum. The RD note recommended Med Pass three times daily.</p> <p>Review of Resident #83's September 2018 orders read she was prescribed Pro-Stat to be given twice daily and Med Pass (calorie supplement) three times daily on 9/6/18. Resident #83 was also ordered weekly weights for 4 weeks then reassess.</p> <p>In an interview on 9/6/18 at 5:10 PM, the Director of Nursing (DON) stated residents with weight loss were discussed daily in their morning meeting and the DM attended the meetings. The DON stated the staff nurse should have notified the DM of the order for the RD to see Resident #83 on 9/6/18.</p> <p>In an interview on 9/7/18 at 12:40 PM, NA #4 stated Resident #83 had no appetite. Observation of NA #4 set up Resident #83's lunch meal. Resident #83 stated she was starving. She was observed feeding herself without difficulty and ate 75% of the meal. There were no observed nutritional supplements on her lunch tray. NA #4 stated she was not receiving any supplements.</p> <p>In a telephone interview on 9/7 at 1:32 PM, the Physician stated it was his expectation that Resident #83 would have been placed on a protein supplement when the low Prealbumin lab result was reviewed by the NP on 8/23/18. The Physician stated he was under the impression that Resident #83 was receiving Magic Cup (fortified frozen nutritional supplement).</p> <p>In a telephone interview on 9/7/18 at 1:45 PM, the</p>	F 692			

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F 692	<p>Continued From page 34</p> <p>NP stated she also was under the impression that Resident #83 was receiving Magic Cup. She stated when she reviewed the abnormal Pre-albumin result on 8/23/18, she thought she wrote an order for it. The NP stated she saw Resident #83 on 9/5/18 and wrote orders then for Pro-Stat and for the RD to see her on the next scheduled RD visit.</p> <p>In an interview on 9/7/18 at 3:20 PM, the Administrator and Director of Nursing stated it was their expectation that Resident #83's receive timely nutritional assessment and interventions for her weight loss.</p> <p>2. Resident #80 was admitted on 11/18/16 with cumulative diagnoses of Anemia, Depression and Breast Cancer.</p> <p>Review of Resident #80's care plan initiated 11/22/16 read she has had a 10.9 weight loss over the past 30 days and 15.6 over the past 6 months. The goal target date was 11/13/18.</p> <p>Review of Resident #80's weight on 1/3/18 was 176.8 pounds</p> <p>Review of Resident #80's April 2018 physician orders read she was prescribed Med-Pass twice daily on 4/23/18.</p> <p>Review of Resident #80's weight on 6/7/18 was 172.1 pounds.</p> <p>Review of a Dietary Manger (DM) note dated 7/21/18 read Resident #80's current weight was 168.4 with reflected 9 pounds of weight loss over the past 6 months. The note read Resident #80 was receiving supplements, but the DM would discuss with nursing about increasing the</p>	F 692			

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F 692	<p>Continued From page 35</p> <p>supplement amount to prevent further weight loss.</p> <p>Review of Resident #80's August 2018 physician orders read the prescribed Med-Pass was discontinued due to hospitalization on 8/4/18.</p> <p>Review of Resident #80's readmission orders dated 8/6/18 did not include any orders for Med-Pass or supplements. She was prescribed a Low Concentrated Sweets (LCS) diet with a diabetic snack every evening.</p> <p>There were no documented weights again until 8/7/18 when she weighed 154 pounds.</p> <p>Resident #80's quarterly Minimum Data Set (MDS) dated 8/13/18 indicated she was cognitive intact and exhibited no behaviors. She was coded for supervision eating, weight loss and intact skin.</p> <p>Review of a DM note dated 8/16/18 read Resident #80 was readmitted after a hospital stay. Her weight loss was 10.9 pounds over the last 30 days. The DM note read that Resident #80 was receiving Med-Pass prior to her hospitalization but it was not re-ordered on readmission. The DM note indicated the DM would discuss restarting the Med-Pass with nursing.</p> <p>Review of Resident #80's August 2018 Medication Administration Record indicated she received no Med-Pass after 8/4/18.</p> <p>Review of Speech Therapy Plan of Care dated 8/28/18 read Resident #80 was being seen for reports of holding food and medications in her mouth.</p>	F 692			

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F 692	<p>Continued From page 36</p> <p>Review of a physician order dated 8/30/18 read Resident #80 was to have her meals on a divided plate.</p> <p>Review of Resident #80's September 2018 Medication Administration Record indicated she was not receiving Med-Pass as of 9/6/18.</p> <p>Review of Resident #80's weight on 9/5/18 was 155.0 pounds.</p> <p>Review of Resident #80's weight on 9/6/18 was 151.6 pounds.</p> <p>In an observation and interview on 9/6/18 at 8:30 AM, Resident #80 was eating her breakfast. She ate 100% and stated it was her favorite meal.</p> <p>In an interview on 9/6/18 at 9:20 AM, Nursing Assistant (NA) #3 stated that Resident #80 did not eat well but liked to snack often.</p> <p>In an interview on 9/6/18 at 3:55 PM, the RD stated she ordered Med-Pass today for Resident #80 because it was not restarted when she was readmitted from the hospital on 8/6/18. The DM stated she could not recall if she spoke with anyone in nursing about restarting Resident #80's Med-Pass as written in her note dated 8/16/18.</p> <p>In an interview on 9/6/18 at 5:10 PM, the Director of Nursing (DON) stated residents with weight loss were discussed daily in their morning meeting and the DM attended the meetings. The DON she was not aware that Resident #80's Med-Pass was not restarted on her readmission to the hospital.</p>	F 692			

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F 692	Continued From page 37 In an interview on 9/7/18 at 3:20 PM, the Administrator and Director of Nursing stated it was their expectation that Resident #80's Med-Pass would have been addressed and restarted after her readmission on 8/6/18 to aid in weight loss.	F 692			
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)  §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  §483.45(c)(2) This review must include a review of the resident's medical chart.  §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		10/5/18	

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F 756	<p>Continued From page 38</p> <p>§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. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, and interviews with staff, Nurse Practitioner, physician, and Pharmacy Consultant, the Pharmacy Consultant failed to identify and address the use of with risk versus benefit and timeframe for hormone therapy (Resident #53 and #79) for 2 of 2 residents reviewed for hormone therapy, and failed to identify and address the use of an antibiotic prescribed on an indefinite basis and without an adequate clinical indication for use (Resident #28) for 1 of 3 residents reviewed for antibiotic therapy.</p> <p>Findings included:</p> <p>1.</p> <p>Resident #53 was admitted to the facility on 5/31/17 and the documented diagnoses were acute coronary thrombosis not resulting in a heart attack, diabetes mellitus type 2, repeated falls, fracture of the thoracic vertebra, ankylosing spondylitis of thoracic and lumbar spine, coronary artery disease, localized edema, peripheral vascular disease, hypertension, and vascular dementia.</p> <p>Physician order dated 5/31/17 (on admission) for Estradiol 1 mg each day for peri-menopause.</p>	F 756	<p>1. Pharmacist did not review the risk versus benefits for Hormone Replacement Therapy (HRT) for resident # 53 and #79 and did not review the adequate use of an antibiotic prescribed for an indefinite basis for resident # 28. Resident #53 had Estradiol(HRT) discontinued as of 9/13/18. Resident #79 had Anestrozole discontinued as of 9/6/18. Resident #28 had Trimethoprim discontinued as of 9/6/18.</p> <p>2. Pharmacy performed a 100% medication review audit of all residents receiving HRT therapy to include risk versus benefits and also to identify any antibiotic without a stop date reviewed for adequate clinical indication, any areas of non-compliance will be corrected at this time. Completed 9/27/2018.</p> <p>Consultant pharmacist (CP) will be given a current census list by room on day one of the monthly visit. CP will indicate the resident's medications have been reviewed by high lighting the resident's name. CP will include in his monthly report that all medications have been reviewed for risk versus benefit and will</p>		

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F 756	<p>Continued From page 39</p> <p>The care plan dated 6/19/18 had goals and interventions for altered mobility, therapeutic diet, impaired vision, potential for skin breakdown, activities of daily living self-care deficit, potential for falls, potential for urinary tract infection, pain, communication deficit, diabetes, hypertension, respiratory deficit, and occasional smoker,</p> <p>The quarterly Minimum Data Set dated 9/6/18 revealed Resident #53 had adequate hearing, clear speech, and was understood and understands. The cognition was moderately impaired. The resident required one-person physical assistance for activities of daily living (ADL) except transfers was extensive assistance of one and meal was set up. Active diagnoses were hypertension, diabetes, chronic obstructive pulmonary disease, unsteadiness on her feet, generalized muscle weakness, and chronic pain syndrome. The resident received scheduled and as needed pain medication.</p> <p>The monthly physician order dated 9/1/2018 revealed Estradiol 0.5 mg each day</p> <p>Resident #58 had a monthly pharmacy medication review documented with recommendations for the six-month look-back. There were no recommendations for Estradiol.</p> <p>A review of Resident #53 ' s past six-months of nurses ' notes and physician progress notes revealed there was no documentation found for assessment of menopausal syndrome including hot flashes, breast exam, or gynecology consultation and no documentation of assessment for thrombosis.</p>	F 756	<p>include this in the Physician <input type="checkbox"/>s recommendations for each resident affected.</p> <p>Anastrozole- Residents who are receiving chemotherapy medications will have a note written by pharmacy to establish how long resident has been on medication and duration of therapy. Along with establishing a timeline for therapy, the pharmacist will establish the correct resident doctor relationship so that the resident would have the optimal risk/benefit analysis and timeline for administration of therapy.</p> <p>Estradiol- Residents who are on hormone replacement therapy will have a general evaluation note issued for therapy such as estradiol that will prompt the review of risk/benefit of therapy. For estrogen therapy, this would include analysis of hot flashes, a breast exam or any other necessary exams. These exams along with a risk versus benefit for continued administration of medication because of cardiovascular risk, will be monitored to make sure of completion while residents are on hormone replacement therapy.</p> <p>Antibiotic -All residents who are prescribed an antibiotic will have an appropriate stop date or re-evaluation date of therapy. If medication is a prophylactic antibiotic, the medication will be addressed monthly until an appropriate re-evaluation (or stop) date is added to medication or in progress note to prompt prescriber review. Upon adding this stop</p>		

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F 756	<p>Continued From page 40</p> <p>On 9/5/18 at 2:20 pm an interview was conducted with the Nurse Practitioner (NP) who stated the resident was receiving Estradiol 0.5 mg (reordered each month), which was decreased from 1 mg for menopausal symptoms. The resident had not had a breast exam or mammogram, one would not be considered unless there was a lump. The NP stated she would evaluate the resident today and consider discontinuing the Estradiol due to the potential risks.</p> <p>On 9/6/18 at 10:35 am an interview was conducted with the physician regarding Resident #53 ' s administration of Estradiol 0.5 mg each day. The physician stated he was not aware when the Estradiol was first started before admission to the facility; the resident was admitted with the order and the diagnoses of menopausal syndrome/hot flashes. The physician stated that Estradiol has a risk for breast cancer and the resident was not evaluated for the risk versus benefit for continued administration considering the resident had a history of acute coronary thrombosis. The physician stated he would discuss the Estradiol with the resident ' s representative.</p> <p>On 9/6/18 at 3:44 pm an interview was conducted with the pharmacist who stated that he assumed the physician had monitored and assessed Resident #53 for hormone replacement therapy, Estradiol. The pharmacist stated he expected the physician to evaluate the risk versus benefits during ongoing treatment before reordering.</p> <p>2.</p>	F 756	<p>date, the pharmacist will continue to monitor that the medication is being reviewed at the appropriate times. With continued review of the pharmacist and monitoring of the medical team, this will optimize the treatment of resident infections.</p> <p>DON/Unit Manager will review the CP report with the providers to improve communication between nursing staff and providers to ensure regulatory compliance. Providers will address all pharmacy recommendations and return to the DON/Unit Managers for appropriated follow up.</p> <p>3. Pharmacy Consultant Supervisor will audit facility CP monthly x 3 months to ensure resident medications have been reviewed for risk versus benefits and also antibiotics have a stop date unless clinically appropriate to continue antibiotic for indefinite basis. Pharmacy Consultant Supervisor will educate CP on Drug Regimen Review and reporting irregularities to the facility provider. Completed 10/5/2018 Results of Pharmacy Consultant Supervisor 3 month CP audit will be presented to DON/Administrator upon CP's exit during monthly review visit. CP will provide the DON/Administrator with an oral review of facility monthly report upon exit on monthly review visit. This will be an ongoing process change. Administrator will present completed</p>		

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F 756	<p>Continued From page 41</p> <p>Resident #79 was readmitted to the facility on 4/28/18 and the diagnoses were acute on chronic congestive heart failure, Alzheimer's disease, pneumonia, urinary tract infection, hypertension, depression, chronic atrial fibrillation, and osteoarthritis.</p> <p>Physician order dated 4/28/18 was for Anastrozole 1 mg each day for breast cancer.</p> <p>The significant change Minimum Data Set dated 8/11/18 revealed the resident had adequate hearing, clear speech, sometimes understands and sometimes understood. The cognition was unable to be assessed due to the inability to answer the questions. The resident required extensive assistance of 2 staff for bed mobility and all transfers including toileting. Total dependence for locomotion and extensive assistance of 2 staff for personal care, bathing, and dressing. One-person assistance was needed for meals. The active diagnoses were Alzheimer's disease, pneumonia, urinary tract infection, hypertension, depression, chronic atrial fibrillation, and osteoarthritis.</p> <p>The care plan dated 8/11/18 was updated and revealed goals and interventions for impaired thought process and memory loss, regular diet, potential for skin breakdown, potential for falls, pain, communication deficit, diuretic, in-room socialization, Hospice services, at risk for pneumonia, cardiac, and at risk for urinary tract infection.</p> <p>On 09/06/18 at 8:15 am during medication pass it was identified that Resident #79 had received Anastrozole for breast cancer, the resident had also received Hospice services and there was not</p>	F 756	<p>Pharmacy audit monthly in QAPI and ongoing to ensure compliance and to assess need for furthering monitoring. Compliance date 10/5/2018</p>		

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F 756	<p>Continued From page 42</p> <p>an oncologist following since admission to the facility.</p> <p>A review of Resident #79 ' s record since admission did not reveal an assessment and/or monitoring nor a care plan for breast cancer and oncological treatment. There was no consultation with an oncologist. There was no start date for the Anastrozole or a timeframe for how long the resident had been taking the Anastrozole documented.</p> <p>On 9/6/18 at 10:30 am an interview was conducted with the attending physician regarding medication order of Anastrozole 1 mg for Resident #79. The physician stated the resident was admitted from assisted living on Anastrozole and was followed by Oncology. The resident ' s Anastrozole medication continued by reorder each month at the facility and the management was not continued by Oncology since 8/31/17. The physician stated that he did not know when the Anastrozole was first started before admission to the facility and the usual timeframe for administration was 5 years. The physician stated other than the diagnoses of breast cancer, he was not aware why the resident was taking Anastrozole (i.e. active breast cancer or metastasis for pain control) and the diagnoses of breast cancer was not an adequate diagnosis to continue the Anastrozole. The physician stated that the resident was admitted to the facility on Hospice services and the goals for care would not be in line with Anastrozole administration because it was an oncological treatment. The physician stated that he would not typically manage Anastrozole, it would be ordered and followed by an oncologist. The physician indicated that the risk versus benefit had not been evaluated and</p>	F 756			

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F 756	<p>Continued From page 43</p> <p>he would discuss this with the family. The risks included chronic pain and osteoporosis.</p> <p>On 9/6/18 at 3:44 pm an interview was conducted with the pharmacist who stated that he assumed the physician had monitored and assessed resident #79 for cancer and the treatment in consultation with an oncologist for aromatase therapy which is a chemotherapy drug (Anastrozole). The pharmacist assumed the physician had consulted an oncologist and stated that he read the physician progress notes. The pharmacist was not aware of the start date for Anastrozole and was aware that it was given for a specified timeframe, usually 5 years.</p> <p>On 9/7/18 at 2:00 pm an interview was conducted with the Director of Nursing (DON) who stated that she called Resident #79' s resident representative (RR) who stated the resident had been on Anastrozole for 4 to 5 years and an oncologist had been following the breast cancer and administration of Anastrozole before admission to the facility. The RR did not know the exact start date nor who the oncologist' s name. The DON stated she was not familiar with Anastrozole and would expect the physician to evaluate for risk versus benefit and to know the timeframe for administration.</p> <p>3. Resident #28 was admitted to the facility on 6/8/15 with diagnoses that included heart disease, diabetes mellitus type 2, hypertension, and Alzheimer ' s.</p> <p>A review of the facility ' s Antibiotic Stewardship Program ' s policy, last revised 12/2016, indicated appropriate indications for use of antibiotics included: "a. Criteria met for clinical definition of active infection or suspected sepsis; and b.</p>	F 756			

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F 756	<p>Continued From page 44</p> <p>Pathogens susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending)." The policy additionally stated that if an antibiotic was ordered that a start and stop date or number of days of therapy was to be indicated on the order.</p> <p>A Nurse Practitioner (NP) note dated 3/14/18 indicated Resident #28 had recurrent Urinary Tract Infections (UTIs). A trial of Trimethoprim (antibiotic) was to be initiated as a prophylactic (preventative) medication as discussed with the physician and Resident #28 ' s family member.</p> <p>A physician ' s order dated 3/14/18 indicated Trimethoprim 25 milligrams (mg) twice daily for Resident #28. There was no stop date for this order.</p> <p>Nursing notes dated 3/14/18, 3/25/18, 3/29/18, and 4/7/18 indicated Resident #28 continued to receive a maintenance antibiotic for recurrent UTIs.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 4/26/18 indicated Resident #28 ' s cognition was moderately impaired. She was administered antibiotics on 7 of 7 days during the MDS review period. Resident #28 was assessed with no UTI within the last 30 days.</p> <p>A review of Resident #28 ' s current physician ' s orders was conducted on 9/5/18. The orders included the Trimethoprim 25 mg twice daily that was initiated on 3/14/18 as a prophylactic measure related to Resident #28 ' s recurrent UTIs. A further review of Resident #28 ' s record revealed there continued to be no stop date for this antibiotic.</p>	F 756			

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F 756	<p>Continued From page 45</p> <p>There was no evidence in Resident #28 ' s medical record of the Pharmacy Consultant identifying and addressing the use of prophylactic Trimethoprim prescribed indefinitely.</p> <p>An interview was conducted with the Director of Nursing (DON) on 9/5/18 at 2:30 PM. She stated that Resident #28 was on Trimethoprim for prophylaxis related to recurrent UTIs and had no stop date.</p> <p>An interview was conducted with the NP on 9/5/18 at 4:00 PM. The order for Resident #28 ' s prophylactic Trimethoprim that had been in place since 3/14/18 was reviewed with the NP. The NP reported that Resident #28 had recurrent UTIs and the Trimethoprim was initiated as a preventative measure because Resident #28 ' s family wanted to try something to prevent UTI reoccurrence. The NP indicated she was going to discontinue the Trimethoprim on this date (9/5/18).</p> <p>A physician ' s order dated 9/5/18 indicated the discontinuation of Trimethoprim 25 mg twice daily for Resident #28.</p> <p>An interview was conducted with the facility ' s Medical Director/Resident #28 ' s physician on 9/6/18 at 10:32 AM. The order for Resident #28 ' s prophylactic Trimethoprim that had been in place since 3/14/18 was reviewed with the physician. He indicated the Trimethoprim was initiated based on Resident #28 ' s family member ' s insistence on wanting to try something to prevent the resident ' s recurrent UTIs. He stated that it was prescribed prophylactically and at a very low dose. He</p>	F 756			

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F 756	Continued From page 46 confirmed there was no stop date for the Trimethoprim, reporting that prophylactics were normally ordered indefinitely. He indicated that the Trimethoprim should have been re-evaluated and discontinued prior to 9/5/18 when the NP wrote the order to discontinue it.  A phone interview was conducted with the Pharmacy Consultant on 9/6/18 at 3:30 PM. Resident #28 ' s prophylactic Trimethoprim that had been in place since 3/14/18 was reviewed with the Pharmacy Consultant. He confirmed he had made no recommendations related to Resident #28 ' s prophylactic Trimethoprim. He stated that he had identified that this antibiotic was prescribed prophylactically with no stop date and assumed that the prescriber was monitoring it to ensure it was still appropriate for use.  A follow up interview was conducted with DON on 9/7/18 at 2:25 PM. She stated she expected Pharmacy Consultant to identify and address the use of an antibiotic prescribed with no stop date and without an adequate clinical indication for use during the monthly drug regimen reviews.	F 756			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-  §483.45(d)(1) In excessive dose (including duplicate drug therapy); or  §483.45(d)(2) For excessive duration; or	F 757		10/5/18	

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F 757	<p>Continued From page 47</p> <p>§483.45(d)(3) Without adequate monitoring; or</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, Nurse Practitioner and Physician interview, and staff interviews, the facility failed to evaluate need for and timeframe of the administration of hormone therapy replacement and hormone chemotherapy for risk versus benefits for 2 of 4 residents reviewed for unnecessary medication (Resident #53 and #79).</p> <p>Findings included:</p> <p>1.</p> <p>Resident #53 was admitted to the facility on 5/31/17 and the documented diagnoses were acute coronary thrombosis not resulting in a heart attack, diabetes mellitus type 2, repeated falls, fracture of the thoracic vertebra, ankylosing spondylitis of thoracic and lumbar spine, coronary artery disease, localized edema, peripheral vascular disease, hypertension, and vascular dementia.</p> <p>Physician order dated 5/31/17 (on admission) for Estradiol 1 mg each day for peri-menopause.</p>	F 757	<p>1. Pharmacy and Medical providers did not evaluate the need for nor the timeframe for the administration of HRT and hormone chemotherapy for risk versus benefits for resident #53 and resident #79. Resident #53 had Estradiol (HRT) discontinued as of 9/13/18. Resident #79 had Anastrozole discontinued as of 9/6/18.</p> <p>2. Pharmacy performed a 100% medication review audit of all residents receiving HRT therapy and Aromatase inhibitor to include risk versus benefits, areas of non-compliance corrected at this time. DON/Nurse Managers will provide facility providers with a list of new admissions medications for review to include risk versus benefits of appropriate medications that will be signed following review by facility medical provider to inform DON/Nurse Managers that medications have been reviewed for appropriate clinical indications including risk versus benefits. This new admission</p>		

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F 757	<p>Continued From page 48</p> <p>The care plan dated 6/19/18 had goals and interventions for altered mobility, therapeutic diet, impaired vision, potential for skin breakdown, activities of daily living self-care deficit, potential for falls, potential for urinary tract infection, pain, communication deficit, diabetes, hypertension, respiratory deficit, and occasional smoker,</p> <p>The quarterly Minimum Data Set dated 9/6/18 revealed Resident #53 had adequate hearing, clear speech, and was understood and understands. The cognition was moderately impaired. The resident required one-person physical assistance for activities of daily living (ADL) except transfers was extensive assistance of one and meal was set up. Active diagnoses were hypertension, diabetes, chronic obstructive pulmonary disease, unsteadiness on her feet, generalized muscle weakness, and chronic pain syndrome. The resident received scheduled and as needed pain medication.</p> <p>The physician order dated 2/13/18 for Estradiol 0.5 mg each day was for peri-menopause</p> <p>The monthly physician order dated 9/1/2018 revealed Estradiol 0.5 mg each day</p> <p>Resident #58 had a monthly pharmacy medication review documented with recommendations for the six-month look-back. There were no recommendations for Estradiol.</p> <p>A review of Resident #53 ' s past six-months of nurses ' notes and physician progress notes revealed there was no documentation found for assessment of menopausal syndrome including hot flashes, breast exam, or gynecology consultation and no documentation of</p>	F 757	<p>medication review list will be brought to clinical meeting Monday thru Friday per DON/Nurse Managers to ensure nursing management staff is aware of compliance issues. Members of clinical meeting include DON, Unit Managers, MDS Nurse, Therapy, and Wound care nurse. Consultant pharmacist (CP) will be given a current census list by room on day one of the monthly visit. CP will indicate the resident's medications have been reviewed by high lighting the resident's name. CP will include in his monthly report that all medications have been reviewed for risk versus benefit and will include this in the Physician's recommendations for each resident affected. DON/Unit Manager will review the CP report with the providers to improve communication between nursing staff and providers to ensure regulatory compliance.</p> <p>3. Pharmacy Consultant Supervisor will audit facility CP monthly x 3 months to ensure resident medications have been reviewed for risk versus benefits and also antibiotics have a stop date unless clinically appropriate to continue antibiotic for indefinite basis.</p> <p>Pharmacy Consultant Supervisor will educate CP on Drug Regimen Review and reporting irregularities to the facility provider.</p> <p>Results of Pharmacy Consultant Supervisor CP audit will be presented to DON/Administrator upon exit of monthly</p>		

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F 757	<p>Continued From page 49 assessment for thrombosis.</p> <p>On 9/5/18 at 2:20 pm an interview was conducted with the Nurse Practitioner (NP) who stated the resident was receiving Estradiol 0.5 mg (reordered each month), which was decreased from 1 mg for menopausal symptoms. The resident had not had a breast exam or mammogram, one would not be considered unless there was a lump. The NP stated she would evaluate the resident today and consider discontinuing the Estradiol due to the potential risks.</p> <p>On 9/6/18 at 10:35 am an interview was conducted with the physician regarding Resident #53 ' s administration of Estradiol 0.5 mg each day. The physician stated he was not aware when the Estradiol was first started before admission to the facility; the resident was admitted with the order and the diagnoses of menopausal syndrome/hot flashes. The physician stated that Estradiol has a risk for breast cancer and the resident was not evaluated for the risk versus benefit for continued administration considering the resident had a history of acute coronary thrombosis. The physician stated he would discuss the Estradiol with the resident ' s representative.</p> <p>On 9/6/18 at 3:44 pm an interview was conducted with the pharmacist who stated that he assumed the physician had monitored and assessed Resident #53 for hormone replacement therapy, Estradiol. The pharmacist stated he expected the physician to evaluate the risk versus benefits during ongoing treatment before reordering.</p> <p>On 9/7/18 at 2:00 pm an interview was conducted</p>	F 757	<p>review visit. CP will provide the DON/Administrator with an oral review of facility monthly report upon exit on monthly review visit. This will be an ongoing process change. DON will present the reviewed New Admission Medication list and CP monthly report to QAPI monthly for review to ensure compliance and assess need for further monitoring. This will be an ongoing process systems change. DON will present completed Pharmacy audit monthly in QAPI and ongoing to ensure compliance and to assess need for furthering monitoring. Facility administrator and DON educated Medical Providers and Licensed nursing staff on New Admission Medication Review procedures. Completed 10/5/2018. Any licensed staff not educated by 10/5/2018 will not be allowed to work until education received.</p> <p>Compliance date 10/5/2018</p>		

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F 757	<p>Continued From page 50</p> <p>with the Director of Nursing (DON) who stated that she would expect the physician to evaluate for risk versus benefit and to know the timeframe for administration.</p> <p>2.</p> <p>Resident #79 was readmitted to the facility on 4/28/18 and the diagnoses were acute on chronic congestive heart failure, Alzheimer's disease, pneumonia, urinary tract infection, hypertension, depression, chronic atrial fibrillation, and osteoarthritis.</p> <p>Physician order dated 4/28/18 was for Anastrozole 1 mg each day for breast cancer.</p> <p>The significant change Minimum Data Set dated 8/11/18 revealed the resident had adequate hearing, clear speech, sometimes understands and sometimes understood. The cognition was unable to be assessed due to the inability to answer the questions. The resident required extensive assistance of 2 staff for bed mobility and all transfers including toileting. Total dependence for locomotion and extensive assistance of 2 staff for personal care, bathing, and dressing. One-person assistance was needed for meals. The active diagnoses were Alzheimer's disease, pneumonia, urinary tract infection, hypertension, depression, chronic atrial fibrillation, and osteoarthritis.</p> <p>The care plan dated 8/11/18 was updated and revealed goals and interventions for impaired thought process and memory loss, regular diet, potential for skin breakdown, potential for falls, pain, communication deficit, diuretic, in-room socialization, Hospice services, at risk for</p>	F 757			

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F 757	<p>Continued From page 51</p> <p>pneumonia, cardiac, and at risk for urinary tract infection.</p> <p>On 09/06/18 at 8:15 am during medication pass it was identified that Resident #79 had received Anastrozole for breast cancer, the resident had also received Hospice services and there was not an oncologist following since admission to the facility.</p> <p>A review of Resident #79 ' s record since admission did not reveal an assessment and/or monitoring nor a care plan for breast cancer and oncological treatment. There was no consultation with an oncologist. There was no start date for the Anastrozole or a timeframe for how long the resident had been taking the Anastrozole documented.</p> <p>On 9/6/18 at 10:30 am an interview was conducted with the attending physician regarding medication order of Anastrozole 1 mg for Resident #79. The physician stated the resident was admitted from assisted living on Anastrozole and was followed by Oncology. The resident ' s Anastrozole medication continued by reorder each month at the facility and the management was not continued by Oncology since 8/31/17. The physician stated that he did not know when the Anastrozole was first started before admission to the facility and the usual timeframe for administration was 5 years. The physician stated other than the diagnoses of breast cancer, he was not aware why the resident was taking Anastrozole (i.e. active breast cancer or metastasis for pain control) and the diagnoses of breast cancer was not an adequate diagnosis to continue the Anastrozole. The physician stated that the resident was admitted to the facility on</p>	F 757			

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F 757	Continued From page 52 Hospice services and the goals for care would not be in line with Anastrozole administration because it was an oncological treatment. The physician stated that he would not typically manage Anastrozole, it would be ordered and followed by an oncologist. The physician indicated that the risk versus benefit had not been evaluated and he would discuss this with the family. The risks included chronic pain and osteoporosis.  On 9/6/18 at 3:44 pm an interview was conducted with the pharmacist who stated that he assumed the physician had monitored and assessed resident #79 for cancer and the treatment in consultation with an oncologist for aromatase therapy which is a chemotherapy drug (Anastrozole). The pharmacist assumed the physician had consulted an oncologist and stated that he read the physician progress notes. The pharmacist was not aware of the start date for Anastrozole and was aware that it was given for a specified timeframe, usually 5 years.  On 9/7/18 at 2:00 pm an interview was conducted with the Director of Nursing (DON) who stated that she called Resident #79' s resident representative (RR) who stated the resident had been on Anastrozole for 4 to 5 years and an oncologist had been following the breast cancer and administration of Anastrozole before admission to the facility. The RR did not know the exact start date nor who the oncologist' s name. The DON stated she was not familiar with Anastrozole and would expect the physician to evaluate for risk versus benefit and to know the timeframe for administration.	F 757			
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		10/5/18	

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F 867	<p>Continued From page 53</p> <p>§483.75(g) Quality assessment and assurance.</p> <p>§483.75(g)(2) The quality assessment and assurance committee must:</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and to monitor the interventions that the committee put into place in 10/2017. This was for one recited deficiency for Minimum Data Set accuracy which was originally cited on 10/26/17 during the recertification survey. The continued failure of the facility during the two federal surveys of record show a pattern of the facility's inability to sustain an effective QAPI program. The findings included:</p> <p>This tag is cross referred to: 483.20 Accuracy of Assessments: Based on record review and staff interview the facility failed to accurately code the Minimum Data Set (MDS) in the area of active diagnoses (Resident #53 and #79) for 2 of 5 residents reviewed for medications.</p> <p>During the recertification survey of 10/26/17, the facility was cited at 483.20 for failure to code the MDS accurately in the area of active diagnosis.</p> <p>On 9/7/18 at 1:26 pm an interview was conducted with the Administrator who stated the repeat areas of accurately code MDS for active diagnosis reason for failure was a turnover in management of the Administrator and Director of</p>	F 867	<p>. Facility failed to accurately code the MDS in the area of active diagnosis for resident #53 and resident #79. MDS nurse failed to accurately code section I active diagnosis for resident #53 &amp; resident #79. MDS nurse stated the omission was an oversight. This was a system failure that resulted in a recited deficiency. The most recent MDS for resident #53 and #79 was corrected per facility MDS Nurse on 9/13/19.</p> <p>2. Most recent MDS for all current residents for census date of 9/7/18 will be audited by Regional Reimbursement Manager (RRM) for accuracy of active diagnosis coding. Areas of non-compliance corrected per facility MDS nurse at this time. Completed 10/5/2018.</p> <p>MDS nurse and Interdisciplinary team will code the MDS assessment based on the Resident Assessment Instrument (RAI) Manual to ensure the MDS assessment reflects the active diagnoses. Regional Reimbursement Manager will audit 25% of completed MDS weekly x4, then bi-weekly x4, then monthly x3 to ensure regulatory compliance and coding</p>		

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F 867	Continued From page 54 Nursing. New management has been auditing for accuracy and processes and some staff have been let go and new staff brought on board.	F 867	accuracy. Any area of non-compliance will be corrected and appropriate staff educated. IDT and Administrator was educated on importance of coding accuracy by the Regional MDS Manager on 9/25/2018.  3. The Administrator will review the completed MDS weekly audits x 4, then bi-weekly x 4 then monthly x3. Administrator will present the results of these audits to QAPI monthly x 6 months to determine sustained compliance and need for further assessment. Compliance date 10/5/2018		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3)  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Nurse Practitioner (NP), Physician and Pharmacy Consultant, the facility failed to identify and address the use of prophylactic (preventative) antibiotics prescribed on an indefinite basis for 1 of 3 residents (Resident #28) reviewed for antibiotic therapy. The findings included:	F 881	1. Resident #28 receiving a prophylactic antibiotic for prevention of UTI without review for a stop date. Medication was discontinued 9/6/2018.  2.DON/Unit Managers performed a 100% audit of all antibiotic orders to ensure orders have a stop date. No other areas of non-compliance noted. Completed	10/5/18	

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F 881	<p>Continued From page 55</p> <p>Resident #28 was admitted to the facility on 6/8/15 with diagnoses that included heart disease, diabetes mellitus type 2, hypertension, and Alzheimer ' s.</p> <p>A review of the facility ' s Antibiotic Stewardship Program ' s policy, last revised 12/2016, indicated appropriate indications for use of antibiotics included: "a. Criteria met for clinical definition of active infection or suspected sepsis; and b. Pathogens susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending)." The policy additionally stated that if an antibiotic was ordered that a start and stop date or number of days of therapy was to be indicated on the order.</p> <p>A Nurse Practitioner (NP) note dated 3/14/18 indicated Resident #28 had recurrent Urinary Tract Infections (UTIs). A trial of Trimethoprim (antibiotic) was to be initiated as a prophylactic (preventative) medication as discussed with the physician and Resident #28 ' s family member.</p> <p>A physician ' s order dated 3/14/18 indicated Trimethoprim 25 milligrams (mg) twice daily for Resident #28. There was no stop date for this order.</p> <p>Nursing notes dated 3/14/18, 3/25/18, 3/29/18, and 4/7/18 indicated Resident #28 continued to receive a maintenance antibiotic for recurrent UTIs.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 4/26/18 indicated Resident #28 ' s cognition was moderately impaired. She was administered antibiotics on 7 of 7 days during the MDS review period. Resident #28 was</p>	F 881	<p>9/14/2018.</p> <p>Pharmacy Consultant performed a 100% antibiotic medication review to ensure antibiotics have a stop date. No other areas of non-compliance noted. Completed 9/27/2018.</p> <p>DON/Unit Managers will provide facility medical providers with a list of new admission medications for review to ensure antibiotics have a stop date, DON/Unit Managers will review new antibiotic orders as received from facility providers to ensure antibiotic orders have a stop date. DON/Unit Managers will bring new antibiotic orders to clinical meeting qd Monday thru <input type="checkbox"/> Friday for review and to ensure regulatory compliance. This will be an on-going process change.</p> <p>Weekend Manager will review antibiotic orders received on the weekend for stop dates and will leave new antibiotic orders received in the DON office for review in clinical meeting.</p> <p>3. Pharmacy Consultant Supervisor will audit facility CP monthly x 3 months to ensure resident antibiotic medications have been reviewed to ensure antibiotic orders have a stop date unless clinically appropriate to continue antibiotic for indefinite basis. DON/Unit Manager will review CP report monthly to ensure antibiotic medications have been reviewed; this will be an ongoing process. DON/Unit Manager will present new antibiotic order reviews to monthly QA to ensure compliance and assess need for</p>		

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F 881	<p>Continued From page 56</p> <p>assessed with no UTI within the last 30 days.</p> <p>A review of Resident #28 ' s current physician ' s orders was conducted on 9/5/18. The orders included the Trimethoprim 25 mg twice daily that was initiated on 3/14/18 as a prophylactic measure related to Resident #28 ' s recurrent UTIs. A further review of Resident #28 ' s record revealed there continued to be no stop date for this antibiotic.</p> <p>There was no evidence in Resident #28 ' s medical record of the Pharmacy Consultant identifying and addressing the use of prophylactic Trimethoprim prescribed indefinitely.</p> <p>An interview was conducted with the Director of Nursing (DON) on 9/5/18 at 2:30 PM. She stated that Resident #28 was on Trimethoprim for prophylaxis related to recurrent UTIs. The DON confirmed that prophylactic antibiotics prescribed on an indefinite basis were not in accordance with the facility ' s Antibiotic Stewardship Program ' s (ASP) policy.</p> <p>An interview was conducted with the NP on 9/5/18 at 4:00 PM. The NP was asked what the facility ' s Antibiotic Stewardship Program ' s policy stated about the use of prophylactic antibiotics prescribed indefinitely. She indicated that she was aware that prophylactic antibiotics prescribed on an indefinite basis were not in accordance with the facility ' s ASP ' s policy. The order for Resident #28 ' s prophylactic Trimethoprim that had been in place since 3/14/18 was reviewed with the NP. The NP reported that Resident #28 had recurrent UTIs and the Trimethoprim was initiated as a preventative measure because Resident #28 ' s</p>	F 881	<p>further monitoring, this will be an on-going process.</p> <p>DON/Unit Manager educated nurses (Full-time, part-time, weekend) on new admission medication review and weekend procedure for receipt of new antibiotic orders. Completed 10/5/2018 Administrator will educate Medical Providers on New Admission Medication Review. Completed 10/5/2018 CP supervisor educated CP on Antibiotic Stewardship guidelines including antibiotic stop dates on 9/27/2018. Any licensed staff not educated by 10/5/2018 will not work until education received. Compliance Date 10/5/2018</p>		

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F 881	<p>Continued From page 57</p> <p>family wanted to try something to prevent UTI reoccurrence. The NP indicated she was going to discontinue the Trimethoprim on this date (9/5/18).</p> <p>A physician ' s order dated 9/5/18 indicated the discontinuation of Trimethoprim 25 mg twice daily for Resident #28.</p> <p>An interview was conducted with the facility ' s Medical Director/Resident #28 ' s physician on 9/6/18 at 10:32 AM. The order for Resident #28 ' s prophylactic Trimethoprim that had been in place since 3/14/18 was reviewed with the physician. He indicated the Trimethoprim was initiated based on Resident #28 ' s family member ' s insistence on wanting to try something to prevent the resident ' s recurrent UTIs. He stated that it was prescribed prophylactically and at a very low dose. He confirmed there was no stop date for the Trimethoprim, reporting that prophylactics were normally ordered indefinitely. The Medical Director confirmed that he was aware prophylactic antibiotics were not in accordance with the facility ' s Antibiotic Stewardship Program ' s policy. He indicated that the Trimethoprim should have been re-evaluated and discontinued prior to 9/5/18 when the NP wrote the order to discontinue it.</p> <p>A phone interview was conducted with the Pharmacy Consultant on 9/6/18 at 3:30 PM. The Pharmacy Consultant was asked what the facility ' s Antibiotic Stewardship Program ' s policy stated about the use of prophylactic antibiotics prescribed indefinitely. He indicated he was not sure what the ASP ' s policy stated about prophylactic antibiotics, but that generally</p>	F 881			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 881	<p>Continued From page 58</p> <p>prophylactics were prescribed with no stop date because they were for infection prevention. Resident #28 ' s prophylactic Trimethoprim that had been in place since 3/14/18 was reviewed with the Pharmacy Consultant. He confirmed he had made no recommendations related to Resident #28 ' s prophylactic Trimethoprim. He stated that he had identified that this antibiotic was prescribed prophylactically with no stop date and assumed that the prescriber was monitoring it to ensure it was still appropriate for use.</p> <p>A follow up interview was conducted with DON on 9/7/18 at 2:25 PM. She stated that she expected the facility ' s staff and providers to be aware of the Antibiotic Stewardship Program ' s policy and for the policy to be followed.</p>	F 881			