STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. BUILDING ______ B. WING ______	R 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments An unannounced Medicare/Medicaid survey, a first revisit to the standard survey which was conducted on 6/11/18 through 6/15/18 was conducted 8/7/18 through 8/8/18. The facility was found to be in compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities at the time of the revisit survey.	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid survey, a first revisit to the standard survey which was conducted on 6/11/18 through 6/15/18 was conducted 8/7/18 through 8/8/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567- B. The census in this 145 certified bed facility was 132 at the time of the survey. The survey sample consisted of 15 current resident reviews, Residents #101 through # 115.	{F 000}		
{F 580} SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	{F 580}		8/31/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 08/24/2018

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 580}	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review	{F 580}	The Laurels of University Park wishes to	

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{F 580} Continued From page 2

and clinical record review, the facility staff failed to notify the physician of a change in condition for one of 15 residents in the survey sample, Resident #103.

The facility staff failed to notify the physician of Resident #103's elevated blood sugar of 500 on 8/4/18.

The findings include:

Resident #103 was admitted to the facility on 7/29/18 with diagnoses that included but were not limited to head injury, difficulty swallowing, dementia without behavioral disturbance, type two diabetes and muscle weakness. Resident #103's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/13/18. Resident #103 was coded as being moderately impaired in cognitive function scoring 11 out of 15 on the BIMS (brief interview for mental status) exam. Resident #103 was coded as requiring supervision only with ADLS (activities of daily living).

Review of Resident #103's August 2018 physician order summary documented the following orders: "Accu check before breakfast, lunch, dinner at bedtime. before meals and at bedtime. Notify MD (medical doctor) of BS <70 or >400.

Humalog Solution (1) 100 UNIT/ML Inject per sliding scale: If 150-200= 2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; 401 -500= 12 units Call MD is (sic) BS over 400, subcutaneously before meals and at bedtime for diabetes."

{F 580}

have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is August 31, 2018

Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.

Ftag 580

Resident #103: No negative outcome occurred as a result of this practice. The physician was notified of the elevated blood sugar reading.

Diabetic residents in the facility have the potential to be affected by this practice.

DON or designee will educate licensed nursing staff on following blood sugar parameters as ordered by the physician.

DON or designee will audit MARs of current diabetics with orders for blood sugar parameters for the last 14 days.

DON or designee will monitor blood sugar order changes 5 times a week for 4

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{F 580}	Continued From page 3 Review of Resident #103's August 2018 MAR (Medication Administration Record) revealed that on 8/4/18 at 11:30 a.m., Resident #103's blood sugar was 500. Further review of the MAR revealed that Resident #103 received 12 units of Humalog per order. There was no evidence that the physician was made aware of Resident #103's blood sugar reading on 8/4/18. Review of the August 2018 nursing notes failed to evidence any documentation that the physician was made aware that her blood sugar was 500 on 8/4/18. Resident #103's Blood Sugar care plan dated 12/20/17, documented the following: "At risk for fluctuation in blood sugars related to Diabetes. Guest will be free from signs of complications from fluctuation blood sugars such as mental status changes, tremors/shakiness, dizziness, weakness, appetite loss thru next review date. Interventions: "Administer medications per orders. Observe for ineffectiveness and side effects. Report findings to physician. Observe and document s/sx (signs/symptoms) of complications from fluctuating blood sugar. Report abnormal findings to physician." On 8/8/18 at 11:54 a.m., an interview was conducted with LPN (licensed practical nurse) #2, the nurse who worked with Resident #103 on 8/4/18. When asked what the above order meant, LPN #2 stated that if the blood sugar was higher than 400, then the medical doctor should be notified before giving the 12 units of sliding scale insulin. When asked if it should be documented anywhere in the clinical record that the physician was notified, LPN #2 stated, yes, it should be documented in a note. LPN #2 stated	{F 580}	weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: August 31, 2018	

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{F 580}	Continued From page 4 she was still new to documenting in the computer system and was still trying to figure out PCC (point click care). When asked if she could recall notifying the physician on 8/4/18 regarding Resident #103's blood sugar of 500, LPN #2 stated she did not notify the physician because she did not realize the order directed nursing staff to notify the physician. LPN #2 stated she only gave the 12 units of sliding scale insulin per order. LPN #2 confirmed that the physician order was not followed. On 8/8/18 at 2:51 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Clinical Transition Specialist, and ASM #4, the Regional Director of Operations was made aware of the above concerns. Facility policy titled, "Observations to Report to the Physician" did not address the above concerns. No further information was presented prior to exit. (1) Humalog (insulin lispro) is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from The National Insitutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c8ecbd7a-0e22-4fc7-a503-faa58c1b6f3f.	{F 580}		
{F 623} SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	{F 623}		8/31/18

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{F 623}	Continued From page 5	{F 623}		

Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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{F 623}	Continued From page 6 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility	{F 623}		

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{F 623} Continued From page 7
must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written notification to the responsible party (RP) for a facility initiated transfer for one of 15 residents in the survey sample, Resident #103.

The facility staff failed to provide written notification to Resident #103's RP documenting her reason for transfer to the hospital on 7/28/18.

The findings include:

Resident #103 was admitted to the facility on 7/29/18 with diagnoses that included but were not limited to head injury, difficulty swallowing, dementia without behavioral disturbance, type two diabetes and muscle weakness. Resident #103's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/13/18. Resident #103 was coded as being moderately impaired of cognitive function scoring 11 out of 15

{F 623}

Ftag 623

Resident # 103: No negative outcome has occurred from this practice. The resident has returned to the facility

All residents have the potential to be affected.

The DON or designee will educate licensed nursing staff on completing a transfer notice to ensure the resident representative is notified and given reason for the resident transfer in writing.

The DON or designee will audit the last 14 days of hospital transfers.

Nursing administration will monitor hospital transfers 5 times a week for 4 weeks for appropriate documentation and evidence that a notice of transfer has

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{F 623}	Continued From page 8	{F 623}		

on the BIMS (brief interview for mental status) exam.

Review of Resident #103's clinical record revealed that she went to the hospital on 7/28/18. The following note was documented at 3:30 p.m., "Loud noise from room 226. Guest noted lying on her left side beside B bed with rolling walker in front of her. Guest states, "I was trying to unlock the bed." Guest noted with increased confusion. RP (responsible party) notified of incident and transfer. Unable to reach on call MD (medical doctor) at this time. Will continue to call MD. Guest will be transported by (Name of Ambulance)."

The next note dated 7/28/18 at 6:57 p.m., documented the following: "Bed hold policy, care plan/goals, and copy of MARS/TARS sent with guest to ER (emergency room)."

There was no evidence in the clinical record that the responsible party received written notification of Resident #103's hospital transfer.

Further review of the clinical record revealed that Resident #103 returned to the facility on 7/28/18 with a diagnosis of a UTI (urinary tract infection).

On 8/8/18 at 12:00 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process staff follows when a resident is transferred to the hospital for an acute condition, LPN #1 stated that she would assess the patient, obtain vital signs, then notify the MD (medical doctor) and RP (responsible party). LPN #1 stated that she would then call the rescue squad and send the transfer sheet, face sheet, and the bed hold policy. When asked how

been given. Checking hospital transfers will remain a process of the clinical meeting. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee.

Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.

Completion Date:
August 31, 2018

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{F 623}	Continued From page 9	{F 623}		

the RP was notified, LPN #1 stated that RP was notified verbally. LPN #1 stated that she does not send written notification to the RP.

On 8/8/18 at 1:07 p.m., an interview was conducted with LPN #7, the unit manager. LPN #7 stated that social services was responsible for providing written notification to the responsible party for a hospital transfer.

On 8/8/18 at 1:25 p.m., an interview was conducted with OSM (other staff member) #2, the director of social services. When asked her role when a resident is transferred to the hospital, OSM #2 stated that she does not have a role during a transfer to the hospital. OSM #2 stated that nursing was responsible notifying the responsible party.

On 8/8/18 at 1:41 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that nursing was responsible for sending a written notification form with the resident to the RP at the time of transfer, and then medical records was responsible for mailing out a written notification sheet to the RP.

On 8/8/18 at 1:47 p.m., an interview was conducted with OSM #4, medical records. OSM #4 stated that when a resident is transferred to the hospital, she will review the resident's chart and then mail out a transfer notification sheet explaining why the resident was sent out. OSM #4 stated that she will send the notification within a reasonable timeframe. OSM #4 stated she kept copies of the documents that are sent to the RP. OSM #4 was asked to provide the transfer notification sheet for Resident #103.

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{F 623}	Continued From page 10 On 8/8/18 at 1:51 p.m., OSM #4 stated that she could not find a notification sheet for Resident #103. On 8/8/18 at 2:51 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Clinical Transition Specialist, and ASM #4, the Regional Director of Operations was made aware of the above concerns. A policy could not be provided regarding the above concerns.	{F 623}		
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	{F 656}		8/31/18

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recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for two of 15 residents in the survey sample, Resident #103, 106, and 108.

1. The facility staff failed to follow Resident #103's care plan and notify the physician of an abnormal blood sugar.

2. The facility staff failed to provide care to the suprapubic catheter per the comprehensive care plan for Resident #106.

The findings include:

1. Resident #103 was admitted to the facility on 7/29/18 with diagnoses that included but were not limited to head injury, difficulty swallowing,

{F 656}

Ftag 656

Resident#103: No negative outcome resulted from this practice. The physician has been notified of the elevated blood sugar reading

Resident # 106: No negative outcome resulted from this practice. The catheter care schedule has been adjusted to the resident□s preference.

Diabetic residents and residents with catheters have the potential to be affected

DON or designee will educate licensed nursing staff on notifying the physician of abnormal blood sugar readings and providing catheter care per the resident comprehensive care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 12 dementia without behavioral disturbance, type two diabetes and muscle weakness. Resident #103's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/13/18. Resident #103 was coded as being moderately impaired in cognitive function scoring 11 out of 15 on the BIMS (brief interview for mental status) exam. Resident #103 was coded as requiring supervision only with ADLS (activities of daily living). Review of Resident #103's August 2018 physician order summary documented the following orders: "Accu check before breakfast, lunch, dinner at bedtime. before meals and at bedtime. Notify MD (medical doctor) of BS <70 or >400. Humalog Solution (1) 100 UNIT/ML Inject per sliding scale: If 150-200= 2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; 401 -500= 12 units Call MD is (sic) BS over 400, subcutaneously before meals and at bedtime for diabetes." Review of Resident #103's August 2018 MAR (Medication Administration Record) revealed that on 8/4/18 at 11:30 a.m., Resident #103's blood sugar was 500. Further review of the MAR revealed that Resident #103 received 12 units of Humalog per order. There was no evidence that the physician was made aware her blood sugar reading on 8/4/18. Review of the August 2018 nursing notes failed to evidence that the physician was made aware that her blood sugar was 500 on 8/4/18. Resident #103's Blood Sugar care plan dated	{F 656}	The DON or designee will audit: 1. Residents with blood sugar parameters 2. Residents catheters. Nursing administration will monitor 1. Residents with blood sugar parameters 5 times a week for 4 weeks. 2. Monitor new orders for catheters and treatment record according to the orders and care plan. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: August 31, 2018	

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12/20/17, documented the following: "At risk for fluctuation in blood sugars related to Diabetes. Guest will be free from signs of complications from fluctuation blood sugars such as mental status changes, tremors/shakiness, dizziness, weakness, appetite loss thru next review date. Interventions: "Administer medications per orders. Observe for ineffectiveness and side effects. Report findings to physician. Observe and document s/sx (signs/symptoms) of complications from fluctuating blood sugar. Report abnormal findings to physician."

On 8/8/18 at 11:54 a.m., an interview was conducted with LPN (licensed practical nurse) #2, the nurse who worked with Resident #103 on 8/4/18. When asked what the above order meant, LPN #2 stated that if the blood sugar was higher than 400, then the medical doctor should be notified before giving the 12 units of sliding scale insulin. When asked if it should be documented anywhere in the clinical record that the physician was notified, LPN #2 stated, yes, it should be documented in a note. LPN #2 stated she was still new to documenting in the computer system and was still trying to figure out PCC (point click care). When asked if she could recall notifying the physician on 8/4/18 regarding Resident #103's blood sugar of 500, LPN #2 stated she did not notify the physician because she did not realize the order directed nursing staff to notify the physician. LPN #2 stated she only gave the 12 units of sliding scale insulin per order. LPN #2 confirmed the order was not followed. When asked the purpose of the care plan, LPN #2 stated the care plan served as a guide of care for nurses to follow for each resident. LPN #2 stated that all nurses had access to the care plan. When asked if the care

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plan should be followed, LPN #2 that it should. When asked some reasons why the care plan would not be followed, LPN #2 stated that if the nurse was not paying attention to the care plan. When asked if Resident #103's care plan was followed if the physician was not notified of an abnormal blood sugar per order, LPN #2 confirmed that Resident #103's care plan was not followed.

On 8/8/18 at 2:51 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Clinical Transition Specialist, and ASM #4, the Regional Director of Operations was made aware of the above concerns.

ASM #3 stated that the facility did not have a policy on care plans.

No further information was presented prior to exit.

According to Potter and Perry's, Fundamentals of Nursing, 7th Edition, page 269 states "A written care plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of care by listing specific nursing interventions needed to achieve the goals of care. The complete care plan is the blueprint for nursing action. It provides direction for implementation of the plan plus the framework for evaluation of the client's response to nursing actions."

(1) Humalog (insulin lispro) is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from The National Institutes of Health.

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https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c8ecbd7a-0e22-4fc7-a503-faa58c1b6f3f
.
2. The facility staff failed to provide care to the suprapubic catheter per the comprehensive care plan for Resident #106.

Resident #106 was admitted to the facility on 2/2/01 and readmitted on 9/24/12 with diagnoses that included but were not limited to: multiple sclerosis (1), inability to urinate, high blood pressure and arthritis.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/28/18 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living except for eating which the resident could perform independently.

Review of the resident's care plan initiated on 2/9/18 documented, "Need UTI (urinary tract infection): At risk for Urinary Tract Infection R/T (related to) S/P (suprapubic) [2] indwelling catheter due to neurogenic (3) bladder R/T MS (multiple sclerosis), hx (history) UTI, limited mobility. Interventions. S/P (status/post) cath (catheter) care daily and as needed per MD (medical doctor) orders."

Review of the August 2018 physician orders documented, "Cleanse around suprapubic site with normal saline apply bacitracin every evening and night shift for suprapubic catheter care. Start Date. 09/20/2017. Suprapubic Cath Care every

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shift for maintenance. Start Date. 05/09/2018. Change dressing around suprapubic catheter, use bacitracin (4) around site every evening and night shift for maintenance Start Date. 07/05/2018."

Review of the August 2018 treatment administration record documented, "Cleanse around suprapubic site with normal saline apply bacitracin every evening and night shift for suprapubic catheter care. Start Date. 09/20/2017. Suprapubic Cath (catheter) Care every shift for maintenance. Start Date. 05/09/2018. Change dressing around suprapubic catheter, use bacitracin (4) around site every evening and night shift for maintenance Start Date. 07/05/2018." Each order was documented as being administered.

An interview was conducted on 8/8/18 at 12:55 p.m. with RN (registered nurse) #1, the unit manager. When asked why residents had care plans, RN #1 stated, "So we can refer to them as to how to direct their care and if we have someone (staff member) who is new it gives them a snap shot of what's going on with that resident. When asked who used the care plan, RN #1 stated, "The staff. The nurses, the nursing assistants, the doctors." When asked if the care plans were to be followed, RN #1 stated, "Yes."

An interview was conducted on 8/8/18 at 1:45 p.m. with LPN (licensed practical nurse) #3, the resident's nurse. When asked which suprapubic catheter order the staff followed, LPN #3 stated, "It gets done in the evening and I think on nights." When asked if the care was provided as ordered on the day shift, LPN #3 stated, "No. He refuses it." When asked why it was documented as being

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done on the day shift, LPN #3 stated, "I should have put refused and called the doctor." When asked if the care plan was being followed, LPN #3 stated it was not.

An interview was conducted on 8/8/18 at 2:35 p.m. with LPN #7, a unit manager. When asked what was included in catheter care, LPN #7 stated, "Cath [catheter] care means we wipe around the site."

On 8/8/18 at 2:50 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical transition specialist and ASM #4, the regional director of clinical operations were made aware of the findings. A request for the facility's policy on care plans was requested of ASM #1 at that time.

On 8/8/18 at 4:20 p.m., ASM #3 returned with a note that the care plans were done per the RAI (resident assessment instrument) manual.

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)

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(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

1. Multiple sclerosis -- Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from: https://medlineplus.gov/multiplesclerosis.html

2. Suprapubic catheter -- A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. This information was obtained from: wwwqa.nlm.nih.gov/medlineplus/275/ency/patientinstructions/000145.htm

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{F 656}	Continued From page 19 3. Neurogenic bladder -- Neurogenic bladder is a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from: wwwqa.nlm.nih.gov/medlineplus/275/ency/article/000754.htm 4. Bacitracin -- The antibiotic, Bacitracin, exerts a profound action against many gram-positive pathogens, including the common Streptococci and Staphlococci. It is also destructive for certain gram-negative organisms. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=6ed2f2bd-9d2f-46af-a44c-95a02ca034de	{F 656}		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		8/31/18

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F 657	Continued From page 20 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, it was determined that facility staff failed to review and revise the care plan for one of 15 residents in the survey sample, Resident #105. The facility staff failed to revise Resident #105's comprehensive care plan when her sectional plate was no longer needed for meals. The findings include: Resident #105 was admitted to the facility on 11/23/13 and readmitted on 4/8/18 with diagnoses that included but were not limited to hydrocephalus (1), unspecified convulsions, high blood pressure, congenital spondylolisthesis (2), stroke, and disorder of the bone. Resident #105's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 7/7/18. Resident #105 was coded as being moderately impaired in cognitive function scoring 11 out of 15 on the BIMS (brief interview for mental status) exam. Resident #105 was coded as requiring extensive assistance from one staff member with bed mobility, locomotion, dressing, and personal hygiene; total dependence on two staff members with transfers, and limited	F 657	Ftag 657 Resident #105- No negative outcome occurred as a result of this practice Resident was assessed by therapy during the survey. She was assessed at no longer requiring the section plate. The care plan has been revised to reflect this change. All residents have the potential to be affected by this practice The DON or designee will educate licensed staff on revising the care plan and following the plan of care for adaptive equipment needed with meals. The DON or designee will audit care plans for current residents that require adaptive equipment for meals. The DON or designee will monitor care plans for new orders for adaptive equipment 5 times a week for 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee.	

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F 657	Continued From page 21 assistance with one staff member for meals. Resident #105's nutritional care plan dated 3/1/18 and revised on 7/30/18, documented the following: "At nutritional and/or dehydration risk R/T (related to) hx (history) CVA (cerebral vascular accident (stroke), HTN (hypertension (high blood pressure), GERD (Gastrointestinal Reflux disease), obesity, and depression. Requires therapeutic diet...Interventions: Sectional plate with meals." This intervention was initiated on 4/17/18. On 8/7/18 at 5:45 p.m., an observation was made of Resident #105. Resident #105 was sitting up in bed eating dinner. She had a sandwich and peas on the same plate. Resident #105 did not have a sectional plate. Her meal ticket documented "Adaptive Equipment: Sectional Plate." Resident #105 was feeding herself her meal. Resident #5 did not appear to have any difficulties eating her meal. On 8/8/18 at 8:53 a.m., an observation was made of Resident #105. Resident #105 was sitting up eating breakfast. Resident #105 had eggs and toast on the same plate. Resident #105 did not have a sectional plate. Her meal ticket documented "Adaptive Equipment: Sectional Plate." Resident #105 was feeding herself her meal. Resident #5 did not appear to have any difficulties eating her meal. Review of Resident #105's August 2018 POS (physician order summary) failed to evidence an order for a sectional plate. Review of her dietary orders failed to evidence an order for a sectional plate.	F 657	Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: August 31, 2018	

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Review of Resident #105's clinical record revealed that she was currently receiving occupational therapy. The occupational therapy notes failed to evidence any recommendations or orders for a sectional plate.

Further review of Resident #105's clinical record failed to evidence when the sectional plate was recommended and by what department.

On 8/8/18 at 12:42 p.m., an interview was conducted with OSM (other staff member) #1, the dietary manager. When asked if Resident #103 was supposed to have a sectional plate, OSM #1 stated that she was supposed to have a sectional plate because it was ordered on her meal ticket. OSM #1 stated a dietary order from nursing was required in order for the resident to get special adaptive equipment. When asked why Resident #103 needed a sectional plate, OSM #1 stated that he was not sure, that dietary was never told the reason why a resident needed certain adaptive items. When OSM #1 was informed of the observation made that morning, OSM #1 stated the a new guy was doing tray line that morning and must of missed the sectional plate. When OSM #1 was informed about the observations made the previous night, OSM #1 stated that he wasn't sure why it was missed.

On 8/8/18 at 1:07 p.m., an interview was conducted with LPN (licensed practical nurse) #7, the unit manager and the nurse who wrote the intervention for the sectional plate on Resident #103's care plan. When asked if Resident #103 was supposed to have a sectional plate for meals, LPN #7 stated that she did not know. When LPN #7 was shown Resident #103's care plan with the April 2018 intervention for a

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sectional plate, LPN #7 stated, "It must have come from somewhere." LPN #7 stated it may have been recommended by therapy. When asked the purpose of the care plan, LPN #7 stated that the purpose of the care plan was to communicate resident needs. LPN #7 stated that all direct care staff had access to the care plan. When asked if the care plan should be accurate, LPN #7 stated that it should be accurate.

On 8/8/18 at 1:37 p.m., an interview was conducted with OSM #3, the Director of Therapy. OSM #3 stated that the resident used a sectional plate back in 2016 but has not needed a sectional plate for some time. OSM #3 stated that OT (occupational therapy) recently evaluated Resident #103 in April for contractures, but that a sectional plate was not recommended. OSM #3 stated Resident #103 did not have difficulties eating her meals and just needed set up help for self feeding. OSM #3 stated the above intervention should not have been on her care plan.

On 8/8/18 at 2:51 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Clinical Transition Specialist, and ASM #4, the Regional Director of Operations was made aware of the above concerns.

ASM #3 stated that the facility did not have a policy on care plans. No further information was presented prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 24 members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1) Hydrocephalus is the buildup of too much cerebrospinal fluid in the brain. Normally, this fluid cushions your brain. When you have too much, though, it puts harmful pressure on your brain. Hydrocephalus can be congenital, or present at birth. Causes include genetic problems and problems with how the fetus develops. An unusually large head is the main sign of congenital hydrocephalus. Hydrocephalus can also happen after birth. This is called acquired hydrocephalus. It can occur at any age. Causes can include head injuries, strokes, infections, tumors, and bleeding in the brain. This information was obtained from The National Institutes of Health. https://medlineplus.gov/hydrocephalus.html. (2) Congenital spondylolisthesis is a condition in which one vertebrae slips forward on one another, may result from an accident, degenerative condition or in rare cases, may be present at birth (congenital). This information was obtainted from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024994/.	F 657		
{F 658} SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	{F 658}		8/31/18

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§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for two of 15 residents in the survey sample, Resident #106 and Resident #108.

1. The facility staff failed to clarify and accurately document the suprapubic care as ordered by the physician for Resident #106.

2. The facility staff failed to document the blood sugars as ordered by the physician for Resident #108.

The findings include:

1. Resident #106 was admitted to the facility on 2/2/01 and readmitted on 9/24/12 with diagnoses that included but were not limited to: multiple sclerosis (1), inability to urinate, high blood pressure and arthritis.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/28/18 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living except for eating which the resident could perform

{F 658}

Ftag 658

Resident #106: No negative outcome occurred from this practice. Catheter care orders have been clarified with the physician and is being provided to resident preference.

Resident# 108- No negative outcome occurred from this practice.

Diabetic residents with blood sugar orders and residents receiving catheter care have the potential to be affected.

The DON or designee will educate licensed nursing staff on accurate documentation of catheter care and blood sugar readings.

DON or designee will audit MARs of current diabetic residents with blood sugar orders and TARs of residents with catheter care orders for accurate documentation.

The DON or designee will monitor blood sugar documentation for diabetic residents with blood sugar orders 5 times a week for 4 weeks. Monitoring of new catheter orders and documentation of

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independently.

Review of the resident's care plan initiated on 2/9/18 documented, "Need UTI (urinary tract infection): At risk for Urinary Tract Infection R/T (related to) S/P (suprapubic) [2] indwelling catheter due to neurogenic (3) bladder R/T MS (multiple sclerosis), hx (history) UTI, limited mobility. Interventions. S/P (status/post) cath (catheter) care daily and as needed per MD (medical doctor) orders."

Review of the August 2018 physician orders documented, "Cleanse around suprapubic site with normal saline apply bacitracin every evening and night shift for suprapubic catheter care. Start Date. 09/20/2017. Suprapubic Cath (catheter) Care every shift for maintenance. Start Date. 05/09/2018. Change dressing around suprapubic catheter, use bacitracin (4) around site every evening and night shift for maintenance Start Date. 07/05/2018."

Review of the August 2018 treatment administration record documented, "Cleanse around suprapubic site with normal saline apply bacitracin every evening and night shift for suprapubic catheter care. Start Date. 09/20/2017. Suprapubic Cath Care every shift for maintenance. Start Date. 05/09/2018. Change dressing around suprapubic catheter, use bacitracin (4) around site every evening and night shift for maintenance Start Date. 07/05/2018." Each order was documented as being administered.

An interview was conducted on 8/8/18 at 1:45 p.m. with LPN (licensed practical nurse) #5, the resident's nurse. When asked which suprapubic

treatment provided will occur 5 times a week for 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee.

Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.

Completion Date:
August 31, 2018

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catheter order the staff followed, LPN #5 stated, "It gets done in the evening and I think on nights." When asked if the care was provided as ordered on the day shift, LPN #5 stated, "No. He refuses it." When asked why it was documented as being done on the day shift, LPN #5 stated, "I should have put refused and called the doctor." When asked why accurate documentation was important, LPN #5 stated, "To note it is being done or not done."

An interview was conducted on 8/8/18 at 2:05 p.m. with LPN #8. When asked to review the resident's orders for suprapubic catheter care, LPN #8 stated, "I would clarify that." When asked why, LPN #8 stated, "Because it kinda contradicts itself."

An interview was conducted on 8/8/18 at 2:35 p.m. with LPN #7, a unit manager. When asked to review the three different suprapubic catheter orders for Resident #106, LPN #7 stated, "I would clarify the order." When asked why documentation was done, LPN #7 stated, "There are many reasons. One is so we know that things are done. Communicate with the physicians or whoever else may need to know the information." When asked if it was acceptable for staff to document something as being done when it wasn't, LPN #7 stated, "Oh no, no, no."

On 8/8/18 at 2:50 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical transition specialist and ASM #4, the regional director of clinical operations were made aware of the findings. A request for the facility's policy on professional standard for accurate documentation and clarification of physician orders were

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requested from ASM #1 at that time.

On 8/8/18 at 4:20 p.m. ASM #3 returned and stated the facility used their policy and procedures as their profession standards.

Review of the facility's policy titled, "OBSERVATIONS TO REPORT TO THE PHYSICIAN" did not address clarification of orders. There was no policy for accurate documentation.

No further information was provided prior to exit.

According to Potter and Perry's, Fundamentals of Nursing, 7th edition, page 268 documents the following statements: "Clarifying an order is competent nursing practice, and it protects the client and members of the health care team. When you carry out an incorrect or inappropriate intervention, it is as much your error as the person who wrote or transcribed the original order."

The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." Potter and Perry (2005) also includes the following information: "As members of the health

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care team, nurses need to communicate information about clients accurately and in a timely, effective manner."

1. Multiple sclerosis -- Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from: https://medlineplus.gov/multiplesclerosis.html

2. Suprapubic catheter -- A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. This information was obtained from: wwwqa.nlm.nih.gov/medlineplus/275/ency/patientinstructions/000145.htm

3. Neurogenic bladder -- Neurogenic bladder is a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from: wwwqa.nlm.nih.gov/medlineplus/275/ency/article/000754.htm

4. Bacitracin -- The antibiotic, Bacitracin, exerts a profound action against many gram-positive pathogens, including the common Streptococci and Staphlococci. It is also destructive for certain gram-negative organisms. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=6ed2f2bd-9d2f-46af-a44c-95a02ca034de

2. The facility staff failed to document the blood

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sugars as ordered by the physician for Resident #108.

Resident #108 was admitted to the facility on 10/23/17 and readmitted on 4/9/18 with diagnoses that included but were not limited to: heart failure, diabetes, high blood pressure, lung disease and morbid obesity.

The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 7/17/18 coded the resident as having a BIMS (brief interview for mental status) of 13 out of 15 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the resident's care plan initiated on 11/3/17 and revised on 8/7/18 documented, "Need At risk for fluctuation (sic) blood sugars R/T (related to) Diabetes. Interventions Obtain labs (laboratory specimens)/diagnostics per physician orders, report abnormal finding to physician. Start Date 06/17/2018."

Review of the August 2018 physician orders documented, "Check BS (blood sugar) before meals and QHS (every night) notify MD (medical doctor) if over 400. Start Date 06/18/2018."

Review of the July 2018 medication administration record (MAR) documented, "Check BS (blood sugar) before meals and QHS (every night) notify MD if over 400." From 7/28/18 at 7:30 a.m. to 7/31/18 at 11:30 a.m. in the box labeled "BS" there was an "x". No blood sugars were documented.

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Review of the July 2018 blood sugar summary form did not evidence the blood sugar results for 7/28/18 at 7:30 a.m., 11:30 a.m. and bed time; 7/29/18 at 7:30 a.m. and bedtime and 7/30/18 at 7:30 a.m. and 11:30 a.m.

Review of the nurse's notes from 7/28/18 through 7/30/18 did not evidence documentation regarding the blood sugars.

An interview was conducted on 8/8/18 at 12:55 p.m. with RN (registered nurse) #1, a nurse who cared for the resident on 7/30/18. When asked to review the medication administration record for the resident's blood sugars, RN #1 stated, "I would have done it, I always do. There was no prompt (in the computer system) to have to document it." When asked why staff documented the blood sugars, RN #1 stated, "So we can prove that we did it. So we can go back in our records and see what's been done." When asked if complete documentation was considered a professional standard, RN #1 stated, yes.

An attempt to interview another nurse who did not document the blood sugars was unsuccessful.

On 8/8/18 at 2:50 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical transition specialist and ASM #4, the regional director of clinical operations were made aware of the findings. A request for the facility's policy on professional standard for accurate documentation was requested from ASM #1 at that time.

On 8/8/18 at 4:20 p.m., ASM #3 returned and stated the facility used their policy and

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{F 658}	Continued From page 32 procedures as their professional standards. No policy was provided regarding accurate documentation. No further information was provided prior to exit.	{F 658}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure residents received treatment and services in accordance with professional standards of practice and the comprehensive care plan for three of 15 residents in the survey sample, Resident #103 108, and 110. 1. The facility staff failed to notify the physician per physician's order when Resident #103's blood sugar was over 400 on 8/4/18. 2. The facility staff failed to document non-pharmacological interventions as ordered by the physician for Resident #108. 3. The facility staff failed to document non-pharmacological interventions as ordered by the physician for Resident #110.	{F 684}	Ftag 684 Resident # 103: No negative outcome occurred from this practice. The physician was notified of the elevated blood sugar reading. Resident #108: No negative outcome occurred from this practice Resident #110: No negative outcome occurred from this practice. All residents have the potential to be affected. The DON or designee will educate licensed nursing staff on notifying the physician of blood sugar readings per the	8/31/18

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The findings include:

1. Resident #103 was admitted to the facility on 7/29/18 with diagnoses that included but were not limited to head injury, difficulty swallowing, dementia without behavioral disturbance, type two diabetes and muscle weakness. Resident #103's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/13/18. Resident #103 was coded as being moderately impaired in cognitive function scoring 11 out of 15 on the BIMS (brief interview for mental status) exam. Resident #103 was coded as requiring supervision only with ADLS (activities of daily living).

Review of Resident #103's August 2018 physician order summary documented the following orders: "Accu check before breakfast, lunch, dinner at bedtime. before meals and at bedtime. Notify MD (medical doctor) of BS <70 or >400.

Humalog (1) Solution 100 UNIT/ML Inject per sliding scale: If 150-200= 2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; 401 -500= 12 units Call MD is (sic) BS over 400, subcutaneously before meals and at bedtime for diabetes."

Review of Resident #103's August 2018 MAR (Medication Administration Record) revealed that on 8/4/18 at 11:30 a.m., Resident #103's blood sugar was 500. Further review of the MAR revealed that Resident #103 received 12 units of Humalog per order. There was no evidence that the physician was made aware her blood sugar reading on 8/4/18.

{F 684}

physician□s orders and documentation of non-pharmacological interventions prior to administering pain medication.

The DON or designee will audit MAR□s for current diabetic residents with blood sugar parameters for compliance with physician notification. The DON or designee will audit MARs for current residents with PRN pain medication to ensure there is an order for non-pharmacological interventions to be attempted prior to the administration of pain medication.

Nursing administration will monitor blood sugar orders 5 times a week for 4 weeks for appropriate physician notification. Nursing administration will monitor documentation of non-pharmacological interventions as ordered 5 times a week for 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee.

Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.

Completion date:
August 31, 2018

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Review of the August 2018 nursing notes failed to evidence that the physician was made aware that her blood sugar was 500 on 8/4/18.

Resident #103's Blood Sugar care plan dated 12/20/17, documented the following: "At risk for fluctuation in blood sugars related to Diabetes. Guest will be free from signs of complications from fluctuation blood sugars such as mental status changes, tremors/shakiness, dizziness, weakness, appetite loss thru next review date. Interventions: "Administer medications per orders. Observe for ineffectiveness and side effects. Report findings to physician. Observe and document s/sx (signs/symptoms) of complications from fluctuating blood sugar. Report abnormal findings to physician."

On 8/8/18 at 11:54 a.m., an interview was conducted with LPN (licensed practical nurse) #2, the nurse who worked with Resident #103 on 8/4/18. When asked what the above order meant, LPN #2 stated that if the blood sugar was higher than 400, then the medical doctor should be notified before giving the 12 units of sliding scale insulin. When asked if it should be documented anywhere in the clinical record that the physician was notified, LPN #2 stated, yes, it should be documented in a note. LPN #2 stated she was still new to documenting in the computer system and was still trying to figure out PCC (point click care). When asked if she could recall notifying the physician on 8/4/18 regarding Resident #103's blood sugar of 500, LPN #2 stated she did not notify the physician because she did not realize the order directed nursing staff to notify the physician. LPN #2 stated she only gave the 12 units of sliding scale insulin per

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order. LPN #2 confirmed that the order was not followed.

On 8/8/18 at 2:51 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Clinical Transition Specialist, and ASM #4, the Regional Director of Operations was made aware of the above concerns.

ASM #3 stated that the facility did not have a policy regarding following physician's orders.

No further information was presented prior to exit.

(1) Humalog (insulin lispro) is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c8ecbd7a-0e22-4fc7-a503-faa58c1b6f3f.

2. The facility staff failed to document the non-pharmacological interventions as ordered by the physician for Resident #108.

Resident #108 was admitted to the facility on 10/23/17 and readmitted on 4/9/18 with diagnoses that included but were not limited to: heart failure, diabetes, high blood pressure, lung disease and morbid obesity.

The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 7/17/18 coded the resident as having a BIMS (brief interview for

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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mental status) of 13 out of 15 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the comprehensive care plan initiated on 10/23/17 documented, "Pain risk." There was no specific interventions regarding documentation of non-pharmacological interventions.

Review of the August 2018 physician's orders documented, "Document non-pharmacological interventions prior to administering PRN (as needed) medication for pain. Start Date - 07/24/2018. Morphine Sulfate (1) Solution 20 MG/ML (milligram per milliliter) Give 0.25 ml by mouth every 4 hours as needed for Pain..."

Review of the July 2018 and August 2018 medication administration records documented, "Document non-pharmacological interventions prior to administering PRN (as needed) medication for pain. Start Date - 07/24/2018. Morphine Sulfate (1) Solution 20 MG/ML (milligram per milliliter) Give 0.25 ml by mouth every 4 hours as needed for Pain..." On 7/28/18 at 11:13 p.m., 7/30/18 at 10:05 p.m. and 8/5/18 at 12:44 a.m. it was documented the the resident received the morphine. There was no documented evidence that the resident had non-pharmacological interventions prior to receiving the morphine.

Review of the nurse's notes from 7/28/18 through 8/5/18 did not evidence documentation regarding non-pharmacological interventions.

An interview was conducted on 8/8/18 at 12:55

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p.m. with RN (registered nurse) #1, the unit manager. When asked about the process staff follows when a resident complained of pain, RN #1 stated, "The staff should offer some repositioning, some non-medical treatment and ask them to rate their pain." When asked if this would be documented, RN #1 stated, "Yes. They would document it on the MAR (medication administration record)." When asked to review Resident #108's July and August MAR for the non-pharmacological documentation, RN #1 stated, there was nothing there. When asked if there should be documentation as ordered by the physician, RN #1 stated there should be.

An interview was conducted on 8/8/18 at 1:35 p.m. with LPN (licensed practical nurse) #3. When asked about the process staff follows when a resident complained of pain, LPN #3 stated, "I ask them if it's (the pain) between one to ten and they tell you. Like say it's (the pain) is in their shoulder you may offer a warm compress or massage it to see if it would help first (prior to giving pain medication)." When asked if this would be documented, LPN #3 stated, "Yes. It's supposed to be."

On 8/8/18 at 2:50 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical transition specialist and ASM #4, the regional director of clinical operations were made aware of the findings. A request for the facility's policy on complete and accurate clinical records was requested at from ASM #1 at that time.

Review of the facility's policy titled, "PAIN MANAGEMENT RECORD" documented, "Policy: The Pain Management Record will be used by

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nursing staff to document the effectiveness of medication and/or non-pharmacy interventions for guests experiencing acute pain or exacerbation of chronic pain. Purpose: The Pain Management Record will be used to assess the effectiveness of the current pain regimen, and to revise the plan as needed to achieve pain control. Procedure: 10 If other non-pharmacy interventions are implemented, the intervention is documented in the Non-Pharmacy column."

No further information was obtained prior to exit.

1. Morphine Sulfate -- Morphine is considered the "gold standard" for relieving pain and is currently one of the most effective drugs available clinically for the management. This information was obtained from: www.ncbi.nlm.nih.gov/pmc/articles/PMC3158334/

3. The facility staff failed to document the non-pharmacological interventions as ordered by the physician for Resident #110.

Resident #110 was admitted to the facility on 12/21/17 with diagnoses that included but were not limited to: pain, falls, diabetes, irregular heartbeat and dementia.

The resident's most recent MDS, a significant change assessment, with an ARD of 7/7/18 coded the resident as having a six out of 15 on the BIMS indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the comprehensive care plan initiated on 12/21/17 documented, "Potential for pain d/t

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(due to) dx (diagnosis) of...diabetes..." There was no specific intervention regarding documenting the non-pharmacological interventions.

Review of the August 2018 physician's orders documented, "Document non-pharmacological interventions prior to administering PRN (as needed) medication for pain. Tylenol Tablet 325 MG (milligrams) Give 2 tablet (sic) by mouth every 6 hours as needed for pain."

Review of the August 2018 MAR (medication administration record) documented, "Document non-pharmacological interventions prior to administering PRN medication for pain. Tylenol Tablet 325 MG (milligrams) Give 2 tablet (sic) by mouth every 6 hours as needed for pain." On 8/1/18 at 2:18 p.m., it was documented that the Tylenol was given. There was was no documented evidence that a non-pharmacological intervention was attempted.

Review of the 8/1/18 nurse's notes did not evidence documentation regarding non-pharmacological interventions.

An interview was conducted on 8/8/18 at 12:55 p.m. with RN (registered nurse) #1, the unit manager. When asked about the process staff follows when a resident complained of pain, RN #1 stated, "The staff should offer some repositioning, some non-medical treatment and ask them to rate their pain." When asked if that would be documented, RN #1 stated, "Yes. They would document it on the MAR (medication administration record)." When asked to review Resident #108's July and August MAR for the non-pharmacological documentation, RN #1

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stated, there was nothing there. When asked if there should be documentation as ordered by the physician, RN #1 stated there should be.

An interview was conducted on 8/8/18 at 1:35 p.m. with LPN (licensed practical nurse) #3, the nurse who administered the Tylenol. When asked about the process staff follows when a resident complained of pain, LPN #3 stated, "I ask them if it's (the pain) between one to ten and they tell you. Like say it's (the pain) is in their shoulder you may offer a warm compress or massage it to see if it would help first (prior to giving pain medication)." When asked if this would be documented, LPN #3 stated, "Yes. It's supposed to be." When asked to review the resident's MAR, LPN #3 stated she did attempt non-pharmacological interventions, but must not have documented them. When asked if the physician ordered the interventions to be documented, should they be, LPN #3 stated they should.

On 8/8/18 at 2:50 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical transition specialist and ASM #4, the regional director of clinical operations were made aware of the findings.

No further information was provided prior to exit.

{F 695} SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	{F 695}		8/31/18

§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy

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{F 695}	Continued From page 41 care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide respiratory treatment and services for two of 15 residents in the survey sample, Resident #101 and #114. 1 a. The facility staff failed to check oxygen saturation levels and wean the oxygen as ordered by the physician for Resident #101. 1 b. The facility staff failed to store the oxygen tubing in a sanitary manner for Resident #101. 1 c. The facility staff failed to administer the oxygen at the rate ordered by the physician for Resident #101. 2. The facility staff failed to store oxygen tubing in a sanitary manner for Resident #114. The findings include: 1 a. Resident #101 was admitted to the facility on 7/8/18 with diagnoses that included but were not limited to: fractured pelvis, high blood pressure, dementia and arthritis. The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 7/22/16 coded the resident as having scored a three out of 15 on the BIMS	{F 695}	Ftag 695 Resident #101- No negative outcome occurred from this practice The physician had discontinued the order for oxygen. The oxygen tubing was replaced and properly stored. Resident #114: No longer resides in the facility, however during the survey process the tubing was replaced and properly stored. Residents receiving oxygen treatments have the potential to be affected. The DON or designee will educate licensed nursing staff on following oxygen orders including checking saturation levels and verifying oxygen settings. DON or designee will educate licensed nursing staff on storage of oxygen tubing in a sanitary manner. The DON or designee will audit current residents with oxygen orders. Room rounds will be completed to ensure oxygen is at the correct settings and oxygen tubing is stored properly. Nursing administration will conduct rounds 5 times a week for four weeks for oxygen	

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(brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was set up. The resident was coded as receiving oxygen therapy.

Review of the resident's comprehensive care plan initiated on 7/19/18 did not address the resident's oxygen order.

An observation was made on 8/8/18 at 8:47 a.m. of Resident #101. The resident was sitting in the wheelchair. The oxygen tubing was lying on the bed. The flow rate of the oxygen concentrator was set at 2 and 3/4 liters per minute.

An observation was made on 8/8/18 at 10:10 a.m. of Resident #101. The resident was sitting in the wheelchair. The resident was receiving oxygen via a nasal cannula (soft plastic prongs that fit in the nose to deliver oxygen) connected to the oxygen concentrator. The oxygen flow rate on the oxygen concentrator was set at 2 and 3/4 liters per minute.

Review of the August 2018 physician orders documented, "Please wean oxygen as toleratead (sic), o2 (oxygen) sats (saturations) > (greater than) 92%. Start Date - 08/01/2018."

Review of the August 2018 treatment administration record (TAR) documented, "Please check oxygen sats (saturations) TID (three times a day), PRN (as needed) and with activity, Three times a day for wean (sic) oxygen for 5 days." The boxes for 8/1/18 at 4:00 p.m., 8:00 p.m. and 8/2/18 at 8:00 a.m. were blank. From 8/2/18 at

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settings and the storage of respiratory equipment. MARs will be monitored 5 times a week for 4 weeks for oxygen saturation documentation as ordered. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee.

Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.

Completion Date:
August 31, 20

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4:00 p.m. through 8/6/18 at 6:00 a.m., there were nurses' initials in the boxes but no saturation result.

Review of the August 2018 oxygen saturation summary record failed to evidence that the oxygen saturation level was obtained on 8/1/18 at 4:00 p.m., 8:00 p.m.; 8/2/18 at 8:00 a.m., 8:00 p.m.; 8/3/18 at 4:00 p.m. and 8:00 p.m.; 8/5/18 at 4 p.m. and 8:00 p.m., 8/6/18 at 4:00 p.m. and 8:00 p.m. and 8/7/18 at 4:00 p.m. and 8:00 p.m. Further review of the summary record documented: "08/01/2018 10:23 (a.m.) 97 % (oxygen saturation level) (Oxygen via Nasal Cannula); 08/04/2018 10:48 (a.m.) 93 % (Oxygen via Nasal Cannula); 08/06/2018 09:44 (a.m.) 99 % (Oxygen via Nasal Cannula); 08/08/2018 09:59 (a.m.) 93 % (Oxygen via nasal Cannula)."

Review of the nurses' notes for Resident #101, did not evidence documentation regarding the oxygen saturations.

An interview was conducted on 8/8/18 at 1:35 p.m. of LPN (licensed practical nurse) #3, the resident's nurse. When asked about the process staff follows when a resident has oxygen, LPN #3 stated, "We check the oxygen rate when we see the patient." When asked how much oxygen was ordered for Resident #101, LPN #3 stated, "Two liters." When asked when she checked the oxygen saturation for Resident #101, LPN #3 stated, "I checked it this morning." When asked if the resident had oxygen on, LPN #3 stated, "Yes she did." When asked to review the resident's order for weaning the oxygen, LPN #3 stated, "This is my first day with her. We are weaning the oxygen. Anything 92 or below we put her on it (oxygen)." When asked to review this morning's

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{F 695}	Continued From page 44 oxygen saturation, LPN #3 stated, "It was 93." When asked if the resident was supposed to be wearing oxygen if the saturation was 93 %, LPN #3 stated, "I took it off her when I got the saturation." When the observation at 10:10 a.m. was shared with LPN #3, LPN #3 stated, "I must have gone back in and taken it off later." LPN #3 was asked to review the oxygen saturation summary form. When asked if the documentation that the nasal cannula was on meant the resident was wearing oxygen, LPN #3 stated yes it did. When asked if the resident was supposed to have the oxygen on, LPN #3 stated she was not. An interview was conducted on 8/8/18 at 2:04 p.m. with LPN #8. LPN #8 was asked to review the August 2018 treatment administration record for the oxygen saturations. When asked what the blank boxes meant, LPN #8 stated, "It's not documented, it's not done." When asked if the staff had followed the physician's order, LPN #8 stated they were not. LPN #8 was asked to review the resident's order to wean off the oxygen and the oxygen summary form. When asked if the staff were following the physician's order to wean off the oxygen, LPN #8 stated, "No. They are greater than 92 (percent)." A telephone interview was conducted on 8/8/18 at 2:12 p.m. with LPN #9, the resident's nurse. When asked if the documentation that the oxygen was on when the saturation was checked was correct, LPN #9 stated, "Yes or I would have put room air." When asked about the resident's order to wean off the oxygen, LPN #9 stated, "I would have to look that up." When asked if she knew the resident was to be weaned off the oxygen, LPN #9 did not have a response.	{F 695}		

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On 8/8/18 at 2:50 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical transition specialist and ASM #4, the regional director of clinical operations were made aware of the findings. A request for the facility's policy on oxygen therapy was made to ASM #1 at that time. No policy was received.

No further information was obtained prior to exit.

1 b. The facility staff failed to store the oxygen tubing in a sanitary manner for Resident #101.

An observation was made on 8/7/18 at 12:55 p.m. of Resident #101's room. The resident was not in the room, the nasal cannula was draped over the oxygen concentrator. There was no plastic bag observed.

An observation was made on 8/7/18 at 5:14 p.m. of Resident #101. The resident was up in the wheelchair. The nasal cannula was draped over the oxygen concentrator. There was an oxygen tank on the back of the resident's wheelchair; the nasal cannula was folded up next to the tank. The cannula was uncovered.

An observation was made on 8/8/18 at 8:47 a.m. of Resident #101. The resident was up in the wheelchair. The nasal cannula was lying across the bed uncovered. The nasal cannula was attached to the oxygen tank on the wheelchair and remained uncovered.

An observation was made on 8/8/18 at 10:10 a.m. of Resident #101 was sitting in the wheelchair. The resident was wearing the oxygen via nasal cannula connected to the oxygen concentrator.

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The nasal cannula attached to the oxygen tank on the wheelchair remained uncovered.

An observation was made on 8/8/18 at 12:48 p.m. of Resident #101 with LPN #3, the resident's nurse. The resident was not in the room. The nasal cannula was lying on the floor. LPN #3 left the room without picking the nasal cannula up off the floor.

An interview was conducted on 8/8/18 at 12:55 p.m. with RN (registered nurse) #1, a unit manager. When asked how the nasal cannula was to be stored when not in use, LPN #3 stated, "In a bag." When asked why, RN #1 stated, "So it doesn't get dirty. Keeps it cleaner." When asked what staff would do if the nasal cannula was on the floor, RN #1 stated, "You need to change it."

An interview was conducted on 8/8/18 at 1:35 p.m. with LPN #3. When asked how the nasal cannula was to be stored when not in use, LPN #3 stated, "We have to put the tubing in a little baggie." When asked how the nasal cannula on the oxygen tank was to be stored, LPN #3 stated, "It's supposed to be in a little baggie too." When asked where the resident's oxygen was during the observation at 12:48 p.m., LPN #3 stated, "I think it was on the bed." When informed it was observed on the floor, LPN #3 stated, "I'll get rid of it."

On 8/8/18 at 2:50 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical transition specialist and ASM #4, the regional director of clinical operations were made aware of the findings.

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No further information was obtained prior to exit.

1 c. The facility staff failed to administer the oxygen at the rate ordered by the physician for Resident #101.

An observation was made on 8/8/18 at 10:10 a.m. of Resident #101. The resident was sitting in the wheelchair. The resident was receiving oxygen via a nasal cannula (soft plastic prongs that fit in the nose to deliver oxygen) connected to the oxygen concentrator. The oxygen flow rate on the oxygen concentrator was set at 2 and 3/4 liters per minute.

An observation was made on 8/8/18 at 12:48 p.m. of Resident #101 with LPN #3. The resident was not in the room, the oxygen concentrator was on. When asked what rate of oxygen Resident #101 was prescribed, LPN #3 stated, "Two." When asked what the oxygen was set at, LPN #3 stated, "It's two and a half." LPN #3 immediately adjusted the flow rate to two liters.

Review of the August 2018 physician orders documented, "Oxygen at 2 lpm (two liters per minute) via nasal canula (sic) continuously every shift for sob (shortness of breath) Start Date - 07/08/2018. D/C (discontinue) Date - 08/01/2018. Please wean oxygen as toleratead (sic), o2 (oxygen) sats (saturations) > (greater than) 92%. Start Date - 08/01/2018."

Review of the August 2018 treatment administration record documented, "Please check oxygen sats (saturations) TID (three times a day), PRN (as needed) and with activity, Three times a day for wean (sic) oxygen for 5 days."

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 695}	Continued From page 48	{F 695}		

An interview was conducted on 8/8/18 at 12:55 p.m. with RN #1, a unit manager. When asked how often staff check the oxygen flow rate, RN #1 stated, "I would think they would check it every time they go in there."

An interview was conducted on 8/8/18 at 1:35 p.m., with LPN #3. When asked how often staff checked the oxygen flow rate on the concentrators, LPN #3 stated, "We usually check it once a shift." When asked if she had checked Resident #101's oxygen rate that day, LPN #3 did not have a response.

An interview was conducted on 8/8/18 at 2:35 p.m., with LPN #7, a unit manager. When asked to review the physician's orders for Resident #101's oxygen and the weaning of the oxygen, LPN #7 stated, "I would clarify the order because I don't know what oxygen level they were on." When asked how staff checked the oxygen flow rate, LPN #7 stated, "You check it at eye level and the ball should be in the middle of the line."

On 8/8/18 at 2:50 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical transition specialist and ASM #4, the regional director of clinical operations were made aware of the findings. A request for the manufacturer's operating instructions and facility policy for oxygen was made at that time to ASM #1.

Review of the facility's policy titled, "Oxygen Concentrators" documented, Policy: The oxygen concentrator will be used in the place of an oxygen cylinder (in non-emergency situations). Procedure: 2. Turn concentrator on and adjust liter flow (to that ordered by the physician)...The

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black liter flow ball on the gauge should be positioned in the middle of the number line (2.0, 2.5, 3.0 3.5) prescribed by the physician. 3. Liter Flow should be checked by being (sic) eye level with flow meter."

No further information was provided prior to exit.
2. The facility staff failed to store oxygen tubing in a sanitary manner for Resident #114.

Resident #114 was admitted to the facility on 6/25/18 with diagnoses that included but were not limited to unspecified fracture of the left tibia, vitamin D deficiency, respiratory failure, high blood pressure, and BPH (benign prostatic hyperplasia) (enlarged prostate). Resident #114's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 7/9/18. Resident #114 as coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (brief interview for mental Status) exam. Resident #114 was coded in Section 0 (Special treatments, procedures and programs) as receiving respiratory services.

Review of Resident #114's August 2018 POS (physician order summary) revealed the following order: "Oxygen 2 L (liters) via nasal cannula continuous every shift. Keep 02 sats (saturation) above 90 % (percent)."

On 8/8/18 at 10:35 a.m., an observation was made of Resident #114's oxygen. He was not in his room. His oxygen tubing that was hooked to his oxygen concentrator was found on the floor. The oxygen tubing was dated "8/14/18" as the date to be changed next.

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On 8/8/18 at 10:49 a.m., CNA (certified nursing assistant) #1, was observed in Resident #114's room. CNA #1 was observed making Resident #114's bed. CNA #1 was then observed picking the oxygen tubing up off the floor. CNA #1 then rolled up the oxygen tubing and placed it in the plastic bag that was hanging from the oxygen concentrator.

On 8/8/18 at 12:20 p.m., an interview was conducted with CNA #1. When asked how oxygen tubing should be stored when not in use, CNA #1 stated that oxygen tubing should be stored in a plastic bag. When asked why tubing should be stored in a plastic bag, CNA #1 stated to prevent contamination of germs. When asked what she would do if she were to find oxygen tubing on the floor, CNA #1 stated that she would throw it away and get a new one from the nurse. When asked if it was ever okay to place oxygen tubing that was found on the floor, back in the plastic bag, CNA #1 stated that the tubing should not be placed back in the plastic bag. When asked if she placed Resident #114's oxygen tubing back in the plastic bag after it was found on the floor, CNA #1 stated that she did not place it in the plastic bag. When CNA #1 was informed of the above observations made at 10:49 a.m., CNA #1 stated. "So I have to throw it away?" CNA #1 stated she could not recollect placing Resident #114's oxygen tubing back in the plastic bag after it was found on the floor.

On 8/8/18 at 1:13 p.m., an interview was conducted with RN (registered nurse) #1, a unit manager. When asked how oxygen tubing should be stored when not in use, RN #1 stated that oxygen tubing should be stored in a plastic bag,

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{F 695}	Continued From page 51 to prevent contamination. When asked what should be done if oxygen tubing is found on the floor, RN #1 stated that the tubing should be changed. RN #1 stated that oxygen tubing found on the floor should never be placed back in the plastic storage bag. On 8/8/18 at 2:51 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Clinical Transition Specialist, and ASM #4, the Regional Director of Operations was made aware of the above concerns. No further information was presented prior to exit. A policy could not be provided regarding the above concern.	{F 695}		
{F 842} SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	{F 842}		8/31/18

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(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;

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{F 842}	Continued From page 53 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined facility staff failed to maintain a complete and accurate clinical record for two of 15 residents in the survey sample, Resident #108 and Resident #110. 1. The facility staff failed to document the non-pharmacological interventions as ordered by the physician for Resident #108. 2. The facility staff failed to document the non-pharmacological interventions as ordered by the physician for Resident #110. The findings include: 1. Resident #108 was admitted to the facility on 10/23/17 and readmitted on 4/9/18 with diagnoses that included but were not limited to: heart failure, diabetes, high blood pressure, lung disease and morbid obesity. The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 7/17/18 coded the resident as having a BIMS (brief interview for mental status) of 13 out of 15 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring	{F 842}	F842 Resident #108: No negative outcome occurred from this practice Resident # 110: No negative outcome occurred from this practice. Residents receiving PRN pain medication have the potential to be affected. The DON or designee will educate licensed nursing staff on documentation of non-pharmacological interventions prior to administering pain medication per physician order. The DON or designee will audit MARs for current residents with PRN pain medication to ensure there is an order for non-pharmacological interventions to be attempted prior to the administration of pain medication. Nursing administration will monitor documentation of non-pharmacological interventions as ordered 5 times a week for 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the	

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{F 842}	Continued From page 54 assistance from staff for all activities of daily living. Review of the comprehensive care plan initiated on 10/23/17 documented, "Pain risk." There was no specific interventions regarding documentation of non-pharmacological interventions. Review of the August 2018 physician's orders documented, "Document non-pharmacological interventions prior to administering PRN (as needed) medication for pain. Start Date - 07/24/2018. Morphine Sulfate (1) Solution 20 MG/ML (milligram per milliliter) Give 0.25 ml by mouth every 4 hours as needed for Pain..." Review of the July 2018 and August 2018 medication administration records documented, "Document non-pharmacological interventions prior to administering PRN (as needed) medication for pain. Start Date - 07/24/2018. Morphine Sulfate (1) Solution 20 MG/ML (milligram per milliliter) Give 0.25 ml by mouth every 4 hours as needed for Pain..." On 7/28/18 at 11:13 p.m., 7/30/18 at 10:05 p.m. and 8/5/18 at 12:44 a.m. it was documented the the resident received the morphine. There was no documented evidence that the resident had non-pharmacological interventions prior to receiving the morphine. Review of the nurse's notes from 7/28/18 through 8/5/18 did not evidence documentation regarding non-pharmacological interventions. An interview was conducted on 8/8/18 at 12:55 p.m. with RN (registered nurse) #1, the unit manager. When asked about the process staff follows when a resident complained of pain, RN	{F 842}	DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: August 31, 2018	

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#1 stated, "The staff should offer some repositioning, some non-medical treatment and ask them to rate their pain." When asked if this would be documented, RN #1 stated, "Yes. They would document it on the MAR (medication administration record)." When asked to review Resident #108's July and August MAR for the non-pharmacological documentation, RN #1 stated, there was nothing there.

An interview was conducted on 8/8/18 at 1:35 p.m. with LPN (licensed practical nurse) #3. When asked about the process staff follows when a resident complained of pain, LPN #3 stated, "I ask them if it's (the pain) between one to ten and they tell you. Like say it's (the pain) is in their shoulder you may offer a warm compress or massage it to see if it would help first (prior to giving pain medication)." When asked if this would be documented, LPN #3 stated, "Yes. It's supposed to be."

On 8/8/18 at 2:50 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical transition specialist and ASM #4, the regional director of clinical operations were made aware of the findings. A request for the facility's policy on complete and accurate clinical records was requested at from ASM #1 at that time.

Review of the facility's policy titled, "PAIN MANAGEMENT RECORD" documented, "Policy: The Pain Management Record will be used by nursing staff to document the effectiveness of medication and/or non-pharmacy interventions for guests experiencing acute pain or exacerbation of chronic pain. Purpose: The Pain Management Record will be used to assess the effectiveness

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of the current pain regimen, and to revise the plan as needed to achieve pain control. Procedure: 10 If other non-pharmacy interventions are implemented, the intervention is documented in the Non-Pharmacy column."

No further information was obtained prior to exit.

1. Morphine Sulfate -- Morphine is considered the "gold standard" for relieving pain and is currently one of the most effective drugs available clinically for the management. This information was obtained from: www.ncbi.nlm.nih.gov/pmc/articles/PMC3158334/

2. The facility staff failed to document the non-pharmacological interventions as ordered by the physician for Resident #110.

Resident #110 was admitted to the facility on 12/21/17 with diagnoses that included but were not limited to: pain, falls, diabetes, irregular heartbeat and dementia.

The resident's most recent MDS, a significant change assessment, with an ARD of 7/7/18 coded the resident as having a six out of 15 on the BIMS indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the comprehensive care plan initiated on 12/21/17 documented, "Potential for pain d/t (due to) dx (diagnosis) of...diabetes..." There was no specific intervention regarding documenting the non-pharmacological interventions.

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Review of the August 2018 physician's orders documented, "Document non-pharmacological interventions prior to administering PRN (as needed) medication for pain. Tylenol Tablet 325 MG (milligrams) Give 2 tablet (sic) by mouth every 6 hours as needed for pain."

Review of the August 2018 MAR (medication administration record) documented, "Document non-pharmacological interventions prior to administering PRN medication for pain. Tylenol Tablet 325 MG (milligrams) Give 2 tablet (sic) by mouth every 6 hours as needed for pain." On 8/1/18 at 2:18 p.m., it was documented that the Tylenol was given. There was was no documented evidence that a non-pharmacological intervention was attempted.

Review of the 8/1/18 nurse's notes did not evidence documentation regarding non-pharmacological interventions.

An interview was conducted on 8/8/18 at 12:55 p.m. with RN (registered nurse) #1, the unit manager. When asked about the process staff follows when a resident complained of pain, RN #1 stated, "The staff should offer some repositioning, some non-medical treatment and ask them to rate their pain." When asked if that would be documented, RN #1 stated, "Yes. They would document it on the MAR (medication administration record)." When asked to review Resident #108's July and August MAR for the non-pharmacological documentation, RN #1 stated, there was nothing there.

An interview was conducted on 8/8/18 at 1:35 p.m. with LPN (licensed practical nurse) #3, the nurse who administered the Tylenol. When asked

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{F 842}	Continued From page 58 about the process staff follows when a resident complained of pain, LPN #3 stated, "I ask them if it's (the pain) between one to ten and they tell you. Like say it's (the pain) is in their shoulder you may offer a warm compress or massage it to see if it would help first (prior to giving pain medication)." When asked if this would be documented, LPN #3 stated, "Yes. It's supposed to be." When asked to review the resident's MAR, LPN #3 stated she did attempt non-pharmacological interventions, but must not have documented them. On 8/8/18 at 2:50 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical transition specialist and ASM #4, the regional director of clinical operations were made aware of the findings.	{F 842}		
{F 880} SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	{F 880}		8/31/18

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{F 880}	Continued From page 59 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	{F 880}		

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{F 880}	Continued From page 60 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and facility document review, it was determined that the facility staff failed to follow infection control practices for two of 15 residents in the survey sample, Resident #114 and #101; One of nine residents in the medication administration observation, Resident #15; and in one of three dining rooms, the main dining room. 1. The facility staff failed to discard Resident #114's oxygen tubing that was found on the floor by the nursing aide. 2. The facility staff failed to store the nasal cannula according to infection control practices for Resident #101. 3. The facility staff failed to administer medication in a sanitary manner for Resident #115. 4. The facility staff failed to open mayonnaise packets in a sanitary manner in one of three dining rooms, the main dining room. The findings include:	{F 880}	Ftag 880 1. 1. Resident #114: Resident no longer resides in the facility, however during the survey process the oxygen tubing was replaced. No negative outcome occurred as a result of this practice. 2. 2. Resident #101: The tubing was replaced and bagged appropriately. No negative outcome occurred as a result of this practice. 3. 3. Resident #115- No negative outcome occurred as a result of this practice. The staff member was educated during the survey process 4. The staff member was educated during the survey process and no negative outcome occurred as a result of this practice. All residents currently in the facility have the potential to be affected.	

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	495109	A. BUILDING ______ B. WING ______	R 08/08/2018

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1. Resident #114 was admitted to the facility on 6/25/18 with diagnoses that included but were not limited to unspecified fracture of the left tibia, vitamin D deficiency, respiratory failure, high blood pressure, and BPH (benign prostatic hyperplasia) (enlarged prostate). Resident #114's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 7/9/18. Resident #114 as coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (brief interview for mental Status) exam. Resident #114 was coded in Section 0 (Special treatments, procedures and programs) as receiving respiratory services.

Review of Resident #114's August 2018 POS (physician order summary) revealed the following order: "Oxygen 2 L (liters) via nasal cannula continuous every shift. Keep 02 sats (saturation) above 90 % (percent)."

On 8/8/18 at 10:35 a.m., an observation was made of Resident #114's oxygen. He was not in his room. His oxygen tubing that was hooked to his oxygen concentrator was found on the floor. The oxygen tubing was dated "8/14/18" as the date to be changed next.

On 8/8/18 at 10:49 a.m., CNA (certified nursing assistant) #1, was observed in Resident #114's room. CNA #1 was observed making Resident #114's bed. CNA #1 was then observed picking the oxygen tubing up off the floor. CNA #1 then rolled up the oxygen tubing and placed it in the plastic bag that was hanging from the oxygen concentrator.

{F 880}

The DON or designee will educate licensed nursing staff on the proper storage of respiratory equipment and infection control practices with medication pass. Education will be provided on sanitary serving in the dining room with licensed nursing staff.

The DON or designee will audit current residents on oxygen for proper storage of tubing. Medication pass observations will be completed on all licensed nursing staff. Dining room observations for serving in a sanitary manner will be conducted daily for 5 days.

The DON or designee will conduct medication pass observations 2 times a week for 4 weeks. Dining room observations will be conducted 2 times a week for 4 weeks. Room rounds on oxygen storage will be conducted 5 times a week for 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee.

Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.

Completion Date:
August 31,2018

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On 8/8/18 at 12:20 p.m., an interview was conducted with CNA #1. When asked how oxygen tubing should be stored when not in use, CNA #1 stated that oxygen tubing should be stored in a plastic bag. When asked why tubing should be stored in a plastic bag, CNA #1 stated to prevent contamination of germs. When asked what she would do if she were to find oxygen tubing on the floor, CNA #1 stated that she would throw it away and get a new one from the nurse. When asked if it was ever okay to place oxygen tubing that was found on the floor, back in the plastic bag, CNA #1 stated that the tubing should not be placed back in the plastic bag. When asked if she placed Resident #114's oxygen tubing back in the plastic bag after it was found on the floor, CNA #1 stated that she did not place it in the plastic bag. When CNA #1 was informed of the above observations made at 10:49 a.m., CNA #1 stated. "So I have to throw it away?" CNA #1 stated she could not recollect placing Resident #114's oxygen tubing back in the plastic bag after it was found on the floor.

On 8/8/18 at 1:13 p.m., an interview was conducted with RN (registered nurse) #1, a unit manager. When asked how oxygen tubing should be stored when not in use, RN #1 stated that oxygen tubing should be stored in a plastic bag, to prevent contamination. When asked what should be done if oxygen tubing is found on the floor, RN #1 stated that the tubing should be changed. RN #1 stated that oxygen tubing found on the floor should never be placed back in the plastic storage bag.

On 8/8/18 at 2:51 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Clinical

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Transition Specialist, and ASM #4, the Regional Director of Operations was made aware of the above concerns.

No further information was presented prior to exit. A policy could not be provided regarding the above concern.
2. The facility staff failed to store the nasal cannula according to infection control practices for Resident #101.

Resident #101 was admitted to the facility on 7/8/18 with diagnoses that included but were not limited to: fractured pelvis, high blood pressure, dementia and arthritis.

The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 7/22/16 coded the resident as having scored a three out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was set up. The resident was coded as receiving oxygen therapy.

Review of the resident's comprehensive care plan initiated on 7/19/18 did not address the resident's oxygen order.

An observation was made of Resident #101 on 8/7/18 at 12:55 p.m. of Resident #101's room. The resident was not in the room at the time. The nasal cannula (soft plastic prongs that fit in the nose to deliver oxygen) was draped over the oxygen concentrator. There was no plastic bag observed.

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An observation was made on 8/7/18 at 5:14 p.m. of Resident #101. The resident was up in the wheelchair. The nasal cannula was draped over the oxygen concentrator. There was an oxygen tank on the back of the resident's wheelchair; the nasal cannula was folded up next to the tank. The cannula was uncovered.

An observation was made on 8/8/18 at 8:47 a.m. of Resident #101. The resident was up in the wheelchair. The nasal cannula was lying across the bed uncovered. The nasal cannula attached to the oxygen tank on the wheelchair, remained uncovered.

An observation was made on 8/8/18 at 10:10 a.m. of Resident #101 was sitting in the wheelchair. The resident was wearing the oxygen via the oxygen concentrator. The nasal cannula attached to the oxygen tank on the wheelchair, remained uncovered.

An observation was made on 8/8/18 at 12:48 p.m. of Resident #101 with LPN #3, the resident's nurse. The resident was not in the room. The nasal cannula was lying on the floor. LPN #3 left the room without picking the nasal cannula up off the floor.

An interview was conducted on 8/8/18 at 12:55 p.m. with RN (registered nurse) #1, a unit manager. When asked how the nasal cannula was to be stored when not in use, LPN #3 stated, "In a bag." When asked why, RN #1 stated, "So it doesn't get dirty. Keeps it cleaner." When asked what staff would do if the nasal cannula was on the floor, RN #1 stated, "You need to change it."

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An interview was conducted on 8/8/18 at 1:35 p.m. with LPN #3. When asked how the nasal cannula was to be stored when not in use, LPN #3 stated, "We have to put the tubing in a little baggie." When asked how the nasal cannula on the oxygen tank was to be stored, LPN #3 stated, "It's supposed to be in a little baggie too." When asked where the resident's oxygen was during the observation at 12:48 p.m., LPN #3 stated, "I think it was on the bed." When informed it was observed on the floor, LPN #3 stated, "I'll get rid of it."

On 8/8/18 at 2:50 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical transition specialist and ASM #4, the regional director of clinical operations were made aware of the findings.

Review of the facility's policy on oxygen concentrators did not address the proper storage of oxygen tubing.

No further information was obtained prior to exit.

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment."

3. The facility staff failed to administer medication in a sanitary manner for Resident #115.

Resident #115 was admitted to the facility on 3/1/17 and readmitted on 10/26/17 with diagnosis that included but were not limited to: weakness,

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dementia, kidney cancer and high blood pressure.

The most recent minimum data set, a quarterly assessment, with an assessment reference date of 5/17/18 coded the resident has having an eight out of 15 on the brief interview for mental status indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

A medication administration observation was conducted on 8/8/18 at 8:45 a.m. with LPN (licensed practical nurse) #5. LPN #5 took a pill card of colchicine (1) from the medication cart. LPN #5 popped the pill out of the card and the pill fell onto the top of the medication cart. LPN #5 then scooped the pill up into a medication cup. LPN #5 then administered the medication to Resident #115.

Review of the August 2018 physician's orders documented, "Colchicine Tablet 0.6 MG (milligrams) Give 1 tablet by mouth one time a day for gout (2)."

Review of the August 2018 medication administration record documented, "Colchicine Tablet 0.6 MG Give 1 tablet by mouth one time a day for gout."

An interview was conducted on 8/8/18 at 1:30 p.m. with LPN #5. When asked if the top of the medication cart was considered clean, LPN #5 stated she normally wiped her cart off at the beginning of the shift. When asked what staff did if a pill fell onto the top of the medication cart, LPN #5 stated, "Toss it. I know I put it back in the

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cup." When asked why staff discarded the medication, LPN #5 stated, "Contamination."

An interview was conducted on 8/8/18 at 2:35 p.m. with LPN #7, a unit manager. When asked what staff should do if they drop a pill on the medication cart, LPN #7 stated, "They need to discard the pill." When asked why, LPN #7 stated, "It's dirty."

On 8/8/18 at 2:50 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical transition specialist and ASM #4, the regional director of clinical operations were made aware of the findings. A request for the facility's policy on medication administration was requested from ASM #1 at that time.

On 8/8/18 at 4:40 p.m., ASM #3 stated she did not have a policy.

No further information was provided prior to exit.

1. Colchicine is used to prevent or treat attacks of gout (also called gouty arthritis). This information was obtained from:
https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=cochicine

2. Gout - Gout is a common, painful form of arthritis. It causes swollen, red, hot and stiff joints. Gout happens when uric acid builds up in your body. This information was obtained from:
https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=gout

4. The facility staff failed to open mayonnaise packets in a sanitary manner in one of three

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dining rooms, the main dining room.

A dining observation was made on 8/7/18 at 4:40 p.m. in the main dining room. LPN #4 was observed taking a pair of scissors out of her uniform pocket and cutting off the top of a mayonnaise packet and then placing the packet on the edge of the resident's plate. LPN #4 replaced the scissors back into her pocket. Another observation was made of LPN #4 taking her scissors out of her pocket and cutting the top off another mayonnaise packet and then replacing the scissors into her pocket. LPN #4 did not clean the scissors prior to or after cutting the mayonnaise packets.

An interview was conducted on 8/8/18 at 12:45 p.m. with LPN #4. When asked if her uniform pockets were considered clean, LPN #4 stated, "No." When asked about the process staff follows before and after using their scissors, LPN #4 stated, "Wipe them with alcohol before and after." When asked what she used her scissors for in the dining room the evening before, LPN #4 stated, "I used them to open up the mayo packets."

An interview was conduction on 8/8/18 at 12:55 p.m. with RN (registered nurse) #1, the unit manager. When asked about the process staff follows when using their scissors, RN #1 stated, "She should wipe them down with a bleach pad or alcohol." The above observation was described to RN #1. RN #1 stated, "She didn't wipe them down." When asked why the scissors should be cleaned, RN #1 stated, "So don't pass on germs."

On 8/8/18 at 2:50 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the

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{F 880}	Continued From page 69 director of nursing, ASM #3, the clinical transition specialist and ASM #4, the regional director of clinical operations were made aware of the findings. A request for the facility's policy on cleaning medical equipment was requested from ASM #1 at that time. No further information was obtained prior to exit.	{F 880}		