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	345219	A. BUILDING _____ B. WING _____	C 07/21/2016

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F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to label and properly store personal hygiene products and resident care equipment on 2 of 2 resident halls. The findings included: 1. a. Observations of room 94 A on 07/18/16 at 10:25 AM revealed three unlabeled and uncovered toothbrushes and an unlabeled tube of toothpaste on a shelf over a shared sink. Observations of room 94 A on 07/19/16 at 9:31 AM AM revealed three unlabeled and uncovered toothbrushes and an unlabeled tube of toothpaste on a shelf over a shared sink. Observations of room 94 on 07/20/16 at 9:18 AM revealed three unlabeled and uncovered toothbrushes and an unlabeled tube of toothpaste on a shelf over a shared sink. Observations of room 94 on 07/21/16 at 8:57 AM revealed three unlabeled and uncovered toothbrushes and an unlabeled tube of toothpaste on a shelf over a shared sink. During an interview on 07/21/16 at 3:02 PM the Director of Nursing (DON) stated she expected personal hygiene products to be labeled with the	F 253	On 7/21/16, the toothbrush and toothpaste found on the shelf on the shelf of resident #94 over a shared sink were removed and discarded. A new toothbrush and toothpaste were placed on the shelf over the shared sink labeled and covered as indicated by the Staff Facilitator (SF). The toothbrush, a can of shaving cream and mouthwash belonging to resident #98 found on the shelf of a shared sink were removed and discarded. A new toothbrush, can of shaving cream and mouthwash were placed on the shelf labeled and covered as indicated by the SF. The unlabeled toothbrush, bedpan and 2 washbasins belonging to resident #104 found on a shelf and/or shared bathroom were removed and discarded. A new toothbrush, bedpan and washbasin were provided, labeled and covered as indicated by the SF. The toothbrush, 2 tubes of toothpaste, 2 toothbrush holders and a bedpan belonging to resident #88 were removed and discarded. A new toothbrush, toothpaste, toothbrush holder and bedpan were provided, labeled and covered as indicated by the SF. The washbasin belonging to resident #110 was removed and discarded. A new washbasin was provided, labeled and	8/18/16

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

Electronically Signed | 08/12/2016

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F 253	Continued From page 1 resident's name, placed in a bag, and stored in the bedside table. The DON further stated bedpans and wash basins should be labeled with the residents' name, wrapped in a clear trash bag, and stored off the floor. b. Observations of room 98 on 07/18/16 at 11:01 AM revealed one unlabeled and uncovered toothbrush, one unlabeled can of shaving cream, and one unlabeled bottle of mouthwash on a shelf over a shared sink. Observations of room 98 on 07/19/16 at 10:25 AM revealed one unlabeled and uncovered toothbrush, one unlabeled can of shaving cream, and one unlabeled bottle of mouthwash on a shelf over a shared sink. Observations of room 98 on 07/20/16 at 12:35 PM AM revealed one unlabeled and uncovered toothbrush, one unlabeled can of shaving cream, and one unlabeled bottle of mouthwash on a shelf over a shared sink. Observations of room 98 on 07/21/16 at 10:35 AM revealed one unlabeled and uncovered toothbrush, one unlabeled can of shaving cream, and one unlabeled bottle of mouthwash on a shelf over a shared sink. During an interview on 07/21/16 at 3:02 PM the Director of Nursing (DON) stated she expected personal hygiene products to be labeled with the resident's name, placed in a bag, and stored in the bedside table. The DON further stated bedpans and wash basins should be labeled with the residents' name, wrapped in a clear trash bag, and stored off the floor.	F 253	covered, by the SF. Using an audit tool, a 100% audit was completed by the Administrator and Staff Facilitator (SF) by 8/12/16, to ensure that all personal hygiene items (toothbrush, toothpaste, toothbrush holders, shaving cream, mouthwash, soap, bedpans, washbasins, urinals) were labeled and/or covered if stored in the bathroom or sink area shared by other residents and that no items were being stored on the floor. Any items found unlabeled, uncovered or on the floor in areas shared by other residents were removed and discarded with replacement items provided to include appropriate labeling and covered as indicated. 100% of nursing staff, Administrator, DON, MDS Coordinator, Staff Facilitator, Accounts Payable Manager, Accounts Receivable Manager, Maintenance Director, Housekeeping/Laundry Supervisor, Dietary Manager, Social Worker, Activity Director, and Medical Records Manager were in-serviced by the Staff Facilitator on 8/11/16 regarding the need to label and cover personal hygiene and/or toileting items, to ensure no personal items are being stored on the floor and to check the shared bathrooms/sink shelves of assigned rooms for unlabeled or uncovered personal hygiene items with instruction on the procedure to follow if any identified. Newly hired licensed nursing staff will receive the in-service by the SF during orientation regarding the need to label and	

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F 253	Continued From page 2 c. Observations of the shared bathroom for room 104 on 07/18/16 at 11:12 AM revealed one unlabeled and uncovered toothbrush on the back of the sink. In addition, there was one unlabeled and uncovered grey bedpan, and two unlabeled and uncovered grey wash basins on the floor near the toilet. Observations of the shared bathroom for room 104 on 07/19/16 at 9:26 AM revealed one unlabeled and uncovered toothbrush on the back of the sink. In addition, there was one unlabeled and uncovered grey bedpan, and two unlabeled and uncovered grey wash basins on the floor near the toilet. Observations of the shared bathroom for room 104 on 07/20/16 at 9:46 AM revealed one unlabeled and uncovered toothbrush on the back of the sink. In addition, there was one unlabeled and uncovered grey bedpan, and two unlabeled and uncovered grey wash basins on the floor near the toilet. Observations of the shared bathroom for room 104 on 07/21/16 at 8:42 AM revealed one unlabeled and uncovered toothbrush on the back of the sink and one unlabeled pink bedpan wrapped in a clear bag on the floor near the toilet. During an interview on 07/21/16 at 3:02 PM the Director of Nursing (DON) stated she expected personal hygiene products to be labeled with the resident's name, placed in a bag, and stored in the bedside table. The DON further stated bedpans and wash basins should be labeled with the residents' name, wrapped in a clear trash bag, and stored off the floor.	F 253	cover personal hygiene and/or toileting items, to ensure no personal items are being stored on the floor and to check the shared bathrooms and sink shelves of assigned rooms for unlabeled or uncovered personal hygiene items with instruction on the procedure to follow if any identified. Using an audit tool, the Administrator, Social Worker, Accounts Payable Manager, Accounts Receivable Manager, Maintenance Director, Housekeeping/Laundry Supervisor, MDS Coordinator, Staff Facilitator, Medical Records Manager, Activity Director and Receptionist will make one round on each scheduled work day of 2-4 assigned rooms to ensure no unlabeled and/or uncovered items are being stored in the residents shared bathroom, sink shelves or on the floor. These rounds will continue indefinitely with the audit tools given to the Administrator for review weekly. The audit tools will be reviewed monthly by the Executive QI Committee for identification of potential trends and development of plans of action to determine the need for continued monitoring.	

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d. Observations of room 88 on 07/18/16 at 3:01 PM revealed one unlabeled and uncovered toothbrush on the shelf over the shared sink. In the shared bathroom there was one unlabeled and uncovered bedpan on the floor next to the toilet.

Observations of room 88 on 07/20/16 at 12:23 PM revealed one unlabeled and uncovered toothbrush and two unlabeled tubes of toothpaste on the shelf over the shared sink. There were also two unlabeled toothbrush holders on the back of the sink. In the shared bathroom there was one unlabeled and uncovered bedpan on the floor next to the toilet.

Observations of room 88 on 07/21/16 at 10:37 AM revealed one unlabeled and uncovered toothbrush and two unlabeled tubes of toothpaste on the shelf over the shared sink. There were also two unlabeled toothbrush holders on the back of the sink. In the shared bathroom there was one unlabeled and uncovered bedpan on the floor next to the toilet.

During an interview on 07/21/16 at 3:02 PM the Director of Nursing (DON) stated she expected personal hygiene products to be labeled with the resident's name, placed in a bag, and stored in the bedside table. The DON further stated bedpans and wash basins should be labeled with the residents' name, wrapped in a clear trash bag, and stored off the floor.

e. Observations of the shared bathroom for room 110 on 07/19/16 at 9:05 AM revealed one uncovered wash basin on the floor near the toilet. The wash basin had two different names written on the side and one was crossed off with a black

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F 253	Continued From page 4 marker. Observations of the shared bathroom for room 110 on 07/20/16 at 12:09 PM revealed one uncovered wash basin on the floor near the toilet. The wash basin had two different names written on the side and one was crossed off with a black marker. In addition, there was one unlabeled and uncovered toothbrush on the back of the sink. Observations of the shared bathroom for room 110 on 07/21/16 at 8:41 AM revealed one uncovered wash basin on the floor near the toilet. The wash basin had two different names written on the side and one was crossed off with a black marker. In addition, there was one unlabeled and uncovered toothbrush on the back of the sink. During an interview on 07/21/16 at 3:02 PM the Director of Nursing (DON) stated she expected personal hygiene products to be labeled with the resident's name, placed in a bag, and stored in the bedside table. The DON further stated bedpans and wash basins should be labeled with the residents' name, wrapped in a clear trash bag, and stored off the floor.	F 253		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at	F 272		8/18/16

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F 272	Continued From page 5 least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete Care Area Assessments that addressed the underlying causes, contributing factors and risk factors for 5 of 19 sampled residents (Residents #50, #23, #1, #44, #39).	F 272	On 8/12/16, the MDS Coordinator completed a general care plan progress note of resident #50 and #23 related to the Psychotropic Drug Use Care Area Assessment (CAA). The notes include a description of the problem, name/dose of the medications, underlying causes, contributing factors and risk factors	

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F 272	Continued From page 6 The findings included: 1. Resident #50 was admitted to the facility on 02/25/14 with diagnoses including seizure disorder and depression. Review of the annual Minimum Data Set (MDS) dated 01/27/16 revealed Resident #50 was severely cognitively impaired with long and short term memory impairment. Review of the Care Area Assessment (CAA) summary for Psychotropic Drug Use dated 02/13/16 revealed Resident #50 required an antidepressant and antianxiety medication. The CAA stated use of psychotropic drugs (antidepressant, antianxiety) with the potential for side effects of cardiac, neuromuscular, gastrointestinal systems to diagnoses of depression. Will show no side effects of medications taken through next review. Will have no injury related to medication usage/side effects through the next review. Administer medications per physician's orders, evaluate effectiveness and side effects of medications for possible reduction/elimination of psychotropic drugs. Mini-mental evaluation per facility protocol (Social Worker), monitor resident's mental status functioning on ongoing basis and monitor vital signs per facility protocol. The CAA summary did not paint a picture of the resident or include strengths and weaknesses of the resident, underlying causes, contributing factors and risk factors.	F 272	related to the use of psychotropic medications supporting the need to proceed to care plan. Resident #1 has deceased. On 8/12/16, the MDS Coordinator completed a general care plan progress note for resident #44 related to his chronic diagnosis of Parkinson's Disease Care Area Assessment (CAA) to include analysis of findings with details regarding his condition and how these impact his treatment plan determining the need to proceed to care plan. On 8/12/16, the MDS Coordinator completed a general care plan progress note for resident #39 related to his Nutritional Status Care Area Assessment (CAA). The note identifies causes, risk factors and how this information impacted his nutritional status determining need to proceed to care plan. Using an audit tool, the Staff Facilitator and DON will review 100% of resident Care Area Assessments (CAA) related to Psychotropic Drug Use, Nutritional Status and Diagnosis by 8/18/16 to ensure that the CAA's address the underlying causes, contributing factors and risk factors for our residents per the RAI Manual. Any Care Area Assessments (CAA) identified as not addressing the underlying causes, contributing factors and risk factors related to Psychotropic Drug Use, Nutritional Status and Diagnosis will be corrected per the RAI Manual. The MDS nurse and DON were in-serviced on 8/6/16 by the Staff Facilitator regarding the CAA process and	

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F 272	Continued From page 7 During an interview on 07/21/16 at 2:43 PM the MDS Nurse stated she had been taught to write the CAA Summary by checking all of the boxes and placing interventions in each box by the Corporate MDS Nurse. She stated she had never been trained to write a summary describing the resident's strengths and weaknesses and what factors contributed to the area being care planned. During an interview conducted on 07/21/16 at 2:55 PM the Director of Nursing stated she had never really understood what was required in the CAA Summary and she depended on the Corporate MDS Nurse to teach MDS staff how to do the summaries correctly. 2. Resident #23 was admitted to the facility on 09/06/13 with diagnoses of chronic obstructive pulmonary disease, respiratory failure and depression. Review of the annual Minimum Data Set (MDS) dated 09/15/15 revealed Resident #23 was cognitively intact. Review of the Care Area Assessment (CAA) summary for Psychotropic Drug Use dated 10/02/15 revealed Resident #23 required an antidepressant, antianxiety and hypnotic medications. The CAA stated use of psychotropic drugs (antidepressant, antianxiety) with the potential for side effects of cardiac, neuromuscular, gastrointestinal systems to diagnoses of depression. Will show no side	F 272	CAA documentation requirements per the RAI Manual to include the need to determine underlying causes, contributing factors and risk factors of each problem identified during the MDS assessment. Using an audit tool, the DON will review 50% of Psychotropic Drug Use, Nutrition and Diagnosis Care Area Assessments written weekly x 8 weeks then 25% of Care Area Assessments written weekly x 8 weeks to ensure each CAA has addressed the underlying causes, contributing factors and risk factors. Any identified CAA not meeting the documentation guidelines per the RAI manual will be corrected prior to the required completion date. The audit tools will be reviewed by the Executive QI Committee monthly for identification of potential trends and development of plans of action to determine the need for continued monitoring.	

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effects of medications taken through next review. Will have no injury related to medication usage/side effects through the next review. Administer medications per physician ' s orders, evaluate effectiveness and side effects of medications for possible reduction/elimination of psychotropic drugs. Monitor resident's mood/behaviors (anxiety, tearfulness, restlessness, decreased appetite, insomnia) with documentation per facility policy. Notify physician of any significant changes. Monitor vital signs per facility protocol. Pharmacy review of medications monthly and/or as ordered. The CAA summary did not paint a picture of the resident or include strengths and weaknesses of the resident, underlying causes, contributing factors and risk factors.

During an interview on 07/21/16 at 2:43 PM Nurse #2 stated she had been taught to write the CAA Summary by checking all of the boxes and placing interventions in each box by the Corporate MDS Nurse. She stated she had never been trained to write a summary describing the resident's strengths and weaknesses and what factors contributed to the area being care planned.

During an interview conducted on 07/21/16 at 2:55 PM the Director of Nursing stated she had never really understood what was required in the CAA Summary and she depended on the Corporate MDS Nurse to teach MDS staff how to do the summaries correctly.

3. Resident #1 was admitted to the facility on

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F 272	Continued From page 9 03/23/94 with diagnoses of traumatic brain injury, aphasia, hemiplegia, anxiety and depression. Review of the annual Minimum Data Set dated 10/21/15 revealed Resident #1 was severely cognitively impaired. Review of the Care Area Assessment (CAA) summary dated 11/07/16 revealed Resident #1 required an antidepressant and antianxiety medication. The CAA stated use of drugs having an altering effect on the mind with the potential for side effects of cardiac, neuromuscular, gastrointestinal systems due to diagnoses of bipolar disorder, decline in mood/behavior, depression, psychosis. Will show minimal use of medications through next review. Will receive therapeutic dose through next review. Administer medications per physicians order. DISCUS evaluation per facility protocol. Monitor drug blood levels as per physician orders and report results to physician. Monitor resident's mental status functioning on ongoing basis. Monitor resident's mood/behaviors (yelling, aggression, throwing self or thins) with documentation per facility protocol. The CAA summary did not paint a picture of the resident or include strengths and weaknesses of the resident, underlying causes, contributing factors and risk factors . During an interview on 07/21/16 at 2:43 PM Nurse #2 stated she had been taught to write the CAA Summary by checking all of the boxes and placing interventions in each box by the Corporate MDS Nurse. She stated she had never been trained to write a summary describing the	F 272		

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resident's strengths and weaknesses and what factors contributed to the area being care planned.

During an interview conducted on 07/21/16 at 2:55 PM the Director of Nursing stated she had never really understood what was required in the CAA Summary and she depended on the Corporate MDS Nurse to teach MDS staff how to do the summaries correctly.

4. Resident # 44 was admitted to the facility on 06/13/2016. A review of a Minimum Data Set (MDS) completed on 06/20/16 revealed the resident was cognitively intact, ambulatory, and was able to assist in his own care. The MDS in the area of Active Diagnosis had marked as "No" for the diagnosis of anxiety, depression, gastroesophageal reflux disease, hypertension, and Parkinson's disease.

During interview on 07/18/16 at 10:00 AM the resident stated he had diagnosis of Parkinson's Disease, COPD, and had previous cerebral infarct and heart surgery. The Resident was able to communicate needs and recall facts about his care.

On 07/18/16 at 4:00 PM an interview was conducted with Nurse #1 and the MDS Nurse. In the interview both nurses stated that the diagnosis listed on the MDS did not include all the diagnosis for which the resident received treatment. The MDS Nurse confirmed that the Care Area Assessment (CAA) summary should have included an analysis of findings that had details regarding Resident #44's chronic illnesses and how these impacted his treatment plans.

5. Resident #39 was admitted on 10/09/14 with

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diagnoses including end stage renal disease and diabetes mellitus.

Review of the annual Minimum Data Set (MDS) dated 08/27/15 revealed Resident #39 was cognitively intact and required set up help only with eating. The annual MDS noted Resident #39 weighed 165 pounds and there was no weight loss noted. The annual MDS stated Resident #39 received dialysis.

Review of the Care Area Assessment (CAA) summary for Nutritional Status dated 09/15/15 revealed Resident #39 was just over his ideal body weight range and currently weighed 165 pounds. The CAA stated Resident #39 was unavailable at the time of the interview. The CAA summary did not include why Nutritional Status had triggered and did not identify causes and risk factors and how this information impacted his nutritional status.

An interview with the MDS Nurse 07/21/16 at 2:43 PM revealed she had been taught to write the CAA Summary by checking all of the boxes and placing interventions in each box by the Corporate MDS Nurse. She stated she had never been trained to write a summary describing the resident's strengths and weaknesses and what factors contributed to the area being care planned.

During an interview conducted on 07/21/16 at 2:55 PM the Director of Nursing stated she had never really understood what was required in the CAA Summary and she depended on the Corporate MDS Nurse to teach MDS staff how to do the summaries correctly.

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F 272	Continued From page 12 During a follow up interview on 07/21/16 at 4:09 PM the MDS Nurse reviewed Resident #39's CAA summary for Nutritional Status dated 09/15/15 and stated it had been completed by a dietary manager who was no longer employed by the facility. The MDS Nurse confirmed the CAA summary should have had an analysis of findings that included details regarding Resident #39's chronic illnesses, dialysis, and therapeutic diet and how these impacted his nutritional status.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278		8/18/16

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F 278	Continued From page 13 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview the facility failed to accurately code the Minimum Data Set to reflect traumatic brain injury, depression, anxiety and Parkinson's disease for 2 of 19 sampled residents (Resident #1 and #44). The findings included: 1. Resident #1 was admitted to the facility on 03/23/94 with diagnoses of traumatic brain injury, aphasia, hemiplegia and respiratory failure. Review of the annual Minimum Data Set (MDS) dated 10/21/15 revealed Resident #1 was severely cognitively impaired and required extensive to total assistance with all activities of daily living. The MDS was not coded that Resident #1 had a diagnoses of traumatic brain injury. An interview was conducted with the MDS Nurse on 07/21/16 at 2:43 PM. The MDS Nurse stated she completed Resident #1's annual MDS dated 10/21/15, and his main diagnoses was a traumatic brain injury. She reviewed the annual 10/21/15 MDS with the surveyor and agreed traumatic brain injury was not checked for Resident #1. The MDS Nurse stated the diagnoses for a resident were pulled over from a diagnoses list the admission staff entered into the computer and she did not check to make sure all diagnoses were coded for Resident #1.	F 278	On 8/8/16, the MDS assessment for resident #1 with ARD of 10/21/15, was modified to include the diagnosis of Traumatic Brain Injury (TBI) by the MDS nurse. On 8/8/16, the MDS assessment for resident #44 with ARD of 6/20/16 was modified to include the diagnosis of Depression, Anxiety and Parkinson's Disease. On 8/6/16, the MDS nurse and DON were in-serviced by the Staff Facilitator on how to correctly code Section I (Active Diagnosis) of the MDS per the RAI Manual. Using an audit tool, the Staff Facilitator completed an audit of 100% resident's last completed MDS, Section I (Active Diagnosis), comparing the Medical Record diagnosis as ordered by the MD to the diagnosis coded on the MDS, Section I. Any MDS, Section I (Active Diagnosis) found to be coded incorrectly will be modified and transmitted to the National Repository by 8/18/16. The DON will utilize an audit tool to review 50% completed MDS assessments weekly x 8 weeks then 25% of completed MDS assessments weekly x 8 weeks to ensure accuracy of Section I (Active Diagnosis) prior to being transmitted to	

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F 278	Continued From page 14 An interview conducted on 07/21/16 at 2:55 PM with the Director of Nursing revealed it was her expectation for the MDS nurse to check the diagnoses section and all sections of the MDS to make sure they were coded correctly. 2. Resident # 44 was admitted to the facility on 06/13/16. A review of the Minimum Data Set (MDS) dated 06/20/16 revealed the resident was cognitively intact, ambulatory, and able to assist in his own care. The MDS assessment indicated the resident had received treatment within the last 7 days for anxiety and depression. The Diagnosis and Active disease section had the areas of anxiety and depression marked as "No." The Diagnosis section of the MDS had "No" marked beside Parkinson's Disease. During interview on 07/18/16 at 10:00 AM Resident #44 stated he had diagnosis of Parkinson's disease, COPD, and a previous history of cerebral infarct and heart surgery. On 7/18/16 at 4:00 PM an interview was conducted with Nurse # 1 and the MDS Nurse. Nurse # 1 verified that the diagnosis of depression, anxiety, and Parkinson's disease had all been marked as "No" on the MDS. The MDS Nurse stated that she had gotten the information about the diagnosis from the Long-Term Services prior approval form (FL-2) which was on the resident's chart. The MDS Nurse stated she did not ask the resident or follow up with the physician to verify correct diagnosis and the incomplete diagnosis list had impacted the monitoring and treatment plans for the resident.	F 278	the National Repository, with retraining provided as indicated. The Executive QI Committee will review the audit tools monthly for identification of potential trends and development of plans of action to determine the need for continued monitoring.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		8/18/16

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F 281	Continued From page 15 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and Nurse Practitioner interviews, the facility failed to transcribe an order to a Medication Administration Record which resulted in a resident not being administered a diuretic for edema as ordered by the Nurse Practitioner for 1 of 5 residents reviewed for unnecessary medication use (Resident # 19). The findings included: Resident #19 was admitted on 09/30/12 with diagnoses including congestive heart failure (CHF), diabetes mellitus, and chronic obstructive pulmonary disease (COPD). Review of the quarterly Minimum Data Set (MDS) dated 04/07/16 revealed Resident #19 was cognitively intact and received a diuretic daily during the 7 day review period. Review of a progress note dated 05/20/16 revealed Resident #19 was seen by the Nurse Practitioner (NP) due to weight gain. Resident #19 reported increased edema in both her lower legs. The NP noted the plan was to increase Resident #19's Lasix (a diuretic) to 60 mg (milligrams) daily. Review of the medical record revealed an order written by the NP on 05/20/16 to increase Resident #19's Lasix to 60 mg by mouth every morning for CHF. The order was signed off by	F 281	Resident #19 had an order for Lasix 60mg every morning correctly transcribed to the MAR on 7/21/16 by the Director of Nursing. Using an audit tool, the Staff Facilitator (SF) and Director of Nursing (DON) audited 100% of our active residents to verify that all physician telephone orders written in the past three(3) months (May/June/July) were transcribed accurately onto the MAR completed by 8/12/16. The SF in-serviced all licensed nurses by 8/12/16 on the correct transcription of physician telephone orders and monthly MAR review. No licensed nurses were permitted to work until they received this in-service and newly hired licensed staff will receive the in-service by the SF during orientation. An audit tool will be utilized each night by the third shift nursing staff to review 100% of all physician telephone orders to verify correct transcription of orders to the MAR. The DON, MDS Coordinator or SF will re-check physician telephone orders Monday thru Friday for accuracy of physician telephone orders to the MAR. Re-training will be provided for any errors identified by the DON, SF or MDS	

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F 281	Continued From page 16 Nurse #4 on 05/20/16. Review of Resident #19's Physician's orders for May, June, and July of 2016 revealed Lasix 40 mg was prescribed every morning for CHF. Further review of the June 2016 Physician's orders revealed Nurse #1 did not transcribe the order to increase Resident #19's Lasix to 60 mg every morning when he completed the month to month reconciliation of orders on 05/27/16. Review of Resident #19's May 2016 Medication Administration Record (MAR) revealed nurses initialed the MAR from 05/01/16 through 05/31/16 indicating they had administered Lasix 40 mg by mouth every morning. Further review of the May 2016 MAR revealed the order to increase Lasix to 60 mg every morning was not transcribed to the MAR by Nurse #4 on 05/20/16. Review of the June 2016 MAR revealed Resident #19 was administered Lasix 40 mg every morning from 06/01/16 through 06/30/16. Review of the July 2016 MAR revealed Resident #19 was administered Lasix 40 mg every morning from 07/01/16 through 07/20/16. An interview with Nurse #1 on 07/20/16 at 10:17 AM revealed when he completed the month to month reconciliation of Physician's orders he typically compared the current months MAR to the new MAR and reviewed the medical record for any medication orders written for the resident since the last review. Nurse #1 reviewed Resident #19's June 2016 Physician's orders and confirmed he completed the review on 05/27/16. Nurse #1 stated he should have crossed out the order for Lasix 40 mg on Resident #19's June	F 281	Coordinator. These audits will continue indefinitely. The DON, MDS Coordinator and/or SF will review new monthly MAR's, comparing them to physician telephone orders, to verify accurate transcription onto the MAR each month with MD review. The audit tools will be reviewed by the Executive QI Committee monthly for identification of potential trends and development of plans of action to determine the need for continued monitoring.	

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2016 MAR and transcribed the order for Lasix 60 mg every morning to the June 2016 MAR per the order written on 05/20/16. Nurse #1 indicated he must not have seen the order to increase Resident #19's Lasix to 60 mg when he completed the reconciliation.

An interview was conducted with the Director of Nursing (DON) on 07/20/16 at 10:23 AM. The DON stated the nurses on the hall typically signed off the Physician's orders and were expected to sign and date orders, fax a copy of medication orders to the pharmacy, and transcribe the medication to the residents' current MAR. The DON confirmed Nurse #4 signed off the Physician's order on 05/20/16 for Resident #19's Lasix to be increased to 60 mg by mouth every morning. The DON further stated she could not explain how this medication error occurred because Nurse #4 was no longer employed by the facility. The interview further revealed the DON would have expected Nurse #1 to catch the omission of the order for Lasix 60 mg daily dated 05/20/16 when he completed the reconciliation of Resident #19's May and June of 2016 Physician's orders and MARs on 05/27/16.

An interview with the NP on 07/20/16 at 10:41 AM revealed she expected orders to be carried out when she writes them. The NP stated she increased Resident #19's daily Lasix on 05/20/16 because she reported increased edema in both her lower legs. The NP further stated Resident #19 did not suffer any negative outcome as a result of not receiving the increased dose of Lasix.

During a telephone interview on 07/20/16 at 2:35 PM Nurse #4 stated when she received a

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F 281	Continued From page 18 medication order she signed off and dated the order, faxed a copy of the order to the pharmacy, and transcribed the order to the residents' MAR. Nurse #4 further stated she was no longer employed by the facility and did not recall signing off a medication order for Resident #19 on 05/20/16.	F 281		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and nurse practitioner interviews, the facility failed to administer an increased dose of diuretic ordered for edema by the Nurse Practitioner for 1 of 5 residents reviewed for unnecessary medication use (Resident # 19). The findings included: Resident #19 was admitted on 09/30/12 with diagnoses including congestive heart failure (CHF), diabetes mellitus, and chronic obstructive pulmonary disease (COPD). Review of the quarterly Minimum Data Set (MDS) dated 04/07/16 revealed Resident #19 was cognitively intact and received a diuretic daily during the 7 day review period. Review of a progress note dated 05/20/16 revealed Resident #19 was seen by the Nurse Practitioner (NP) due to weight gain. Resident	F 333	Resident #19 had an order for Lasix 60mg every morning correctly transcribed to the Medication Administrator Record (MAR) on 7/21/16 by the Director of Nursing (DON) Using an audit tool, the Staff Facilitator (SF) and Director of Nursing (DON) audited 100% of our active residents to verify that all physician telephone orders written in the past three (3) months (May/June/July) were transcribed accurately onto the MAR completed by 8/12/16. The SF in-serviced all licensed nurses by 8/12/16 on the correct transcription of physician telephone orders and monthly MAR review. No licensed nurses were permitted to work until they received this in-service and newly hired licensed staff will receive the in-service during	8/18/16

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F 333	Continued From page 19 #19 reported increased edema in both her lower legs. The NP noted the plan was to increase Resident #19's Lasix (a diuretic) to 60 mg (milligrams) daily. Review of the medical record revealed an order written by the NP on 05/20/16 to increase Resident #19's Lasix to 60 mg by mouth every morning for CHF. The order was signed off by Nurse #4 on 05/20/16. Review of a progress note dated 05/26/16 revealed Resident #19 was seen by the NP for a follow up after a recent increase in Lasix. The NP noted the edema had improved and planned to continue the Lasix 60 mg every morning and monitor Resident #19's kidney function and electrolytes. Review of Resident #19's Physician's orders for May, June, and July of 2016 revealed Lasix 40 mg was prescribed every morning for CHF. Further review of the June 2016 Physician's orders revealed Nurse #1 did not transcribe the order to increase Resident #19's Lasix to 60 mg every morning when he completed the month to month reconciliation of orders on 05/27/16. Review of Resident #19's May 2016 Medication Administration Record (MAR) revealed nurses initialed the MAR from 05/01/16 through 05/31/16 indicating they had administered Lasix 40 mg by mouth every morning. Further review of the May 2016 MAR revealed the order to increase Lasix to 60 mg every morning was not transcribed to the MAR by Nurse #4 on 05/20/16. Review of the June 2016 MAR revealed Resident #19 was administered Lasix 40 mg every morning	F 333	orientation by the SF. An audit tool will be utilized each night by the third shift nursing staff to review 100% of all physician telephone orders written to ensure transcription accuracy onto the MAR. The DON, SF or MDS Coordinator will review physician telephone orders Monday thru Friday to ensure that physician telephone orders have been transcribed accurately onto the MAR. The SF will provide retraining for errors identified. The audit tools will be reviewed monthly by the Executive QI Committee for identification of potential trends and development of plans of action to determine the need for continued monitoring.	

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from 06/01/16 through 06/30/16.

Review of the July 2016 MAR revealed Resident #19 was administered Lasix 40 mg every morning from 07/01/16 through 07/20/16.

An interview with Nurse #1 on 07/20/16 at 10:17 AM revealed when he completed the month to month reconciliation of Physician's orders he typically compared the current months MAR to the new MAR and reviewed the medical record for any medication orders written for the resident since the last review. Nurse #1 reviewed Resident #19's June 2016 Physician's orders and confirmed he completed the review on 05/27/16. Nurse #1 stated he should have crossed out the order for Lasix 40 mg on Resident #19's June 2016 MAR and transcribed the order for Lasix 60 mg every morning to the June 2016 MAR per the order written on 05/20/16. Nurse #1 indicated he must not have seen the order to increase Resident #19's Lasix to 60 mg when he completed the reconciliation.

An interview was conducted with the Director of Nursing (DON) on 07/20/16 at 10:23 AM. The DON stated the nurses on the hall typically signed off the Physician's orders and were expected to sign and date orders, fax a copy of medication orders to the pharmacy, and transcribe the medication to the residents' current MAR. The DON confirmed Nurse #4 signed off the Physician's order on 05/20/16 for Resident #19's Lasix to be increased to 60 mg by mouth every morning. The DON further stated she could not explain how this medication error occurred because Nurse #4 was no longer employed by the facility. The interview further revealed the DON would have expected Nurse #1 to catch the

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F 333	Continued From page 21 omission of the order for Lasix 60 mg daily dated 05/20/16 when he completed the reconciliation of Resident #19's May and June of 2016 Physician's orders and MARs on 05/27/16. An interview with the NP on 07/20/16 at 10:41 AM revealed she expected orders to be carried out when she writes them. The NP stated she increased Resident #19's daily Lasix on 05/20/16 because she reported increased edema in both her lower legs. The NP further stated Resident #19 did not suffer any negative outcome as a result of not receiving the increased dose of Lasix and noted Resident #19's edema had decreased despite not receiving the increased dose. During a telephone interview on 07/20/16 at 2:35 PM Nurse #4 stated when she received a medication order she signed off and dated the order, faxed a copy of the order to the pharmacy, and transcribed the order to the residents' MAR. Nurse #4 further stated she was no longer employed by the facility and did not recall signing off a medication order for Resident #19 on 05/20/16. An interview with Resident #19 on 07/21/16 revealed she could not say whether the edema in her lower legs had decreased the last few months. Resident #19 stated she always had edema in her lower legs.	F 333		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431		8/18/16

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F 431	Continued From page 22 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to monitor safe storage temperatures of medications in 1 of 2 refrigerators designated for medication storage. The facility also failed to ensure residents would not receive potentially ineffective medications as a result of having out of date medications in 2 of 2	F 431	On 7/20/16, all medications were removed and discarded from the brown refrigerator designated for medication storage at the Central Hall Medication Room by the Director of Nursing (DON). All expired medications or supplements and medications or supplements dated	

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F 431	Continued From page 23 medication storage rooms. 1. On 7/20/16 @ 10:30 AM the medication storage room for the Central Hall was observed. The brown refrigerator designated for medication storage had a thermometer inside which read 35 degrees. There was not a log of recorded daily temperatures for January through current date available. Paper logs for 2015 with recorded temperatures were on top of the refrigerator. Nurse # 1 and the Minimum Data Set (MDS) Nurse were asked who monitored the temperatures of the refrigerator, and where the temperatures were recorded. Nurse #1 and the MDS Nurse said that the third shift nurse was responsible for monitoring the temperatures of the refrigerator. They also stated they didn't know where the documentation was to be kept. a. Medications stored in the refrigerator where temperatures had not been recorded included 28 Tylenol 650 mg suppositories (suppositories unopened) 55 25mg suppositories (in plastic zip lock bag) (suppositories unopened) 1 Insulin Humalog 100 units/1 ml Qwik pen (unopened) 1 10 ml vial Novolog Insulin, 100 units/1 ml (unopened) 1 Tuberculin Purified Protein Derivative, open date 6/30/16. 10 test vial appeared to be half full (5 US units per test) 1 Tuberculin purified protein derivative open date 7/11/16, appeared to have one dose remaining in vial1 10 ml Vial Lantus insulin 100units/1ml (unopened) 2 vial Lantus insulin 100 units/1ml both opened 7/15/16 1 3 ml vial Humalog 100 units / 1ml (unopened)	F 431	but past the time frame noted by the manufacturer found in the Central Hall or Main Hall Medication Storage rooms were discarded by the DON on 7/20/16. Medications of discharged residents observed in the Central Hall or Main Hall Medication Storage rooms were returned to the pharmacy by the DON on 7/21/16. Temperatures of the refrigerators were checked in the Central(35 degrees) and Main Hall(37 degrees) Medication Storage rooms by the DON. On 7/21/16, the Staff Facilitator (SF) inspected the Central Hall Medication Storage room, the Main Hall Medication Storage room and the Medication carts (2) for any expired medications, medications or supplements dated but past the designated time frame noted by the manufacturer and medications belonging to discharged residents. Any medications found to be expired or belonging to discharged residents were returned to the pharmacy. Temperature logs were placed on each refrigerator located in the Central and Main Medication Storage rooms by the SF for documentation of daily temperatures to be recorded by licensed staff daily. 100% of licensed nurses were in-serviced by the SF, completed by 8/12/16, regarding Medication Storage, Storage of Refrigerated Medications, Insulin storage, Labeling of Medications, Disposal of Unused Medications, safe storage temperatures of medications requiring refrigeration and documentation of daily	

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	345219	A. BUILDING _____ B. WING _____	C 07/21/2016

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F 431	Continued From page 24 1 10 ml vial Levemir 100units/1ml opened 7/16/16 11 10 ml vials Levemir 100units/1ml unopened On July 20, 2016 the medications that were observed in medication storage room which were past the expiration dates included: 31 Heparin 5 ml prefilled syringes (100units/ml) Expiration date 1/2016 17 Heparin 5 ml prefilled syringes (100units/ml) Expiration date 6/2017 Influenza Vaccine Fluzone High Dose, unopened10 prefilled syringes (0.5ml each) expiration date 12 June 2016; Influenza Vaccine Fluzone High Dose, (0.5ml each) opened box 6 syringes expiration date 12 June 2016 Influenza Virus Vaccine Fluvirin 2015-2016 formula Expiration date 5/20/16, 2 unopened vials An opened bottle for liquid EryPed 200 (erythromycin ethysuccinate for oral suspension 200 mg per 5 ml) was labeled as opened on 4/19/16. The label instructions stated medication was to be used within 35 days of being opened. The prescription was for a resident who remained in the facility. b. In the Medication Storage Room on Central Hall medications prescribed for discharged resident observed to be on shelf in cabinet on 7/20/16. The resident had been in the facility from April 14 through April 16, 2016. The medications observed included an opened box of Sodium Chloride 9% 10 ml prefilled syringes which contained 20 out of 30 dispensed syringes. There were Heparin Flush 5 ml prefilled syringes with 10 units/ml observed in an opened box on shelf in medication cabinet. There were 19 remaining syringes of the 30 syringes dispensed in April. In the same medication storage cabinet there were observed Heparin PosiFlush prefilled	F 431	refrigerator temperatures. All newly hired licensed nurses will receive the in-service regarding Medication storage and labeling during orientation by the SF. Utilizing an audit tool, the DON, SF or MDS Coordinator will inspect the Central and Main Hall Medication Storage Rooms and medications carts (2) weekly x 4 weeks then monthly indefinitely for expired medications, undated medications, medications belonging to discharged residents and medications/supplements dated but past the time frame recommended by the manufacturer. The temperature logs will be reviewed weekly x 4 weeks then monthly indefinitely by the DON, SF or MDS Coordinator to ensure refrigerators are kept within appropriate range with daily temperature documentation completed. The audit tools will be reviewed monthly by the Executive QI Committee for identification of potential trends and development of plans of action to determine the need for continued monitoring.	

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F 431	Continued From page 25 syringes, with 10 units/1ml for a previously discharged resident. The prescription date for the PosiFlush syringes was 11/16/15. Twenty-eight syringes of Heparin PosiFlush remained in a box that had been opened. c. The Medication Storage room on the Main Hall was observed on 7/20/2016 at 11:00 AM. An out of date medication was observed. The medication observed was a vial of Lorazepam for Intramuscular injection with dose of 2 mg/ml. The vial had expiration date of 2/2016. The medication was prescribed for resident who remained in the facility. Nurse # 3 was present during the observation of the Main Hall storage room and verified that the vial of Lorazepam was out of date. On 7/20/16 @ 10:40 AM and 11:10 AM an interview was conducted with the Director of Nursing (DON) who stated it was her expectation that medications in storage rooms be reviewed for expiration date and removed from medication supply when medications found to be out of date. DON also stated that it was her expectation that refrigerators designated for medication storage would be monitored and temperatures recorded on written log to ensure medications are stored at proper temperatures.	F 431		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520		8/18/16

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F 520	Continued From page 26 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in September and October of 2015. This was for two recited deficiencies which were originally cited in September 2015 on a recertification and complaint survey and 1 recited deficiency which was cited in October 2015 on a follow up and complaint survey. The deficiencies were in the areas of housekeeping and maintenance services, Care Area Assessments and significant medication errors. The continued failure during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 520	On 8/8/16, the facility Executive QI Committee held a meeting to include the Medical Director, Administrator, DON, MDS Coordinator, SF, Maintenance Director, Housekeeping/Laundry Supervisor and Activity Director to determine attendees that will attend Executive QI Committee meetings on an on-going quarterly basis and then assign additional team members as appropriate. On 8/8/16,the facility consultant in-serviced administrator, DON, MDS Coordinator, Medical Director, Maintenance Director, Dietary Manager, SF, Activity Director, Housekeeping/Laundry Supervisor, Accounts Payable Manager and Accounts	

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F 520	Continued From page 27 The findings included: These tags are cross referred to: · F253 Housekeeping and Maintenance Services: The facility was recited for F253 for failing to label and properly store personal hygiene products and resident care equipment on 2 of 2 resident halls. · F253 was originally cited during a recertification and complaint survey on 09/11/15 for failure to label bedpans and bath basins with resident names (resident room #86, #87, #105 and #106), failed to clean a privacy curtain in a resident's room (room #99), failed to store lift slings and straps off the floor (receptionist area), failed to repair damaged handrails (main hall), failed to repair base molding (between resident rooms #100 and #101, receptionist area and across from nurses station on the main hall), failed to repair broken laminate on a cabinet (room #100) and failed to repair broken areas of wood and laminate on smoke prevention doors (100 hall). · F272 Care Area Assessments: The facility was recited for F272 for failing to complete Care Area Assessments that addressed the underlying causes, contributing factors and risk factors for 5 of 19 sampled residents (Residents #50, #23, #1, #44, #39). · F272 was originally cited during a recertification and complaint survey on 09/11/15 for failure to complete Care Area Assessments that addressed the underlying causes, contributing factors and risk factors for triggered areas for 3 of 17 (Residents #25, #53, and #56)	F 520	Receivable Manager about the QAPI process, appropriate function of the QI Committee, the purpose of the committee, identification of issues related to quality assessment and assurance and developing/implementing appropriate plans of action for identified facility concerns to include F253 Housekeeping and Maintenance, F272 Care Area Assessments, F333 Significant Medication Errors and F 431 Drug Records, Label/Storage Drugs & Biologicals. The Executive QI Sub-Committee, Medical Director, Administrator, DON and SW will begin monthly meetings to review audit tools to determine the need for changes to the audits, frequency of audits and need for continued monitoring as indicated related to F253, F272, F278, F 281, F333 and F 431. Quarterly, the Regional Vice President of Operations, the Vice President of Clinical Services and the Facility Consultant will attend and review the facility audit tools and Executive QI Committee meeting minutes to ensure systems are in place to prevent reoccurrence of non-compliance with F253 Housekeeping & Maintenance Services, F272 Comprehensive Assessments, F278 Assessment Accuracy, F281 Services Provided to meet Professional Standards, F333 Residents Free of Significant Med Errors and F431 Drug Records, Label/Store Drugs & Biologicals x 1 year with retraining provided as indicated.	

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F 520	Continued From page 28 sampled residents. · F333 Significant Medication Error: The facility was recited for F333 for failing to administer an increased dose of diuretic ordered for edema by the Nurse Practitioner for 1 of 5 residents reviewed for unnecessary medication use (Resident # 19). · F333 was originally cited during a follow up and complaint survey on 10/22/15 for failure to prevent significant medication error by administering the incorrect dose of blood pressure medication (Cozaar) for high blood pressure for 1 of 1 of residents (Resident #26) sampled for unnecessary medications. During an interview conducted on 07/21/16 at 3:45 PM the Director of Nursing (DON) stated the Quality Assessment and Assurance Committee currently met on a monthly basis with their meetings focusing on clinical indicators not being met. She stated they continued to discuss previously cited issues and were continuing to work on those issues. The DON further stated she felt like the re-cites had a lot to do with the training staff received from the corporate level.	F 520		