STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155721	A. BUILDING 00 B. WING	11/02/2018

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LAWRENCE MANOR HEALTHCARE CENTER	8935 E 46TH ST INDIANAPOLIS, IN 46226

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00275638. Complaint IN00275638 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: October 29, 30, 31, November 1 and 2, 2018. Facility number: 000383 Provider number: 155721 AIM number: 100289610 Census Bed Type: SNF/NF: 29 Total: 29 Census Payor Type: Medicare: 3 Medicaid: 22 Other: 4 Total: 29 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 13, 2018	F 0000		
F 0576 SS=D Bldg. 00	483.10(g)(6)-(9) Right to Forms of Communication w/ Privacy §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at			

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

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	the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law.			
	Based on interview and record review, the facility failed to ensure residents received his or her mail on Saturdays. This had a potential to affect 29 to 29 residents that reside in the facility. (Resident F)	F 0576	**F576** The practice of timely delivery of resident mail affects all residents, including resident F who voiced her concern at the time of the	12/02/2018

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	Findings include: During a resident council meeting, on 10/30/18 at 11:07 a.m., Resident F indicated she was the Resident Council President and mail was delivered only Monday through Friday. Residents do not receive his or her mail on Saturdays. An interview was conducted with the Business Office Manager on 11/1/18 12:02 p.m. She indicated the weekend Manager on Duty passes the mail out to the residents on Saturdays. There have been times, when she had come in on Monday, and residents' mail had been sitting on her desk that had been delivered on Saturday needing to be passed out to the residents. A "Mail and Electronic Communication" policy indicated "...Policy Statement. Residents are allowed to communicate privately with individuals of their choice and may send and receive personal mail, email and other electronic forms of communication confidentially... Policy Interpretation and Implementation..4. Mail and packages will be delivered to the resident within twenty-four (24) hours of delivery on premises or to the facility's post office (including Saturday deliveries)...." 3.1-3(s)		survey. The practice for ensuring the timely delivery of resident mail was clarified with facility managers at the time of survey, and reinforced with one-on-one inservices beginning 11/19/18 and ongoing. The practice of timely delivery of resident mail affects all residents. The practice of ensuring the timely delivery of mail to all residents was clarified and reinforced to all facility managers, in accordance with applicable regulations and Chosen's "Mail and Electronic Communication" policy. Resident mail will be delivered Monday through Friday by the Activity Director or, in her absence, the Business Office Manager. Saturday mail will be delivered by the manager on duty. This was addressed at the time of the survey and reinforced during one-on-one inservices. Administrator or designee will use a mail delivery audit tool to ensure mail is delivered in a timely manner. The Administrator or designee will use the audit tool to monitor compliance weekly for six months. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure at least 95% compliance. If this	

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			benchmark is not met, an action plan will be developed and implemented to ensure compliance.	
F 0577 SS=C Bldg. 00	483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. Based on observation and interview, the facility failed to ensure the survey reports from the Indiana State Department of Health were available to the residents for review. This had the potential to affect 29 of 29 residents that reside in the	F 0577	**F577** The availability of survey reports from the Indiana State Department of Health for resident review affects all residents, including resident F	12/02/2018

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	facility. (Resident F) Findings include: During a resident council meeting, on 10/30/18 at 11:07 a.m., Resident F indicated she was the Resident Council President, and she did not know where the survey reports from the Indiana State Department of Health were located to review. A random observation of the facility was made on 11/1/18 at 11:00 a.m. There was no posting of where the Indiana State Department of Health survey reports were located. An interview was conducted with the Activities Director on 11/1/18 at 11:15 a.m. She indicated the survey reports are kept in a binder up front. If residents ask she tells them the binder was up front in a plastic shelf that was mounted on the wall next to the Administrator's office. An observation was made on 11/1/18 at 11:18 a.m., of a plastic shelf that was mounted next to the Administrator's office. The shelf included a green binder which indicated it was the vendor sign in sheet log binder and behind the green binder was a yellow empty binder that indicated it was the Indiana State Department of Health survey reports. There was no posting on the wall the location of the binder. An interview was conducted with the Administrator on 11/1/18 at 11:20 a.m. She indicated there was no posting indicating the location of the survey reports. The binder did have the reports in it, but a former staff person had removed. 3.1-3(b)(1)		who voiced her concern at the time of the survey. The requirement to ensure that survey reports are readily available to residents was reviewed with facility staff at the time of the survey, and reinforced with one-on-one inservices beginning 11/19/18 and ongoing. The availability of survey reports from the Indiana State Department of Health for resident review affects all residents. The requirement to ensure that survey reports are readily available to residents was clarified and reinforced to all facility staff. Survey reports will be made readily available for resident review. The location of the survey reports will also be prominently posted. Residents will be notified of availability and location of survey reports. Administrator or designee will use an audit tool to ensure survey reports remain available and accessible to residents. The Administrator or designee will use the audit tool to monitor compliance daily for six months. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure at least 95% compliance. If this benchmark is not met, an action plan will be developed and	

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			implemented to ensure compliance.	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's			

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	medical, social, and administrative records in accordance with State law. Based on interview and record review, the facility failed to ensure a resident's medical documentation was kept secure and confidential for 1 of 14 residents' records reviewed. (Resident M and Q) Findings include: The clinical record for Resident Q was reviewed on 10/31/18 at 9:00 a.m. The diagnosis for Resident Q included, but was not limited to, major depressive disorder. A physician order dated 3/29/18, indicated the staff was to obtain Resident Q's ammonia level and depakote level every 3 months. The clinical record for Resident Q's did not include the lab that contained ammonia or depakote level. An interview was conducted with the Assisted Director of Nursing on 11/1/18 at 2:20 p.m. She indicated she was able to locate Resident Q's ammonia and depakote lab. Resident M had removed it from the nurse's station and had been writing on the back of it. An interview was conducted with the Director of Nursing on 11/1/18 at 2:24 p.m. She indicated the fax machine was too close to the counter. We will consider moving the fax machine, so residents are unable to reach the documents. Resident M should not have had Resident Q's lab result. 3.1- 3(o)	F 0583	**F 583** The practice of securing residents' medical documentation to ensure confidentiality affects all residents, including resident Q whose records were reviewed at the time of the survey. The necessity and legal requirement to secure residents' medical documentation was reviewed with facility staff at the time of the survey, and reinforced with one-on-one inservices beginning 11/19/18 and ongoing. Resident Q's medical documentation was secured and placed out of reach of Resident M. The practice of securing residents' medical documentation to ensure confidentiality affects all residents. All residents' documentation was secured and placed out of reach of other residents. Access to residents' medical documentation was limited to facility staff. The fax machine at the nurse's station was relocated to prevent unauthorized access to documents. Organization and storage of medical documents at the nurse's station was revised to prevent unauthorized access. The necessity and legal requirement to secure residents' medical documentation was clarified and reinforced to all facility staff.	12/02/2018

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			Residents' medical documentation will be properly secured to ensure confidentiality in adherence with HIPPA regulations. The Director of Nursing and Assistant Director of Nursing will use an audit tool to ensure that residents' medical documentation is kept secure at all times. The Director of Nursing and Assistant Director of Nursing will use the audit tool to monitor compliance daily for six months. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure at least 95% compliance. If this benchmark is not met, an action plan will be developed and implemented to ensure compliance.	
F 0607 SS=D Bldg. 00	483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, Based on interview and record review, the facility	F 0607	**F607**	12/02/2018

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	failed to implement their abuse policy and ensure a staff person was provided annual abuse in-servicing training for 1 of 10 employee files reviewed. (License Practical Nurse (LPN) 24) Findings include: The Abuse policy was provided by the Administrator on 10/29/18 at 1:20 p.m. It indicated "...Policy Each resident has the right to be free from abuse, neglect, and misappropriation of resident property. All allegations will be reported according to State and Federal Law and investigated. This policy applies to all employees....Training.. The facility will train employees, through orientation, annually and on-going sessions, on issues related to abuse prohibition practices such as: Appropriate Interventions to deal with aggressive and/or catastrophic reactions or residents; How staff should report their knowledge related to allegations without fear of reprisal; How to recognize signs of burnout, frustration, and stress that may lead to abuse, and The identification of abuse, neglect and misappropriation of resident property..." The Employee Records were reviewed on 10/2/18 at 10:30 a.m. The Employee Records form indicated LPN 24's start date was 9/20/07, and she was a part time employee. The personnel file for LPN 24 did not include annual abuse in-servicing training. An interview was conducted with the Regional Business Office Manager on 11/2/18 at 2:47 p.m. She indicated she was unable to provide any documentation regarding LPN 24's completion of annual abuse training.		The implementation of the facility abuse policy, including annual abuse in-service training of staff affects all staff, including LPN 24 whose employee file was reviewed during the survey. Details of facility abuse policy and the importance of corresponding adherence was reviewed with facility staff at the time of the survey, and reinforced with one-on-one inservices beginning 11/19/18 and ongoing. The facility abuse policy will also be reviewed during planned staff in-service 11/26/18. The implementation of the facility abuse policy, including annual abuse in-service training of staff affects all staff. Details of facility abuse policy and the importance of corresponding adherence was clarified and reinforced to all facility staff. This information will be reviewed and reinforced during planned staff in-service 11/26/18 and ongoing. All staff records will be reviewed to ensure that every staff member has received in-service abuse training upon employment, and annually thereafter. All staff will receive in-service abuse training upon employment, and annually thereafter. The Director of Nursing and Assistant Director of Nursing will use an audit tool to ensure that employee	

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	3.1-28(a)		records reflect completion of this required training. Weekly surveillance will ensure new employees and staff who miss scheduled in-services receive required information in a timely manner. This includes all part-time and PRN staff. After an initial review and remediation of employee files and training, the Director of Nursing and Assistant Director of Nursing will use the audit tool to monitor compliance weekly for six months. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure at least 95% compliance. If this benchmark is not met, an action plan will be developed and implemented to ensure compliance.	
F 0638 SS=D Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on interview and record review, the facility failed to complete a BIMS (brief interview for mental status) as part of the Quarterly MDS (Minimum Data Set) assessment for 1 of 14 residents whose MDS assessments were reviewed. (Resident C)	F 0638	**F638** The accurate and timely completion of BIMS as part of the quarterly MDS assessment affects all residents, including resident C whose record was reviewed during the survey period. The practice of	12/02/2018

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	Findings include: The clinical record for Resident C was reviewed on 11/2/18 at 11:00 a.m. The diagnoses for Resident C included, but were not limited to, schizophrenia and Alzheimer's disease. The 6/1/18 Annual MDS assessment indicated Resident C had a BIMS score of 12, indicating he was cognitively intact. The 7/26/18 Quarterly MDS assessment indicated the BIMS interview was not conducted. An interview was conducted with the MDS Coordinator and the Regional MDS Coordinator on 11/2/18 at 12:15 p.m. The MDS Coordinator indicated the BIMS section of Resident C's 7/26/18 Quarterly MDS assessment was completed by the facility's previous Social Services Director. The Regional MDS Coordinator indicated the BIMS should have been attempted to be completed within the 7 day look-back period. The CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Manual read, "Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference DATE (ARD) and is not contingent upon item B0700, Makes Self Understood." 3.1-31(d)(3)		timely and accurate quarterly MDS assessment, including BIMS, was reviewed with MDS coordinator at time of survey, and reinforced to the MDS and Social Service coordinators ongoing. The accurate and timely completion of BIMS as part of the quarterly MDS assessment affects all residents. The practice of timely and accurate quarterly MDS assessment, including BIMS, was reviewed with MDS coordinator at time of survey, and reinforced to the MDS and Social Service coordinators ongoing. All resident records were reviewed to ensure there are no overdue quarterly MDS assessments and corresponding BIMS. All resident MDS assessments will be completed quarterly and as required with change of condition. This includes BIMS as indicated. Resident records will be reviewed to ensure that no quarterly MDS assessments are overdue, and a calendar will be developed to ensure impending deadlines are anticipated and met. The Director of Nursing and Assistant Director of Nursing will use an audit tool to ensure compliance. After an initial review and remediation of resident records, the Director of Nursing and Assistant Director of Nursing will	

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			use the audit tool to monitor compliance weekly for six months. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure at least 95% compliance. If this benchmark is not met, an action plan will be developed and implemented to ensure compliance.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure accuracy of the MDS (Minimum Data Set) assessment for 2 of 14 residents whose MDS assessments were reviewed. (Residents B and D) Findings include: 1. The clinical record for Resident B was reviewed on 11/2/18 at 11:10 a.m. The diagnoses for Resident C included, but were not limited to, end stage renal disease. The 9/5/18 Quarterly MDS assessment indicated Resident B received dialysis treatments and used an indwelling catheter. An interview was conducted with Resident B on 10/30/18 at 12:01 p.m. He indicated he was a dialysis patient and did not produce urine. He was observed without a catheter at this time. An interview was conducted with the MDS	F 0641	**F641** Accurate MDS coding affects all residents, including residents B and D whose records were reviewed at the time of the survey. Resident B's MDS was reviewed and coded appropriately to reflect that he does not have an indwelling catheter. Resident D's MDS was reviewed and coded appropriately to reflect his total dependence and use of Hoyer lift for all transfers. The need for accurate MDS coding to reflect resident status and level of care reviewed with MDS coordinator at time of survey. This was also reinforced during subsequent in-services with the MDS coordinator and a corporate consultant. Accurate MDS coding affects all	12/02/2018

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	Coordinator and Regional MDS Coordinator on 11/2/18 at 1:10 p.m. The MDS Coordinator indicated Resident B did not currently have a catheter, and could could not find any information to indicate he ever did. The Regional MDS Coordinator indicated the 9/5/18 Quarterly MDS assessment was coded incorrectly, in regards to Resident B having a catheter, and a correction would be done. 2. The clinical record for Resident D was reviewed on 10/31/18 at 10:45 a.m. The diagnoses for Resident D included, but were not limited to: degenerative joint disease of the spine, left side hemiparesis, and osteoporosis. The 4/10/17 care plan, revised 9/14/17 indicated an intervention, initiated 9/21/16, was to, "Provide staff assist and use of Hoyer lift up in his w/c [wheel chair] daily as tolerates." Observations of Resident D were made on the following dates and times with a Hoyer pad behind him, while sitting in his Broda chair: 10/29/18 at 11:24 a.m., 10/30/18 at 10:14 a.m., and 10/31/18 at 11:01 a.m. An interview was conducted with CNA (Certified Nursing Assistant) 4 on 11/2/18 at 12:44 p.m. She indicated Resident D required the use of a Hoyer lift for all transfers. An interview was conducted with the ADON (Assistant Director of Nursing) on 11/2/18 at 12:41 p.m. She indicated Resident D required the use of a Hoyer lift for transfers, as he was unable to bare weight. Resident D's 7 day look back documentation logs used to code his 8/7/18 Quarterly MDS		residents. All resident records were reviewed to ensure accurate coding r/t urinary elimination and method of transfer. The need for accurate MDS coding to reflect resident status and level of care reviewed with MDS coordinator at time of survey. This was also reinforced during subsequent in-services with the MDS coordinator and a corporate consultant. Pertinent charting and most recent physician orders will be reviewed at the daily morning QA meeting to ensure that any changes in resident condition are accurately reflected in MDS coding. The MDS coordinator will continue to be in-serviced by the corporate MDS consultant regarding accurate MDS coding. The Director of Nursing and Assistant Director of Nursing will use an audit tool to ensure compliance. After an initial review and remediation of resident records, the Director of Nursing and Assistant Director of Nursing will use the audit tool to monitor compliance weekly for six months. New admissions, residents with significant change in condition, and residents due for quarterly MDS assessment will be audited by the MDS coordinator for accurate reflection of residents' urinary elimination status and	

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	assessment, indicated he was coded extensive assistance on 8/5/18, but total dependence on all other days. The 8/7/18 Quarterly MDS assessment indicated Resident D required extensive assistance of 2 plus persons for transfers. An interview was conducted with the MDS Coordinator and Regional MDS Coordinator on 11/2/18 at 12:15 p.m. The MDS Coordinator indicated Resident D required the use of a Hoyer lift for transfers. The Regional MDS Coordinator indicated, typically a resident who required the use of a hoyer lift was coded as totally dependent for transfers.		method of transfer. This audit will also be completed weekly for six months. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure at least 95% compliance. If this benchmark is not met, an action plan will be developed and implemented to ensure compliance.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive 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			

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	the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on interview and record review, the facility failed to create a care plan to address Resident E's pain for 1 of 14 residents whose care plan were reviewed. (Resident E) Findings include: The clinical record for Resident E was reviewed on 10/31/18 at 3:09 p.m. The diagnoses for Resident E included, but were not limited to, heart failure. The October, 2018 MAR (medication administration record) for Resident E indicated he was administered PRN (as needed) Hydrocodone-Acetaminophen 7.5-325 mg 22 times during the month, mostly for "all over" pain. During review of Resident E's care plans, no care	F 0656	**F656** The need for a care plan to address resident pain affects all residents, including resident E whose record was reviewed during the survey. Resident E's pain medication administration record was reviewed and an appropriate care plan to address his pain was developed and implemented. The importance of a care plan to address resident pain was reviewed with MDS coordinator and clinical staff at time of survey, and this was reinforced during subsequent one-on-one in-services.	12/02/2018

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	plan to address his pain was found. An interview was conducted with the MDS (Minimum Data Set) Coordinator on 11/2/18 at 1:43 p.m. She indicated Resident E did not have a pain care plan. Creating one was discussed on 10/18/18, but it was never done. 3.1-35(a)		The need for a care plan to address resident pain affects all residents. All resident records were reviewed to ensure all residents have an updated care plan that addresses their pain. The importance of a care plan to address resident pain was reviewed with MDS coordinator and clinical staff at time of survey, and this was reinforced during subsequent one-on-one in-services. Medication Administration Records will be reviewed to evaluate effectiveness of scheduled pain medications and the frequency of PRN pain medication use. Appropriate pain assessment tools will be used to determine pain regimen effectiveness and resident satisfaction and comfort. This information will be reviewed weekly, and the Director of Nursing and Assistant Director of Nursing will coordinate with the Medical Director to make changes as indicated. Any changes in resident orders will be reviewed with MDS coordinator to ensure accuracy of care plan. Information reviewed during one-on-one in-services will be reinforced during planned clinical meeting 11/26/18. The Director of Nursing and Assistant Director of Nursing will use an audit tool to monitor	

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			compliance. After an initial review and remediation of resident records, the Director of Nursing and Assistant Director of Nursing will use the audit tool to monitor compliance weekly for six months. New admissions, residents with significant change in condition, and residents due for quarterly MDS assessment will be audited by the MDS coordinator for accurate reflection of residents' pain regimen. This audit will also be completed weekly for six months. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure at least 95% compliance. If this benchmark is not met, an action plan will be developed and implemented to ensure compliance.	
F 0657 SS=D Bldg. 00	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. (C) A nurse aide with responsibility for the resident.			

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	(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 interview and record review the facility failed to assure care plans were reviewed by an interdisciplinary team quarterly for 1 of 1 residents reviewed for participation in care planning. (Resident F) Findings include: The clinical record for resident F was reviewed on 10/29/2018 at 2:20 p.m. The diagnosis for resident F included, but were not limited to, paraplegia. During an interview on 10/29/2018 at 12:08 p.m., resident F indicated that she had not attended a care plan meeting in several months. The clinical record contained a MDS (Minimum Data Set) Assessment dated 08/09/2018. The assessment indicated resident F was cognitively intact. A care plan signature sheet, located in the medical	F 0657	**F657** The accurate and timely completion of quarterly care plan meetings that include the resident affects all residents, including resident F whose record was reviewed during the survey period. The practice of timely and accurate quarterly care plan review and corresponding resident inclusion was reviewed with MDS coordinator at time of survey, and reinforced to the MDS and Social Service coordinators ongoing. The accurate and timely completion of quarterly care plan meetings that include the resident affects all residents. The practice of timely and accurate quarterly care plan review and corresponding resident inclusion was reviewed with MDS	12/02/2018

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	record, contained signatures of the MDS Coordinator, Activity Director, Certified Dietary Manager and Resident F for the date of 05/17/2018. During an interview on 11/01/2018, the MDS Coordinator indicated that the last care plan for resident F had been held on 5/17/2018. She indicated that Resident F should have had a care plan meeting in August 2018, however, there was no documentation that a meeting had been held. Care plan meetings were held quarterly and with significant changes in the resident's status. 3.1-35(c)(2)		coordinator at time of survey, and reinforced to the MDS and Social Service coordinators ongoing. All resident care plan reviews will be completed quarterly and as required with change of condition. Residents and/or representatives/family members will be notified a minimum of seven days prior to planned care plan meetings to facilitate attendance by resident/representative/family members. Resident records will be reviewed to ensure that no quarterly care plan reviews are overdue, and a calendar will be developed to ensure impending deadlines are anticipated and met. The Director of Nursing and Assistant Director of Nursing will use an audit tool to ensure compliance. After an initial review and remediation of resident records, the Director of Nursing and Assistant Director of Nursing will use the audit tool to monitor compliance weekly for six months. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure at least 95% compliance. If this benchmark is not met, an action plan will be developed and implemented to ensure compliance.	

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F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. Based on interview and record review, the facility failed to ensure a discharge summary included a recapitulation of stay, final summary of status, reconciliation of medications, and post discharge plan of care for 1 of 1 resident reviewed for discharge. (Resident G)	F 0661	**F661** The need for a comprehensive discharge summary affects all residents, including resident G whose post discharge record was reviewed during the survey. The four required components of a	12/02/2018

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	Findings include: The closed clinical record for Resident G was reviewed on 11/1/18 at 12:00 p.m. The diagnoses for Resident G included, but were not limited to, paranoid schizophrenia. She was discharged home from the facility on 8/11/18. The 8/11/18 Post Discharge Instructions form did not include a recapitulation of stay that included the course of illness. It did not include a final summary of status that included vision, mood and behavior patterns, and dental status. It did not include a reconciliation of her pre and post discharge medications. An interview was conducted with the ADON (Assistant Director of Nursing) and DON (Director of Nursing) on 11/1/18 at 2:51 p.m. The ADON indicated the Post Discharge Instructions form served as the facility's discharge summary. The DON indicated the form did not include all of the necessary components in their discharge summaries, and was unaware it needed to. The Discharge of Resident policy was provided b the Regional Director of Clinical Operations on 11/1/18 at 3:50 p.m. It read, "When the facility anticipates discharge, a Resident must have a discharge summary that includes the following: 1) A recapitulation of the Resident's stay 2) A final summary of the Resident's status to include the components of the comprehensive assessment, at the time of the discharge that is available for release to authorized persons and agencies with the consent of the resident or legal representative. 3) A post discharge care plan..." The policy did not reference a reconciliation of pre and post discharge medications.		discharge summary as provided by the state surveyor were reviewed with clinical staff during the time of survey. This information was reinforced during one-on-one in-services with clinical staff, and will be further reinforced during planned in-service 11/26/18. The need for a comprehensive discharge summary affects all residents. The four required components of a discharge summary as provided by the state surveyor were reviewed with clinical staff during the time of survey. This information was reinforced during one-on-one in-services with clinical staff, and will be further reinforced during planned in-service 11/26/18. A new discharge summary template was developed and implemented to ensure each of the required four components are included and addressed: 1. Recapitulation of resident stay 2. Final summary of resident status 3. Reconciliation of medications 4. Post discharge plan of care Resident information will be reviewed daily at morning QA meeting to identify residents with pending discharges. Comprehensive discharge summary will be initiated upon identification of pending	

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	3.1-36(a)(1) 3.1-36(a)(2)		discharges. This summary will be completed to allow review by Nursing, Activities, Dietary and Therapy departments before information is reviewed with resident and/or representative/family prior to discharge to ensure understanding. The Director of Nursing and Assistant Director of Nursing will use an audit tool to ensure compliance. The Director of Nursing and Assistant Director of Nursing will use the audit tool to review every resident discharge to monitor compliance for indefinitely. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure 100% compliance. If this benchmark is not met, an action plan will be developed and implemented to ensure compliance.	
F 0684 SS=E Bldg. 00	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. Based on interview and record review, the facility	F 0684	**F684**	12/02/2018

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	failed to ensure labs were obtained as ordered, to administer insulin as ordered, to address a recommendation to decrease an antidepressant medication, and to flush nephrostomy tubes and accurately monitor the output of nephrostomy tubes for 1 of 1 resident reviewed for catheters, 1 of 1 residents reviewed for dialysis, and 2 of 5 residents reviewed for unnecessary medications. (Resident B, F, L, and Q) Findings include: A. The clinical record for Resident B was reviewed on 10/31/18 at 1:00 p.m. The diagnoses for Resident B included, but were not limited to, chronic kidney disease and epilepsy. A urology consultation dated 9/19/18, indicated a recommendation to obtain a testosterone and prolactin level for Resident B. A physician ordered dated 9/19/18, indicated to obtain a serum testosterone level and prolactin level for Resident B and send results to urologist. The clinical record did not include a testosterone or prolactin level. An interview was conducted with the Director of Nursing on 10/31/18 at 9:30 a.m. She indicated the testosterone and prolactin level was missed. The labs had not been obtained. B. The clinical record for Resident L was reviewed on 10/31/18 at 10:00 a.m. The diagnosis for Resident L included, but was not limited to, diabetes mellitus type 2. A physician order dated 7/26/18, indicated blood sugar checks were to be obtained 4 times a day		The timely and accurate follow-up of MD orders affects all residents, including residents B, F, L and Q whose records were reviewed during the survey. The lab was called to complete blood draw for resident B testosterone and prolactin levels and reported to resident's urologist as ordered. An active order was obtained to flush resident F's nephrostomy tubes daily. Resident L's insulin MAR was updated to draw clinician attention to the fact that resident does not receive sliding scale insulin with each accucheck, only 8am and 5pm as indicated per MD order. Resident Q's Cymbalta order was reviewed and clarified by MD to ensure resident receiving proper dose. Resident orders were reviewed with clinical staff in each of these instances to ensure understanding and reinforce absolute necessity of adherence to MD orders. This was reinforced during one-on-one in-services, and will be further reinforced during planned clinical meeting 11/26/18. The timely and accurate follow-up of MD orders affects all residents. All resident records reviewed for identification of missed labs, adherence to insulin administration orders, orders for care of indwelling urinary catheters and accurate I&O documentation, and follow-up of pharmacy	

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	and night. Staff was to call if Resident L's blood sugar was less than 70 or greater than 350. A physician order dated 11/11/17, indicated Resident L was to receive novolog insulin using a sliding scale. The sliding scale was the following: 151 - 200 blood sugars = 2 units, 201-250 blood sugars = 4 units, 251 - 300 blood sugars = 6 units, 301 -350 blood sugars = 8 units. The sliding scale was scheduled to be administered at 8:00 a.m., and 5:00 p.m. A physician order dated 7/9/18, indicated Resident L was to receive 4 units of Novolog three times a day. A physician order dated 8/17/18, indicated Resident L was to receive 16 units of levemir at night. The October 2018, Medication Administration Record (MAR) indicated Resident L received the novolog sliding scale not as ordered on the following days and times : 10/3/18 - 6:00 a.m., 11:00 a.m., 9:00 p.m., 10/4/18 - 6:00 a.m., 4:00 p.m., 9:00 p.m., 10/5/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m., 10/6/18 - 11:00 a.m., 10/7/18- 6:00 a.m., 11:00 a.m., 4:00 p.m., 10/8/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m., 9:00 p.m., 10/9/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m., 9:00 p.m., 10/11/18 - 11:00 a.m., 4:00 p.m., 10/12/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m., 10/13/18 - 11:00 a.m., 4:00 p.m., 9:00 p.m., 10/14/18 - 11:00 a.m., 10/15/18 - 11:00 a.m., 10/16/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m., 10/17/18 - 6:00 a.m., 11:00 p.m., 4:00 p.m., 9:00 p.m., 10/18/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m.,		recommendations. Resident orders were reviewed with clinical staff in each of these instances to ensure understanding and reinforce absolute necessity of adherence to MD orders. This was reinforced during one-on-one in-services, and will be further reinforced during planned clinical meeting 11/26/18. Lab tracker developed to record labs when ordered and ensure follow-up and reporting as indicated. MD orders (yellow sheets) to be reviewed daily during morning QA meeting by Director of Nursing and Assistant Director of Nursing to ensure lab tracker being used appropriately. All residents with indwelling urinary catheters will have active orders for care and maintenance, and output will be accurately recorded per MD orders. The Director of Nursing and Assistant Director of Nursing will review documentation daily to ensure accurate documentation. Insulin administration MARs and corresponding blood sugar logs will be updated to accurately reflect MD orders and minimize possible errors. The Director of Nursing and Assistant Director of Nursing will review documentation daily to ensure adherence to MD orders. Pharmacy recommendations will be reviewed and delivered to MD in a timely	

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	10/19/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m., 9:00 p.m., 10/20/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m., 9:00 p.m., 10/21/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m., 9:00 p.m., 10/22/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m., 9:00 p.m., 10/23/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m., 10/25/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m., 10/26/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m., 10/27/18 - 11:00 a.m., 10/28/18 - 6:00 a.m., 11:00 a.m., 9:00 p.m.,and 10/30/18 - 11:00 a.m. An interview was conducted with the Director of Nursing on 11/1/18 at 3:35 p.m. She indicated Resident L was to receive the novolog sliding scale only twice a day at 8:00 a.m., and 5:00 p.m. C. The clinical record for Resident Q was reviewed on 10/31/18 at 9:00 a.m. The diagnosis for Resident Q included, but was not limited to, major depressive disorder. A physician order dated 5/13/17, indicated Resident Q was to receive 60 milligrams of cymbalta daily. A psychological consultation dated 10/16/18, indicated a recommendation to decrease Resident Q's cymbalta from 60 milligrams to 30 milligrams daily. An October 2018, Medication Administration Record indicated Resident Q had received 60 milligrams of cymbalta daily from 10/1/18 through 10/30/18. An interview was conducted with the Assisted Director of Nursing on 11/1/18 at 2:15 p.m. She indicated she could not locate documentation the recommendation to decrease Resident Q's cymbalta was addressed by the medical provider		manner for consultation and possible order changes. Recommendations will be submitted to MD via fax upon receipt and a copy will be placed in MD follow-up book for review at next visit. All pharmacy consults will be kept on record with fax verification of delivery to MD. The Director of Nursing and Assistant Director of Nursing will ensure this process is followed with every pharmacy consult. Audit tools will be utilized by the Director of Nursing and Assistant Director of Nursing to ensure compliance with each of these initiatives. The Director of Nursing and Assistant Director of Nursing will use the audit tools to monitor adherence to MD orders daily r/t lab orders, insulin administration, urinary catheter care, and output documentation. This daily monitoring will continue for six months. The Director of Nursing and Assistant Director of Nursing will use an audit tool to monitor compliance with each pharmacy consult, generally completed monthly. This monthly monitoring will continue indefinitely. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure at least 95% compliance. If this benchmark is not met, an action plan will be developed and implemented to ensure	

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	to agree or disagree with the gradual dose reduction. The "Medication Administration" policy was provided by the Director of Nursing on 11/2/18 at 1:14 p.m. It indicated "..Physician's Orders - Medications are administered in accordance with written orders of the attending physician..."D. The clinical record for resident F was reviewed on 10/29/2018 at 2:20 p.m. The diagnosis for resident F included, but were not limited to, paraplegia and hydronephrosis (excess fluid in the kidneys due to a backup of urine). During an interview on 10/29/2018 at 12:13 p.m., resident F indicated she had recently returned from a hospitalization. She was hospitalized for a urinary infection. She indicated staff do not always empty her nephrostomy tube (tube going into the kidney) drainage bags each shift. The clinical record contained hospitalization records from 10/12/2018 to 10/15/2018. The hospital Urology progress noted dated 10/15/2018 at 07:22 a.m., indicated, ".....Assessment/ Plan: ....3. Sepsis [wide spread infection} with complicated uti [urinary tract infection] with possible nephrostomy tube malfunction...patient underwent...bilateral nephrostomy tube replacement... on 10/14/2018." A Quarterly MDS (Minimum Data Set) Assessment completed 8/9/2018 indicated that resident F was cognitively intact and nephrostomy tubes were present. The physician's orders for August 2018 contained an order to flush right and left nephrostomy tubes with 10 milliliters of normal saline daily. The MAR (medication administration record) indicated that		compliance.	

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	the nephrostomy tubes had been flushed as ordered for the month of August 2018. The physician's orders for September and October 2018 did not contain an order to flush the right and left nephrostomy tubes with 10 milliliters of normal saline daily. The MAR for September and October 2018 did not contain any documentation that the nephrostomy tubes had been flushed with normal saline. The clinical record did not contain a physician's order to discontinue the flushing of the nephrostomy tubes. The physician's orders for October 2018 contained an order to record the nephrostomy tube output of right and left each shift daily. The comprehensive intake and output record for October 2018 was reviewed. No output was documented for the following days and shifts; 10/01/2018 night shift, 10/02/2018 night shift, 10/03/2018 night shift, 10/04/2018 night shift, 10/05/2018 night shift, 10/06/2018 night shift,10/07/2018 night shift, 10/08/2018 night shift, 10/09/2018 evening shift, 10/10/2018 evening and night shift, 10/11/2018 night shift, 10/16/2018 evening shift, 10/17/2018 evening and night shift, 10/18/2018 evening and night shift, 10/20/2018 night shift, 10/ 21/2018 day, evening and night shift, 10/22/2018 night shift, 10/24/2018 night shift, 10/25/2018 night shift, 10/26/2018 evening and night shift, 10/27/2018 evening and night shift, 10/29/2018 night shift, 10/30/2018 night shift and 10/31/2018 night shift. During an interview on 11/02/2018 at 11:23 a.m., the DON (Director of Nursing) indicated that nephrostomy tubes should have been flushed			

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	daily and that the order for the nephrostomy tube flushes had not been transcribed properly. The output of the nephrostomy tubes should have been recorded as ordered by the physician. On 11/02/2018 at 1:14 p.m., the DON provided the "Care of Nephrostomy Tube" policy, which indicated "...General Guidelines... 3. Empty drainage bag once per shift and as needed...5. Measure output as follows: ... c. Every 8 hours, 6. Measure output from right and left kidneys separately... 3.1-37			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to implement a resident's restorative nursing program for 1 of 1 resident	F 0688	**F688** A properly implemented Restorative Nursing program to	12/02/2018

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	reviewed for positioning and mobility. (Resident D) Findings include: The clinical record for Resident D was reviewed on 10/31/18 at 10:45 a.m. The diagnoses for Resident D included, but were not limited to: degenerative joint disease of the spine, left side hemiparesis, and osteoporosis. The 9/1/18 Restorative Nursing Program read, "Treatment Recommendations: ...Also apply wedge abductor or pillow between legs to decrease pressure areas. The 9/12/18 physician's order read, "OT [Occupational Therapy] Recommendations: 1. Place the abductor wedge or folded pillow between pt's [patient's] [symbol for "bilateral"] knees. Check for redness...." Observations of Resident D were made on 10/29/18 at 11:24 a.m., 11:36 a.m., 12:53 a.m., and 2:31 p.m. His right leg was positioned underneath his left leg, with no pillow or abductor wedge between his knees. An observation of Resident D was made on 10/30/18 at 10:14 a.m. He was sitting in his Broda chair, with no pillow or abductor wedge between his knees. An observation of Resident D was made on 10/31/18 at 11:01 a.m. He was lying in his Broda chair with no pillow or abductor wedge between his knees. An interview was conducted with Resident D on 10/31/18 at 11:01. He indicated sometimes he used		increase/prevent decrease in ROM/mobility affects all residents, including resident D whose record was reviewed during the survey. Resident D's Restorative Nursing program and related MD orders were reviewed, and recommendations were implemented. Importance of adherence to Restorative Nursing program recommendations was reviewed with staff during time of survey. This information was reinforced during one-on-one in-services and CNA training. A properly implemented Restorative Nursing program to increase/prevent decrease in ROM/mobility affects all residents. All residents Restorative Nursing programs and related MD orders were reviewed, and recommendations were implemented. Importance of adherence to Restorative Nursing program recommendations was reviewed with staff during time of survey. This information was reinforced during one-on-one in-services and CNA training. Restorative Nursing program reviewed with MDS coordinator and therapy representatives to ensure roles and responsibilities fully understood. All resident records reviewed to ensure that all residents deemed appropriate for Restorative Nursing have a current	

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	a pillow between his legs, and sometimes he did not. Nursing left it up to him, if he used a pillow or not. He could tolerate it between his legs for a while, then it began to irritate him. He indicated nursing did not ask him this day, if he wanted the pillow between his knees, but he would be fine with using the pillow at this time. An interview and observation was conducted with CNA (Certified Nursing Aide) 5 on 10/31/18 at 11:12 a.m. in Resident D's room. She indicated he was supposed to have a pillow between his legs. The MDS Coordinator entered the room with a wedge, she indicated as having retrieved from the therapy department. The MDS Coordinator proceeded to place the wedge between Resident D's knees. Resident D accepted the wedge. An interview was conducted with COTA 7 on 10/31/18 at 11:19. She indicated Resident 7 should have a wedge or pillow between his knees, something to keep the knees separated, to reduce the pressure and ensure skin off skin. She indicated Resident D was total dependence for transfers and required a Hoyer lift, and staff would have to put a pillow or wedge between his legs. The 9/1/18 Restorative Nursing Program read, "...Perform PROM [passive range of motion] ex [exercises] to Res [resident's] nonfunctional extremity 3 sets of 10 reps with a 5 sec [second] hold to encourage a stretch." The September and October, 2018 Restorative Care Plan And Charting read, "Resident will complete 2 sets of 15 reps [repetitions] of active range of motion exercises to both upper extremities to each joint through each plane daily..." The charting portions indicated the exercises were completed 12 times in September,		program that addresses resident needs, including pain, positioning, mobility, and splints/braces. Resident progress with therapy will be reviewed daily during morning QA meeting to identify residents who will shortly be appropriate for Restorative Nursing. Development of the resident's individualized Restorative Nursing program will begin at this time, and implementation will occur at time of therapy DC. Residents currently on Restorative Nursing program will be monitored with daily review of documentation. This will be tracked with an audit tool by the Director of Nursing and Assistant Director of Nursing. The Director of Nursing and Assistant Director of Nursing will use the audit tools to monitor daily for six months. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure at least 95% compliance. If this benchmark is not met, an action plan will be developed and implemented to ensure compliance.	

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	2018 and 15 times in October, 2018. An interview was conducted with the MDS Coordinator on 10/31/18 at 2:14 p.m. She indicated Resident D's restorative program was supposed to be implemented Monday through Friday, but it was not, which is part of the reason the previous restorative aide no longer worked at the facility. The July, 2018 Splint/Brace Restorative Care Plan and Charting read, "Problem: Resident has BUE [bilateral upper extremity] contracture's related to ROM [range of motion] loss r/t [related to] stroke Hx [history] with L[left] hemiparesis. Goal: Resident will tolerate soft hand cone as ordered without c/o [complaints of] pain or discomfort for at least 4 hours daily through next review. Plan: Perform PROM [passive range of motion] to prior to donning cone, using fingers extend residents fingers while holding fingers open place cone inside resident's hand. Observe for pain, open areas, reddened areas, or swelling....Refer to therapy as needed for increased pain or worsing (sic) of contracture....Week 2 Progress: 7/12 Resident refused majority of week [symbol for "with'] complaint of pain & discomfort [cursing & attempting to hit at aides.] Week 3 Progress: 7/20 Resident refused to let aide wash hand/or put cone in hand for complaint of pain. Resident yelled, cursed and held hand [symbol for "with"] opposite hand to block cone." An interview was conducted with COTA 7 on 10/31/18 at 11:19. She indicated the splint/brace program was implemented a while back, and it should have continued. An interview was conducted with the MDS Coordinator on 10/31/18 at 2:14 p.m. She indicated they stopped implementing Resident D's			

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	splint/brace program, because he refused, but was unsure if his refusing or increased pain was ever discussed with therapy. An interview was conducted with the COTA (Certified Occupational Therapy Assistant) 7 and the MDS Coordinator on 10/31/18 at 11:55 a.m. COTA 7 indicated therapy was never involved in discontinuing Resident D's splint/brace program in regards to his use of a cone. The Restorative Nursing Policy and Procedure was provided by the MDS Coordinator on 11/1/18 at 9:02 a.m. It read, "It is the policy of this facility to provide restorative nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible....Minutes of restorative nursing must be tracked and documented daily." 3.1-42(a)(2)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth			

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	in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.			
	Based on interview and record review, the facility failed to timely address a pharmacy recommendation for 1 of 5 residents reviewed for unnecessary medications. (Resident E) Findings include: The clinical record for Resident E was reviewed on 10/31/18 at 3:09 p.m. The diagnoses for Resident E included, but were not limited to, atrial fibrillation. The October, 2018 physician's orders for Resident	F 0756	**F756** The timely follow-up of pharmacy recommendations affects all residents, including resident E whose record was reviewed at the time of the survey. All referenced pharmacy recommendations reviewed with MD, recommended digoxin level obtained and reported to MD as indicated. The importance of pharmacy recommendations and subsequent follow-up reviewed with clinical	12/02/2018

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	E indicated for a 125 mcg tablet of digoxin to be administered once a day, effective 2/1/18. The 2/2/18 digoxin care plan indicated an intervention, initiated 2/2/18, was, "Serum Digoxin levels monthly or as ordered by physician." The last digoxin lab result in Resident E's clinical record was dated 11/30/17. The 8/9/18 pharmacy recommendation for Resident E read, "[Name of Resident E] receives digoxin [Lanoxin], and does not have a digoxin serum concentration evaluation in the resident record within the previous 6 months. Recommendation: Please consider monitoring serum digoxin concentration on the next convenient lab day and every 6 months thereafter to monitor for potential toxicities of this therapy. Rationale for Recommendation: Routine serum concentration monitoring is recommended with digoxin use as it is a narrow therapeutic index medication." There was no physician response in the clinical record to this 8/9/18 pharmacy recommendation. An interview was conducted with the DON (Director of Nursing) on 11/2/18 at 10:32 a.m. She indicated the facility was unable to provide a response to the 8/9/18 digoxin pharmacy recommendation. The 10/10/18 pharmacy recommendation for Resident E read, "Repeated Recommendation from 8/9/18: Please respond promptly to assure facility compliance with Federal regulations. [Name of Resident E] receives digoxin [Lanoxin], and does not have a digoxin serum concentration evaluation in the resident record within the previous 6 months. Recommendation: Please		staff at time of survey. This was reinforced during one-on-one in-services and will be further reinforced at planned clinical meeting 11/26/18. The timely follow-up of pharmacy recommendations affects all residents. All pharmacy recommendations for the last three months (August, September, October) reviewed for follow-up, including medication changes and labs. Medical Director consulted as appropriate. The importance of pharmacy recommendations and subsequent follow-up reviewed with clinical staff at time of survey. This was reinforced during one-on-one in-services and will be further reinforced at planned clinical meeting 11/26/18. Pharmacy recommendations will be reviewed and delivered to MD in a timely manner for consultation and possible order changes. Recommendations will be submitted to MD via fax upon receipt and a copy will be placed in MD follow-up book for review at next visit. All pharmacy consults will be kept on record with fax verification of delivery to MD. The Director of Nursing and Assistant Director of Nursing will ensure this process is followed with every pharmacy consult. An audit tool will be utilized by the Director of Nursing and Assistant Director of	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	consider monitoring serum digoxin concentration on the next convenient lab day and every 6 months thereafter to monitor for potential toxicities of this therapy. Rationale for Recommendation: Routine serum concentration monitoring is recommended with digoxin use as it is a narrow therapeutic index medication....Physician's Response: I accept the recommendation(s) above with the following modification(s): digoxin level X [times] [symbol for "one"] then q [every] 3 months." 3.1-25(i)		Nursing to ensure compliance with each of these initiatives. The Director of Nursing and Assistant Director of Nursing will use an audit tool to monitor compliance with each pharmacy consult, generally completed monthly. This monthly monitoring will continue indefinitely. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure 100% compliance. If this benchmark is not met, an action plan will be developed and implemented to ensure compliance.	
F 0757 SS=D Bldg. 00	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 §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			

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	155721	A. BUILDING 00 B. WING	11/02/2018

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	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. Based on interview and record review, the facility failed monitor a resident's digoxin medication use, as care planned, for 1 of 5 residents reviewed for unnecessary medications. (Resident E) Findings include: The clinical record for Resident E was reviewed on 10/31/18 at 3:09 p.m. The diagnoses for Resident E included, but were not limited to, atrial fibrillation. The October, 2018 physician's orders for Resident E indicated for a 125 mcg tablet of digoxin to be administered once a day, effective 2/1/18. The 2/2/18 digoxin care plan indicated an intervention, initiated 2/2/18, was, "Serum Digoxin levels monthly or as ordered by physician." There was no order found in the clinical record, regarding laboratory monitoring of Resident E's digoxin use. The 8/9/18 pharmacy recommendation for Resident E read, "[Name of Resident E] receives digoxin [Lanoxin], and does not have a digoxin serum concentration evaluation in the resident record within the previous 6 months. Recommendation: Please consider monitoring serum digoxin concentration on the next convenient lab day and every 6 months thereafter to monitor for potential toxicities of this therapy.	F 0757	**F757** Regular monitoring of resident labs to ensure therapeutic medication regimen affects all residents, including resident E whose record was reviewed during the survey. Recommended digoxin level obtained and reported to MD as indicated. Lab draw scheduled for 04/30/19 for six month surveillance. The importance of pharmacy recommendations and subsequent follow-up reviewed with clinical staff at time of survey. This was reinforced during one-on-one in-services and will be further reinforced at planned clinical meeting 11/26/18. Regular monitoring of resident labs to ensure therapeutic medication regimen affects all residents. All resident records and pharmacy reports reviewed to ensure lab monitoring completed at recommended intervals. The importance of pharmacy recommendations and subsequent follow-up reviewed with clinical staff at time of survey. This was reinforced during one-on-one in-services and will be further reinforced at planned clinical meeting 11/26/18.	12/02/2018

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	Rationale for Recommendation: Routine serum concentration monitoring is recommended with digoxin use as it is a narrow therapeutic index medication. [Ref (Reference): Lanoxin (package insert). GlaxoSmithKline, Research Triangle Park, NC. December 2016.]" The last digoxin lab result in Resident E's clinical record was dated 11/30/17. The 10/10/18 pharmacy recommendation for Resident E read, "Repeated recommendation from 8/9/18: Please respond promptly to assure facility compliance with Federal regulations. [Name of Resident E] receives digoxin [Lanoxin], and does not have a digoxin serum concentration evaluation in the resident record within the previous 6 months. Recommendation: Please consider monitoring serum digoxin concentration on the next convenient lab day and every 6 months thereafter to monitor for potential toxicities of this therapy. Rationale for Recommendation: Routine serum concentration monitoring is recommended with digoxin use as it is a narrow therapeutic index medication. [Ref (Reference): Lanoxin (package insert). GlaxoSmithKline, Research Triangle Park, NC. December 2016.]" ...Physician's Response: I accept the recommendation(s) above with the following modification(s): digoxin level X [times] [symbol for "one"] then q [every] 3 months." An interview was conducted with the DON on 11/2/18 at 9:35 a.m. She indicated she was unsure of Resident E's digoxin lab monitoirng schedule. 3.1-48(a)(3)		Lab tracker developed to record labs when ordered and ensure follow-up and reporting as indicated. MD orders (yellow sheets) to be reviewed daily during morning QA meeting by Director of Nursing and Assistant Director of Nursing to ensure lab tracker being used appropriately. Upon admission resident diagnoses/medications will be reviewed to ensure that appropriate lab monitoring is care planned and scheduled for draw. Pharmacy recommendations will be reviewed and delivered to MD in a timely manner for consultation and possible lab orders. Recommendations will be submitted to MD via fax upon receipt and a copy will be placed in MD follow-up book for review at next visit. All pharmacy consults will be kept on record with fax verification of delivery to MD. The Director of Nursing and Assistant Director of Nursing will ensure this process is followed with every pharmacy consult. An audit tool will be utilized by the Director of Nursing and Assistant Director of Nursing to ensure compliance with each of these initiatives. The Director of Nursing and Assistant Director of Nursing will use an audit tool to monitor compliance with each pharmacy consult, generally completed	

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			monthly. This monthly monitoring will continue indefinitely. A separate audit tool will be used monthly to review resident records independent of pharmacy recommendations to ensure high-risk medications are being appropriately monitored. This monthly monitoring will also continue indefinitely. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure 100% compliance. If this benchmark is not met, an action plan will be developed and implemented to ensure compliance.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5 percent for 1 of 5 residents observed during medication pass. There were 35 opportunities with 2 errors resulting in a 5.71% medications error rate. The errors involved 1 resident (Resident M) in the sample of 16. Findings include: The clinical record for resident M was reviewed on 10/31/2018 at 10:42 a.m. The diagnosis for resident M included, but were not limited to, Autism and hypertension.	F 0759	**F759** Accurate medication administration, limiting medication errors to five percent or less, affects all residents, including resident M whose record was reviewed during the survey. An active MD order to crush resident medications was obtained. Pharmacist was consulted for alternatives to extended release meds (Bupropion and Metoprolol) that could be safely crushed. Medical Director consulted, orders	12/02/2018

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	A physicians order dated 9/26/18 indicated resident M was to receive Budeprion SR (sustained release antidepressant) 150 milligrams twice daily and Metoprolol ER (extended release antihypertensive) 50 milligrams one time daily. There was no order present in the clinical record to crush medications prior to administering them. On 10/31/2018 at 10:32 a.m., QMA (Qualified Medication Aide) 6 was observed administering medications to resident M. She crushed the Budeprion SR and Metoprolol ER and mixed the medications in applesauce. She administered the crushed medications to resident M. The website "Oral Dosage Forms That Should Not Be Crushed" revised on November 20, 2016 from the Institute of Safe Medications Practices (ISMP), indicates Metoprolol ER and Budeprion SR should not be crushed prior to administration. During an interview on 10/31/2018 at 10:42 a.m., pharmacist 10 indicated Budeprion SR should not be crushed prior to administration. The possible side effects of crushing Budeprion SR include, but are not limited to, agitation, constipation and headache. He indicated that Metoprolol ER should not be crushed prior to administration. The possible side effects of crushing Metoprolol ER include, but are not limited to, low blood pressure and dizziness. During an interview on 11/01/2018 at 8:55 a.m., the DON (Director of Nursing) indicated that extended release medications should not be crushed. 3.1-48(c)(1)		obtained, resident medication regimen/MAR updated. Sixteen-page PDF from the Institute of Safe Medication Practices (ISMP) reviewed with clinical staff at time of survey. This information was reinforced during one-on-one inservices and will be further reinforced at clinical meeting 11/26/18. A copy of this PDF was also placed in the medication room. Accurate medication administration, limiting medication errors to five percent or less, affects all residents. All resident records were reviewed to ensure anyone receiving crushed meds has active MD order. Resident records also reviewed to ensure no inappropriate meds being crushed, with subsequent follow-up and adjustment of med regimen as indicated. Sixteen-page PDF from the Institute of Safe Medication Practices (ISMP) reviewed with clinical staff at time of survey. This information was reinforced during one-on-one inservices and will be further reinforced at clinical meeting 11/26/18. A copy of this PDF was also placed in the medication room. Pertinent charting and physician orders will be reviewed daily at the morning QA meeting to identify residents with new dysphagia and residents with newly prescribed	

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			medications. Medical director will be consulted if new crush orders are needed and/or residents with crush orders are prescribed medications that should not be crushed. The Director of Nursing and Assistant Director of Nursing will use an audit tool to monitor compliance. All new residents will be evaluated for need to crush meds and medication regimen will be assessed to ensure no inappropriate meds being crushed. The Director of Nursing and Assistant Director of Nursing will use an audit tool to monitor compliance daily for six months. Weekly monitoring will continue indefinitely thereafter. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure 100% compliance. If this benchmark is not met, an action plan will be developed and implemented to ensure compliance.	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a resident's seizure medications were administered as ordered for 1 of 1 residents reviewed for dialysis and to assure extended release medication was not crushed for 1 of 16 residents reviewed for significant medication	F 0760	**F760** Accurate medication administration, preventing any and all significant med errors, affects all residents, including residents B and M whose records were	12/02/2018

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	errors. (Resident B and M) Findings include: A. The clinical record for Resident B was reviewed on 10/31/18 at 1:00 p.m. The diagnoses for Resident B included, but were not limited to, chronic kidney disease and epilepsy. A physician order dated 9/21/18, indicated Resident B was to receive 2 tablets of vimpat a total of 400 milligrams by mouth daily. A physician order dated 9/21/18, indicated Resident B was to receive an additional 1 tablet of vimpat a total of 200 milligrams after dialysis on Tuesdays, Thursdays and Saturdays. Resident B was to take the 200 milligrams with him to dialysis. A physician order dated 10/21/18, indicated Resident B was to receive 500 milligrams of keppra twice a day for seizures. A physician order dated 10/21/18, indicated Resident B was to receive 250 milligrams of keppra 3 times a week after dialysis. A Controlled Substance Record dated 9/21/18, indicated Resident B did not receive vimpat as ordered on the following days and times: 9/29/18 - Saturday - no dosages administered, 10/2/18 - 4:00 a.m., Tuesday 2 tablets administered = 400 milligrams, 10/4/18 - Thursday - no dosages administered, 10/6/18 - 4:00 a.m., Saturday 1 tablet administered = 200 milligrams, 10/8/18 - Monday = no dosages administered, 10/9/18 - 4:00 a.m., Tuesday 1 tablet administered = 200 milligrams,		reviewed during the survey period. Resident B's vimpat order was clarified with Medical Director and pharmacy. Resident B's MAR was updated to bring clinician attention to the order and limit incorrect interpretation. Pharmacist was consulted for alternatives to extended release meds (Bupropion and Metoprolol) that could be safely crushed for resident M. Medical Director consulted, orders obtained, resident M medication regimen/MAR updated. The absolute necessity of adherence to MD orders r/t seizure meds reviewed with clinical staff during time of survey. Resident B's vimpat order also reviewed during one-on-one inservices to ensure understanding. Sixteen-page PDF from the Institute of Safe Medication Practices (ISMP) reviewed with clinical staff at time of survey. This information was reinforced during one-on-one inservices and will be further reinforced at clinical meeting 11/26/18. A copy of this PDF was also placed in the medication room. Accurate medication administration, preventing any and all significant med errors, affects all residents. The absolute necessity of adherence to MD orders r/t seizure meds reviewed with clinical staff during time of	

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	10/11/18 - Thursday = no dosages administered, 10/13/18 - Saturday = no dosages administered, 10/16/18 - Tuesday = no dosages administered, 10/18/18 - 4:00 a.m., Thursday 1 tablet administered = 200 milligrams, 10/20/18 - 4:00 a.m., Saturday 1 tablet administered = 200 milligrams, 10/21/18 - Sunday = no dosages administered, 10/23/18 - Tuesday - no dosages administered, 10/25/18 - 4:00 a.m., Thursday 1 tablet administered = 200 milligrams, 10/27/18 - 4:00 a.m., Thursday 1 tablet administered = 200 milligrams, 10/27/18 - 11:15 a.m., Wednesday 1 tablet administered = 200 milligrams, and 10/30/18 - 4:00 a.m., Tuesday 1 tablet = 200 milligrams, The October 2018 Medication Administered Record for Resident B indicated the 500 milligrams of keppra was administered twice a day on 10/22/18 through 10/30/18. The 250 milligrams of keppra that was to be administered 3 times a week after dialysis was not administered. An interview was conducted with Resident B on 10/30/18 at 11:47 a.m. He indicated the staff does not always give him his seizure medications. An interview was conducted with License Practical Nurse (LPN) 1 on 11/1/18 at 8:39 a.m. She indicated Resident B goes to dialysis on Tuesdays, Thursdays, and Saturdays. He leaves at 4:00 a.m. Resident B does at times refuse his medications, but never refuses his seizure medications. On dialysis days, Resident B gets receives 1 tablet of vimpat at 4:00 a.m., and then takes another tablet of vimpat with him to take immediately after dialysis due to seizures.		survey. This information was also reinforced during one-on-one inservices to ensure understanding. Sixteen-page PDF from the Institute of Safe Medication Practices (ISMP) reviewed with clinical staff at time of survey. This information was reinforced during one-on-one inservices and will be further reinforced at clinical meeting 11/26/18. A copy of this PDF was also placed in the medication room. All resident records will be reviewed to identify inconsistencies/errors in medication administration. Any identified errors and/or sources of possible confusion will be clarified with the Medical Director and reviewed with clinical staff. The Director of Nursing and Assistant Director of Nursing will use an audit tool to monitor compliance. The Director of Nursing and Assistant Director of Nursing will use an audit tool to monitor compliance daily for six months. Weekly monitoring will continue indefinitely thereafter. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure 100% compliance. If this benchmark is not met, an action plan will be developed and implemented to ensure compliance	

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	An interview was conducted with the Director of Nursing (DON) on 11/2/18 at 9:37 a.m. She indicated the staff had not been administrating the seizure medications as ordered. She was unable to determine why Resident B had not received any dosages of vimpat on 9/29/19, 10/4/18, 10/8/18, 10/13/18, 10/16/18, 10/21/18 and 10/23/18. She indicated Resident B was to receive 400 milligrams of vimpat daily and an additional 200 milligrams of vimpat on dialysis days after dialysis. She indicated Resident B was to receive 500 milligrams of keppra twice a day and then an additional 250 milligrams of keppra on dialysis days after dialysis. B. The clinical record for resident M was reviewed on 10/31/2018 at 10:42 a.m. The diagnosis for resident M included, but were not limited to, Autism and hypertension. A physicians order dated 9/26/18 indicated resident M was to receive Budeprion SR (sustained release antidepressant) 150 milligrams twice daily and Metoprolol ER (extended release antihypertensive) 50 milligrams one time daily. On 10/31/2018 at 10:32 a.m., QMA (Qualified Medication Aide) 6 was observed administering medications to resident M. She crushed the Budeprion SR and Metoprolol ER and mixed the medications in applesauce. She administered the crushed medications to resident M. The website "Oral Dosage Forms That Should Not Be Crushed" revised on November 20, 2016 from the Institute of Safe Medications Practices (ISMP), indicates Metoprolol ER and Budeprion SR should not be crushed prior to administration. During an interview on 10/31/2018 at 10:42 a.m., pharmacist 10 indicated Budeprion SR should not be crushed prior to administration. The possible			

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	side effects of crushing Budeprion SR include, but are not limited to, agitation, constipation and headache. He indicated that Metoprolol ER should not be crushed prior to administration. The possible side effects of crushing Metoprolol ER include, but are not limited to, low blood pressure and dizziness. During an interview on 11/01/2018 at 8:55 a.m., the DON (Director of Nursing) indicated that extended release medications should not be crushed. 3.1-48(c)(2)			
F 0761 SS=D Bldg. 00	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			

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	package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview the facility failed to assure medications were stored in locked compartments for 1 of 1 medication room observered. Findings include: On 11/02/2018 at 12:10 p.m., the door to the medication room was observed to be ajar with the door latch resting on the inside of the door frame. There were no licensed nurses present in the nursing station or in the medication room. On 11/02/2018 at 12:20 p.m., LPN (licensed practical nurse) 1 was observed entering the medication room. She did not need to use her key to unlock the medication room door due to the door being ajar and the latch resting on the inside of the door frame. During an interview on 11/02/2018 at 12:20 p.m., LPN 1 indicated that the medication room door does not shut completely at times and needs to be pulled shut in order for it to lock. The door must not have gotten shut completely when the last nurse left the room. 3.1-25(m)	F 0761	**F761** Strict authorized access to drugs and biologicals affects all residents. This includes utilization of a medication room with a functioning lock that is only accessible by clinical staff entrusted with key as appropriate. Medication room lock has been repaired. Strict authorized access to drugs and biologicals affects all residents. Medication room lock has been repaired. Medication room lock has been repaired, and the key has been identified and included on key ring supplied to charge nurse during each shift. The Director of Nursing and Assistant Director of Nursing will use an audit tool to monitor compliance. The Director of Nursing and Assistant Director of Nursing will use an audit tool to monitor compliance daily for six months. Weekly monitoring will continue indefinitely thereafter. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure 95% compliance. If this benchmark is not met, an action plan will be developed and implemented to	12/02/2018

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			ensure compliance.	
F 0880 SS=D Bldg. 00	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 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			

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	precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §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 interview and record review, the facility failed to maintain a method to track and analyze trends of infections in the facility each month for 1 of 5 months reviewed. Findings include:	F 0880	**F880** Accurate infection tracking, analysis, and prevention affects all residents. This includes consistent utilization of the	12/02/2018

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	An infection control binder was reviewed on 11/2/18 11:03 a.m. It indicated monthly mapping and monitoring of infections in the facility. The binder did not include a color coded map or monitoring method of the facility's infections in July 2018. An interview was conducted with the Director of Nursing (DON) on 11/2/18 at 11:21 a.m. She indicated the binder was utilized to track and analyze infections. The infection control binder should include each month with the following: a map that is color coded, a document "Line List of infections", and a document "Antibiotic Use Report" to monitor the infections in the facility. July 2018 was missed and was not done. An "Infection Prevention Program Overview" was provided by the DON on 11/2/18 at 1:14 p.m. It indicated "..I. Goals. The goals of the Infection Prevention Program are to: A. Decrease the risk of infection to residents and personnel. B. Monitor for occurrence of infection and implement appropriate control measures. C. Identify and correct problems relating to infection prevention practices. D. Maintain compliance with state and federal regulations relating to infection prevention. II. Scope of the Infection Prevention Program. The Infection Prevention Program is comprehensive in that it addresses detection, prevention and control of infections among residents and personnel. The scope of services depends on the resident population, and specialized needs of the healthcare facility. The Major Activities of the Program are: A. Surveillance of Infections with implementations of control measures and prevention of infections. There is on-going monitoring for infections among residents and personnel and subsequent		facility's existing infection control binder and its various components. Infection control binder updated to accurately reflect resident infections and antibiotic use. Accurate infection tracking, analysis, and prevention affects all residents. Infection control binder updated to accurately reflect resident infections and antibiotic use. Pertinent charting and physician orders will be reviewed daily at the morning QA meeting to identify residents with newly diagnosed infections and new antibiotic orders. Infection control binder will be updated simultaneously by Director of Nursing and Assistant Director of Nursing as indicated. The Director of Nursing and Assistant Director of Nursing will use an audit tool to monitor compliance. The Director of Nursing and Assistant Director of Nursing will use an audit tool to monitor compliance daily for six months. Weekly monitoring will continue indefinitely thereafter. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure 100% compliance. If this benchmark is not met, an action plan will be developed and implemented to	

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	documentation of infections that occur. Prevention of spread of infections is accomplished by use of standard precautions and other barriers, appropriate treatment and follow-up, and employees work restrictions for illness...." 3.1-18(b)(1)		ensure compliance.	
F 9999 Bldg. 00	3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired	F 9999	**F9999** Accurate and timely new-hire and annual tuberculin skin testing and organized ongoing in-service education and training affects all employees, including CNA 18, QMA 20, Dietary Staff 21, and LPN 24. Identified employee records were reviewed, and employees brought up to date with tuberculin skin testing. Employees were also in-serviced individually on the following topics: 1. Residents' rights 2. Prevention and control of infection 3. Fire prevention 4. Safety and accident prevention 5. Needs of specialized populations served 6. Care of cognitively impaired residents Importance of accurate record-keeping reviewed with HR coordinator during time of survey, and this information was reinforced on subsequent occasions by	12/02/2018

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	residents and to gain understanding of the current standards of care for residents with dementia. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method, (5 TU PPD), administered by person having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or		corporate HR consultant. Accurate and timely new-hire and annual tuberculin skin testing and organized ongoing in-service education and training affects all employees. All employee records were reviewed, and employees brought up to date with tuberculin skin testing. Employees were also in-serviced individually on the following topics: 1. Residents' rights 2. Prevention and control of infection 3. Fire prevention 4. Safety and accident prevention 5. Needs of specialized populations served 6. Care of cognitively impaired residents Importance of accurate record-keeping reviewed with HR coordinator during time of survey, and this information was reinforced on subsequent occasions by corporate HR consultant. Corporate in-service program will be implemented to ensure twelve hours of in-service for clinical staff and six hours of in-service for non-clinical staff completed each calendar year. Calendar with fixed in-service dates will be developed and implemented by Director of Nursing and Assistant Director of Nursing. New staff will receive training upon hire and will receive	

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	preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to provide staff members with new-hire and annual tuberculin skin testing, resident rights and dementia training for 4 of 10 employee personal files reviewed. (Certified Nursing Assistant (CNA)18, Qualified Medication Aide (QMA) 20, Dietary Staff 21 and License Practical Nurse (LPN 24) Findings include: 1a. The Employee Records were reviewed on 11/2/18 at 10:30 a.m. The Employee Records form indicated CNA 18's start date was 12/16/17, and he was a full time employee. The personnel file for CNA 18 did not include new hire dementia training within 6 months of CNA 18's hire date. 1b. The Employee Records were reviewed on 10/2/18 at 10:30 a.m. The Employee Records form indicated Dietary Aide 21's start date was 9/23/13, and she was a full time employee. The personnel file for Dietary Aide 21 did not include annual resident rights or dementia in-servicing training. 1c. The Employee Records were reviewed on 10/2/18 at 10:30 a.m. The Employee Records form indicated LPN 24's start date was 9/20/07, and she was a part time employee.		subsequent training according to in-service calendar. New staff will also receive a two-step tuberculin skin test upon hire, with the first step completed within one month prior to employment. The second step will be completed one to three weeks after the first as required. Tuberculin skin testing will be completed annually thereafter. The Director of Nursing and Assistant Director of Nursing will monitor compliance with an audit tool. The Director of Nursing and Assistant Director of Nursing will use an audit tool to monitor compliance weekly for six months. Monthly monitoring will continue indefinitely thereafter. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure 100% compliance. If this benchmark is not met, an action plan will be developed and implemented to ensure compliance.	

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	The personnel file for LPN 24 did not include annual resident rights or dementia in-servicing training. 2a. The Employee Records were reviewed on 11/2/18 at 10:30 a.m. The Employee Records form indicated QMA 20s start date was 7/25/84, and he was a full time employee. The personnel file for QMA 20 indicated the last tuberculin skin testing was completed 8/27/17. 2b. The Employee Records were reviewed on 11/2/18 at 10:30 a.m. The Employee Records form indicated CNA 18's start date was 12/16/17, and he was a full time employee. The personnel file for CNA 18 indicated CNA 18 had a tuberculin skin testing on 8/22/17. It did not include an annual or new hire tuberculin skin testing. 2c. The Employee Records were reviewed on 10/2/18 at 10:30 a.m. The Employee Records form indicated Dietary Aide 21's start date was 9/23/13, and she was a full time employee. The personnel file for Dietary Aide 21 indicated the last tuberculin skin testing assessment was completed on 10/10/13. The file did not include annual tuberculin skin testing for Dietary Aide 21. 2d. The Employee Records were reviewed on 10/2/18 at 10:30 a.m. The Employee Records form indicated LPN 24's start date was 9/20/07, and she was a part time employee. The personnel file for LPN 24 indicated LPN 24's annual tuberculin skin testing was given on 10/20/18, but was not read.			

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	An interview was conducted with the Regional Business Office Manager on 11/2/18 at 2:47 p.m. She indicated she was unable to provide any other documentation for the completion of tuberculin skin testing, resident rights, or dementia training to the staff. A "In-Service Training Program" policy was provided by the Administrator on 11/2/18 at 3:15 p.m. It indicated "...Our facility has developed an effective in-service training program. Policy Interpretation and Implementation 1. Our staff development program is divided into two classifications, one being orientation and the other in-service training (staff development)...3. Our in-service training program (staff development) is planned and conducted for the development and improvement of skills of all our personnel..." A tuberculosis screening employees policy was provided by the Administer on 11/2/18 at 3:!5 p.m. It indicated "..Each employee will be screened for tuberculosis ("TB") infection and disease. Employees with active TB diseases shall not be permitted to work until TB disease is successfully treated and the employee is free from the communicate disease according to the written statement of a licensed physician...All employees.. A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by a person having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded			

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	in millimeters of induration with: i. The date given, date read, and identity of person administering test. ii. The tuberculin skin test must be read prior to the employee starting work. iii. For employees who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step....The facility will conduct an annual tuberculin skin test on all employees and nonpaid personnel with a history of negative results..."			