STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515189	A. BUILDING _____ B. WING _____	01/31/2019

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FAIRMONT REHABILITATION AND HEALTHCARE CENTER LLC	130 KAUFMAN DRIVE Fairmont, WV 26554

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F 000	INITIAL COMMENTS . An unannounced annual re-certification and annual re-licensure survey was conducted at Fairmont Healthcare and Rehabilitation Center from 01/28/19 through 01/31/19. The deficiencies contained in this report are based on observations, review of residents' clinical records, resident interviews, family interviews, and staff interviews, and review of other facility documentation as indicated. The facility's census on the first day of the survey was 108 residents. .	F 000	Please accept this 2567 with our completed Plan of Correction thereon as our letter of assertion of substantial compliance. Preparation and submission of this plan of correction does not constitute an admission of agreement of the alleged deficiencies. This plan of correction is provided as required by the CMS regulations.	
F 550 SS=E	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer,	F 550	F550 (a,b,c) Residents #404, 101, 83,112 had already been served their meal but after being brought to our attention this situation was corrected by the C.N.As and residents were served at the same time. The NHA immediately informed nursing staff and kitchen staff that all residents/roommates are to be served at the same time. This had the potential to affect all residents. The NHA did a staff meeting for all departments on 2/21/19 to re-educate employees on this regulation. A manager will monitor meal times to I validate residents are served together 5 x week for 1 month and then monthly for 2	03/20/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/28/2019

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	discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. . d) Resident #205 On 01/29/19, random observations between 7:45 AM and 10:00 AM, found Resident (R) #205 awake in bed, uncovered and wearing a brief from the waste down, behind the bedside curtain. At 10:00 AM, R#205 could be seen from the hall, uncovered from the waste down, wearing only a brief. The bed side curtains had been removed from the room. At 10:02 AM, Licensed Practical Nurse (LPN) #10, viewed R#205 from the hall and reported the bedside curtains had been removed for cleaning, the door should have been closed or pants put on the resident. LPN #10 agreed this was a dignity concern and stated he would find a nurse aide to dress the resident. .		months and randomly thereafter. The Dietary Manager/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter. F550 (d) The C.N.A. immediately dressed resident #205. The Unit Managers did facility rounds on 1/29/19 to ensure no other residents were exposed with none identified. This had the potential to affect all Residents. Staff in all departments were re-educated on 2/21/19 on ensuring residents were provided with privacy. Unit Managers will make two rounds 5 x week for one month and randomly thereafter to validate residents are provided with privacy. The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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	. Based on observation, resident interview and staff interview the facility failed to ensure a dignified experience during dining and receiving care. These were random opportunityies for discovery. Resident identifiers: #404, #101, #83 and 205. Facility census: 108. Findings included: a) Resident # 404 During an observation on 01/28/19 at 1:13 PM, Resident #404 said that, she always gets her tray 30 minutes to an hour after her roommate does. Her roommate had already finished her meal. During an interview on 01/28/19 at 1:20 PM, Nurse Aide (NA) #112 stated he does not know why the lunch trays were not delivered together. He also said it is anywhere from 30 minutes to an hour between tray deliveries. During an interview on 01/29/19 at 11:30 AM, DoN was asked about residents not being served lunch at the same time. She said the residents that are diabetic get their tray first, so their blood sugars do not drop. b) Resident #101 During an interview on 01/28/19 at 12:57 PM, NA #112 confirmed Resident #101 did not get her tray when roommate did, and it was an hour apart from when her roommate got hers. During an interview on 01/29/19 at 11:30 AM, DoN was asked about residents not being served lunch at the same time. She said the residents that are diabetic get their tray first, so their blood			

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	sugars do not drop. c) Resident #83 During an observation on 01/29/19 at 7:40 AM, Resident # 13 served on the first round of trays that were passed out, Resident #83 received her tray at 08:07 AM, both residents reside in the same room. NA #103 was asked why they were not severed at the same time, she said their trays were not on the same tray cart. She was informed that her roommate was served 27 minutes after her roommate. She turned her back and just walked away. During an interview on 01/29/19 at 10:59 AM, Consultant Dietitian said that, they are looking into changing the way trays are sent out. She provided the times the food carts are sent out. Breakfast Times --1st 100-200 halls 7:05 --1st 300-400 halls 7:10 --2nd 100-200 halls 7:20 --2nd 300-400 halls 7:25 --3rd 100-200 halls 7:35 --3rd 300-400 halls 7:40 --4th 100-200 halls 7:50 --4th 300-400 halls 7:55 This was the only schedule that was provided. The NA's would give trays to a fourth of the people on each hall with each food cart delivered. .			
F 558 SS=D	483.10(e)(3) Reasonable Accommodations Needs/Preferences	F 558	F558	03/20/19

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	§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. . Based on observation, staff interview, family interview, and resident interview, the facility failed to ensure reasonable accommodations of the resident's needs. Resident #153, who was able to use the call light system, did not have his call light within reach. This was a random opportunity for discovery. Resident identifier: #153. Facility census: 108. Findings included: a) Resident #153 On 01/28/19, at 1:12 PM, the resident's responsible party and the resident said the call light was not always within reach. The resident said he frequently uses the light to call for assistance when needed. Today the call light was within reach. The responsible party said she had placed the call light where the resident could reach it when she came to visit. Observation of the resident with Registered Nurse (RN) #69 at 8:00 AM on 01/29/19, found the resident was in bed. The resident's call light was wrapped around the bed frame, dangling downward towards the floor, at the top of the bed. The resident demonstrated he could not reach or find the call light. RN #69 placed the call light beside his left arm and clipped it to the bed for easy access. .		Resident #153 call light was placed within reach by the C.N.A. The Unit Managers did facility rounds to validate no other residents had call cords not in reach. This had the potential to affect all Residents. A whole house audit was completed on Feb 1, 2019 by the Director of Nursing and call cords without clips identified and corrected. Education ' on call lights being within reach and ensuring clips are utilized was completed on 2/21/19 by the NHA. Unit Managers/Designee will make 2 rounds 5 x week x 1 month with corrective action immediately upon discovery and randomly thereafter to validate residents have call lights within reach. The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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F 561 SS=D	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. . Based on observation, resident interview and staff interview, the facility failed to ensure resident choice was honored for breakfast to be served earlier instead of being the last person to be served. This was true for two (2) of three (3) residents reviewed for choices. Resident identifier: #55 and #43. Facility census 108. Findings included:	F 561	F561 (Res 55, 43) Since meal was already served for residents #55 & 43, the facility interviewed for their preference and changed their meal time. The ADON completed a whole house audit with immediate corrective action regarding resident preferences upon discovery. The Dietary Manager adjusted their preference accordingly on 2/1/19. This had the potential to affect all Residents. The NHA did re-education with staff in all departments on 2/21/19 to ensure resident choice was honored for breakfast. The Dietary Manager/Designee will interview current census residents monthly to review meal time choices/preferences x 1 month and randomly thereafter. The Dietary Manager/Designee will audit meal time choices and preferences for satisfaction interviewing 10 residents 3 x week x 1 month and randomly thereafter. The Dietary Manager will present results of these audits monthly to the Quality Assurance and improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	03/20/19

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a) Resident #55

During an interview on 01/28/19 at 11:30 AM, Resident #55 stated they bring her breakfast to her before she was even awake.

During an interview on 01/30/19 at 11:00 AM, Resident # 55 stated if she does not get up and eat her breakfast when they bring it, they take it away uneaten.

During an interview on 01/29/19 at 9:03 AM, DoN was asked why Resident #55 gets her breakfast so early when she would prefer to get hers later, because she does not like to wake up that early. DoN said this occurs because diabetics Residents are served first. Resident # 55 is not a diabetic.

b) Resident #43

During an interview on 01/28/19 at 1:41 PM, Resident # 43 stated his breakfast does not come until 8:30 AM, and the people across the hall gets their trays before 8:00 AM. He stated he does not understand why he must wait 30 - 40 mins longer. He also stated the potion sizes is too small, and he only gets a half of a slice of bacon.

During an interview and observation, on 01/29/19 at 8:22 AM, Resident # 43 states that he asked for fresh water at 7 AM, and still does not have any and is still waiting for his breakfast tray. All of 400 hall has trays except him and his roommate.

An observation on 01/29/19 at 8:33 AM, Resident #43 was served his trays no bacon or any other type of meat was on his tray. Fresh water was

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	given at 8:45 AM. During an interview on 01/30/19 at 10:12 AM, Kitchen Manager #28 said that if there is a resident who wants to eat later he can move their delivery time back to came out on a later food cart and if someone wants to eat sooner her can move them to get an earlier delivery, but it will take him awhile to figure it out how to do so. .			
F 584 SS=D	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584	F584 Resident #47 arm rest on wheelchair was replaced by Maintenance Director on 2/1/19. The DON completed a whole house audit on 2/2/19 to validate that arm rests of residents wheelchairs were in good repair and any identified were corrected by 2/23/19. This had the potential to affect all Residents. The NHA re-educated staff in all departments on 2/21/19 related to ensuring wheelchair arm rests are in good repair. The Unit Managers/Designee's will monitor equipment to ensure it is in good repair by doing 1 unit per week per month x 3 months and randomly thereafter. The DON will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will	03/20/19

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	§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. . Based on observation, resident interview, and staff interview, the facility failed to ensure resident equipment was in good repair. Resident #47's wheelchair arm rests were torn with rough edges. This was a random opportunity for discovery. Resident identifier: #47. Facility census: 108. Findings include: a) Resident #47 On 01/28/19 at 1:34 PM, the resident said, "The arms of my wheelchair are rough, I may have gotten a place on my arm from hitting it." The resident pointed to a small scab on the inner, lower, right arm. Observation found both arm rests on the wheelchair were cracked and torn. At 2:20 PM on 01/31/19, the resident's nurse, Registered Nurse (RN) #76 observed the wheelchair and said, "I will get maintenance to change the arm rests." The resident again stated the arm rests were rough and sometimes		continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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	scratched her skin. .			
F 622 SS=D	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident	F 622	F622 The Physician was not able to correct his note for resident #103 as the Resident was discharged from this facility on 11/3/18. This had the potential to affect all Residents. The Physician and facility licensed nurses will be educated on Physician Resident/Patient discharge process by 3/20/19 by the DON. The Assistant Director of Nursing (ADON) will utilize the Physician's discharge summary for this documentation. The DON/ADON or designee will audit discharges/transfers to the hospital over the next 30 days and randomly thereafter. The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	03/20/19

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	exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information			

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(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
.
Based on medical record review and staff interview, the facility failed to ensure a discharge summary was completed for Resident #103 following his hospitalization. This was true for one (1) of three (3) closed records reviewed for discharge. Resident identifier: #103. Facility census: 108.

Findings included:

a) Resident #103

During a review of Resident #103's electronic medical record on 01/30/19 at 7:13 AM, it was noted that Resident #103 was discharged from the facility on 11/03/18 and had not returned to the facility prior to the survey.

On 01/30/19 at 10:40 AM, the facility's Director of Nursing (DoN) was asked for the Physician's documentation regarding Resident #103's discharge from the facility. At 11:10 AM, the DoN provided a copy of Resident #103's Physician's progress notes. The progress notes contained two entries signed by the Physician. Only one entry was from 11/03/18. The entry said, "Transfer to hospital." When asked if there was any more information from the physician regarding the transfer, the DoN stated that the information on this sheet was all that the

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	Physician had documented regarding Resident #103's discharge to the hospital. On 01/30/19 at 11:16 AM, the DoN was asked for a copy of Resident #103's discharge summary. At 11:27 AM, the DoN provided a copy of a document titled, "Resident/Patient Discharge Summary," which was completed by the interdisciplinary team and contained no documentation by the Physician. Under a section of the document titled, "Recapitulation of Stay," the reason for discharge was listed as, "Discharged to hospital." The DoN stated that this was all the discharge documentation she was able to provide. On 01/30/19 at 12:08 PM, the facility's Administrator was informed of the above findings. She stated that the Physician usually only writes a short note regarding a resident's discharge. .			
F 641 SS=D	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. . Based on record review and staff interview, the facility failed to ensure a correct and accurate Minimum Data Set (MDS) for one (1) of 31 residents reviewed during the long-term care survey process. Resident #36's MDS was inaccurate in the area of falls and medications. Resident identifier: 36. Facility census: 108. Findings included:	F 641	F641 Resident #36's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11.24.18 was modified, submitted by the MDS Coordinator and accepted 2.4.19. The most recent MDS for current residents as of 2.25.19 with falls occurring in the last 92 days were audited for accuracy to MDS item J1800 and those with orders for diuretics were audited by the Regional Clinical	03/20/19

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	a1) Resident #36 Review of Resident #36's medical records revealed she had experienced a fall on 09/14/18. Review of Resident #36's MDS with Assessment Reference Date (ARD) 11/24/18, Section J, Health Conditions, documented resident had not experienced a fall since the prior assessment. During an interview on 01/31/19 at 11:43 AM, MDS Registered Nurse (RN) #11 stated Resident #36's MDS with ARD 11/24/18 was incorrect in the area of falls. MDS RN #11 stated the assessment should have indicated Resident #36 had experienced one (1) fall since the prior assessment. a2) Resident #36 Review of Resident #36's medical records revealed she took the diuretic medication acetazolamid (Diuretic) since 07/05/18. Review of Resident #36's MDS with ARD 08/24/18, Section N, Medications, documented resident had taken diuretic medication zero (0) days during the seven (7) day look back period. During an interview on 01/31/19 at 11:50 AM, MDS Registered Nurse (RN) #11 stated Resident #36's MDS with ARD 11/24/18 was incorrect in the area of diuretic. MDS RN #11 stated the assessment should have indicated Resident #36 had taken a diuretic seven (7) days during the look back period. . 483.21(b)(1) Develop/Implement Comprehensive		Reimbursement Coordinator for accuracy to MDS item N0410. This had the potential to affect all Residents. Education will be provided by the Regional Clinical Reimbursement Consultant to the MDS department staff per Resident Assessment Instrument (RIA) Manual on coding of MDS items J1800 and N0410 by 3/1/19. MDS sections 11800 and N0410 will be reviewed for accuracy weekly prior to submission by MDS Staff peer review or designee. The audit will be performed on completed MDSs x 3 weeks and then 10 random completed MDSs x 3 weeks and randomly thereafter. The RNAC and/or designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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F 656 SS=D	Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the 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	F 656	F656 Resident #47's Comprehensive care plan and order was updated by the MDS Coordinator to include: Resident Prefers to change dialysis dressing herself as desired, and for dialysis site to be assessed by licensed staff when dressing is removed. Care plan updated by the MDS Coordinator on 02/06/2019 to include individualized measurable goals and interventions related to her current health status. Resident# 34 Comprehensive care plan was updated by the MDS Coordinator to reflect that Resident has been determined to not have decision making capabilities. Care plan was updated by the MDS Coordinator on 02/06/2019 to include individualized measurable goals and interventions to meet resident's current health status. Resident #3 Comprehensive care plan updated by the MDS Coordinator to include that resident will notify staff when he will see the dentist at his convenience. Care plan was updated on 02/01/2019 by the MDS Coordinator to include individualized measurable goals and interventions to meet his current health status. 2. All residents have the potential to be affected by this deficient practice. 3. The facility's DON and/or designee educated licensed nursing staff and the interdisciplinary team on Comprehensive Care Plans and	03/20/19

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	requirements set forth in paragraph (c) of this section. . Based on resident interview, record review, and staff interview, the facility failed to develope and or implement care plans for three (3) of thirty-one (31) residents reviewed. For Resident #47 a care plan was not developed to include the Residents removal of her dressing after dailysis and her ablility to assess the dialysis access site after removal of the dressing. Resident #34's care plan did not include current information about advance directive. Resident #3's care plan was not implemented for dental care. Resident identifiers: #47, #34, and #3. Facility census: 108. Findings included: a) Resident #47 During an interview with the resident on 01/28/19 at 1:31 PM, regarding her dialysis treatment, the resident said she removes her own bandages to the fistula in the upper right arm. "I don't want them (meaning the facility) to do it. I remove it after dialysis between 3:00 PM and 4:00 PM." The resident said sometimes she has some bleeding to the area. Observation of the residents' upper right arm found the dressing, placed by the dialysis center was still in place. The resident had received her dialysis treatment today. She said she has a 6:00 AM appointment every Monday, Wednesday and Friday. Medical record review found the resident receives hemodialysis at the dialysis center, three (3) times a week on Monday, Wednesday, and Friday at 6:00 AM.		implementation of person-centered , care plans for residents that includes measurable goals and appropriate interventions on 2/21/19. The DON/Designee will complete 5 random audits weekly x 4 weeks, and then monthly X 2 months and randomly thereafter of new admissions, readmissions, and those with any significant change in condition. 4. The RNAC and/or designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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Resident #47 was admitted to the facility on 07/01/18. She has capacity to make her own medical decisions.

The treatment administration record (TAR) found a current order for, "May remove dressing to right upper extremity at bedtime after dialysis." The order did not dictate who would remove the dressing. The January 2019, TAR was never initialed on any days by any of the nursing staff.

The resident is receiving Warfarin (Coumadin) 9 milligrams daily. Coumadin is a blood thinner that treats and prevents blood clots.

On 01/29/19 at 4:09 PM, a second interview and observation of the resident found the bandage to the upper arm had been removed. The resident said she removed the dressing yesterday.

At 4:12 PM on 01/29/19, the resident's Licensed Practical Nurse (LPN) #65, said, "Usually she doesn't ask for the dressing to be removed. She will take it off herself." LPN #65 said the resident had never had any complications.

On 01/29/19 at 4:22 PM, the Director of Nursing said, "She can remove the dressing herself if care planned." The DON reviewed the care plan and confirmed the care plan did not include the anything about the resident removing her own dressing. Removal of the dressing, accessing the dialysis access site after removal, was not care planned.

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b) Resident #34

Review of Resident #34's comprehensive care plan revealed the following focus:

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"Advance Directives

Resident has been determined to have decision making capacity

Resident has a DNR [do not resuscitate] order

HCS [health care surrogate] on file for medical decision making"

On 04/16/17, Resident #34's physician signed a form that determined resident "demonstrates incapacity to make medical decisions."

During an interview on 01/29/19 at 3:56 PM, Registered Nurse (RN) #11 stated Resident 34's care plan was incorrect in stating resident had decision making capacity.

During an interview on 01/29/19 at 4:20 PM, the Director of Nursing (DoN) was informed Resident #34's comprehensive care plan stated both that he had medical decision making capacity and also that he had a health care surrogate for medical decision making. The DoN was also informed that Resident #34 had physician documentation that he did not have medical decision making capacity.

The DoN had no additional information regarding the matter.

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c) Resident #3

During an interview on 01/31/19 at 10:38 AM, Resident #3 stated that his teeth were infected. Resident #3 then opened his mouth to reveal that he was missing many teeth. Resident #3's

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remaining bottom row teeth appeared broken and discolored. Resident #3 stated that his bottom left tooth had been scratching his tongue and causing him pain. He also said that his dental problems were causing him to have difficulty with chewing food. He stated that he would like to keep his two (2) front teeth, but have the remaining teeth extracted due to his discomfort. He added that he had told staff about his dental discomfort, but the facility had not helped him obtain a dental consult.

A review of Resident #3's care plan was conducted during the survey. The dental portion of the care plan revealed the following problem: "Dental or oral cavity health problems related to possible carious teeth." The care plan goals associated with this problem were, "Will be able to eat and drink free of pain," "Will have no bleeding from gums," "Will have no swelling/inflammation outcomes," and "Will maintain good oral hygiene." Care plan interventions included the following: "Refer to dentist/hygienist for evaluation/recommendations regarding denture realignment, new fitting, teeth extraction, repair of carious teeth," and "Report changes in oral cavity, chewing ability, signs and symptoms of oral pain, etc."

A review of Resident #3's Minimum Data Set (MDS) assessments was also conducted during the survey. Resident #3's annual MDS assessment with an Assessment Reference Date (ARD) of 07/14/18 had triggered the dental care portion of Section V, requiring a Care Area Assessment (CAA) to be completed by staff. The following description was written in the CAA for dental care: "as noted from nursing assessment 7/18 resident states having issues with his teeth, this can lead to pain,infection wt

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	(weight) loss and overall decline." During an interview on 01/31/19 at 11:23 AM, Registered Nurse (RN) #11 was asked if Resident #3 had ever had a dental consult. RN #11 said that Resident #3 had never complained about his teeth and that no dental consult had been obtained for him. The CAA information above was reviewed with RN #11. After reviewing the information, RN #11 said that she would look further for information regarding how the facility responded to this dental problem. Later on 01/31/19, RN #11 said that no dental consult had been obtained for Resident #3, but that she would address Resident #3's dental complaints that day. On 01/31/19 at 2:49 PM, the facility's Administrator was notified of the above information. She stated that Resident #3 had refused multiple dental appointments in the past, but that none of these refusals or facility attempts at making arrangements had been documented. .			
F 657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §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.	F 657	F657 On 2/4/19 resident #94 care plan goal was updated by the MDS Coordinator. Care plans for residents who are noted to wander will have their care plan reviewed quarterly and/or with any significant change, by the Licensed Social Worker (LSW) to validate measurable goals to address behaviors.	03/20/19

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	(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 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. . Based on observations, record review and staff interview, the facility failed to implement individualized interventions, as well as revise the care plan accordingly, to address a resident's new behaviors. Person-centered interventions with measurable goals were not developed in response to Resident #94's wandering into other residents' rooms and rummaging through others belongings. This was found for 1 of 31 care plans reviewed. Resident identifier: #94. Facility census: 108. Findings include: a) Random observations on 01/28/19 and 01/29/19, found Resident (R) #94 wandering through the facility and into other residents' rooms. Review of the medical record on 01/29/19, revealed R#94 was admitted to the facility in 2012 with a diagnosis of dementia without		This had the potential to affect all Residents. The facility's DON and/or designee educated licensed nursing staff and the interdisciplinary team on Comprehensive Care Plans and implementation of person-centered care plans for each resident that includes measurable goals and appropriate interventions on 2/21/19. The RNAC/Designee will complete weekly audits x 4 weeks, and then monthly X 2 months and randomly thereafter and with any significant change in condition. The DON and/or designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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behaviors. The annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/06/18, notes R#94 had a Brief Interview for Mental Status (BIMS) score of 9 (indicating moderate cognitive impairment) and no behaviors. The quarterly MDS with an ARD of 01/04/19, notes R#94's BIMS score has decreased to 6 (indicating severe cognitive impairment). In addition, she has verbal behavioral symptoms directed towards others (threatening others, screaming at others, cursing at others) 1-3 days of the 7 day look back period.
The computerized records note the following documentations: 01/25/19 - Nursing wrote: "Resident went into room (number) and took bed ones breakfast tray and over bed table into her room and ate 50% of it..."
01/05/19 - Nursing wrote: "Resident was at med cart attempting to take items off of med cart. Resident was threatening to strike out. Resident was redirected 2x (twice) before returning to room.

The care plan, last revised 10/18/18, lists the following focus, goals and interventions for R#94's behaviors:
- Focus: Rummaging (other resident rooms) related to cognitive impairment - Goal: Will return items belonging to others - Interventions: Distract and redirect as needed. Monitor room as needed and return items/belongings to others.
-Focus: Repetitive physical movements/entering others rooms related to cognitive impairment related to dementia - Goal: Reduce frequency/duration of repetitive movements - Interventions: Administer medications as ordered and (typed as written)"Redirect behavior by (specify action)"
-Focus: Verbal/physical agitation/aggression related to cognitive impairment - Goals: Will not

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	harm self or others and will not verbally abuse others - Interventions: Allow time to respond to directions or requests, approach slowly, attempt psychotropic drug reduction per physician orders, give clear, concise explanations, provide diversional activities, and use consistent routines and caregivers. **The current care plan lacks measurable goals and individualized person centered interventions for staff to utilize in response to R#94's behaviors. Registered Nurse (RN) #11, reviewed R#94's care plan on 01/29/19 at 4:30 PM. RN #11, acknowledged R#94 wanders into other residents' rooms and takes their belongings. When asked about the goal to return items belonging to others, she stated "We have to return their belongings" and agreed this was not a person centered goal for Resident #94. Upon further review of the care plan, RN #11 agreed the care plan lacks measurable goals and person centered interventions for R#94's behaviors and wandering. .			
F 677 SS=E	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; . Based on observation, resident interview, staff interview and record review, the facility failed to ensure activities of daily living to maintain grooming, and personal and oral hygiene needs were met. This is true for two (2) of two (2)	F 677	F677 Showers were offered immediately to resident #55 and #73 by the C.N.As. ADL assistance was provided upon discovery by the C.N.As. Management staff interviewed residents on 2/5/19 to determine if showers/ADL assistance was being provided.	03/20/19

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	reviewed in the care area of Activities of Daily Living. Resident identifiers: #55 and #73. Facility census 108. Findings included: a) Resident #55 During an interview on 01/28/19 at 11:40 AM, Resident # 55 said they do not help with washing her face and brushing her teeth, they tell her to go to the her bathroom and do it herself, but she cannot get her wheelchair (W/C) in and out of the bathroom. She states she cannot open the bathroom door, turn on the lights or get her wheelchair even close to the sink. During an interview on 01/29/19 at 12:00 PM, Resident #55 said that, she did not receive help this morning. During an interview on 01/30/19 at 11:03 AM, Resident #55 said a Nurse Aide helped her today. She gave her a warm wash cloth to wash her face and a basin to use to brush her teeth. During an interview on 01/30/19 at 11:07 AM, Nurse Aide (NA) #112 was asked who provided care for Resident #55. He looked on a wall computer and said it was NA #105. He was not sure why she documented total dependent full staff, because he said she only needs to be set-up. NA#105 documented this on Monday and Tuesday. Record review revealed Bath/Shower for the month of January Resident # 55 did not have a bath/shower from 1/1/19 to 1/16/19. There was inconsistent documentation on providing am care.		The ADON added a refusal option to the Point of Care (POC) on 2/22/19 to document refusal of showers/ADLs', Nursing staff was re-educated by the DON on the new icon addition on 2/21/19. The RNAC/Designee will audit Point Click Care (PCC) dashboard for missed/refused showers 5x 1 week for 1 month and randomly thereafter with corrective action upon discovery. The DON and/or designee will present results of these audits monthly to the ' Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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In December there was a period on nine (9) days she did not receive a bath/shower.

During an interview on 01/30/19 at 12:10 PM, DON was informed of findings. She stated she already knew.

Review of medical records revealed the following assistance needed on the Care Plan for Resident #55:
--ADL Self-care deficit related to disease process deconditioning, Parkinson and physical limitations
--Will receive assistance necessary to meet ADL needs
--Will be clean, dressed and well-groomed daily to promote dignity and psychosocial well-being
--Assist of one with ADL's
--Assist to bathe/shower as needed
--Assist with daily hygiene, grooming, dressing, oral care and eating as needed.
--Break ADL tasks into subtasks for easier patient performance
--Nursing Ambulation concurrent with therapy program
--Ambulation: Extensive assist of 1-2
--Toileting: Extensive assist of 1
--Transfers: Extensive assistance of 1
--Bed Mobility: Extensive assist of 1 [Nursing staff]
--Bathing: Extensive assistant of 1-2 [Nursing staff]
--Dressing: Limited assistance [Nursing staff]
--Hygiene and Grooming: Extensive assistance [Nursing staff]

b) Resident #73

During an interview on 01/28/19 at 1:19 PM,

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Resident #73 said he can't get help between 7:00 and 8:00 AM, and 10:30 PM to11:30 PM, He was told that was shift change. has never reported, but sometimes cannot get help getting to bed until after 11:30 PM.

During an interview on 01/29/19 at 8:40 AM, Resident # 73 was in the same cloths as he wore yesterday with food stains. He said that, he asked a Nurse Aide for help at 7:00 AM, and the Nurse Aide told him to wait until the day shift Nurse Aides came on. Around 8:00 AM a Nurse Aide came in his room and asked him what he needed, and he said some help with some clean clothes and she turned around and told him that he could do that himself.

During an interview on 01/29/19 at 9:05 AM, DoN was informed about the complaint. She said, well he is probably being told that to encourage him to do more for himself. She asked if I had looked at his care plan, because it probably says to encourage him to do self-care.

Review of medical records for Resident #73 revealed the following from his electronic chart:
--ADL Self-care deficit related to disease process deconditioning s/p cardiopulmonary resuscitation and rt malleolar fx , physical limitations (rt leg NWB)
--will improve with ADLs to return to community
--Will be clean, dressed and well-groomed daily to promote dignity and psychosocial well-being
--Will not develop complications related to decreased mobility
--Will receive assistance necessary to meet ADL needs
--Sliding board with all transfers
--Assist to bathe/shower as needed
--Assist with daily hygiene, grooming, dressing,

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	oral care and eating as needed. --Break ADL tasks into subtasks for easier patient performance --Therapy evaluation and treatment per physician orders. Refer to the Therapy Plan of Treatment in the medical record for more detail --AMBULATION: Extensive assist of (Specify 2 of staff assist) with gait belt --TOILETING: Extensive assist of (Specify 2 staff assist) --TRANSFERS: Extensive assistance of (Specify 2 staff assist with gait belt) --BED MOBILITY: Extensive assist of (Specify 1-2 assist) --BATHING: Extensive assistant of 1 assist for bathing 2 for transfers -DRESSING: Limited assistance --HYGIENE/GROOMING: Extensive assistance --EATING: Limited assistance A review of his Bath/Shower records revealed he had not received a bath/shower for 20 days from 12/27/18 until 01/17/19. .			
F 684 SS=E	483.25 Quality of Care § 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. . d) Resident #47	F 684	F684 Stat PT INRs were ordered by the Physician on the 4 residents identified (#72, 101, 47, 37) and will be completed by the Phlebotomist on 1/30/19 and results will be reviewed by the Physician. This had the potential to affect all Residents of the facility. The facility PT INR machine has been pulled from use on 1/30/19 at 1:00 p.m.	03/20/19

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	Review of the current medication administration record (MAR) found the resident is receiving Warfarin (Coumadin) 5 milligrams daily at 5:00 PM and Coumadin 4 milligrams at 5:00 PM, for a total of 9 milligrams of Coumadin a day. On 01/30/19 at 8:01 AM, the residents Licensed Practical Nurse (LPN), #65 said the resident is to have a PT/INR completed weekly according to the physician's orders. Review of the PT/INR flowsheet for December 2018 and January 2019, with LPN #65 found on 12/10/18 only an IRN had been obtained. The PT was not obtained. LPN #65 said the facility has their own testing machine. There was a problem with the machine. An error message came up that day when I tried to get the PT reading. A PT/INR was performed on the week prior on 12/03/18 and the week following 12/17/18. On 01/30/19 at 08:04 AM, the Registered Nurse Unit Manager, RN #75 confirmed she was unable to find a PT test for 12/10/18. . . Based on medical record review and staff interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. The facility failed to ensure protime (PT) and International Normalized Ratio (INR) testing was obtained according to the physician orders for Residents #72 and #101, #47, and #37. These residents were receiving the anticoagulation medication warfarin. Four (4) out of four (4) residents in the		along with all other supplies and will be secured in the Administrator's office. Upon receiving physician orders, the PT INR will now be drawn by a licensed Phlebotomist and sent to the Lab Provider. New physician's orders and new admissions will be reviewed 5 x week by Nurse Managers at the morning clinical meeting. New Coumadin and/or PT INR orders will be added to the new audit system by the Unit Manager/Designee at the next clinical meeting. Licensed nurses will be educated by the DON/Designee on 2/21/19 on the process of the system of obtaining PT INR and documentation. The DON or designee will audit PT/INR orders weekly to validate that labs were obtained per physician order and communicated appropriately. The DON will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter. Past practice of documentation with check marks cannot be fixed. Current residents with IV PICC line orders had the potential to be affected.	

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	facility receiving warfarin were affected. Facility identifiers: #72, #101, #47, #37. Facility census: 108. Findings included: a) Resident #72 On 11/30/18, Resident #72's physician wrote an order for INR testing to be performed every day. Review of Resident #72's medical records demonstrated that INR testing was not performed on the following dates: 12/21/18, 12/25/18, 12/26/18, and 12/30/18. On 01/17/19, Resident #72's physician changed the order from daily INR testing to weekly PT/INR testing. Review of Resident #72's medical records demonstrated that PT/INR testing was last performed on 01/16/18. On 01/30/19 at 1:33 PM, Registered Nurse (RN) #13 confirmed INR testing had not been performed for Resident #72 on 12/21/18, 12/25/18, 12/26/18, and 12/30/18. RN #13 also confirmed Resident #72 had not had PT/INR testing since 01/16/19. He stated stat PT/INR testing would be performed. On 01/29/19, this surveyor requested the facility's Director of Nursing (DoN) to provide a copy of Resident #72's Medication Administration Record (MAR) for January 2019. The copy of the MAR provided by the DoN contained a page with orders for central line care. Resident #72's central line was a peripherally inserted central catheter (PICC) line inserted in his arm for intravenous antibiotics and fluid. The MAR included the order, "Change positive pressure cap(s) every 72 hours and as needed with each		The DON did licensed staff education on 2/21/19 and the center implemented EMAR and ETAR on 2/20/19 where the documentation for all charting can be monitored with appropriate training. All documentation will have the licensed nurse's electronic signature on it along with date and time charting completed. The UM's/Designee will audit EMAR and ETAR for completion 2 x week for 4 weeks and randomly thereafter. The DON and/or designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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catheter change." The dates 01/11/19 through 01/21/19 had either nurse initials or check marks for this order. The dates 01/21/19 through 01/24/19 and 01/26/19 through 01/28/19 contained no nurse initials or check marks.

On 01/31/19 at 8:48 AM, Licensed Practical Nurse (LPN) #72 and #64 were interviewed regarding Resident #72's PICC line care. LPNs #72 and #64 stated they did not know what the check marks meant on the MAR. This surveyor also noticed additional check marks had been placed on the MAR for the order, "Change positive pressure cap(s) every 72 hours and as needed with each catheter change." The dates 01/21/19 through 01/24/19 and 01/26/19 through 01/28/19 now contained check marks, when they previously did not. A copy of the updated MAR was requested and was provided to this surveyor by Registered Nurse Unit Manager #13.

During an interview on 01/31/19 at 9:18 AM, the Director of Nursing and Regional Nurse Consultant were shown additional check marks had been made on Resident #72's MAR between the time the MAR was first obtained on 01/29/19 and when the MAR was next observed on 01/31/19. The Director of Nursing and Regional Nurse Consultant had no further information regarding the matter.

During this interview, the Director of Nursing was also questioned regarding whether a check mark means the pressure cap was changed on that day or whether a check mark means the cap was present and intact. The Director of Nursing stated she could not identify from the MAR the dates the pressure cap was changed. She acknowledged initialing the MAR was the correct method to document the pressure cap was

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changed.
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b) Resident #101

After a review of medical records, it was discovered that Resident # 101 was ordered to have a Prothrombin Time (PT) and International Normalized Ratio (INR) (used to monitor how well the blood-thinning medication in working) drawn every month for the diagnosis of History of Deep Vein Thrombosis and Atrial Fibrillation. She receives Warfarin 4 mg (a blood-thinner).

Review of medical records revealed she had a PT and INR done on 11/27/18, the lab draw was due to be done again on 12/27/18. No record could be found of this being done. In the month of January, a due date of 01/07/19 was listed and a completed date 01/18/19, but the facility could not provide any results.

During an interview on 01/30/19 at 9:28 AM, Unit Manager #75 was asked for the results for PT and INR for Resident # 101.

On 01/30/19 at 3:05 PM, Unit Manager #13 provided a nursing note that was printed from the electronic chart.

The nursing note read:
Res refused lad draws this am, states she only wants them done in the hospital.
This note did not say that the Attending Physician was notified.

Upon review of the electronic record it was discovered, that it was a late entry note was created on 1/30/19 at 10:26 AM, 23 days after the date the physician ordered the lab work.

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Standards of practice is a late entry cannot be made after 24 hours.

During an interview on 01/30/19 at 03:38 PM, Unit Manager (UM) #75 and Licensed Practical Nurse (LPN) #68 was asked about a nurse note that was printed that stated Resident # 101 refused a lab draw on 1/7/19. LPN #68 stated that he wrote the noet. He was asked why was the nurses note was not wrote until today at 10:26 AM, if it occurred 23 days ago after the encounter. He said because I was there that day. He was asked if the Physician was notified. He did not answer. Both UM #75 and LPN #68 were asked how much time can pass before it is too late to make a late entry note. LPN #68 stated he did not know UM #75 stated 24 hours. UM #75 was asked if she had any results or reliable information about the missing lab for the month of December and she shook her head no.

c) Resident #37

During a review of records, it was discovered that Resident #37 was ordered to have a lab draw for a PT and INR every month. On 12/06/18 only the INR results could be found.

On 01/30/19 at 9:28 AM, UM #75 was asked if she could find out why only half of the order was completed.

During an interview on 01/30/19 LPN# 65 stated that the machine that they were using to check the PT and INRs was using broke and it would only give results for the INR.
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483.25(e)(1)-(3) Bowel/Bladder Incontinence,

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F 690 SS=D	Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. . Based on observation, staff interview and policy review, the facility failed to ensure the catheter is securely anchored to prevent excessive tension	F 690	F690 Resident #66 catheter tubing was anchored to top of her leg on 1/28/19 by the C.N.A. Residents with catheter tubing were checked by the Unit Managers to validate the catheter was anchored on 2/22/19. This had the potential to affect all Residents with catheters. Nursing staff re-education completed by the NHA on 2/21/19 to include catheter tubing to be securely anchored. The Unit Managers/designee will audit residents with Foley catheters to validate they are anchored 5 x week for 1 month and randomly thereafter. The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	03/20/19

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	on the catheter. The anchoring of the Foley catheter tubing are used for interventions (such as avoiding tugging on the catheter during transfer and positioning) used to prevent inadvertent catheter removal or tissue injury from dislodging the catheter. This was true for one (1) of Three (3) reviewed urinary catheter or Urinary tract Infection. Resident Identifiers: #66 . Facility census: 108. Findings included: During an interview on 01/28/19 at 12:07 PM, with Resident # 66 it was noted that there was no anchor in place the stabilize the Foley catheter. Licensed Practical Nurse (LPN)#12 witnessed and verified the missing anchor and placed a belt on her leg to stabilize the Indwelling Foley catheter tubing. During an interview on 01/29/19 at 10:20 AM, DON was made aware of findings and provided no further information. .			
F 695 SS=D	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. . Based on observation and staff interview, the	F 695	F695 An order was immediately obtained from the physician and the RN wrote the order 1/28/19 to increase oxygen for resident #67 to 10L via nasal cannula. An audit was performed on 2/23/19 and there were no other residents receiving oxygen without an order. This had the potential to affect all Residents who receive respiratory services.	03/20/19

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	facility failed to ensure the necessary respiratory care and services that is in accordance with professional standards of practice, the resident's care plan, and physician's orders. This was true for one (1) of five (5) residents reviewed for oxygen usage. Resident identifier: #67. Facility census: 108. Findings include: a) Resident #67 Review of the resident's current physician's orders found an order, dated 01/26/19, to discontinue oxygen at 5 liters via the nasal cannula. Start O2 at 5 liters with mask continuously. Review of the nursing notes found a change of condition note completed on 01/26/19 at 11:03 AM. The residents oxygen saturation level was recorded as 87.0%. The nurse recorded, Nursing observations, evaluation, and recommendations are decreased O2 saturation on 5 liters of oxygen via nasal cannula. On 01/28/19 at 2:50 PM, observation of the residents oxygen concentrator with Registered Nurse, #76 found the resident's oxygen concentrator was set at 10 liters instead of 5 liters, the current physician's orders. RN #76 said we need a clarification order from the physician. RN #76 said the resident has a non-rebreather mask and, "You can't run it with anything less than 10 liters of oxygen." RN #76 said she would have to ask the unit manager, Registered Nurse (RN) #75 about getting an order.		The NHA re-educated staff in all department on 2/21/19 to ensure the respiratory care and services are in accordance with professional standards of practice, resident care plans and physicians orders. The Unit Managers/Designee will audit new oxygen orders/change in orders in Point Click Care (PCC) 5 times per week for one month and randomly thereafter at the morning clinical meeting and as changes occur. The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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FAIRMONT REHABILITATION AND HEALTHCARE CENTER LLC	130 KAUFMAN DRIVE Fairmont, WV 26554

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	At 3:21 PM on 01/28/19, RN #75 said, "I am writing a clarification order right now. I had the order this morning but I just hadn't transcribed it yet" RN #75 said the oxygen had been running at 5 liters until this morning. According to the American Red Cross a non-rebreather mask is a face mask with an attached oxygen reservoir bag and one-way valve between the mask and bag; victim inhales oxygen from the bag and exhaled air escapes through flutter valves on the side of the mask. The common air flow rate for a non-rebreather mask is 10 to 15 liters. On 01/30/19 at 10:04 AM, the Director of Nursing (DON) said the nurse had until the end of her shift to document new orders. The DON could not say when the resident began receiving 10 liters of oxygen, the amount required for the non-rebreather mask. .			
F 697 SS=E	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. . Based on resident interview, family interview, record review, and staff interview, the facility failed to consistently assess the effectiveness of as needed (PRN) pain medication for two (2) of four (4) residents reviewed for the care area of	F 697	F697 Resident #53 and resident #153 were immediately assessed for pain by the licensed nurse. This had the potential to affect all Residents who receive pain management. An audit of the last 7 days of residents who received prn pain medication will be completed by the Director of Nursing (DON) to validate effectiveness of medication.	03/20/19

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	pain management. Resident identifiers: #53 and #153. Facility census: 108. Findings included: a) Resident #53 On 01/28/19 at 1:02 PM, observation found the resident was complaining of pain to his foot. He said he thought it felt like he was wearing a steel toed shoe and someone needs to get it off. Record review found the resident was receiving Hospice services due to a diagnosis of Coronary artery disease (CAD.) The resident was currently receiving Hydrocodine 5-325 milligrams every eight hours as needed for pain. Review of the January 2019, medication administration record (MAR) found the resident received the Hydrocodine 5-325 milligrams on: 01/03/18 at 8:00 AM, 01/08/19 at 2:00 PM, 01/09/19 at 8:00 AM, 01/13/19 at 8:00 AM, 01/15/19 at 9:00 PM. On 01/30/19 at 10:00 AM, the resident's Licensed Practical Nurse (LPN) #65 said the effectiveness of the residents PRN medication is documented on a pain monitoring sheet. The monitoring sheet is suppose to be with the MAR. LPN #65 said someone must have forgotten to make a pain monitoring sheet for Resident #53 for the month of January 2019, so no one documented the effectiveness of the resident's pain medication on the monitoring sheet.		With implementation of electronic MAR's, all residents will require a pain score each shift. The computer will prompt Licensed Nurses to address pain and document effectiveness of any medications given. The DON/Designee did staff education with Licensed Nurses on 2/21/19 and EMAR training on the week of 2/11/19. The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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At 11:30 AM on 01/30/19, the Director of Nursing (DON) confirmed nursing staff should document the effectiveness of an as needed (PRN) pain medication about 1 hour after the medication is given. The DON was unable to find evidence of this practice.

b) Resident #153

On 01/28/19 at 02:30 PM, the resident and the resident's responsible party said the resident is having some pain in his left foot.

The resident was admitted to the facility, from the hospital, on 01/17/19, with a diagnosis of a left heel ulceration, status post (s/p) debridement including bone consistent with osteomylitis. The resident has a wound vac on his left foot. A wound vac is negative-pressure wound therapy (NPWT) which is therapeutic technique using a vacuum dressing to promote healing in acute or chronic wounds.

The resident was admitted with the PRN pain medication, Oxycodone 5-325 mg. every 4 hours.

The resident had received the PRN medication on several occasions. On the following days and times the medication was administered without evidence of the effectiveness of the PRN medication:
01/17/19 at 3:00 PM,
01/18/19 at 8:30 AM,
01/22/19 at 8:30 AM,
01/22/19 at 12:30 PM,
01/23/19 at 9:00 AM,
01/28/19 (time was illegible)

At 11:30 AM on 01/30/19, the DON was interviewed regarding the resident's pain

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	medication. No information was provided. At 4:25 PM on 01/30/19, the Registered Nurse Unit Manager #75, was asked if she could provide any evidence the pain medication was monitored after administration to determine the effectiveness of the medication. At the close of the survey on 01/31/19 at 6:00 PM, no further evidence had been provided. .			
F 698 SS=D	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. . Based on resident interview, observation, staff interview, and record review the facility failed to ensure one (1) of one (10 resident reviewed for the care area of dialysis received care and services consistent with professional standards of practice. Resident #47 was not assessed for her ability to remove her own dressings and provide monitoring and assessment for any complications after dialysis treatment. Resident identifier: #47. Facility census 108. Findings include: a) Resident #47 During an interview with the resident on 01/28/19 at 1:31 PM, regarding her dialysis treatment, the resident said she removes her own bandages to	F 698	F698 Resident #47 was immediately assessed by the licensed nurse. This had the potential to affect all Residents on dialysis. No other residents affected by this deficient practice. The physician was notified by the Licensed Nurse about resident wishing to remove her own dressing after dialysis and physician notified and order obtained. The DON assessed resident #47 and determined to be able to safely remove her own dialysis dressing. The care plan was updated by the Clinical Reimbursement Coordinator on 2/6/19 to reflect the same. The Unit Manager entered a new order for licensed staff to assess dialysis site once dressing has been removed by resident. Resident will be re-evaluated quarterly by the DON/Designee for competency on	03/20/19

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	the fistula in the upper right arm. "I don't want them (meaning the facility) to do it. I remove it after dialysis between 3:00 PM and 4:00 PM." The resident said sometimes she has some bleeding to the area. Observation of the residents' upper right arm found the dressing, placed by the dialysis center was still in place. The resident had received her dialysis treatment today. She said she has a 6:00 AM appointment every Monday, Wednesday and Friday. Medical record review found the resident receives hemodialysis at the dialysis center, three (3) times a week on Monday, Wednesday, and Friday at 6:00 AM. Resident #47 was admitted to the facility on 07/01/18. She has capacity to make her own medical decisions. The treatment administration record (TAR) found a current order for, "May remove dressing to right upper extremity at bedtime after dialysis." The order did not dictate who would remove the dressing. The January 2019, TAR was never initialed on any days by any of the nursing staff. The resident is receiving Warfarin (Coumadin) 9 milligrams daily. Coumadin is a blood thinner that treats and prevents blood clots. On 01/29/19 at 4:09 PM, a second interview and observation of the resident found the bandage to the upper arm had been removed. The resident said she removed the dressing yesterday. At 4:12 PM on 01/29/19, the resident's Licensed Practical Nurse (LPN) #65, said, "Usually she doesn't ask for the dressing to be removed. She will take it off herself." LPN #65 said the resident		removing her own dressing with any significant change in condition. The MDS Coordinator/Designee will audit dialysis residents for competency if/when resident chooses to remove their dialysis dressing weekly x 4 weeks, then bi weekly for 1 month and randomly thereafter.\\ The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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had never had any complications.

On 01/29/19 at 4:22 PM, the Director of Nursing said, "She can remove the dressing herself if care planned." The DON reviewed the care plan and confirmed the care plan did not include the anything about the resident removing her own dressing. Removal of the dressing was not care planned.

At 4:53 PM on 01/29/19, the above issues were discussed with the Administrator and the DON. There was no evidence provided to indicate the resident had been assessed for her ability to remove the dressing and what the resident should do if she has any bleeding at the access site. There was no evidence the resident was care planned to remove the dressing and no evidence the physician was aware the resident was removing her own dressing.

At 8:09 AM on 01/30/19, the administrator said the resident's physician was on the telephone and wanted to talk to the surveyor. The physician said, "It is OK for her to take off her dressing, she has capacity. I will write that down in my notes."

On 01/31/19 at 9:35 AM, the physician provided the following hand-written progress note, dated 01/30/19, "Pt. (patient) has capacity to remove dressing when she comes from dialysis. If she has any problem she alerts nursing."

On 01/31/19 at 2:45 PM, the resident's Registered Nurse (RN) #76 and the RN unit manager #75 were unable to provide evidence of any education provided to Resident #47 to indicate she was able to assess the dialysis access site and safely remove her dressings.

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F 726 SS=E	. 483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. . Based on medical record review and staff interview, the facility failed to ensure staff was competent to provide treatment and care for residents receiving anticoagulant medication.	F 726	F726 Stat PT INR's were ordered on the 4 residents identified (#72, 101, 47, 37) and will be completed by the Phlebotomist on 1/30/19 and results will be reviewed by the Physician on 1/30/19. This had the potential to affect all Residents. The facility PT INR machine was pulled from use on 1/30/19 at 1:00 p.m. by the NHA along with all other supplies and will be secured in the Administrator's office. PT INR will now be drawn by a licensed Phlebotomist per Physician's orders and sent to the Lab Provider. New physician's orders and new admissions will be reviewed by Licensed Nurse Managers at the morning clinical meeting 5 x week and randomly thereafter. The ADON added new Coumadin and/or PT INR orders to the new audit system on 1/30/19. Licensed nurses will be educated by the DON on 1/30/19 on the process of the system of obtaining PT INR and documentation. The DON or designee will audit PT/INR orders weekly to validate that labs were obtained per physician order and	03/20/19

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	The facility failed to ensure protime (PT) and International Normalized Ratio (INR) testing was obtained according to the physician orders for Residents #72 and #101, #47, and #37. These residents were receiving the anticoagulation medication warfarin. Four (4) out of four (4) residents in the facility receiving warfarin were affected. Facility census: 108. Findings include: a) Resident #72 On 11/30/18, Resident #72's physician wrote an order for INR testing to be performed every day. Review of Resident #72's medical records demonstrated that INR testing was not performed on the following dates: 12/21/18, 12/25/18, 12/26/18, and 12/30/18. On 01/17/19, Resident #72's physician changed the order from daily INR testing to weekly PT/INR testing. Review of Resident #72's medical records demonstrated that PT/INR testing was last performed on 01/16/18. Resident #72 was prescribed the medication Warfarin, which is also known by the brand name Coumadin and is a medication used to prevent harmful blood clots from forming or growing larger. Because warfarin interferes with the formation of blood clots, it is called an anticoagulant. Many people refer to anticoagulants as "blood thinners " ; however, warfarin does not thin the blood but instead causes the blood to take longer to form a clot. The goal of warfarin therapy is to decrease the clotting tendency of blood, not to prevent clotting completely. Therefore, the effect of warfarin must		communicated appropriately. The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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	be monitored carefully with blood testing. On the basis of the results of the blood test, the daily dose of warfarin will be adjusted to keep the clotting time within a target range. The blood test used to measure the time it takes for blood to clot is referred to as a prothrombin time test, or protime (PT). The PT is reported as the International Normalized Ratio (INR). It is important to monitor the PT/INR to make sure that the level of warfarin remains in the effective range. If the INR is too low, blood clots will not be prevented, but if the INR is too high, there is an increased risk of bleeding. On 01/30/19 at 1:33 PM, Registered Nurse (RN) #13 confirmed INR testing had not been performed for Resident #72 on 12/21/18, 12/25/18, 12/26/18, and 12/30/18. RN #13 also confirmed Resident #72 had not had PT/INR testing since 01/16/19. He stated stat PT/INR testing would be performed. .			
F 755 SS=D	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755	F755 No negative outcome from resident #153 not receiving antibiotic timely. No new orders received from physician. All other residents with orders for medications had the potential to be affected. The DON did licensed staff education on 2/21/19 related to utilizing e-box if medication has not yet been received	03/20/19

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	dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. . Based on record review and staff interview, the facility failed to ensure medications were available for one (1) of nine (9) residents reviewed for unnecessary medications. The facility failed to have available a physician's ordered antibiotic for Resident #153. Resident identifier: #153. Facility census: 108. Findings include: a) Resident #153 Medical record review found the resident was admitted to the facility on 01/17/19. The resident was admitted with the antibiotic Unasyn, 3 grams, intravenously, every 6 hours, with the last dose to be administered on 02/15/19 at 6:00 PM. There was no diagnosis listed on the MAR for the use of the antibiotic. The resident's admitting diagnosis included a		from pharmacy. The nurses were also educated to utilize the local back up pharmacy if the primary pharmacy is unable to get the medications here timely. The DON/Designee will audit new admissions and new orders for antibiotics 5 x week for 1 month and then monthly x 2 months and i randomly thereafter. The DON/Designee will present results of these audits monthly to the Quality I Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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	non-pressure chronic ulcer of unspecified heel and mid foot with unspecified severity and acute osteomyelitis. Review of the nursing notes found the resident's admission assessment was completed at 1:30 PM on 01/17/19. Further review of the medication administration record (MAR) found the Unasyn was not administered on 01/17/19 or 01/18/19. The first dose of Unasyn was administered at 6:00 AM on 01/19/19. On 01/31/19 at 09:10 AM, the Director of Nursing said she was unaware of the above situation. She said most likely the antibiotic was ordered for the infection to his foot. She said she assumed the medication wasn't available. The DON reviewed the MAR and confirmed the antibiotic was not administered as directed by the physician. At 9:47 AM on 01/31/19, the residents nurse, Registered Nurse #76 said she guessed the medication wasn't available to administer. .			
F 757 SS=E	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757	F757 Clarification order received from Physician on 1/30/19 for Resident #72 Vitamin B12 2000 mcg per day for vitamin deficiency related to anemia. Clarification received from physician indicated for heparin use was to prevent	03/20/19

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	§483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. . b) Resident #96 Review of the medical record on 01/30/19, revealed Resident (R) #96 was admitted to the facility on 01/07/19. Diagnoses included cutaneous abscess of the foot, diabetes mellitus, acute and chronic respiratory failure, obstructive sleep apnea, morbid obesity and depression. The Admission orders dated 01/07/19, include an order for Heparin (an anticoagulant used to prevent blood clots) 5,000 units subcutaneous every eight hours. The current Medication Administration Record (MAR) states "Heparin 5,000 units/ml (milliliter) - Give one ml Subcutaneous every 8 hours IV (intravenous) therapy." Registered Nurse (RN) #13 reviewed R#96's medical record during an interview on 01/30/19 at 10:43 AM, and confirmed the indication for the Heparin was incorrect. R#96 did not have an IV and was receiving the Heparin injections every 8 hours to prevent deep vein thrombosis (DVT) blood clots. .		deep vein thrombosis and/or blood clots for resident #96. This had the potential to affect all other Residents who receive medication. No other residents were affected by this. The DON/Designee did licensed staff education on 2/21/19. The Licensed Nurses had to verify/confirm all orders on 2/20/19 when changing over to EMAR/ETAR, including dosage route and indication for use. New orders are reviewed in the morning clinical meeting. An audit will be done in clinical meeting for accuracy of all new orders received, including dosage, route and indication for use. The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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FAIRMONT REHABILITATION AND HEALTHCARE CENTER LLC	130 KAUFMAN DRIVE Fairmont, WV 26554

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	. Based on medical record review and staff interview, the facility failed to ensure residents were free from unnecessary medications. This was true for two (2) of nine (9) residents reviewed for the care area of unnecessary medications. Resident #72 received an incorrect dosage of Vitamin B-12. Resident #96 had incorrect indications documented for medication use. Resident identifiers: #72, #96. Facility census: 108. Findings include: a) Resident #72 Morning medication pass was observed for Resident #72 on 01/30/19 at 7:20 AM. The medication pass was performed by Licensed Practical Nurse (LPN) #4. Resident #72's Medication Administration Record (MAR) had the following order, "Vitamin B-12 tab [tablet] 100 mcg [micrograms] ie: cyanocobalamin take 2 (200 mcg) by mouth every day for vitamin def [deficiency]." The order had been typed on the MAR. The words "take 2" had been underlined in pen. The words "200 mcg" had also been handwritten on the MAR. LPN #4 noticed the multi-use bottle of Vitamin B-12 located in the medication cart was 1000 mcg strength per tablet. After administering the rest of the medications to Resident #72, LPN #4 went to the medication supply room to obtain 100 mcg tablets of Vitamin B-12. LPN #4 returned from the medication supply room and stated Vitamin B-12 was not available in 100 mcg strength tablets. She stated she would clarify the order with Resident #72's physician.			

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	Review of Resident #72's physician orders revealed the following order was written on 12/11/18, "D/C [discontinue] B-12 100 mcg, 2 tabs daily, start B-12 1000 mg 1 tab po [orally] qd [every day] vitamin deficiency/anemia." During an interview on 01/30/19 at 11:19 AM, the Director of Nursing was informed Resident #72's MAR gave instructions for Vitamin B-12 200 mcg to be administered although the physician's order was for 1000 mcg. The Director of Nursing was informed it appeared Resident #72 received 2000 mcg of Vitamin B-12. Vitamin B-12 is not available in 100 mcg strength tablets. The Vitamin B-12 tablets located in the medication cart were 1000 mcg strength. It appeared that two (2) tablets were administered because the words "take 2" had been underlined in pen and the words "200 mcg" had been handwritten on the MAR. The DoN had no further information regarding the matter. .			
F 758 SS=D	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758	F758 There were no negative side effect from resident #28 receiving the extra dose of medication. This had the potential to affect all Residents on psychotropic medications. None of the other residents on antipsychotic medications were affected by this deficient practice. The facility transitioned to electronic EMAR/ETAR during the week of 2/11/19	03/20/19

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	§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. . Based on record review and staff interview, the facility failed to ensure one (1) of nine (9) residents reviewed for the care area of unnecessary medications was free from psychotropic medications. Resident #28 received extra doses of the antipsychotic		and will no longer be doing month to month reconciliation of orders on paper. New orders are reviewed and verified at the time the order is received by any Licensed Nurse. The order is also reviewed in clinical meeting. Audits will be completed by the DON/Designee on new orders to validate all components are in place 5 x week x 4 weeks for 1 month and then monthly x 2 months and randomly thereafter. The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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medication, Risperidone, in absence of a physician's order to administer the medication. Resident identifier: 28. Facility census: 108.

Findings include:

a) Resident #28

Medical record review found the resident was admitted to the facility, from the hospital, on 11/08/18. Upon admission the resident was receiving Risperidone 1 milligram three times a day (TID). The facility did not have a diagnosis for the medication.

On 12/27/18, the physician discontinued the Risperidone 1 mg. TID and started; Risperidone 1 mg. twice a day (BID), for 7 days; Then Risperidone 1 mg. daily for another 7 days, then discontinue the medication.

On 01/01/19, the old order to give Risperidone 1 mg. TID was copied onto the MAR. The nursing staff administered Risperidone, 1 mg. TID on 1/1/19 instead of the physician's order for Risperidone 1 mg. BID.

On 01/29/19 at 2:59 PM, the Director of Nursing (DON) confirmed the resident did not have a physician's order to give 1 mg. of Risperidone TID on 01/01/19, she said the order was only for Risperidone 1 mg. BID. The DON said someone copied the old order, realized they made a mistake and then discontinued the order on 01/02/19. The DON said the facility physician was discontinuing the medication because the reason the medication was started at the hospital was unclear.
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F 761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. . The facility failed to ensure medications used in the facility were labeled in accordance with currently accepted professional principles. Three (3) of three (3) of Resident #72's metered-dose inhaler medications were not labeled with the dates the inhalers were opened. Resident identifier: #72. Facility census: 108. Findings include: a) Resident #72	F 761	F761 The inhaler medications for resident #72 were immediately discarded and replaced by the licensed nurse. This had the potential to affect all Residents on medications. All other . inhaler medications were checked for date of opening. The DON/Designee educated licensed staff on 2/21/19 on labeling of medications in the box and on the actual inhaler. The Unit Managers/Designee will audit inhalers for date opened on each individual inhaler 2 x week for 4 weeks x 1 then monthly x 2 months and randomly thereafter. The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	03/20/19

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	Morning medication pass was observed for Resident #72 on 01/30/19 at 7:20 AM. The medication pass was performed by Licensed Practical Nurse (LPN) #4. Resident #72 had orders for the following metered-dose inhaler medications: Breo, Combivent, and Symbacort. None of these metered-dose inhalers had dates written on the inhaler box or the inhaler itself to indicate when the inhaler had first been opened. The Breo inhaler stated the inhaler should be discarded within six (6) weeks of opening. LPN #4 confirmed Resident #72's inhalers were not dated when opened. She stated facility practice was to date medication, including inhalers, with the date the medication was opened. During an interview on 01/30/19 at 11:19 AM, the Director of Nursing (DoN) was informed Resident #72's three (3) metered-dose inhaler medications were not dated to indicate when the inhalers were opened. The DoN had no additional information regarding the matter. .			
F 777 SS=D	483.50(b)(2)(i)(ii) Radiology/Diag Srvcs Ordered/Notify Results §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of	F 777	F777 No negative outcome related to delay in STAT ultrasound for resident #153. MD was made aware of ultrasound not being done STAT on 1/3/19. Ultrasound was completed on 2/4/19 at the hospital. This had the potential to affect all Residents who received radiology services. No other residents identified	03/20/19

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	clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. . Based on record review, family interview, and staff interview, the facility failed to ensure radiology testing was preformed when ordered by the physician. Resident #153 was ordered an ultrasound to be performed immediately. The ultrasound was never obtained. This was true for one (1) of three (3) residents reviewed for a change in condition. Resident identifier: #153. Facility census: 108. Findings include: a) Resident #153 At approximately 12:30 PM on 01/28/19, the resident's responsible party (RP) said the residents, "private parts," were very swollen. The RP said she didn't know what the facility was doing about the situation or what was causing the problem. Review of the nurses noted, dated 01/26/19 at 1:29 PM, found the resident had a, "edematous scrotum." Review of the physician's orders found an order for a STAT ultrasound of the scrotum. STAT used as a directive to medical personnel during in an emergency situation, is from the Latin word statim, which means "instantly" or "immediately." On 01/29/19 at 9:19 AM, Registered Nurse (RN), Risk Manager #69 said, "I don't know where the results of the ultrasound are."		with a delay in any STAT orders/treatment. The DON provided education to licensed nurses on STAT orders on 2/21/19. A review of new orders including STAT orders are reviewed in the clinical meeting and will be audited for timeliness of those orders 3x week for 1 month then monthly x 2 months and randomly thereafter. The DON/Designee will present results of these audits monthly to the Quality I Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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	At 11:05 AM on 01/31/19, the Registered Nurse, Minimum Data Set Coordinator, #11 confirmed the ultra sound had never been obtained. At 1:29 PM on 01/31/19, the Regional Clinical Nurse Consultant was unable to find the results of the ultrasound ordered on 01/26/19. .			
F 791 SS=D	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still	F 791	F791 The Unit Manager offered resident # 3 a dental appointment on 1/31/19 for appointment on 2/7/19 at 9:30 a.m. On 2/6/19 resident #3 stated he didn't want to go to the appointment and requested that it be canceled. Care plan was updated by the MDS Coordinator. This had the potential to affect all Residents. No other residents noted related to this deficiency. Licensed Nurses will monitor residents for pain each shift. The DON/Designee educated Licensed Nursing staff on 2/21/19 related to assessing/treating pain when filling out the pain score in Point Click Care. Resident informed by the Unit Manager that whenever he is ready to go to the dental appointment to let staff know and it will be scheduled. Current residents noted with mouth or facial pain on MDS will be audited weekly for need of dental consult x 1	03/20/19

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	eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. . Based on observation, resident interview, medical record review, and staff interview, the facility failed to ensure that dental services were provided to a resident with dental complaints. This was true for one (1) of three (3) residents reviewed for dental care. Resident identifier: #3. Facility census: 108. Findings included: a) Resident #3 During an interview on 01/31/19 at 10:38 AM, Resident #3 stated that his teeth were infected. Resident #3 then opened his mouth to reveal that he was missing many teeth. Resident #3's remaining bottom row teeth appeared broken and discolored. Resident #3 stated that his bottom left tooth had been scratching his tongue and causing him pain. He also said that his dental problems were causing him to have difficulty with chewing food. He stated that he would like to keep his two (2) front teeth, but have the remaining teeth extracted due to his		month and every other week x 1 month and then monthly x 2 months and randomly thereafter. The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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discomfort. He added that he had told staff about his dental discomfort, but the facility had not helped him obtain a dental consult.

A review of Resident #3's care plan was conducted during the survey. The dental portion of the care plan revealed the following problem: "Dental or oral cavity health problems related to possible carious teeth." The care plan goals associated with this problem were, "Will be able to eat and drink free of pain," "Will have no bleeding from gums," "Will have no swelling/inflammation outcomes," and "Will maintain good oral hygiene." Care plan interventions included the following: "Refer to dentist/hygienist for evaluation/recommendations regarding denture realignment, new fitting, teeth extraction, repair of carious teeth," and "Report changes in oral cavity, chewing ability, signs and symptoms of oral pain, etc."

A review of Resident #3's Minimum Data Set (MDS) assessments was also conducted during the survey. Resident #3's annual MDS assessment with an Assessment Reference Date (ARD) of 07/14/18 had triggered the dental care portion of Section V, requiring a Care Area Assessment (CAA) to be completed by staff. The following description was written in the CAA for dental care: "as noted from nursing assessment 7/18 resident states having issues with his teeth, this can lead to pain,infection wt (weight) loss and overall decline."

During an interview on 01/31/19 at 11:23 AM, Registered Nurse (RN) #11 was asked if Resident #3 had ever had a dental consult. RN #11 said that Resident #3 had never complained about his teeth and that no dental consult had been obtained for him. The CAA information

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	above was reviewed with RN #11. After reviewing the information, RN #11 said that she would look further for information regarding how the facility responded to this dental problem. Later on 01/31/19, RN #11 said that no dental consult had been obtained for Resident #3, but that she would address Resident #3's dental complaints that day. On 01/31/19 at 2:49 PM, the facility's Administrator was notified of the above information. She stated that Resident #3 had refused multiple dental appointments in the past, but that none of these refusals or facility attempts at making arrangements had been documented. .			
F 803 SS=E	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;	F 803	F803 Dietary The Consultant Registered Dietician (RD) reviewed the diet for resident #43, corrected that the scoop versus the tongs were used for portioning the BBQ meat and that the ladle was filled for the BBQ sauce and soup. This had the potential to affect all Residents who eat from the facility menu. Kitchen staff were educated by the NHA/Designee on 2/21/19 related to the policy for food preparation and standardized portions. The Dietitian or Food Service Director completed a baseline audit on 3/4/19 to make sure that the tray tickets match physician orders on, the utensils match the	03/20/19

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	§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. . b)Resident #43 During an interview on 01/28/19 at 11:30 AM, Resident #43 said his breakfast was and the portions were very small. He went on to say that he really like bacon, but only gets a half of a slice of bacon. During an interview and observation on 01/29/19 at 8:33 AM, Resident # 43 received his breakfast tray, which consisted of two (2) muffins and small scoop of scrambled eggs, no bacon which was on the menu to be served. Resident # 43 stated his food was not warm. During an interview on 01/29/19 at 2:30 PM, with Consultant Detain and Kitchen Manager # 28 they were asked about the portion sizes of bacon. The print out that was provided read that a regular diet was one (1) slice, and a large portion was two (2) slices. Consultant Detain stated that Resident #43 was to get a large portion. They were asked if they were aware that on 01/29/19 he did not get any bacon or any other meat in place of it. They did not provide any further information. The facility failed to follow the menu and/or provide an alternative to not serving a complete breakfast meal plan. .		spreadsheets and that the utensils are portioned properly. The kitchen staff was educated by the NHA on following physician orders/therapeutic spreadsheets/tray cards and portion control on 2/21/19. The Food Service Director or Designee will complete random audits to verify that the diets tray cards match the physician orders/spreadsheets/tray Cards and that staff are using the correct serving utensils and portioning for meal service 3 x week for 1 month, bi weekly for 1 month and monthly x 1 month and randomly thereafter. The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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	. . Based on observation, resident interview, and staff interview, the facility failed to ensure that food was served per facility menus and in the correct portion sizes. This deficient practice had the potential to affect more than an isolated number of residents. Resident identifier: #43. Facility census: 108. Findings included: a) The Kitchen On 01/28/19 during dining observations, portion sizes appeared small. On 01/31/19 at 11:45 AM, an observation of the lunchtime tray line began in the kitchen. Cook #24 was observed placing a pair of tongs in a container of barbecue meat on the tray line. Cook #24 then began using the tongs to transfer the barbecue meat from the container to sandwich buns for service. Several observations of this tong use were completed and the serving size of the barbecue meat appeared to vary each time. Due to the use of the tongs, it was impossible to tell if each tray was receiving a full portion of the meat. On 01/31/19 at 11:50 AM, Consultant Registered Dietitian (CRD) #121 was asked what the serving size for the barbecue meat was should be. After checking on this, CRD #121 replied that the serving size was to be three (3) ounces of barbecue meat for each sandwich. Meanwhile, Cook #24 was observed removing the tongs from the barbecue meat and replacing them with a three (3) ounce scoop. CRD #121 confirmed that the three (3) ounce scoop was the appropriate			

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	serving utensil to use for the barbecue meat to ensure that the full and correct portion size was served to each resident. On 01/31/19 at 11:53 AM, Cook #24 was observed serving soup from a six (6) ounce ladle. Cook #24 did not completely fill the ladle before pouring the soup into each bowl for service. CRD #121 corrected this practice at the time of the finding and confirmed that the ladle would need to be filled completely with soup to provide the full and correct portion size. At the same time, Cook #24 was observed not to completely fill the ladle he used to transfer barbecue sauce from the tray line to each sandwich for service. CRD #121 acknowledged that Cook #24 did not fill the ladle entirely and therefore did not provide the full and correct portion of barbecue sauce to each resident. On 01/31/19 at 2:49 PM, the above findings were discussed with the facility's Administrator. No further information was provided prior to the end of the survey. .			
F 804 SS=E	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. .	F 804	F804 Dietary The policy on food temperatures was reviewed by the RD on 2/21/19. Dietary staff was educated on 2/21/19 by the Food Service Director on proper food temperatures and on the importance of preparing the trays in a timely manner to ensure proper temperatures are maintained. Dietary Staff will announce when the carts are	03/20/19

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	Based on observation, resident interview, and staff interview, the facility failed to serve food at temperatures appealing to the residents. Hot foods and cold foods were not served at preferable temperatures for residents. This had the potential to affect more than an isolated number of residents. Facility census: 108. Findings include: a) Resident interviews Anonymous interviews with residents found complaints of hot foods not being hot and cold foods not being cold at the time of service. b) Food temperatures At 7:01 PM on 01/29/19, food temperatures were obtained by the dietary manager from the last tray to be served on the 300 hallway. The pureed meal temperatures are as follows: Scrambled eggs 100 degrees Hot cereal 129.7 degrees, Sausage 105.8 degrees Milk 53.6 degrees Juice 55 degrees At 8:15 AM on 1/29/19, the following temperatures were obtained from the last tray to be served on the 200 hallway: Scrambled eggs 99.6 degrees, Bacon 93.5 degrees, Milk 57.8 degrees, Coffee 134.7 degrees, Orange juice 54 degrees. The dietary manager said the milk and juice were definitely too warm. He would have preferred the scrambled eggs, sausage, and bacon to be		being delivered to the nursing wing. This had the potential to affect all residents who receive food from the facility kitchen. The kitchen staff was educated by the NHA/Designee on palatability and preferred temperatures of food on 2/21/19. Nursing staff was educated by the Administrator on passing trays in a timely manner. The Food Service Director or Designee will complete random test tray audits and resident interviews to find out if the foods are palatable 3 x week for 1 month, biweekly for 1 month and monthly x 1 month and randomly thereafter. The Dietary Manager/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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	warmer. c) Resident council meeting Anonymous interviews with the residents at 2:00 PM on 01/30/19, found complaints of cold foods being served. .			
F 835 SS=E	483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. . Based on record review, facility policy review, and staff interview, the facility failed to provide laboratory services to meet the needs of four of four residents who received anticoagulation therapy (Coumadin). The facility had no effective tracking methodology to ensure laboratory (lab) studies were obtained timely and correctly. This practice had the potential to affect all residents receiving Coumadin therapy placing them at serious risk for harm. Additionally, the facility failed to ensure care was provided in accordance with professional standards of care related to Peripherally Inserted Central Catheter (PICC) line care for Resident #72. Resident identifiers: #72, #101, #47, #37. Facility census: 108. Findings included: a) Resident #72 On 11/30/18, Resident #72's physician wrote an	F 835	F835 An audit was performed by a pharmacy liaison of current residents (#72, 101, 47, 37) to validate which residents were on Coumadin and/or PT INR orders and 4 residents identified/confirmed. This had the potential to affect all Residents. Stat PT INR's were ordered by the Physician on the 4 residents identified and will be completed on 1/30/19 and results will be reviewed by the Physician on 1/30/19. The facility PT INR machine has been pulled from use by the NHA on 1/30/19 at 1:00 p.m. along with other supplies and will be secured in the Administrator's office. Upon receipt of physician's orders, PT INR will now be drawn by a licensed Phlebotomist per Physician order and sent to the Lab Provider. New physician's orders and new admissions will be reviewed at the morning clinical meeting 5 x week. New	03/20/19

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	order for INR testing to be performed every day. Review of Resident #72's medical records demonstrated that INR testing was not performed on the following dates: 12/21/18, 12/25/18, 12/26/18, and 12/30/18. On 01/17/19, Resident #72's physician changed the order from daily INR testing to weekly PT/INR testing. Review of Resident #72's medical records demonstrated that PT/INR testing was last performed on 01/16/18. On 01/30/19 at 1:33 PM, Registered Nurse (RN) #13 confirmed INR testing had not been performed for Resident #72 on 12/21/18, 12/25/18, 12/26/18, and 12/30/18. RN #13 also confirmed Resident #72 had not had PT/INR testing since 01/16/19. He stated stat PT/INR testing would be performed. On 01/29/19, this surveyor requested the facility's Director of Nursing (DoN) to provide a copy of Resident #72's Medication Administration Record (MAR) for January 2019. The copy of the MAR provided by the DoN contained a page with orders for central line care. Resident #72's central line was a peripherally inserted central catheter (PICC) line inserted in his arm for intravenous antibiotics and fluid. The MAR included the order, "Change positive pressure cap(s) every 72 hours and as needed with each catheter change." The dates 01/11/19 through 01/21/19 had either nurse initials or check marks for this order. The dates 01/21/19 through 01/24/19 and 01/26/19 through 01/28/19 contained no nurse initials or check marks. On 01/31/19 at 8:48 AM, Licensed Practical Nurse (LPN) #72 and #64 were interviewed regarding Resident #72's PICC line care. LPNs		Coumadin and/or PT INR orders will be added to the new audit system by the DON/Designee at the next clinical meeting. Licensed nurses were educated by the DON on 2/21/19 to the process of the system of obtaining PT INR and documentation. The DON or designee will audit PT/INR orders weekly x 4 weeks then monthly x 2 months and randomly thereafter to validate that labs were obtained per physician order and communicated appropriately. The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter. Past practice of documentation with check marks cannot be fixed. This had the potential to affect all Residents. Current residents with IV PICC line orders had the potential to be affected. The DON did licensed staff education on 2/21/19 and the center implemented EMAR and ETAR on 2/20/19 where the documentation for all charting can be monitored with appropriate training. All documentation will have the licensed nurse's electronic signature on it along	

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	#72 and #64 stated they did not know what the check marks meant on the MAR. This surveyor also noticed additional check marks had been placed on the MAR for the order, "Change positive pressure cap(s) every 72 hours and as needed with each catheter change." The dates 01/21/19 through 01/24/19 and 01/26/19 through 01/28/19 now contained check marks, when they previously did not. A copy of the updated MAR was requested and was provided to this surveyor by Registered Nurse Unit Manager #13. During an interview on 01/31/19 at 9:18 AM, the Director of Nursing and Regional Nurse Consultant were shown additional check marks had been made on Resident #72's MAR between the time the MAR was first obtained on 01/29/19 and when the MAR was next observed on 01/31/19. The Director of Nursing and Regional Nurse Consultant had no further information regarding the matter. During this interview, the Director of Nursing was also questioned regarding whether a check mark means the pressure cap was changed on that day or whether a check mark means the cap was present and intact. The Director of Nursing stated she could not identify from the MAR the dates the pressure cap was changed. She acknowledged initialing the MAR was the correct method to document the pressure cap was changed. b) Resident #101 After a review of medical records, it was discovered that Resident # 101 was ordered to have a Prothrombin Time (PT) and International Normalized Ratio (INR) (used to monitor how well the blood-thinning medication in working)		with date and time charting completed. The UM's/Designee will audit EMAR and ETAR for completion 2 x week for 4 weeks and randomly thereafter. The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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drawn every month for the diagnosis of History of Deep Vein Thrombosis and Atrial Fibrillation. She receives Warfarin 4 mg (a blood-thinner).

Review of medical records revealed she had a PT and INR done on 11/27/18, the lab draw was due to be done again on 12/27/18. No record could be found of this being done. In the month of January, a due date of 01/07/19 was listed and a completed date 01/18/19, but the facility could not provide any results.

During an interview on 01/30/19 at 9:28 AM, Unit Manager #75 was asked for the results for PT and INR for Resident # 101.

On 01/30/19 at 3:05 PM, Unit Manager #13 provided a nursing note that was printed from the electronic chart.

The nursing note read:
Res refused lad draws this am, states she only wants them done in the hospital.
This note did not say that the Attending Physician was notified.

Upon review of the electronic record it was discovered, that it was a late entry note was created on 1/30/19 at 10:26 AM, 23 days after the date the physician ordered the lab work. Standards of practice is a late entry cannot be made after 24 hours.

During an interview on 01/30/19 at 03:38 PM, Unit Manager (UM) #75 and Licensed Practical Nurse (LPN) #68 was asked about a nurse note that was printed that stated Resident # 101 refused a lab draw on 1/7/19. LPN #68 stated that he wrote the noet. He was asked why was the nurses note was not wrote until today at

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10:26 AM, if it occurred 23 days ago after the encounter. He said because I was there that day. He was asked if the Physician was notified. He did not answer. Both UM #75 and LPN #68 were asked how much time can pass before it is too late to make a late entry note. LPN #68 stated he did not know UM #75 stated 24 hours. UM #75 was asked if she had any results or reliable information about the missing lab for the month of December and she shook her head no.

c) Resident #37

During a review of records, it was discovered that Resident #37 was ordered to have a lab draw for a PT and INR every month. On 12/06/18 only the INR results could be found.

On 01/30/19 at 9:28 AM, UM #75 was asked if she could find out why only half of the order was completed.

During an interview on 01/30/19 LPN# 65 stated that the machine that they were using to check the PT and INRs was using broke and it would only give results for the INR.

d) Resident #47

Review of the current medication administration record (MAR) found the resident is receiving Warfarin (Coumadin) 5 milligrams daily at 5:00 PM and Coumadin 4 milligrams at 5:00 PM, for a total of 9 milligrams of Coumadin a day.

On 01/30/19 at 8:01 AM, the residents Licensed Practical Nurse (LPN), #65 said the resident is to have a PT/INR completed weekly according to the physician's orders.
Review of the PT/INR flowsheet for December

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	2018 and January 2019, with LPN #65 found on 12/10/18 only an IRN had been obtained. The PT was not obtained. LPN #65 said the facility has their own testing machine. There was a problem with the machine. An error message came up that day when I tried to get the PT reading. A PT/INR was performed on the week prior on 12/03/18 and the week following 12/17/18. On 01/30/19 at 08:04 AM, the Registered Nurse Unit Manager, RN #75 confirmed she was unable to find a PT test for 12/10/18. .			
F 842 SS=E	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §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 (iv) Systematically organized	F 842	F842 An investigation was completed on 3/5/19 and 3/6/19 by the NHA and the DON on resident #72's documentation in an attempt to determine how/who documented on resident #72's MAR on 1/21/19 through 1/24/19 and 1/26/19 through 1/28/19. The facility was unable to determine the individual(s) responsible who entered the check marks. Therefore past practice of documentation with check marks cannot be fixed related to resident #72. The physician was notified by the DON on 2/1/19 concerning Resident #68's unclear glucoscan results. The resident was evaluated by the MD on that date and no further orders were received.	03/20/19

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	§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; (iv) The results of any preadmission screening		Current residents with IV PICC line orders will be reviewed by the Unit Manager/Designee at the morning clinical meeting to validate that documentation accurately reflects care provided for PICC line. This had the potential to affect all Residents. All residents with IV PICC line orders had the potential to be affected. The facility no longer uses paper MAR's for documentation of glucoscan results. This is now documented in the electronic MAR. No negative outcome related to difficulty reading the result of the glucoscan. Licensed staff were educated on the use and implementation of EMAR/ETAR by the PCC Consultant on February 11 - 13 where documentation for all charting will be legible. All documentation will have the licensed nurse's electronic signature on it along with date and time charting completed. Findings will be reviewed at the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	

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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.
.
Based on medical record review and staff interview, the facility failed to ensure a complete and accurate medical record for two (2) of 31 residents reviewed during the long-term care survey process. Resident #72's medical record was completed late, but not specified as completed late. Resident #68's medical record was illegible. Resident identifiers: #72, #68. Facility census: 108.

Findings include:

a) Resident #72

On 01/29/19, this surveyor requested the facility's Director of Nursing (DoN) to provide a copy of Resident #72's Medication Administration Record (MAR) for January 2019. The copy of the MAR provided by the DoN contained a page with orders for central line care. Resident #72's central line was a peripherally inserted central catheter (PICC) line inserted in his arm for intravenous antibiotics and fluid. The MAR included the order, "Change positive pressure cap(s) every 72 hours and as needed with each catheter change." The dates 01/11/19 through 01/21/19 had either nurse initials or check marks for this order. The dates 01/21/19 through 01/24/19 contained no notations. The date 01/25/19 had a check mark. The dates 01/26/19 through 01/28/19 contained no notations.

On 01/31/19 at 8:48 AM, Licensed Practical

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Nurse (LPN) #72 and #64 were interviewed regarding Resident #72's PICC line care. This surveyor noticed additional check marks had been placed on the MAR for the order, "Change positive pressure cap(s) every 72 hours and as needed with each catheter change." The dates 01/21/19 through 01/24/19 and 01/26/19 through 01/28/19 now contained check marks, when they previously did not. A copy of the updated MAR was requested and was provided to this surveyor by Registered Nurse Unit Manager #13.

During an interview on 01/31/19 at 9:18 AM, the Director of Nursing and Regional Nurse Consultant were shown additional check marks had been made on Resident #72's MAR between the time the MAR was first obtained on 01/29/19 and when the MAR was next observed on 01/31/19. The Director of Nursing and Regional Nurse Consultant had no further information regarding the matter.

b) Resident #68

Resident #68's Medication Administration Record (MAR) contained an order for glucoscans to be obtained at lunch time and at bedtime. A glucoscan is a method to check the blood glucose level by obtaining a drop of blood from the resident's finger. If the blood glucose level was between 200 through 250, the resident was to have 2 units of insulin administered. If the blood glucose level was between 251 through 300, the resident was to have 4 units of insulin administered.

The blood glucose levels were handwritten onto the MAR. The blood glucose level for 01/26/19 at 11:30 AM appeared by this surveyor to have been recorded as 305. The amount of insulin

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	given was recorded as 4 units. A blood glucose level of 305 would have required physician notification because the orders for insulin only covered a blood glucose level up to 300. However, there was no documentation to indicate the physician had been notified. During an interview on 01/29/19 at 4:49 PM, the Director of Nursing (DoN) could not confirm the blood glucose level obtained on 01/26/19 at 11:30 AM read 305. The DoN said she would contact the nurse who had obtained the blood glucose level. On 01/30/19 at 9:03 AM, Licensed Practical Nurse (LPN) #76 called to speak with this surveyor. LPN #76 stated the blood glucose level for Resident #68 on 01/26/19 at 11:30 AM was 300. She stated if the blood glucose level had been over 300, she would have contacted the physician for additional orders. LPN #76 acknowledged the handwritten MARs were sometimes difficult to read. .			
F 867 SS=E	483.75(g)(2)(ii) QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; . Based on record review, staff interview, and policy/procedure review, the facility's Quality Assurance and Process Improvement (QAPI) committee failed to develop, revise, and/or	F 867	F867 The PT INR machine was taken out of service on 1/30/19 by the Administrator. All PT INR labs will be performed by Phlebotomist and sent to Lab. All facility staff have access to the TELS system via PCC to report any equipment issues. This had the potential to affect all Residents including resident #72, 101, 27, 47. The TELS report is reviewed at every morning meeting process.	03/20/19

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	implement corrective plans of action for quality deficiency issues of which they had knowledge or should have had knowledge. The facility failed to ensure residents receiving the anticoagulant Coumadin had Prothrombin (PT) and International Normalized Ratios (INR) completed as ordered. Four of four residents currently receiving Coumadin did not have PT/INR completed as ordered by the physician. Resident identifiers: #72, #101, #37, #47. Facility census: 108. Findings include: a) On 01/31/19 at 2:43 PM and interview with the facility Administrator confirmed she was the person responsible for the Quality Assurance and Process Improvement (QAPI) Committee. It was reported, all departments are included in the monthly meetings. The Administrator acknowledged they were aware of the concerns related to the machines the facility utilized to tests residents' blood for Protime (PT) and International Normalized Ratio (INR) testing. The Administrator agreed the QAPI committee should have known the blood tests were not being done as ordered. She acknowledged there was a failure to follow up after changes were implemented and new testing equipment was obtained. The QAPI policy with a revision date of 03/14/15, states under the section titled: "Performance Improvement Projects (PIPs):" "The facility conducts Performance Improvement Projects (PIPs) to examine and improve care or services in areas that are identified as needing attention. A PIP project typically is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information		The Maintenance Director will now be reporting upon discovery any issues with equipment that is reported in TELS at the monthly QAPI meeting.	

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	systemically to clarify issues or problems, and intervening for improvements..." Section two under the "Committee Audit Process" states: "The Quality Assurance Process Improvement Committee shall help various departments/committees/disciplines/individuals develop and implement plans of correction and monitoring approaches. These plans and approaches should include specific time frames for implementation and follow-up." .			
F 868 SS=C	483.75(g)(1)(i)-(iii)(2)(i) QAA Committee §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. . Based on facility record review and staff interview, the facility failed to ensure the Quality Assurance and Process Improvement (QAPI) Committee is composed of the required committee members. The Medical Director or his designee failed to attended the QAPI Committee meetings at least quarterly. This has the potential	F 868	F868 The Medical Director did attend the QAPI meeting monthly but did not sign the attendance log but the Medical Director will sign at all other upcoming QAPI meetings. This had the potential to affect all residents in the facility. Education was provided to the Medical Director on 1/31/19 via the OHFLAC staff. The NHA/designee will conduct monthly audits x 3 months and randomly thereafter. The NHA/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter.	03/20/19

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	to affect all residents. Facility census 108. Findings include: a) The facility Administrator presented the QAPI sign in sheets for the months of September, October, November, December 2018 and January 2019, on 01/31/19. The sign in sheets were dated 09/27/19 (should have been 09/27/18), 10/25/18, 11/30/18, 12/27/18, and 01/25/19. Further review of the sign in sheets revealed the Medical Director only attended the QAPI meeting once in five months, on 10/25/18. No other physician signatures were identified. On 01/31/19 at 2:43 PM and interview with the facility Administrator confirmed she was the person responsible for the Quality Assurance and Process Improvement (QAPI) Committee. The Administrator reported the QAPI meeting is held monthly and attended by all departments. The Administrator reviewed the sign in sheets and confirmed the Medical Director had only signed the QAPI attendance record on 10/25/18. Once in five months, not quarterly. .			
F 880 SS=F	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §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	F 880	F880 1 a) The Maintenance Director obtained a quote on 2/6/19 for a separation wall between the soiled and clean laundry areas and replacement of broken floor tile. The estimate was $3, 997.00. Supplies have been ordered by contractor and work will begin upon receipt of supplies.	03/20/19

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	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 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		b) Upon knowledge of deficiency related to resident #101, the nurse immediately replaced the nebulizer. c) Upon knowledge of deficiency related to resident #55, the nurse immediately replaced the nasal cannula tubing and replaced new storage bag and hooked the tubing to the concentrator to be ready for use. d) The LPN immediately replaced the oxygen tubing for resident #55. e) The LPN immediately replaced the nebulizer tubing and replaced it with new storage bag for resident #101. f) Upon discovery of items on the floor, all supplies were removed from the room and stored in a centrally located area by the C.N.A. g) The LPN discarded the contaminated inhaler on 1/30/19 and replaced it with a new one for resident #72. h) The nurse placed a plastic container to act as a barrier between urinary catheter and the floor on 1/28/19 for resident #25. This had the potential to affect all Residents. The facility Unit Managers immediately did walking rounds to ensure none of the above mentioned deficiencies were observed on any other	

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	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. §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. . Based on observation, staff interview, and policy review, the facility failed to maintain an effective Infection Prevention and Control Program designed to provide a safe and sanitary environment and to help prevent the development and transmission of disease and infections. The laundry room lacked separation between the clean and soiled area to prevent cross contamination of linen and resident clothing. Staff could not determine the existence of a negative air flow from the clean area to the dirty section. Respiratory equipment was not covered and/or stored properly. Wound care supplies were stored directly on the floor. Staff contaminated medications containers during med administration and a urinary catheter bag rested directly on the floor. This practice has the potential to affect all residents. Resident identifiers: #101, #55, #66, #81, #153, #25. Facility census: 108. Findings included:		residents in the facility. The NHA and the DON did staff education for all departments on Infection Control on 2/21/19 to include all of the above mentioned deficiencies. The DON/Designee will complete weekly audits x 4 weeks x1 month and then bi weekly x 1 month and monthly x 1 month and randomly thereafter on the above mentioned infection control issues The DON/Designee will present results of these audits monthly to the Quality Assurance and Improvement Plan Committee for tracking and trending. These audits will continue quarterly for six months until substantial compliance is achieved and randomly thereafter	

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	a) a) Observation of the laundry room on 01/31/19 at 10:00 AM, in the presence of the Maintenance Supervisor #115, and the laundry staff, revealed the following: --No separation between the soiled and clean linen areas --No identified negative airflow from the clean to soiled areas --Multiple cracked, chipped and stained floor tiles in front of the washing machines During this observation, Maintenance Supervisor (MS) #115 acknowledged the laundry room lacked separation between the clean and soiled areas and noted the facility has been cited in the past for not having a negative airflow in the laundry room. MS #115, agreed the floor tiles were in disrepair. . . f) Resident #153 At approximately 12:00 PM on 01/28/19, the resident's Responsible Party (RP) showed the surveyor a box of medical supplies on the floor of the resident's closet. The RP said, "They just threw this stuff in here. This is the stuff for the wound vac." On 01/28/19 at 12:03 PM, the resident's nurse, Registered Nurse (RN) #76 confirmed the supplies were for the resident's wound vac. RN #76 said, "They shouldn't be on the floor." RN #76 removed the supplies from the room. . . g) Med pass Morning medication pass was observed for Resident #72 on 01/30/19 at 7:20 AM. The			

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medication pass was performed by Licensed Practical Nurse (LPN) #4. Resident #72 had orders for the following metered-dose inhaler medications: Breo, Combivent, and Symbacort. LPN #4 removed these metered-dose inhalers from their boxes and placed them on the top of the medication cart while finished preparing Resident #72's morning medications for administration.

LPN #4 then took Resident #72's medications into his room. She placed his metered-dose inhalers directly on Resident #72's bedside table while she administered oral medications to him. After then administering the metered-dose inhalers to Resident #72, LPN #4 took the inhalers out to the medication cart and placed them back into their boxes.

LPN #4 was informed she had placed Resident #72's metered-dose inhalers directly onto his bedside table without using a barrier between the inhalers and the bedside table. She acknowledged cross-contamination could occur between the bedside table and the medication cart if another nurse would subsequently place the inhalers directly onto the medication cart as she had done during medication preparation.

During an interview on 01/30/19 at 11:19 AM, the Director of Nursing (DoN) was informed LPN #4 had placed Resident #72's metered-dose inhalers directly on his bedside table without using a barrier. The DoN had no further information regarding the matter.

h) Resident #25

During initial observation on 01/28/19 at 11:53 AM, Resident #25's indwelling catheter urine

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collection bag was noted to be lying directly on the floor. Resident #25's bed was in low position, and, therefore, the urine collection bag could not be placed on the bed railing to keep it below the level of the bladder to ensure proper drainage.

On 01/28/19 at 4:12 PM, Resident #25's indwelling catheter urine collection bag continued to be lying directly on the floor. Licensed Practical Nurse (LPN) #15 was notified and stated facility policy was to place the urine collection bag into a plastic pan instead of directly onto the floor. LPN #15 stated he would get a plastic pan for the urine collection bag.

The facility's policy for "Emptying a Urinary Drainage Bag" contained the instructions to "Keep the drainage bag and tubing off the floor at all times to prevent contamination and damage."

During an interview on 01/29/19 at 3:42 PM, the Director of Nursing (DoN) was informed Resident #25's indwelling catheter urine collection bad had been lying directly on the floor without a barrier between the bag and the floor. The DoN had no further information regarding the matter.

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b) Resident #101

During an observation on 01/28/19 at 12:48 PM, a Nebulizer (tubing used for a breathing treatment that goes in the Resident's mouth) was not in a bag to after being used to prevent the potential spread of infection.

On 01/28/19 at 12:50 PM, Licensed Practical Nurse (LPN) #12 was notified and she stated that she will replace the Nebulizer.

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c) Resident #55

During an interview on 01/28/19 at 11:44 AM, Resident # 55 states she is supposed to wear oxygen at night and as needed but she cannot get to it. On inspection it was revealed a bag with oxygen tubing was unopened and hanging on the oxygen concentrator. It was dated 12/07/18 and another bag of oxygen tubing was laying on the chair across the room unopened dated 01/25/19. There was another Nasal Cannula tubing hanging from the glove rack holder that was not in a bag or dated. There was no tubing connected to the oxygen machine ready to be used as needed.

During an interview on 01/28/19 at 11:45 AM, Licensed Practical Nurse (LPN) # 12 was asked about the oxygen tubing's in the room in various places in the room. LPN#12 removed them and said she would replace them and connect to the oxygen concentrator.

d) Resident #66

During an interview on 01/28/19 at 12:00 PM, with Resident # 66, the oxygen concentrator machine was running the Nasal Cannula (NC), (oxygen tubing) was not on nor in reach. The NC tubing was in the trash can. Licensed Practical Nurse #12 came in room to see the NC tubing in the trash can and stated she will replace it.

e) Resident #81

During an interview on 01/28/19 at 12:33 PM, with Resident # 81 her Nebulizer (for breathing treatments) was tied to her bed rail hanging down to the floor and not in a bag to keep clean. This was verified with Licensed Practical Nurse

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	(LPN) #12 who stated she would replace right away. During a brief interview on 01/29/19 at 8:55 AM, DoN was informed of findings and provided no additional information. .			