STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 08/09/2018

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SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		9/5/18

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

Electronically Signed | 08/24/2018

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to serve 1 of 3 residents, who were seated at the same dining room table their lunch meals at the same time to maintain dignity with dining. (Resident #83). The findings included: Resident #83 was admitted on 7/9/18 with a diagnosis of Atrial Fibrillation. Resident #83's admission Minimum Data Set dated 7/17/18 indicated severe cognitive impairment with no exhibited behaviors. She was coded for supervision with eating. Resident #83's care plan dated 7/17/18 indicated staff were to assist with activities of daily living as needed. During an observation on 8/6/18 at 12:55 PM, the meal-tray cart for hall 300 was delivered. Resident #83 was observed sitting at a table in the dining room on hall 300 with two other residents. The two other residents seated at the table with Resident #83 received their meal trays at 1:05 PM while Resident #83 continued to sit at the table. At 1:20 PM, Resident #83 still had not been served and Nursing Assistant (NA) #5 began removing meal trays from the tables of the residents who had finished their lunch. NA #5 was interviewed about Resident #83 not receiving her tray at this time. NA #5 stated she did not realize that Resident #83 had not been served her meal and would see if her meal tray was still on the meal-tray cart. NA #5 retrieved Resident #83's meal tray and set it up for Resident #83. NA #5	F 550	Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. Resident #83 was not served her meal at the same time as the other resident's seated at the same dining table during lunch on August 6, 2018. Upon identification by the surveyor, Nursing Assistant #5 retrieved Resident #83's meal from the meal-tray cart. Nursing Assistant #5 stated that she was aware that residents should be served at the same time and she must have just missed it. Resident #83 was served her meal upon notification that the resident had not been served. The resident did not receive her meal at the same time as the other resident's seated at the same dining table as there was no designated person to oversee or observe the dining process. Licensed Nurses will be assigned to oversee each dining room during all meal times to ensure that resident's dignity is maintained and meals are provided to residents seated at the same table at the same time.	

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F 550	Continued From page 2 stated residents sitting at the same table should be served at the same time and she must have just missed it, but it was not done intentionally. In an interview on 8/9/18 at 4:10 PM, the Administrator stated it was her expectation that residents sitting together should be served their meal trays at the same time for dignity.	F 550	A 100% audit of each dining room for each meal served was completed daily for 7 days, specifically August 21, 2018 through August 27, 2018, by licensed nurses to ensure that each resident's dignity was maintained during meals and that all residents seated at the same table were served meals at the same time. On August 23, 2018 one resident's order was incorrect (resident ordered from alternate menu) and the nurse went to the kitchen to get the corrected tray. This resident was served upon retrieval of tray from kitchen. On August 23, 2018, one resident's tray was sent to the incorrect dining room and staff retrieved the tray from the incorrect dining room and the resident was served upon tray retrieval. The Dietary Manager was informed and this resident's tray will be sent to 300 hall dining room from now on. On August 23, 2018, two resident's trays were delivered to the 100 hall dining room with incorrect diet consistencies. The nurse retrieved the correct trays from kitchen staff and residents were served upon retrieval of trays. No other issues were noted during the dates of August 21, 2018 through August 26, 2018. The Assistant Director of Nursing initiated an in-service to all nursing department staff on August 20, 2018 regarding resident's rights and dignity during meal times. This in-service included that meals must be served to residents dining at the same table at the same time. This in-service also included that charge	

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F 550	Continued From page 3	F 550	nurses will be assigned to oversee each dining room during all meals. All newly hired nursing department staff will receive the appropriate education during orientation. Staff will not be allowed to work until they have received the in-service. To ensure quality assurance, utilizing a dining room observation quality assurance audit tool, licensed nursing staff will complete dining room observations during meal times to ensure dignity is maintained during meals and that meals are provided to all residents at the same time. These audits will be completed daily for two weeks, twice weekly for two additional weeks, and weekly for two months. The Director of Nursing will review the quality assurance audit tools weekly x 8 weeks, then monthly x 1 month for trends and concerns. The Director of Nursing will present the results of these audits to the Quality Assurance Performance Improvement Committee for a minimum of three consecutive meetings to identify trends, concerns, and recommendations for any modification of the process. The Director of Nursing will be responsible for implementing the plan of correction.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and	F 600		9/5/18

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F 600	Continued From page 4 Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff and resident interview, the facility failed to protect a cognitively impaired resident (Resident #62) from unwanted advances from a cognitively intact resident (Resident # 60) and also neglected to provide incontinent care to a resident who needed extensive assist with toileting (Resident #65) for 2 of 2 sampled residents reviewed for abuse and neglect. Findings included: 1. Resident #62 was originally admitted to the facility on 4/14/14 and was readmitted on 8/9/17 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 7/7/18 indicated that Resident #62 had severe cognitive impairment. Resident #60 was admitted to the facility on 9/5/16 and was readmitted on 3/29/17 with multiple diagnoses including diabetes mellitus. The quarterly MDS assessment dated 7/2/18	F 600	On August 6, 2018, Nursing Assistant #3 reported to Nurse #5 that she observed Resident #60 kiss Resident #62 on the lips. Nursing Assistant #3 left the residents alone to go and report the incident to the nurse. Upon hearing of the incident, Nursing Assistant #6 removed Resident #62 from the location of the incident. Nurse #5 completed a head-to-toe assessment of Resident #62 with no abnormal findings. At the time of occurrence on August 6, 2018, Resident #60 was immediately provided with a one-on-one sitter. A complete and thorough investigation was completed and reported to DHSR. Nursing Assistant #3 failed to ensure the safety of Resident #62 as she did not separate the residents and left the residents alone to go and report the incident to the nurse.	

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F 600	Continued From page 5 indicated that Resident #60 had intact cognition with the brief interview for mental status (BIMS) score of 15. The assessment further indicated that Resident #60 needed limited assistance with locomotion on and off unit using a walker or a wheelchair for mobility. An incident investigation report was provided by the Administrator on 8/9/18. The report revealed that the Administrator had received a phone call from the Director of Nursing (DON) on 8/6/18 at approximately 9 PM. The call was to inform her that a Nurse Aide (NA) had observed Resident #60 kissing Resident #62. The Administrator had called the facility and interviewed the NAs and other staff involved. NA # 3 reported that she had witnessed Resident #60 leaned forward and kissed Resident #62 near her lips. NA #3 left the media room to inform the nurse. NA # 6 reported that when she heard the incident, she immediately went to the media room and as she entered the room, she heard Resident #60 asking Resident #62 if he could touch her "titties" (female breast). NA #6 immediately instructed Resident #60 to leave the room. Nurse #5 reported that she was at the 100 hall nurse's station when NA # 3 informed her of the incident. Nurse #5 stated that after ensuring the safety of Resident #62 she notified the DON via phone. She also completed a full skin assessment on Resident #62 with no abnormal or unusual findings. Nurse #5 also indicated that she notified the responsible party of Resident #62 and the nurse assigned to Resident #60. When she interviewed the resident, Resident #60 denied the allegations of kissing and asking to touch Resident #62's titties. The investigation report further indicated that all alert and oriented residents were interviewed by the Director of	F 600	On July 11, 2018, Nursing Assistant #6 failed to provide incontinent care to Resident #65 from approximately 4:30PM until 8:45PM. Upon identification, Resident #65 was provided incontinent care by Nursing Assistant #1. An investigation was initiated, substantiated, and Nursing Assistant #6 terminated on July 13, 2018. The facility investigation included interviewing all residents with a BIMS of 13-15 to determine if there were any concerns for abuse or neglect; however, the facility failed to contact the responsible representatives of all residents with a BIMS score of less than 13 to determine if there were any concerns for abuse or neglect. All residents with a BIMS of 13-15 were interviewed on August 11, 2018 by the Director of Nursing, Admissions Coordinator, Administrator, and Social Worker to determine if there were any concerns for neglect with no incidents of neglect reported. Interviews with all responsible representatives of residents with a BIMS of less than 13 were initiated on August 11, 2018 by the Director of Nursing, Admissions Coordinator, Administrator, and Social Worker to determine if there were any concerns for neglect. Interviews were completed on August 14, 2018 with no incidents of neglect reported. The Administrator provided an in-service to all Administrative Staff on August 20,	

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F 600	Continued From page 6 Social Services (DSS) on 8/9/18 with no reports of inappropriate touching or communication. Resident #62 was interviewed by the Administrator and the DSS and he denied the allegations. The written statement from NA # 3 revealed that on 8/6/18 as she was walking up the 100 hall, she saw Resident #62 sitting in a Geri-chair facing the television and Resident #60 was sitting on the left side of Resident #62 in the media room. She saw Resident #60 leaning toward Resident #62 and she thought they were just talking but when she watched them, she saw Resident #60 kissed Resident #62 on the lips. She then went and reported it to the Nurse #5. The written statement from NA #6 revealed that on 8/6/18 at approximately 9 PM, while standing at the nurse's station on 100 halls, NA #3 approached the desk and stated that Resident #60 was in there kissing Resident #62. She walked to the media room and noticed Resident #60 leaning over Resident #62. Resident #62 was in a Geri-chair facing the television and she was facing Resident #60's back as she was entering the media room. She did not see him kissing Resident #62 however she heard him asking Resident #62 "can I touch your titties?" She immediately told Resident #60 to leave the room which he did. The written statement from Nurse # 5 revealed that she was informed on 8/6/18 around 9 PM that Resident #60 was in the media room on the 100 hall kissing another resident and he was talking sexually to her. She then went to talk to Resident #60 and he denied the allegations.	F 600	2018 regarding complete and accurate investigating of abuse and neglect. This in-service included a review of the facility abuse prevention program and policy for abuse investigating and reporting. All newly hired administrative staff will receive the appropriate education during orientation. Staff will not be allowed to work until they have received the in-service. The Assistant Director of Nursing initiated an in-service to all staff on August 20, 2018 regarding abuse and neglect. This in-service included appropriate actions to take when abuse is suspected, including ensuring the immediate safety of the resident involved. This in-service included examples of abuse and neglect, including resident to resident abuse, and a review of facility policies and procedures for abuse and neglect. All newly hired nursing department staff will receive the appropriate education during orientation. Staff will not be allowed to work until they have received the in-service. The Assistant Director of Nursing initiated an in-service to all nursing assistants on August 20, 2018 regarding incontinent rounds, following resident specific care guides, and timely response to call lights. This in-service included providing timely care to residents returning to the facility from appointments or other leaves of absence. All newly hired nursing assistants will receive the appropriate education during orientation. Staff will not be allowed to work until they have	

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F 600	Continued From page 7 The psychiatry consult dated 8/8/18 was reviewed. The consult revealed that the details of the incident with Resident #62 was discussed with Resident #60 and when he was interviewed, he indicated that he regretted that it happened but he would not promise not to touch anyone here in this facility and that he would be lying if he said he would not do it again. The plan was to observe him vigilantly, observe for inappropriate behaviors and not to leave him alone with any females. On 8/9/18 at 1:10 PM, Resident #62 was observed in bed. She was talking incoherently when questioned. On 8/9/18 at 1:30 PM, Resident #60 was interviewed. When asked of the incident with Resident #62, he admitted kissing her on her lips but he didn't remember asking her if he could touch her breast. On 8/9/18 at 1:15 PM, NA # 6 was interviewed. She stated that she overheard NA #3 informing Nurse #5 that she had observed Resident #60 kissing Resident #62. She immediately went to the media room, and while entering the room she heard Resident #60 asking Resident #62 if he could touch her titties. He was leaning forward that his face was too close to Resident #62's face. She immediately told him that he needed to leave the room and she took him out. On 8/9/18 at 3:20 PM, NA #3 was interviewed. She stated that she was walking down the hall looking at the media room. She saw Resident #60 leaning forward and actually kissing Resident #62 on her mouth. She left the room and went to the nurse's station to inform Nurse #5. When asked why she left the room, she replied that she was	F 600	received the in-service. To ensure quality assurance, the Administrator will review all reports of abuse and neglect in entirety to ensure that appropriate action was taken to ensure the safety of the resident. Any employee witnessing abuse and not ensuring the safety of the resident will be disciplined according to policy. To ensure quality assurance, utilizing a Resident Interview for Neglect quality assurance audit tool, the Social Worker will interview 5 residents with a BIMS of 13-15 and 5 Responsible Representatives of residents with a BIMS less than 13 to ensure no neglect of care has occurred. These audits will be completed weekly x 4 weeks then monthly x 2 months. The Administrator will review the audit tools weekly x 4 weeks, then monthly x 2 months for trends and concerns. The Director of Social Services will present the results of these audits to the Quality Assurance Performance Improvement Committee for a minimum of three consecutive meetings to identify trends, concerns, and recommendations for any modification of the process. The Administrator will be responsible for implementing the plan of correction.	

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shocked and didn't think of separating them.

On 8/9/18 at 1:10 PM, Nurse #5 was interviewed. She stated that NA #3 informed her that while she was walking down the 100 hall around 9 PM she saw Resident #60 leaning forward and kissing Resident #62 in the media room. She was also informed by NA # 6 that she heard Resident #60 asking Resident #62 if he could touch her titties. When she interviewed Resident #60, he denied the allegation. She also observed NA #6 taking Resident #60 out of the media room. She completed a full body assessment on Resident #62 and nothing usual noted. Nurse #5 further indicated that Resident #62 was confused while Resident #60 was alert and oriented.

On 8/9/18 at 12:02 PM, the Administrator was interviewed. She stated that the incident happened on 8/6/18 at night. She was called and was informed of the incident. She then called the facility and interviewed the staff involved. She indicated that Resident #62 was not alert and oriented but Resident #60 was alert and oriented. The allegation was Resident #60 kissed Resident #62 and asked her if he could touch her titties. She indicated that she considered these as abuse allegations. The staff were in-serviced on abuse and all alert and oriented residents were interviewed. Resident #60 was placed on 1:1 sitter.

2. Resident #65 was admitted to the facility on 5/2/18 with cumulative diagnoses of Peripheral Vascular Disease, End-Stage Renal Disease and Diabetes.

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Review of Resident #65's latest revised care plan dated 6/22/18 indicated staff were to assist with his activities of daily living and provide timely incontinent care due to his incontinence of bladder and bowel.

Review of Resident #65's re-admission 5-day Minimum Data Set dated 7/9/18 indicated moderate cognitive impairment with no behaviors and was coded as requiring extensive assistance with hygiene. He was coded as frequently incontinent of bladder and always incontinent of bowel. He was coded for intact skin.

Review of the Allegation Report dated 7/12/18 indicated on 7/11/18 at 8:55 PM, Resident #65 was not offered incontinence care after returning from dialysis at 4:45 PM until his room-mate (Resident #258) requested staff assistance for Resident #65 at 8:55 PM. Review of the Investigation Report dated 7/13/18 indicated Resident #258 was interviewed on 7/11/18 at 9:10 PM. He described how Resident #65 had been left sitting up in his wheelchair wearing his street clothes since returning from dialysis at approximately 4:45 PM. He stated Resident #65 was incontinent of bowel and had been left sitting in his soiled brief until Resident #258 pushed his call bell for staff to assist Resident #65 at approximately 8:55 PM. The FRI was substantiated, and the aide was terminated on 7/13/18.

An interview was attempted with Resident #65 on 8/8/18 at 9:00 AM. He did not recall the incident on 7/11/18. He stated he was happy at the facility and voiced no concerns.

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Resident #258 was admitted 5/5/18. He was discharged to the hospital on 7/30/18. His admission Minimum Data Set dated 5/16/18 indicated he was cognitively intact and exhibited no behaviors.

Attempts to contact Resident #258 and his Responsibly Party were unsuccessful.

In a telephone interview on 8/8/18 at 1:50 PM, Nursing Assistant (NA) #6 stated she was the aide involved in the incident on 7/11/18 and confirmed she was suspended then terminated on 7/13/18. She stated she arrived at work daily at 3:45 PM since she was in school. She stated on 7/11/18 the assignment had been changed from her usual assignment on hall 300 to the short end of the hall 100 and she was unfamiliar with those residents. NA #6 stated Resident #258 pushed his call bell at approximately 8:45 PM so she went to see what he needed. She stated Resident #258 was angry when she went in and stated Resident #65 needed to be undressed, cleaned and assisted to bed. She stated Resident #258 was angry and informed her he was reporting her for not assisting Resident #65 from the time he returned from dialysis at approximately 4:30 PM to 8:45 PM. NA #6 stated she asked why he was using his call bell for Resident #65 and that it was fine if he reported her. She stated she left the room without providing any assistance to Resident #65 because Resident #258 was so angry. She stated Resident #258 followed her out of the room and ambulated up to the nursing station. NA #6 stated she then went back into the room and assisted Resident #65 with undressing and incontinence care when the Director of Nursing came in and told her to stop care, write a statement and then

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F 600	Continued From page 11	F 600		

see her immediately after writing her statement. NA #6 stated when she provided incontinence care to Resident #65, he had apparent episodes of diarrhea. She stated she did not know if incontinence care was provided to Resident #65 while at dialysis and uncertain when he last received incontinence care prior to her arrival at 3:45 PM.

During an observation on 8/9/18 at 10:10 AM, Resident #65's brief was noted clean and dry. Observation of his peri-area was noted intact. NA #2 stated Resident #65 often experienced episodes of diarrhea and needed to be changed often. NA #2 stated Resident #65 attended dialysis every Monday, Wednesday and Friday and left the facility before lunch on those days. NA #2 stated incontinence care was provided to Resident #65 prior to leaving for dialysis and it was not preformed again until he returned after she left at 3:00 PM.

In an interview on 8/9/18 at 10:20 AM, the Director of Nursing (DON) at the time of the incident stated she was in the DON office when she was notified by the Medication Aide (MA) #1 that there was a problem with NA #6. She stated she heard NA #6 coming up the hallway yelling and when exiting her office, she saw Resident #258 also coming up the hallway and he too appeared upset. The previous DON stated she immediately went to check on Resident #65 at approximately 8:55 PM who was still sitting up in his wheelchair in his street cloths and was obviously very soiled with stool. She stated Resident #65 normally returned from dialysis around 4:30 PM so he would not have received any incontinence care since prior to leaving for dialysis before lunch. She asked NA #1 to assist

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F 600	Continued From page 12 Resident #65 while she and the (MA) #1 took Resident #258 to the conference room to get his statement. She directed NA #6 to write her statement and clock out due to suspension pending the outcome of the investigation. In an interview on 8/9/18 at 1:20 PM, MA #1 stated she was assigned Resident #65 on 7/11/18. She stated she heard NA #6 and Resident #258 yelling and observed them both coming up the hallway. She stated she immediately notified the previous DON who was working in her office that something happened, and she needed assistance. In an interview on 8/9/18 at 4:10 PM, the Administrator stated Resident #65 would have not received any incontinence care from the time he left for dialysis that day until approximately 8:55 PM. She stated it was her expectation that Resident #65 would have been immediately gotten out of his wheelchair and incontinence care provided upon return from dialysis.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §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,	F 607		9/5/18

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F 607	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to follow their abuse policy and procedure by not reporting allegation of abuse immediately to the state agency for 1 of 2 sampled residents reviewed for abuse and neglect (Resident #62). Findings included: The facility's abuse policy and procedure with the revised date of July 2017 was reviewed. Under reporting, the policy indicated that "all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator or his/her designee to the following persons or agencies: the state licensing/certification agency." Resident #62 was originally admitted to the facility on 4/14/14 and was readmitted on 8/9/17 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 7/7/18 indicated that Resident #62 had severe cognitive impairment. An incident investigation report was provided by the Administrator on 8/9/18. The report revealed that the Administrator had received a phone call from the Director of Nursing (DON) on 8/6/18 at approximately 9 PM. The call was to inform her that a Nurse Aide (NA) had observed Resident #60 kissing Resident #62. The Administrator had called the facility and interviewed the NAs and other staff involved. NA # 3 reported that she had witnessed Resident #60 leaned forward and kissed Resident #62 near her lips. NA #3 left the	F 607	On August 6, 2018, a resident to resident abuse investigation was initiated. The Administrator did not report this allegation to DHSR in a timely manner. The initial allegation report was submitted on August 9, 2018, three days after the incident occurred. The Administrator failed to follow the abuse policy and procedure by not reporting an allegation of abuse immediately to the state agency. All reportable allegations/incidents occurring over the previous three months were reviewed by the Administrator on August 17, 2018 to ensure timely reporting with no issues identified. Any reportable allegations/incidents occurring The Regional Director of Operations provided an in-service to the Administrator on August 20, 2018 to include timely reporting of abuse allegations. This in-service included a review of the facility abuse prevention program and policy for abuse investigating and reporting. The Administrator provided an in-service to all Administrative Staff on August 20, 2018 regarding complete and accurate investigating of abuse and neglect. This in-service included a review of the facility abuse prevention program and policy for abuse investigating and reporting. All newly hired administrative staff will receive the appropriate education during	

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F 607	Continued From page 14 media room to inform the nurse. NA # 6 reported that when she heard the incident, she immediately went to the media room and as she entered the room, she heard Resident #60 asking Resident #62 if he could touch her "titties" (female breast). NA #6 immediately instructed Resident #60 to leave the room. Nurse #5 reported that she was at the 100 hall nurse's station when NA # 3 informed her of the incident. Nurse #5 stated that after ensuring the safety of Resident #62 she notified the DON via phone. She also completed a full skin assessment on Resident #62 with no abnormal or unusual findings. Nurse #5 also indicated that she notified the responsible party of Resident #62 and the nurse assigned to Resident #60. When she interviewed the resident, Resident #60 denied the allegations of kissing and asking to touch Resident #62's titties. On 8/9/18 at 3:20 PM, NA #3 was interviewed. She stated that she was walking down the hall looking at the media room. She saw Resident #60 leaning forward and actually kissing Resident #62 on her mouth. She left the room and went to the nurse's station to inform Nurse #5. On 8/9/18 at 1:15 PM, NA # 6 was interviewed. She stated that she overheard NA #3 informing Nurse #5 that she had observed Resident #60 kissing Resident #62. She immediately went to the media room, and while entering the room she heard Resident #60 asking Resident #62 if he could touch her titties. On 8/9/18 at 1:10 PM, Nurse #5 was interviewed. She stated that NA #3 informed her that while she was walking down the 100 hall around 9 PM she saw Resident #60 leaning forward and kissing	F 607	orientation. Staff will not be allowed to work until they have received the in-service. To ensure quality assurance, the Director of Nursing will submit all reportable allegations of abuse and neglect to the appropriate agencies and the Administrator will review all reports in entirety to ensure that appropriate reporting has occurred per policy. To ensure quality assurance, utilizing an Allegation/Incident Reporting QI tool the Administrator will conduct an audit of all allegations occurring over the next three months. This audit will specifically outline dates of allegations and dates that reports are submitted. The Regional Director of Operations will be notified of any reports that are not submitted timely so that disciplinary action can occur per policy. The Administrator will present the results of these audits to the Quality Assurance Performance Improvement Committee for a minimum of three consecutive meetings to identify trends, concerns, and recommendations for any modification of the process. The Administrator will be responsible for implementing the plan of correction.	

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F 607	Continued From page 15 Resident #62 in the media room. She was also informed by NA # 6 that she heard Resident #60 asking Resident #62 if he could touch her titties. Nurse #5 indicated that she had reported the incident to the Director of Nursing. On 8/9/18 at 12:02 PM, the Administrator was interviewed. She stated that the incident happened on 8/6/18 at night. She was called and was informed of the incident. The allegation was Resident #60 kissed Resident #62 and asked her if he could touch her titties. She indicated that she considered these as abuse allegations. The Administrator stated that she did not report the allegations of abuse because the corporate had told her that resident to resident abuse was not reportable.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of active diagnosis and antipsychotic medication review (Resident #18), falls (Resident #72), and dental status (Resident #2) for 3 of 27 residents reviewed. The findings included: 1a. Resident #18 was admitted to the facility on 5/22/17 with diagnoses that included osteoarthritis and chronic pain.	F 641	Resident #18 had an active order for Norco once daily for chronic back pain. Section (I) of the MDS on the 5/24/18 assessment indicated no diagnosis related to pain medication. Resident #18's Seroquel was discontinued on 4/3/18 and Risperdal initiated. Section (N) of the MDS on 5/24/18 inaccurately coded to indicate that a GDR had been attempted. Resident #72 had a fall with head injury	9/5/18

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F 641	Continued From page 16 A physician' s order for Resident #18 dated 3/7/18 indicated Norco (narcotic pain medication) 7.5-325 milligrams (mg) once daily for chronic back pain. A physician ' s note dated 5/16/18 indicated Norco daily continued for Resident #18 ' s chronic pain. The annual Minimum Data Set (MDS) assessment dated 5/24/18 indicated Resident 18 ' s cognition was severely impaired. She received opioid medications on 7 of 7 days during the MDS review period. Section I, the Active Diagnoses section, included no diagnosis related to the opioid medication. The plan of care for Resident #18 included the area of risk for pain with diagnoses of arthritis, bilateral foot pain, and back pain at times. This area was initiated on 5/24/18. An interview was conducted with the MDS Nurse on 8/9/18 at 3:50 PM. The MDS dated 5/24/18 for Resident #18 that indicated she received opioid medication on 7 of 7 days was reviewed with the MDS Nurse. The Active Diagnoses section of this 5/24/18 MDS that provided no related diagnosis for the opioid medication was reviewed with the MDS Nurse. The physician ' s order for Norco and the plan of care related to Resident #18 ' s pain were reviewed with the MDS Nurse. She revealed the MDS was coded inaccurately. She stated the 5/24/18 MDS for Resident #18 should have included the diagnosis of chronic pain. An interview was conducted with the	F 641	on 4/19/18. Section (J) of the MDS submitted on 7/5/18 was coded inaccurately for falls. Resident #2 was admitted to the facility with a chipped tooth. Section (L) of the MDS on 5/1/18 was inaccurately coded as having no dental issues. The nurse documented the incident report regarding a fall for Resident #72 with the incorrect date, utilizing the year 2017 rather than 2018, therefore, when the MDS Coordinator reviewed the incident log for this resident the fall was not on the incident log. Based on the incident date being incorrectly entered, the MDS Coordinator was unaware of the fall for Resident #72 and therefore did not code a fall on the MDS. The MDS Coordinator failed to code a diagnosis of chronic pain for a resident prescribed scheduled Norco for Resident #18. The MDS Coordinator incorrectly coded a GDR for Resident #18 when the resident had a change in medication but not a GDR. The Dietician failed to assess Resident #2's dentation prior to completing an assessment. Section (I) of the MDS on the 5/24/18 assessment for Resident #18 was corrected to reflect a diagnosis of Chronic Pain and resubmitted on 8/14/18 by the MDS Coordinator. Section (N) of the MDS on the 5/24/18 assessment for Resident #18 was corrected to reflect that a GDR was not attempted and resubmitted on 8/14/18 by	

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Administrator on 8/9/18 at 4:10 PM. She indicated she expected the MDS to be coded accurately.

1b. Resident #18 was admitted to the facility on 5/22/17 with diagnoses of vascular dementia with behavioral disturbance.

A review of a psychiatry progress note dated 4/3/18 indicated the physician was changing Resident #18 ' s antipsychotic medication from Seroquel (antipsychotic medication) to Risperdal (antipsychotic medication).

A physician ' s order dated 4/3/18 indicated Resident #18 ' s Seroquel was discontinued and Risperdal was initiated.

The annual Minimum Data Set (MDS) assessment dated 5/24/18 indicated Resident 18 ' s cognition was severely impaired. Section N, the Medication Section, indicated Resident #18 was administered antipsychotic medications on 7 of 7 days. The Antipsychotic Medication Review indicated Resident #18 had received routine antipsychotic medication and that a Gradual Dose Reduction (GDR) was attempted on 4/3/18.

An interview was conducted with the MDS Nurse on 8/9/18 at 3:50 PM. The MDS dated 5/24/18 for Resident #18 that indicated a GDR was attempted on 4/3/18 was reviewed with the MDS Nurse. The psychiatry progress note dated 4/3/18 and the physician ' s order dated 4/3/18 that indicated the discontinuation of Resident #18 ' s Seroquel and the initiation of Risperdal was reviewed with the MDS Nurse. The MDS Nurse reported she was unaware that a tapering of an antipsychotic medication performed for the

the MDS Coordinator.

Section (J) of the MDS on the 4/19/18 assessment for Resident #72 was corrected to reflect that the resident sustained a fall and resubmitted on 8/14/18 by the MDS Coordinator.

Section (L) of the MDS on the 5/1/18 assessment for Resident #2 was corrected to reflect a chipped tooth and resubmitted on 8/22/18 by the MDS Coordinator.

The Interdisciplinary Team, including the Dietary Manager, Dietician, and MDS Coordinator were in-serviced by the Corporate MDS Consultant on 8/23/18 regarding accuracy of assessments.

The Assistant Director of Nursing initiated an in-service on 8/21/18 with all licensed nursing staff regarding accuracy of documentation on incident reports. All newly hired licensed nursing staff will receive the appropriate education during orientation. Staff will not be allowed to work until they have received the in-service.

An audit was initiated by the Regional Nurse Consultant on 8/23/18 to ensure assessment accuracy of all sections. Members of the Interdisciplinary Team assisted in the audit following re-education on 8/23/18. All active residents' last assessment was audited for assessment accuracy between 8/23/18

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F 641	Continued From page 18 purpose of switching the resident from one antipsychotic medication to another was not to be coded as a GDR on the MDS. She indicated she had coded the MDS incorrectly for Resident #18. She reported Resident #18 ' s 5/24/18 MDS should have been coded to indicate a GDR was not attempted. An interview was conducted with the Administrator on 8/9/18 at 4:10 PM. She indicated she expected the MDS to be coded accurately. 2. Resident #72 was most recently readmitted to the facility on 8/25/16 with diagnoses that included cerebrovascular disease, heart failure, and respiratory failure. A nursing note dated 4/19/18 indicated Resident #72 had a fall with head injury. He was assessed with a hematoma, was evaluated at the hospital with head and neck CT (computed tomography) scans completed with negative findings, and he returned to the facility. The quarterly Minimum Data Set (MDS) assessment dated 7/5/18 indicated Resident #72 was cognitively intact. He was coded with no falls since his previous MDS assessment (4/6/18 significant change MDS). An interview was conducted with the MDS Nurse on 8/9/18 at 3:50 PM. The 7/5/18 MDS for Resident #72 that indicated he had no falls since his previous MDS assessment was reviewed with the MDS Nurse. The nursing note dated 4/19/18 that indicated Resident #72 had a fall with head injury was reviewed with the MDS Nurse. She	F 641	and 8/24/18. Of 105 assessments audited, 26 assessments were corrected and re-submitted on 8/23/18 and 8/24/18. In order to provide Quality Assurance, the Interdisciplinary Team will complete an MDS audit to ensure assessment accuracy on one assessment per week for 4 weeks and one per month for an additional two months. The MDS Coordinator will present the results of these audits to the Quality Assurance Performance Improvement Committee for a minimum of three consecutive meetings to identify trends, concerns, and recommendations for any modification of the process. The Administrator will be responsible for the plan of correction.	

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indicated she had coded Resident #72 ' s 7/5/18 MDS inaccurately for falls.

An interview was conducted with the Administrator on 8/9/18 at 4:10 PM. She indicated she expected the MDS to be coded accurately.

3. Resident #2 was admitted on 4/24/18 with a diagnosis of Traumatic Brain Injury (TBI).

Resident #'2's admission Minimum Data Set (MDS) dated 5/1/18 indicated she had severe cognitive impairment and required total assistance with all activities of daily living except for supervision with eating. Section L (Oral/Dental Status) of the MDS was coded as having no broken or chipped teeth and no dental concerns. Section L was completed by the Registered Dietician (RD).

Resident #2's care pan dated 5/1/18 did not include any oral or dental concerns.

In an observation on 8/6/18 at 4:44 PM, Resident #2 was noted to have a broken upper right front tooth.

Interview on 8/8/18 at 10:15 AM, Social Worker (SW) stated the facility was aware of Resident #2's "chipped tooth" on admission and the in-house Dentist saw her on 6/22/18. The SW stated the in-house Dentist was scheduled to repair it on 8/17/18 since the Responsible Party recently consented to the in-house dental procedure.

Interview on 8/8/18 at 3:15 PM, the RD stated she completed Section L of Resident #2's admission MDS dated 5/1/18 inaccurately and it was simply

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F 641	Continued From page 20 an oversight on her part. She confirmed she performed visual observation of Resident #2's teeth but did not note the broken front tooth. Interview on 8/9/18 at 4:10 PM, the Administrator stated it was her expectation that the MDS be an accurate reflection of Resident #2's oral/dental status and the RD should have coded Section L of the admission MDS dated 5/1/18 accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		9/5/18

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F 656	Continued From page 21 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to develop a care plan for 1 (Resident #31) of 3 residents reviewed for contractures. The facility also failed to develop a care plan unplanned weight loss. This was for 1 (Resident #90) of 4 residents reviewed for nutrition. The findings included: 1. Resident #31 was admitted on 3/8/12 with cumulative diagnoses of Cerebral Vascular Accident, Diabetes and right-side hemiplegia. Review of Resident #31's Physician orders included an order dated 10/5/17 which read he was wear a right-hand resting splint for 4 hours daily. His Significant Change Minimum Data Set (MDS) dated 6/17/18 indicated severe cognitive impairment with no exhibited behaviors. He was coded for impairment to one upper extremity. Review of Resident #31 latest care plan revised	F 656	The facility failed to develop a care plan for Resident #31 related to contractures. The facility failed to develop a care plan for Resident #90 related to unplanned weight loss. Resident #31 has a right-hand contracture. Resident #31 was discharged to the hospital on 4/15/18 and readmitted to the facility on 4/22/18. Upon readmission, the previous splint order was not re-activated nor was an order received for splinting. Review of medical records and physician orders did not notate the contracture and therefore the contracture was not reflected on the care plan. Resident #90 experienced an unplanned weight loss. The Dietary Manager failed to initiate a care plan addressing weight loss as she is new to her role and was unsure of what to put in the care plan. Resident #31’s Care Plan was updated on	

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F 656	Continued From page 22 6/22/18 did not include a care plan for splinting of his right-hand contracture. During an observation on 8/6/18 at 11:42, Resident #31 was sitting up in his wheelchair. He was observed with a right-hand contracture. In a second observation on 8/7/18 at 3:40 PM, Resident #31 was sitting up in his wheelchair. He was observed with a right-hand contracture. In an interview on 8/9/18 at 3:55 PM, the MDS Nurse stated she accurately coded the Significant Change MDS dated 6/17/18 to reflect impairment to one upper extremity. She stated she reviewed Resident #31's medical record and readmission orders but did not realize staff were not addressing the splint to his right-hand contracture so she neglected to care plan his contracture. The facility provided a care plan dated 8/9/18 for Resident #31's right-hand contracture with the intervention of splinting as ordered. In an interview on 8/9/18 at 4:10 PM, the Administrator stated it was her expectation that at the time of Resident #31's Significant Change MDS, the MDS Nurse would have noted his right-hand contracture and care planned previously ordered interventions. 2. Resident #90 was admitted to the facility on 1/6/16 and was readmitted on 4/30/18 with multiple diagnoses including dementia with behaviors.	F 656	8/9/18 to reflect a risk for decreased ROM due to right hand contracture. Resident #90's Care Plan was updated by the Dietary Manager on 8/8/18 to reflect a significant weight loss. An audit was initiated by the MDS Coordinator on 8/23/18 to ensure that each resident has an accurate comprehensive person-centered care plan. Members of the Interdisciplinary Team assisted in the audit following re-education on 8/23/18. All active residents current care plan was audited for accuracy between 8/23/18 and 8/24/18. Of 105 care plans audited, 15 residents care plans were updated to reflect existing contractures and 18 residents care plans were updated to reflect an edentulous state or other dental issue. The Interdisciplinary Team, including the Dietary Manager and MDS Coordinator were in-serviced by the Corporate Nurse Consultant on 8/23/18 regarding developing appropriate and accurate comprehensive person-centered care plans for each resident. In order to provide Quality Assurance, utilizing a Care Plan quality assurance Audit tool the MDS Coordinator will review care plan accuracy on five residents per week for 4 weeks and then five residents per month for an additional two months. The MDS Coordinator will present the	

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F 656	Continued From page 23 The significant change in Minimum Data Set (MDS) assessment dated 7/20/18 indicated that Resident #90 had severe cognitive impairment and had a significant weight loss in the last 6 months. The Care Area Assessment (CAA) dated 7/20/18 for Nutrition was reviewed. The CAA revealed that nutrition was triggered due to weight loss. Resident #90 was on mechanical soft diet with nectar thick liquids. He required assistance with feeding. Will proceed to care. Review of Resident #90's current care plan dated 7/19/18 revealed that there was no care plan problem, goal and approaches developed for nutrition or weight loss. On 8/9/18 at 8:40 AM, the Dietary Manager (DM) was interviewed. She stated that she started as DM 5 weeks ago and she was still learning how to do care planning. She confirmed that she didn't do the care plan for weight loss for Resident #90 because she didn't know what to put in the care plan. On 8/8/18 at 4:39 PM, the Registered Dietician (RD) was interviewed. She stated that the DM was responsible for developing the care plans. The RD verified that Resident #90 had a significant weight loss and a care plan should have been developed. She added that the DM was new and she was still learning the care plan process. On 8/9/18 at 3:55 PM, the MDS Nurse was interviewed. She stated that the DM was responsible for developing the care plan for	F 656	results of these audits to the Quality Assurance Performance Improvement Committee for a minimum of three consecutive meetings to identify trends, concerns, and recommendations for any modification of the process. The Administrator will be responsible for the plan of correction.	

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F 656	Continued From page 24 nutrition. On 8/9/18 at 4:07 PM, the Administrator and the Director of Nursing were interviewed. The Administrator stated that she expected a care plan developed when CAA indicated to proceed to care plan.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide routine nail care (Resident #31) for 1 of 3 sampled residents who were dependent on staff assistance for activities of daily living (ADL). The findings included: Resident #31 was admitted on 3/8/12 with cumulative diagnoses of Cerebral Vascular Accident, Diabetes and right-side hemiplegia. Resident #31's care plan dated 6/15/18 indicated staff were to assist him with all his activities of daily living (ADLs). His Significant Change Minimum Data Set dated 6/17/18 indicated severe cognitive impairment with no exhibited behaviors. He was coded for extensive staff assistance with hygiene and for a functional limitation to one upper extremity. During an observation on 8/6/18 at 11:42,	F 677	Resident #31 was observed with a right-hand contracture with long, jagged, untrimmed fingernails. Direct care staff failed to assess resident's nails and provide necessary services to maintain grooming of nails. Resident #31's fingernails were trimmed and filed on August 8, 2018 by the licensed nurse assigned to the resident. Administrative nursing staff completed a 100% audit of all resident's nails in the facility on August 17, 2018. At the time of assessment, 18 residents were identified with have long, jagged, or untrimmed nails. These residents nails were cleaned, trimmed, and filed at the time of assessment by licensed nursing staff and certified nursing assistants. For residents who prefer to have long nails, care plans	9/5/18

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Resident #31 was sitting up in his wheelchair. He was observed with a right-hand contracture with long, jagged untrimmed finger nails. His left-hand fingernails were trimmed and filed.

In a second observation on 8/7/18 at 3:40 PM, Resident #31 was sitting up in his wheelchair. He was observed with a right-hand contracture with long, jagged untrimmed fingernails.

In a third observation on 8/8/18 at 8:40 AM, Resident #31 was observed in bed eating his breakfast. He was observed with a right-hand contracture with long, jagged untrimmed fingernails.

In an interview on 8/8/18 at 8:40 AM, Nurse #1 stated since Resident #31 was Diabetic, the nurses were responsible for trimming his fingernails. She stated she was not aware his fingernails on his right hand were long and jagged. She stated the aides on the floor should have reported that to her, but she would trim his right-hand fingernails on 8/8/18.

In an interview on 8/8/18 at 12:00 PM, Nursing Assistant (NA) #2 stated the aides were not allowed to trim the fingernails of Diabetic residents. She stated she did not notice the long fingernails on Resident #31's right-hand because of his contracture.

In a final observation on 8/9/18 at 8:50 AM. Resident #31's fingernails to his right hand were trimmed and filed.

In an interview on 8/9/18 at 4:10 PM, the Administrator stated it was her expectation that the floor nurses trim the fingernails of all Diabetic

were updated on to reflect resident preference.

The Administrator provided an in-service to all Administrative Staff on August 20, 2018 regarding daily room rounds and assessment of resident's nails. This in-service included assessing nails of residents with contractures. All newly hired administrative staff will receive the appropriate education during orientation. Staff will not be allowed to work until they have received the in-service.

The Assistant Director of Nursing initiated an in-service to all nurses and nursing assistants on August 20, 2018 regarding care of fingernails and toenails. This in-service included assessing nails of residents with contractures. Licensed nurse will be responsible for cutting of residents nails for those residents with a diagnosis of diabetes. All newly hired nurses and nursing assistants will receive the appropriate education during orientation. Staff will not be allowed to work until they have received the in-service.

To ensure quality assurance, utilizing a room round audit sheet, administrative staff will audit 100% of resident's fingernails 3 times weekly x 4 weeks, then twice weekly x 2 months. Results of these audits will be discussed daily in Stand-up meeting with any issues reported to the Director of Nursing or Assistant Director of Nursing for follow-up. Stand-up meeting is mandatory for all

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F 677	Continued From page 26 residents. She stated it was her expectation that staff routinely observed Resident #31's fingernails and trimmed as needed.	F 677	administrative staff, including the Director of Nursing, Assistant Director of Nursing, Unit Managers x2, treatment nurse, Central Supply Coordinator, HR/Payroll Director, Social Services Director, MDS Coordinator, Plant Operations Director, Activities Director, Admission Coordinator, Business Office Manager, Administrator, Environmental Services Director, and Medical Records Director. The Administrator will present the results of these audits to the Quality Assurance Performance Improvement Committee for a minimum of three consecutive meetings to identify trends, concerns, and recommendations for any modification of the process. The Administrator will be responsible for implementing the plan of correction.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		9/5/18

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F 686	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on record review, observation and Wound Care Specialist, Registered Dietician (RD) and staff interview, the facility failed to provide preventative measures to prevent pressure ulcer development to a resident who was at risk for pressure ulcer which resulted to the development of 4 additional pressure ulcers for 1 of 3 sampled residents reviewed for pressure ulcer (Resident #90). Findings included: Resident #90 was originally admitted to the facility on 1/6/16 and was readmitted on 4/30/18 with multiple diagnoses including dementia and peripheral vascular disease. The quarterly Minimum Data Set (MDS) assessment dated 4/8/18 indicated that Resident #90 had impaired cognition, needed extensive assistance of 2 persons for bed mobility, was always incontinent of bowel and bladder and had no pressure ulcer. The assessment further indicated that Resident #90 was at risk of developing pressure ulcer. The 5 day MDS assessment dated 5/7/18 indicated that Resident #90 had impaired cognition, needed extensive assistance of 2 persons for bed mobility, was always incontinent of bowel and bladder and was admitted with a stage 2 pressure ulcer. The assessment further indicated that Resident #90 was at risk of developing pressure ulcer. The quarterly MDS assessment dated 7/4/18 revealed that Resident #90 had impaired	F 686	The facility failed to provide preventative measures to prevent pressure ulcer development to Resident #90 who was at risk for pressure ulcers resulting in the development of 4 additional pressure ulcers. Resident #90 readmitted to the facility on 4/30/18 with a stage 2 community acquired pressure ulcer to his sacrum. On 5/30/18, an unstageable pressure ulcer was identified on the resident's left heel, a stage 2 pressure ulcer was identified on the perineum, and the stage 2 pressure ulcer on the resident's sacrum was determined to be deteriorating. On 7/18/18, the resident's Albumin level was 2.8 and the resident started on Prostat. Prostat was discontinued on 7/25/18 because the resident was on thickened liquids. Resident #90 was referred to a wound care specialist on 7/25/18 and an air mattress was applied to the resident's bed. The facility failed to provide preventative measures, including nutritional supplements to promote wound healing and pressure relieving devices to the resident's bed and chair, to prevent pressure ulcer development for Resident #90. On 7/19/18 Resident #90 was care planned to receive a high protein diet with snacks in between meals. Resident #90 was assessed by the wound care	

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F 686	Continued From page 28 cognition, needed extensive assistance of 2 persons for bed mobility, was always incontinent of bowel and bladder and had one (1) unstageable/deep tissue injury (DTI) pressure ulcer that was not present on admission. The significant change in status MDS assessment dated 7/20/18 revealed that Resident #90 had impaired cognition, needed extensive assistance of 2 persons for bed mobility, was always incontinent of bowel and bladder and had three (3) unstageable with eschar pressure ulcers and two (2) unstageable/deep tissue injury (DTI) pressure ulcers that were not present on admission. On 7/16/18, Resident #90's albumin level was 2.8 (normal value 3.6-5.1). Resident #90's care plan dated 7/19/18 was reviewed. The care plan approaches included bunny boots to left foot as ordered, wound doctor to evaluate and treat as indicated and on 7/25/18 the air mattress was added. The approaches did not address repositioning schedule or pressure relief device when out of bed. Review of the facility's wound assessment was conducted. The assessments revealed the following: 5/1/18 - stage 2 pressure ulcer on sacrum - identified on admission (4/30/18) 5/30/18 - unstageable/DTI on lateral left heel - developed in house 6/28/18 - unstageable to left great toe due to slough/eschar - developed in house	F 686	specialist and provided an alternating air mattress and pressure relieving cushion on 7/25/18. Care plan meeting was held with the resident's family on 8/14/18 to discuss PEG placement and Hospice Care. Resident's Responsible Representative and family refused PEG and Hospice at this time. Resident #90 was assessed by the dietician on 8/15/18 with new orders received for vitamin C and zinc sulfate. Resident #90 was reassessed by the attending physician on 8/23/18 with orders received to initiate magic cup to promote wound healing. Resident #90 will continue to be assessed weekly by the dietician and wound care specialist. Resident #90 will be discussed weekly in the patients at risk meeting. On 8/16/18 and 8/17/18 a 100% skin audit was initiated by the Treatment Nurse, Director of Nursing, Assistant Director of Nursing, and Unit Managers x 2 on all residents to identify any new or worsening skin concerns. Three residents were identified with excoriation, 1 resident was identified with a skin tear, 6 residents were identified with existing scabs, 6 residents were identified to have skin discoloration, 7 residents were identified to have skin redness, 2 residents were identified with dry skin, 2 residents were identified with scratches, and 2 residents were identified with facility acquired pressure ulcers. Any residents identified to have new skin concerns were referred to the treatment nurse at the time of identification for immediate assessment and intervention.	

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F 686	Continued From page 29 7/11/18 - unstageable due to slough/eschar on left buttock- developed in house 7/25/18 - unstageable/DTI to left medial heel - developed in house Resident #90's doctor's orders were reviewed. 5/2/18 - prostat (protein supplement) 30 milliliter daily for wound healing and was increased to twice a day on 7/18/18 and was discontinued on 7/25/18. 6/27/18 - bunny boots to left foot at all times, no shoes to left foot 7/17/18 - mechanical soft with nectar thick liquids diet Resident #90 was referred to a wound care specialist on 7/25/18. The notes revealed that the resident had pressure ulcers on the sacrum with yellow necrotic tissue (stage 2), left lateral heel (DTI), Left medial heel (DTI), left great toe with yellow necrotic tissue (unstageable) and left buttock/ischium with yellow necrotic tissue (stage 2). The recommendation was to acquire an air mattress. On 8/7/18 at 12:45 PM, Resident #90 was observed up in a broda chair in the dining room. He had no pressure relieving device in his chair. On 8/8/18 at 3:05 PM, Resident #90 was observed during the dressing change. The pressure ulcers were assessed by the wound care specialist and Nurse #3 provided the	F 686	On 8/21/18 100% of resident's received a Braden Scale Assessment completed by the treatment nurse. At this time, 4 residents were identified as moderate risk for pressure ulcer development and preventative interventions were implemented; three residents received an air mattress, one resident received an order for heel protectors, and one resident received an order for nutritional supplementation. All residents with current pressure ulcers were audited by the treatment nurse on 8/21/18 and 8/22/18 to ensure appropriate interventions are in place to prevent worsening of current pressure ulcers. As a result of this audit, one resident was placed on an air mattress and one resident was referred to the dietician and orders received for nutritional supplementation. 100% of Care Plans were audited by the interdisciplinary team on 8/23/18 and 8/24/18 to ensure appropriate interventions are care planned to prevent pressure ulcer development with one care plan updated to include an air mattress and one care plan updated to include nutritional supplementation to prevent wound deterioration/development of new wounds. The treatment nurse or weekend supervisor will notify the Physician and Dietician when a nutritional problem, including development of pressure ulcers, has been identified and shall collaborate with the Dietician and Physician to initiate	

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F 686	Continued From page 30 dressing change. The left lateral heel pressure ulcer was observed to be black, nickel size with no drainage noted. The pressure ulcer was cleaned with wound cleanser and betadine was applied. The left medial heel pressure ulcer was observed to be black with no drainage noted. The ulcer was cleaned with wound cleanser and betadine was applied. The left buttock pressure ulcer was observed with yellow eschar center of the wound and no drainage noted. The ulcer was cleaned with wound cleanser and zinc oxide was applied. The sacral pressure ulcer had no eschar nor drainage noted. The ulcer was cleaned with wound cleanser and calcium alginate was applied and covered with foam dressing. The left great toe pressure ulcer was black and dry. It was cleaned with wound cleanser and skin prep was applied. On 8/8/18 at 3:30 PM, the wound care specialist was interviewed. She stated that Resident #90 was referred to her on 7/25/18 and she had seen him 3 times since then. The resident was at risk of developing pressure ulcers due to his co-morbidities. The resident was not on any pressure relieving device in bed and on the chair so she ordered an air mattress for him. She also recommended a dietary consult. On 8/8/18 at 3:45 PM, the Registered Dietician (RD) was interviewed. She stated that she was aware of the low albumin level but she had to	F 686	an appropriate process of clinical review for causes of the nutritional problem. The treatment nurse or weekend supervisor will complete a Braden Scale assessment on each resident upon admission or re-admission, weekly for 4 weeks post admission, and then quarterly or with any significant change in condition. Any resident identified at moderate or high risk for developing pressure ulcers will have appropriate preventative interventions initiated at time of assessment. Each resident with an existing pressure ulcer will be discussed weekly with the interdisciplinary team, including the Dietician and treatment nurse, in the patients at risk meeting to determine any needed changes in plan of care. The Dietician was issued a 30-day termination of contract notice on 8/24/18 and a contract was signed to initiate services with a different dietician. The Assistant Director of Nursing initiated an in-service on 8/24/18 to all licensed nursing staff regarding prevention of pressure ulcers. This in-service included identifying factors that place a resident at high risk of pressure ulcers, i.e., immobility, inadequate nutrition, co-morbidities. This in-service also included examples of appropriate interventions to help reduce the risk of pressure ulcer development including frequent repositioning, use of barrier	

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discontinue the prostat because Resident #90 was on nectar thick liquids and prostat could not be thickened. When asked what was added to replace the prostat, the RD stated that she didn't add anything except med pass. The RD further stated that the resident was expected to lose weight due to dementia.

On 8/9/18 at 9:50 AM, Nurse #3, Treatment Nurse, was interviewed. She stated that she started as Treatment Nurse a week or so ago. She revealed that the previous treatment nurse did not come back to work. She indicated that when she looked at the resident's pressure ulcers she immediately referred him to the wound care specialist. She verified that the resident was not placed on pressure relieving devices in bed and in chair until 7/25/18 when the wound care specialist recommended an air mattress.

On 8/9/18 at 3:05 PM, NA #3 was interviewed. She stated that residents were turned/repositioned and provided incontinent care every 2 hours during rounds including Resident #90.

On 8/9/18 at 4:07 PM, the Administrator and Director of Nursing (DON) were interviewed. The Administrator stated that she had 4 changes in Treatment Nurse since she started as Administrator of the facility in February 2018. She revealed that Nurse #3 though was responsible for monitoring the pressure ulcers to ensure interventions were in place for the prevention and treatment of pressure ulcers. She also stated that she expected pressure relieving devices in place and repositioning schedule as part of the plan of care of residents who were at risk. The Administrator added that the RD should

creams, request for nutritional supplementation, monitoring of appropriate labs, etc. All newly hired licensed nursing staff will receive the appropriate education upon hire. Employees will not work until they have received the appropriate education.

The Director of Nursing initiated an in-service to the treatment nurse and weekend supervisor on 8/24/18 that included completion of Braden Scales on all residents upon admission and re-admission, weekly for 4 weeks post admission and quarterly thereafter. This in-service included implementing measures to prevent pressure ulcer development for any residents identified to be at moderate or high risk for pressure ulcer development. All newly hired treatment nurses and weekend supervisors will receive the appropriate education during orientation.

The Director of Nursing provided an in-service to the treatment nurse on 8/24/18 that included treatment nurse roles and responsibilities and mandatory attendance in weekly patients at risk meetings. All newly hired treatment nurses will receive the appropriate education during orientation.

To ensure quality assurance, utilizing a Pressure Ulcer audit tool, the Director of Nursing will audit all residents with current pressure ulcers to ensure appropriate interventions are in place to prevent deterioration of pressure ulcers or

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F 686	Continued From page 32 have tried other protein supplement to replace the prostat to help with the wound healing and low albumin level.	F 686	development of new pressure ulcers. This audit will be completed weekly x 4 weeks, then monthly for 2 months. The Administrator will review the audit tools weekly x 4 weeks, then monthly x 2 month for trends and concerns. To ensure quality assurance, utilizing a Braden Scale Audit tool, the Director of Nursing will audit all residents to ensure that a Braden Scale has been completed upon admission/re-admission, weekly x 4 post admission, with any significant change, and quarterly. This audit will include ensuring residents with a moderate to high risk of development of pressure ulcers have appropriate preventative interventions in place at time of identification of such risk. This audit will be completed weekly x 4 weeks, then monthly for 2 months. The Administrator will review the audit tools weekly x 4 weeks, then monthly x 2 month for trends and concerns. The Director of Nursing will present the results of these audits to the Quality Assurance Performance Improvement Committee for a minimum of three consecutive meetings to identify trends, concerns, and recommendations for any modification of the process. The Director of Nursing will be responsible for implementing the plan of correction.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		9/5/18

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F 688	Continued From page 33 §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. This REQUIREMENT is not met as evidenced by: Based on observations, Rehabilitation Director and staff interviews and record review, the facility failed to apply splinting devices for contracture management (Resident #31) and failed to transcribe and to apply the splints as recommended by the therapy department correctly (Resident #11) for 2 (Resident #31 and Resident #11) of 3 sampled residents reviewed for range of motion. The findings included: 1. Resident #31 was admitted on 3/8/12 with cumulative diagnoses of Cerebral Vascular Accident, Diabetes and right-side hemiplegia. Review of Resident #31's Physician orders included an order dated 10/5/17 which read he was to wear a resting right-hand splint for 4 hours daily.	F 688	The facility failed to apply splinting devices for contracture management for Resident #31 and failed to transcribe and to apply splints as recommended by the therapy department correctly for Resident #31 and Resident #11. Resident #31 was discharged to the hospital on 4/15/18 and readmitted to the facility on 4/22/18. Upon readmission, the previous splint order was not re-activated nor was an order received for splinting. On 4/23/18 there was an order for nursing to apply left upper extremity resting hand splint and remove after 4-6 hours during the night for Resident #11. This order was transcribed to the MAR and initialed by	

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F 688	Continued From page 34 Review of Resident #31's Medication Administration Record (MARs) from 10/6/17 to 4/14/18, read the nurses initialed off that he wore his resting right-hand splint 4 hours daily. Review of Resident #31's April 2018 Physician orders read that the order for his right-hand splint was discontinued on 4/15/18 due to hospitalization. Review of Resident #31's medical record indicated he was readmitted to the facility on 4/22/18, then discharged back to the hospital on 6/6/18 with readmission to the facility on 6/10/18 on Hospice. His Significant Change Minimum Data Set dated 6/17/18 indicated severe cognitive impairment with no exhibited behaviors. He was coded for impairment to one upper extremity. Review of Resident #31 latest care plan revised 6/22/18 did not include a care plan for splinting of his right-hand contracture. Review of Resident #31's Resident Care Guide dated 7/26/18 read he was to wear a splint to his right upper extremity. Review of Resident #31's Physician orders for May, June, July and August 2018 did not include an order for his resting right-hand splint to be applied 4 hours daily. Review of Resident #31's MARs from 4/22/18 to 8/7/18 did not include evidence of right-hand splinting. During an observation on 8/6/18 at 11:42 AM,	F 688	nursing staff; however, the contracture was present on the right hand. Although nursing staff report they were applying the splint to the right hand, the order for the left upper extremity hand splint was not clarified by nursing staff to reflect the correct extremity. On 6/6/18 there was an order for right elbow splint for Resident #11 that was never transcribed to the MAR. Resident #31 was re-assessed by the therapy department on 8/10/18 and an order was received for a resting hand splint to be applied to the right hand during the day for up to 8 hours as tolerated and for a left hand 3rd-4th digit splint to be applied at night for up to 8 hours as tolerated. Resident #11 was assessed by the therapy department on 8/8/18. A clarification order was received on 8/8/18 for Resident #11 to have a right resting hand splint applied for up to 8 hours as tolerated. An order was transcribed for Resident #11 to have a right elbow splint applied nightly for up to 8 hours as tolerated. 100% of residents received an assessment for contractures on 8/21/18 and 8/22/18 by the Director of Nursing, Assistant Director of Nursing, Treatment Nurse, and Unit Managers x2. Any residents noted with contractures were reviewed to ensure orders for contracture management are accurate and transcribed accurately on the MAR. Nine	

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Resident #31 was sitting up in his wheelchair. He was observed with a right-hand contracture. He was not wearing a right-hand splint.

In a second observation on 8/7/18 at 3:40 PM, Resident #31 was sitting up in his wheelchair. He was observed with a right-hand contracture and not wearing a right-hand splint.

In an interview on 8/8/18 at 8:40 AM, Nurse #1 stated Resident #31 had previously worn a right-hand splint. The nurse ensured it was applied after dinner and it would be removed after 4 hours the next shift staff. She stated she had not applied his right-hand splint in a few months because it was no longer on his MAR. Nurse #1 stated she assumed it was discontinued.

In an interview on 8/8/18 at 12:00 PM, Nursing Assistant (NA) #2 stated Resident #31 used to wear a right-hand splint but she had not seen him wearing a splint in several months. She stated he normally he wore it in the evenings.

In an interview on 8/8/18 at 4:50 PM, the Rehabilitation Director stated the Occupational Therapist performed a therapy screen on Resident #31 and noted no significant change in his right-hand contracture as of 8/8/18. She stated new orders were written on 8/8/18 for Resident #31 to wear his resting right-hand splint after dinner daily for 4 hours as tolerated. The Rehabilitation Director stated Resident #31's resting right-hand splint should have been resumed after his hospitalization in April 2018.

In an interview on 8/9/18 at 3:30 PM, NA #1 stated Resident #31 used to wear a right-hand splint, but she had not seen him wearing it for

residents were identified to be on restorative nursing services for contracture management; however, no order was present for contracture management. The therapy department wrote clarification orders for these nine residents on 8/24/18 after evaluation. Six residents were identified with contractures present but were not receiving services for contracture management. These residents were referred to the therapy department for evaluation of contracture management on 8/22/18.

The therapist making a recommendation for contracture management will obtain an order from the resident's attending physician. The order will be provided to the staff nurse to implement. Copies of all orders will be provided to the unit managers or weekend supervisor daily to review for accuracy.

All medical records of residents readmitted to the facility will be reviewed on the day of readmission by the Unit Manager to ensure that any previous splinting orders are clarified if needed, processed, and transcribed accurately.

An in-service was initiated by the Assistant Director of Nursing on August 21, 2018 to all licensed nursing staff regarding accurate processing and transcription of orders. This in-service included discussion of clarifying orders as necessary in regards to splinting of appropriate extremities. All newly hired licensed nursing staff will receive this

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F 688	Continued From page 36 several months. She stated maybe the right-hand splint was discontinued when he went on Hospice. In an interview on 8/9/18 at 4:10 PM, the Administrator stated Resident #31's resting right-hand splint was discontinued when he was admitted to the hospital on 4/15/18 and it apparently was not resumed and added to the MAR after hospitalization. She stated it was her expectation that orders to resume his resting right-hand splint were obtained after his readmission to the facility on 4/22/18 and the splint be applied daily. 2. Resident # 11 was originally admitted to the facility on 2/17/17 and was readmitted on 4/23/18 with multiple diagnoses including spastic hemiplegia affecting right dominant side. The annual Minimum Data Set (MDS) assessment dated 5/7/18 indicated that Resident #11 had memory and decision making problems, had limitation in range of motion and did not receive restorative nursing programs for range of motion (active or passive) or splint or brace application in the last 7 days. Resident #11's care plan dated 5/7/18 was reviewed. One of the care plan problems was contracture of the right upper extremity (RUE) with range of motion (ROM) deficits to all four extremities. The approaches included splints to be applied as ordered. Resident #11's doctor's orders were reviewed. On 4/23/18, there was an order for nursing to apply left upper extremity resting hand splint and remove after 4-6 hours during the night, on at 2 AM and off at 6:30 AM. On 6/6/18, there was an	F 688	education upon orientation. No staff will work until completion of in-service. In order to provide Quality Assurance, utilizing a Contracture Management quality assurance audit tool the Director of Nursing will audit all new orders received for contracture management weekly for 4 weeks, then monthly for 2 months to ensure appropriateness of order and accurate processing and transcription of the order. The Director of Nursing will present the results of these audits to the Quality Assurance Performance Improvement Committee for a minimum of three consecutive meetings to identify trends, concerns, and recommendations for any modification of the process. The Director of Nursing will be responsible for implementing the plan of correction.	

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F 688	Continued From page 37	F 688		

order for right elbow splint-wear at night during sleep and remove during the day.

The Medication Administration Records (MARs) for June, July and August 2018 were reviewed. The order for the left upper extremity resting hand splint was transcribed to the MARs and was initialed by the nurses indicating that it was applied as ordered. The order for the right elbow splint was not transcribed to the MARs.

On 8/8/18 at 2:50 PM, Nurse Aide (NA) # 7 was interviewed. She stated that she was assigned to Resident #11. She indicated that the night shift nurse was responsible for the application of the splint. NA #7 revealed that she observed Resident #11 wearing a splint on his left elbow Monday morning of 8/6/18. She stated that she didn't see any splint/brace on his left or right hand.

On 8/9/18 at 2:37 PM, Nurse #6 was interviewed. She was assigned to Resident #11 on night shift. She indicated that Resident #11 had an order for splint on his left hand at night. Nurse #6 further indicated that she applied the splint to his left hand for 4-6 hours at night as ordered and initialed the MAR. She also verified that Resident #11 did not have an order for the right elbow splint.

On 8/9/18 at 3:55 PM, Nurse # 1 was interviewed. She stated that she was assigned to Resident #11 on day shift. She stated that the resident had an order for left hand splint to be applied at night. She verified that Resident #11 did not have an order for the right elbow splint. Nurse #1 also verified that the resident had contracture to his right hand and not left hand. She revealed that

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F 688	Continued From page 38 the orders for the splint had been clarified to be applied to the right hand and right elbow. On 8/9/18 at 3:56 PM, the room of Resident #11 was observed with Nurse #1. There was an elbow splint observed on top of the bedside table. There was no hand splint observed. On 8/8/18 at 2:10 PM, the Rehabilitation (Rehab) Director was interviewed. The Rehab Director provided the telephone order for the right elbow splint dated 6/6/18 and stated that she didn't know why it was not transcribed to the MAR by nursing. She also verified that Resident #11 had contracture on his right hand and not the left hand. The Rehab Director indicated that she would let nursing know to clarify the orders for the splints. She stated that she expected nursing to follow the recommendation for the splint application. On 8/9/18 at 4:07 PM, the Administrator and the Director of Nursing (DON) were interviewed. The Administrator indicated that she expected that contracture management recommended by the therapy department was transcribed and implemented correctly by nursing.	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		9/5/18

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F 689	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide supervision to prevent a resident who required extensive assistance of 1 person for toileting from having an unsupervised fall in the bathroom for one of seven sampled residents reviewed for accidents. Resident #57 experienced an unsupervised fall in the bathroom and sustained a right femur fracture requiring open reduction internal fixation (ORIF) surgery (a surgical procedure to fix a severe broken bone). Findings included: Resident #57 was originally admitted to the facility on 7/13/11 and was readmitted on 2/5/18 with multiple diagnoses including dementia and right femur fracture. The quarterly Minimum Data Set (MDS) assessment dated 4/2/18 indicated that Resident #57 had moderate cognitive impairment and needed extensive assistance with one person physical assist for toileting. The assessment further indicated that Resident #57 was not steady (only able to stabilize with staff assistance) in moving on and off toilet. The incident report dated 1/30/18 revealed that Resident #57 went to the bathroom unassisted and fell sustaining a right proximal femur fracture. She went to the hospital for surgery and was readmitted on 2/5/18. The surgical consult dated 3/7/18 ordered for the resident to have 30% weight bearing as tolerated to right lower extremity. The consult dated 4/4/18	F 689	The facility failed to provide supervision to prevent Resident #57, who required extensive assistance of 1 person for toileting, from having a fall in the bathroom. Resident #57's Care Plan was last updated on 4/4/18 and noted that the resident had impairment with mobility and was 60% weight bearing as tolerated to the right lower extremity with a knee immobilizer in place for all weight bearing. Resident #57 went to the bathroom unattended on 4/11/18. Nurse #3 responded to an activated call light and observed Resident #57 on the toilet. Nurse #3 stepped from the bathroom to the resident's room to obtain a brief when the resident stood unassisted and fell sustaining a fracture. Nurse #3 was unaware of the residents mental and weight bearing status when assisting resident when responding to a call light and left the resident unattended in the bathroom resulting in the resident sustaining a fall. Resident #57 was admitted to the hospital on 4/11/18 and underwent ORIF. Unit Managers x 2 reviewed Resident #57's care plan and care guide on 8/22/18 to ensure accuracy with no changes made. On 8/22/18 a fall risk assessment was completed on 100% of residents by the Director of Nursing, Assistant Director of	

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F 689	Continued From page 40 ordered for the resident to have 60% weight bearing with immobilizer to the right lower extremity Resident #57's care plan with the last review date of 4/4/18 was reviewed. The care plan problems included resident had activities of daily living (ADL) self-care deficit related to dementia with impaired mobility and at risk for falls and fall related injuries. The goal was to minimize potential for significant injury related to falls. The approaches included 60% weight bearing as tolerated to right lower extremity and knee immobilizer in place for all weight bearing. The care plan did not address supervision. The nurse's notes (written by Nurse #1) dated 4/11/18 at 3:33 PM revealed that Nurse #3 was cleaning Resident #57 in the bathroom after having a bowel movement. Then, the Nurse sat the resident on the toilet and left the bathroom to get a disposable brief leaving the resident unattended. While Nurse #3 stepped out of the bathroom to the resident's room, the resident stood up and fell. The resident complained of pain on the right knee and x-ray was ordered. The x-ray report showed fracture of the distal femur and the resident was sent to the hospital. The hospital discharge summary dated 4/16/18 revealed that the resident was admitted after having a fall at the nursing facility and sustained a right distal femur fracture and underwent ORIF. On 8/8/18 at 9:05 AM, Resident #57 was observed up in wheelchair in her room. She was able to remember what she ate for breakfast but she could not tell the time, day or month.	F 689	Nursing, and Unit Managers x 2. Ninety-two residents were identified to be at high risk for falls. Residents identified to be at high risk for falls were reviewed to ensure appropriate fall interventions are in place, care planned appropriately, and fall interventions are accurately reflected on the resident's care guide. On 8/22/18 the past 90 days of incidents were reviewed by the Director of Nursing, Assistant Director of Nursing, Unit Managers x 2, and MDS Coordinator to ensure appropriate fall interventions and accuracy of care plan and care guide. All residents sustaining a fall within the past 90 days were found to have appropriate fall interventions in place, care planned appropriately, and care guides reflecting interventions. On 8/22/18 fall logs and intervention logs were printed for each individual resident. All intervention logs were reviewed to ensure accuracy by the Director of Nursing, Assistant Director of Nursing, and Unit Manager x 2. The Director of Nursing, Assistant Director of Nursing, and Unit Managers x 2 audited 100% of resident's rooms to ensure that fall interventions are in place. During this audit, one resident was found not to have a fall mattress in the room. At the time of the audit, a fall mattress was placed in the resident's room. During this audit, one resident was found without dycem to her seat cushion. At the time of the audit, dycem was placed in the residents seat cushion.	

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F 689	Continued From page 41 On 8/8/18 at 10:58 AM, Nurse #1 was interviewed. She was assigned to Resident #57 on 4/11/18. She stated that Resident #57 was confused. The resident was on partial weight bearing at that time due to right femur fracture and was wearing an immobilizer to her right lower extremity. Nurse #3 had answered the call light and found the resident in the bathroom. She cleaned the resident, sat her on the toilet and left the room to get a disposable brief. When the nurse stepped out of the bathroom to the resident's room, the resident stood up and fell. On 8/9/18 at 9:05 AM, Nurse #3, the previous Director of Nursing (DON) was interviewed. She stated that she answered the bathroom call light on 4/11/18 and found Resident #57 in the bathroom on the toilet. She stepped out of the bathroom to the resident's room to get a disposable brief, when the resident stood up and fell. Nurse #3 revealed that she didn't know the resident's mental status nor her weight bearing status at that time. On 8/9/18 at 9:10 AM, Clinical Manager #1 was interviewed. She stated that she had investigated the fall incident on 4/11/18. Resident #57 was left in the bathroom unattended by Nurse #3 after providing care. The resident was on partial weight bearing status and should have not left in the bathroom by herself. The Clinical Manager further indicated that the resident went to the bathroom by herself. On 8/9/18 at 9:52 AM, Nurse #1 was again interviewed. She stated that she didn't know who brought the resident to the bathroom but she had a tendency of going to the bathroom by herself. The nurse indicated that Resident #57 could not	F 689	Individual fall intervention logs will be updated by the Director of Nursing, Assistant Director of Nursing, Unit Managers x 2, and/or weekend supervisor daily to ensure documentation is current, interventions are in use, and fall assessments are completed after each fall. Individual intervention logs will be maintained in a notebook and available to nursing staff at all times. Licensed nursing staff will complete a falls risk assessment on each resident upon admission/re-admission, quarterly, and after any fall. The fall risk assessment will be utilized to identify circumstances leading to a fall, identify risk factors for falls, and implement interventions to prevent falls. All new admissions, re-admissions, and residents experiencing a fall will be discussed among the interdisciplinary team during the weekly patients at risk meeting for a minimum of 4 weeks to ensure that interventions are effective and to make any recommendations for changes in or additional interventions. The patients-at-risk meeting will occur once a week. Documentation of this meeting will be recorded in the individual resident's progress notes in the electronic medical record at the time of the meeting by the interdisciplinary team. Resident's care plans and care guides will be updated as needed by the interdisciplinary team.	

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F 689	Continued From page 42 get herself up nor clean herself. She was not steady and was wearing an immobilizer. She should have not left alone in the bathroom. On 8/9/18 at 4:07 PM, the Administrator and the Director of Nursing were interviewed. The Administrator stated that she expected the staff to know the resident's status and if he/she didn't know the resident, the resident should have not left unattended.	F 689	The Director of Nursing initiated an in-service to all department heads on 8/24/18 regarding ensuring fall interventions are in place when making room rounds Monday through Friday. This in-service included a list of all interventions for each resident. The Assistant Director of Nursing initiated an in-serviced to all licensed nursing staff on 8/24/18 regarding completion of the falls risk assessment. This in-service included contacting the Director of Nursing or Assistant Director of Nursing at the time of a fall and implementing fall interventions for residents determined to be at high risk for fall. All newly hired licensed nursing staff will receive the appropriate education during orientation. No staff will work until they have received the appropriate education. The Assistant Director of Nursing initiated an in-serviced to all nursing staff on 8/24/18 regarding utilizing the fall intervention spreadsheet, resident care guide, and care plan. This in-service included the importance of not leaving a resident unattended while in the bathroom without knowing the residents mobility and cognitive status. All newly hired nursing staff will receive the appropriate education during orientation. No staff will work until they have received the appropriate education. To ensure quality assurance, utilizing Room Round Records, administrative staff will audit 100% of resident's rooms 3	

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F 689	Continued From page 43	F 689	times weekly x 4 weeks and then twice weekly x 2 months to ensure fall interventions are in place. The Director of Nursing or Assistant Director of Nursing will be notified immediately of any residents observed without planned interventions in place. The Administrator will review the audit tools weekly x 4 weeks, then monthly x 2 month for trends and concerns. To ensure quality assurance, utilizing a Fall PAR (Patients-At-Risk) Audit tool, the Director of Nursing will audit PAR minutes weekly x 8 weeks then monthly x 1 to ensure any resident experiencing a fall within the previous 4 weeks is being discussed weekly with the interdisciplinary team to ensure that interventions are effective and to make any recommendations for changes in or additional interventions. The Director of Nursing will present the results of these audits to the Quality Assurance Performance Improvement Committee for a minimum of three consecutive meetings to identify trends, concerns, and recommendations for any modification of the process. The Director of Nursing will be responsible for implementing the plan of correction.	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review.	F 756		9/5/18

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F 756	Continued From page 44 §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff	F 756	The Pharmacy Consultant failed to	

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F 756	Continued From page 45 interview, and Pharmacy Consultant interview, the Pharmacy Consultant failed to identify and address/readdress the use of an antibiotic prescribed on an indefinite basis and without an adequate clinical indication for use (Residents #4, #44, and #45) and failed to complete a review for an Abnormal Involuntary Movement Scale assessment (an assessment utilized to monitor involuntary movements for persons on antipsychotic medication) upon initiation of a new antipsychotic medication (Resident #18) for 4 of 5 residents reviewed. The findings included: 1. Resident #4 was admitted to the facility on 2/21/17 with diagnoses that included ectropion of left and right lower eyelids (lower eyelid turns or sags outward, away from your eye, exposing the surface of your inner eyelid). A physician ' s order for Resident #4 dated 10/19/17 indicated Erythromycin (antibiotic) 0.5 percent (%) eye ointment apply 1-centimeter (cm) ribbon onto lower conjunctival sac at night related to ectropion. There was no stop date for this order. The quarterly Minimum Data Set (MDS) assessment dated 11/6/17 indicated Resident #4 ' s cognition was severely impaired. She was administered antibiotics on 7 of 7 days during the MDS review period. Her active diagnoses included ectropion of left and right lower eyelids. Resident #4 was assessed with no active infections. A Pharmacy Consultant recommendation dated 1/16/18 indicated Erythromycin eye ointment was	F 756	identify and address/readdress the use of an antibiotic prescribed on an indefinite basis and without an adequate clinical indication for use and failed to complete a review or recommend an AIMS assessment upon initiation of a new antipsychotic medication. The antibiotic prescribed for Resident #4 was discontinued on 8/10/18. The Responsible Representative for Resident #45 was contacted on 8/7/18 by the Director of Nursing regarding the currently prescribed antibiotic. The Responsible Representative was educated on the risks versus benefits of antibiotic use in the absence of an active infection. The Responsible Representative verbalized an understanding of education; however, requests that the antibiotic not be discontinued citing that each time this medication has been discontinued in the past, her mother has experienced pain related to urinary tract infections. Resident #45 is currently on hospice services and Responsible Representative states she wishes to keep her mother comfortable and pain free. The Medical Director and Hospice were consulted on 8/7/18 regarding the use of prophylactic antibiotics and agreed that the benefits outweigh the risks of use in this individual case as resident is on hospice services and has not had any side effects or adverse reactions to the antibiotic. The resident has not experienced a urinary tract infection since initiation of the	

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ordered 10/19/17 and no stop date was issued. The recommendation was to check with the physician to see if it was able to be discontinued as it was usually ordered with a 10 to 14-day duration. This recommendation was reviewed and signed by the Physician ' s Assistant (PA) on 1/30/18 and indicated to refer to the optometry follow up appointment.

The quarterly MDS assessment dated 5/1/18 indicated Resident #4 ' s cognition was severely impaired. She was administered antibiotics on 7 of 7 days during the MDS review period. Her active diagnoses included ectropion of left and right lower eyelids. Resident #4 was assessed with no active infections.

A review of Resident #4 ' s current physician ' s orders was conducted on 8/7/18. The orders included the Erythromycin eye ointment order that was initiated on 10/19/17. A further review of Resident #4 ' s record revealed there continued to be no stop date for the Erythromycin eye ointment.

A review of the monthly drug regimen reviews and pharmacy recommendations for Resident #4 revealed no further mention of the Erythromycin eye ointment after the 1/16/18 recommendation to discontinue the medication.

An interview was conducted with the Director of Nursing (DON) on 8/7/18 at 3:40 PM. She indicated she was responsible for monitoring antibiotic usage at the facility. The DON was asked if an antibiotic prescribed for prophylaxis (prevention) was an adequate clinical indication for use. She reported she was not sure, but that she was aware the facility tried to deter from the prophylactic antibiotic. Residents care plan updated on 8/7/18 by the MDS Coordinator.

The antibiotic prescribed for Resident #44 was discontinued on 8/7/18.

An Abnormal Involuntary Movement Scale (AIMS) assessment was completed for Resident #18 on 8/8/18 by the Unit Manager.

A 100% audit of all active physician orders was completed on 8/21/18 by the Pharmacy Consultant to identify residents currently prescribed antibiotics in the absence of an active infection. One resident was noted to have an active order for antibiotic eye drops without a stop date. Recommendations were made to the prescribing provider on 8/22/18 for the discontinuation of this medication and the medication was discontinued on 8/22/18 per provider orders.

100% of residents received an AIMS assessment completed by the Unit Manager on 8/17/18 with two residents identified as having tardive dyskinesia.

The Pharmacy Consultant was in-serviced by Managing Pharmacist on 8/21/18 regarding drug regimen review and antibiotic stewardship policies and procedures. This in-service included the requirement for the Pharmacy Consultant to identify and address/readdress any antibiotic prescribed on an indefinite basis and/or without clinical indication for use.

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F 756	Continued From page 47 use of prophylactic antibiotics. She explained that she had just taken over responsibility of antibiotic usage monitoring about a month and a half ago. The DON stated she needed to follow up with the previous responsible staff member to provide additional information. An interview was conducted with the Admissions Coordinator on 8/7/18 at 3:50 PM. She stated she was responsible for monitoring antibiotic usage up until about a month and a half ago. She stated that antibiotics were expected to have an adequate clinical indication for use and were also expected to have a specified duration. She revealed that an antibiotic ordered prophylactically was not an adequate clinical indication for use. A phone interview was conducted with the Pharmacy Consultant on 8/9/18 at 1:05 PM. The Pharmacy Consultant was asked if she identified and addressed prophylactic antibiotics that were prescribed indefinitely during her monthly drug regimen reviews. The Pharmacy Consultant stated she normally waited 4 to 6 months after admission and/or initiation of the antibiotic and would then make a recommendation to discontinue it if no infections had occurred. The pharmacy recommendation dated 1/16/18 to discontinue the Erythromycin eye ointment for Resident #4 was reviewed with the Pharmacy Consultant. She stated that this was an instance in which she identified Resident #4 was on a prophylactic antibiotic and had no infections, so she recommended its discontinuation. She revealed she had made no further recommendations related to Resident #4 ' s Erythromycin eye ointment after 1/16/18. She explained that after her recommendation to	F 756	This in-service included following the pharmacy's policy on AIMS assessments and making recommendations for AIMS assessments with each antipsychotic dosage change. The Pharmacy Consultant will identify and address/readdress any antibiotic prescribed on an indefinite basis and/or without clinical indication and make necessary recommendations to the prescribing physician. The Pharmacy Consultant will make recommendations for AIMS assessments for any resident with an antipsychotic dosage change. The Pharmacy Consultant will complete an exit conference with the Administrator and Director of Nursing monthly and provide a complete list of all residents on antibiotics and recommendations for AIMS assessments for review. All antibiotic orders will be verified by the Unit Managers x 2, Assistant Director of Nursing, and Director of Nursing 5 x weekly to ensure diagnosis and stop dates. AIMS assessments will be completed by the MDS Coordinator upon initiation of a new antipsychotic, at each antipsychotic dosage change, and quarterly for all residents currently prescribed an antipsychotic. In order to provide Quality Assurance, utilizing an Antibiotic QI Audit Tool the Assistant Director of Nursing will audit all active antibiotic orders weekly x 4 weeks	

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F 756	Continued From page 48 discontinue the medication on 1/16/18 she left the decision up to the physician. An interview was conducted with the Administrator on 8/9/18 at 4:10 PM. She stated she expected the Pharmacy Consultant to identify and address the use of an antibiotic prescribed with no stop date and without an adequate clinical indication for use during the monthly drug regimen reviews. She reported that if an initial pharmacy recommendation to discontinue a prophylactic antibiotic was declined by the physician that she expected the Pharmacy Consultant to continue to monitor the antibiotic ' s usage and to readdress it in further recommendations. 2. Resident #45 was admitted to the facility on 3/14/18 with diagnoses that included chronic kidney disease stage 3, heart failure, and palliative care. A physician ' s order dated 3/14/18 indicated Keflex (antibiotic) 250 milligrams (mg) once daily for prophylaxis (prevention). A Physician ' s Assistant (PA) note dated 3/15/18 indicated Resident #45 was on prophylactic Keflex related to a history of Urinary Tract Infections (UTIs). The PA noted that she advised for discontinuation if Resident #45 ' s Responsible Party (RP) agreed. A nursing note dated 3/15/18 indicated Resident #45 was on a prophylactic antibiotic related to UTIs. A physician ' s note dated 3/21/18 indicated	F 756	then monthly x 2 months to ensure each antibiotic prescribed has a clinical indication and a stop date. The Assistant Director of Nursing will notify the prescribing provider of any concerns upon identification. In order to provide Quality Assurance, utilizing an AIMS Audit Tool the Director of Nursing will audit all residents currently prescribed an antipsychotic weekly x 4 weeks then monthly x 2 months to ensure that AIMS assessments have been completed quarterly, upon initiation of a new antipsychotic, and at each antipsychotic dosage change. The Administrator will be responsible for the plan of correction.	

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Resident #45 was on prophylactic Keflex related to a history of UTIs.

The quarterly Minimum Data Set (MDS) assessment dated 6/19/18 indicated Resident #45 ' s cognition was severely impaired. She was administered antibiotics on 7 of 7 days during the MDS review period. Resident #45 was assessed with no active infections.

A review of Resident #45 ' s current physician ' s orders was conducted on 8/7/18. The orders included the Keflex 250 mg once daily for prophylaxis that was initiated on 3/14/18. A further review of Resident #45 ' s record revealed there continued to be no stop date for the prophylactic Keflex.

There was no evidence in Resident #44 ' s medical record of the Pharmacy Consultant identifying and addressing the use of prophylactic Trimethoprim prescribed indefinitely.

An interview was conducted with Clinical Manager #2 on 8/7/18 at 1:08 PM. She reported Resident #45 had been on prophylactic Keflex since her admission on 3/14/18. She stated Resident #45 had no active infection and that the Keflex was prescribed with no stop date.

An interview was conducted with the Director of Nursing (DON) on 8/7/18 at 3:40 PM. She indicated she was responsible for monitoring antibiotic usage at the facility. The DON was asked if an antibiotic prescribed for prophylaxis (prevention) was an adequate clinical indication for use. She reported she was not sure, but that she was aware the facility tried to deter from the use of prophylactic antibiotics. She explained

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that she had just taken over responsibility of antibiotic usage monitoring about a month and a half ago. The DON stated she needed to follow up with the previous responsible staff member to provide additional information.

An interview was conducted with the Admissions Coordinator on 8/7/18 at 3:50 PM. She stated she was responsible for monitoring antibiotic usage up until about a month and a half ago. She stated that antibiotics were expected to have an adequate clinical indication for use and were also expected to have a specified duration. She revealed that an antibiotic ordered prophylactically was not an adequate clinical indication for use.

A phone interview was conducted with the Pharmacy Consultant on 8/9/18 at 1:05 PM. The Pharmacy Consultant was asked if she identified and addressed prophylactic antibiotics that were prescribed indefinitely during her monthly drug regimen reviews. The Pharmacy Consultant stated she normally waited 4 to 6 months after admission and/or initiation of the antibiotic and would then make a recommendation to discontinue it if no infections had occurred. The order for Resident #45 ' s prophylactic Keflex that had been in place since 3/14/18 was reviewed with the Pharmacy Consultant. She confirmed she had made no recommendations related to Resident #45 ' s prophylactic Keflex.

An interview was conducted with the Administrator on 8/9/18 at 4:10 PM. She stated she expected the Pharmacy Consultant to identify and address the use of an antibiotic prescribed with no stop date and without an adequate clinical indication for use during the monthly drug

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regimen reviews.

3. Resident #44 was admitted to the facility on 3/21/18 with diagnoses that included Alzheimer ' s and hypertension.

Resident #44 ' s history and physical dated 3/21/18 completed prior to her admission to the facility indicated she had a history of recurrent Urinary Tract Infections (UTIs) and was on prophylactic (preventative) antibiotics. Resident #44 was noted with no signs of UTI.

A physician ' s order dated 3/21/18 indicated Trimethoprim (antibiotic) 100 milligrams (mg) once daily for Resident #44. There was no stop date for this order.

A Physician ' s Assistant (PA) note dated 3/22/18 indicated Resident #44 was on prophylactic Trimethoprim for a history of UTIs.

A physician ' s note dated 3/26/18 indicated Resident #44 was on Trimethoprim for recurrent UTIs.

The quarterly Minimum Data Set (MDS) assessment dated 6/26/18 indicated Resident #44 ' s cognition was severely impaired. She was administered antibiotics on 7 of 7 days during the MDS review period. Resident #44 was assessed with no active infections.

A review of Resident #44 ' s current physician ' s orders was conducted on 8/7/18. The orders included the Trimethoprim 100 mg once daily for UTI prophylaxis that was initiated on 3/21/18. A further review of Resident #44 ' s record revealed

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there continued to be no stop date for the prophylactic Trimethoprim.

There was no evidence in Resident #44 ' s medical record of the Pharmacy Consultant identifying and addressing the use of prophylactic Trimethoprim prescribed indefinitely.

An interview was conducted with Clinical Manager #2 on 8/7/18 at 11:53 AM. She reported Resident #44 had been on prophylactic Trimethoprim since her admission on 3/21/18. She stated Resident #44 had no active infection and that the Trimethoprim was prescribed with no stop date.

An interview was conducted with the Director of Nursing (DON) on 8/7/18 at 3:40 PM. She indicated she was responsible for monitoring antibiotic usage at the facility. The DON was asked if an antibiotic prescribed for prophylaxis (prevention) was an adequate clinical indication for use. She reported she was not sure, but that she was aware the facility tried to deter from the use of prophylactic antibiotics. She explained that she had just taken over responsibility of antibiotic usage monitoring about a month and a half ago. The DON stated she needed to follow up with the previous responsible staff member to provide additional information.

An interview was conducted with the Admissions Coordinator on 8/7/18 at 3:50 PM. She stated she was responsible for monitoring antibiotic usage up until about a month and a half ago. She stated that antibiotics were expected to have an adequate clinical indication for use and were also expected to have a specified duration. She revealed that an antibiotic ordered

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prophylactically was not an adequate clinical indication for use.

A phone interview was conducted with the Pharmacy Consultant on 8/9/18 at 1:05 PM. The Pharmacy Consultant was asked if she identified and addressed prophylactic antibiotics that were prescribed indefinitely during her monthly drug regimen reviews. The Pharmacy Consultant stated she normally waited 4 to 6 months after admission and/or initiation of the antibiotic and would then make a recommendation to discontinue it if no infections had occurred. The order for Resident #44 ' s prophylactic Trimethoprim that had been in place since 3/21/18 was reviewed with the Pharmacy Consultant. She confirmed she had made no recommendations related to Resident #44 ' s prophylactic Trimethoprim.

An interview was conducted with the Administrator on 8/9/18 at 4:10 PM. She stated she expected the Pharmacy Consultant to identify and address the use of an antibiotic prescribed with no stop date and without an adequate clinical indication for use during the monthly drug regimen reviews.

4. Resident #18 was admitted to the facility on 5/22/17 with diagnoses that included vascular dementia with behavioral disturbance.

An Abnormal Involuntary Movement Scale (AIMS) assessment was completed for 3/13/18 for Resident #18 with a score of 0 (no involuntary movements identified).

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A review of a psychiatry progress note dated 4/3/18 indicated the physician was changing Resident #18 ' s antipsychotic medication from Seroquel (antipsychotic medication) to Risperdal (antipsychotic medication).

A physician ' s order dated 4/3/18 indicated Resident #18 ' s Seroquel was discontinued and Risperdal 0.5 milligrams (mg) at 1:00 PM and 1 mg at night was initiated.

A physician ' s order dated 4/18/18 indicated a continuation of Resident #18 ' s current Risperdal orders (0.5 mg at 1:00 PM and 1 mg at night) and the addition of Risperdal 0.5 mg at 9:00 AM.

The annual Minimum Data Set (MDS) assessment dated 5/24/18 indicated Resident 18 ' s cognition was severely impaired. Section N, the Medication Section, indicated Resident #18 was administered antipsychotic medications on 7 of 7 days.

A review of Resident #18 ' s current physician ' s orders on 8/7/18 indicated Risperdal continued at 0.5 mg at 9:00 AM, 0.5 mg at 1:00 PM, and 1 mg at night.

A review of the medical record from 4/3/18 through 8/7/18 revealed an AIMS assessment or any other involuntary movement assessment had not been completed for Resident #18 after the new antipsychotic medication Risperdal was initiated (4/3/18) or when the Risperdal ' s dosage was increased (4/18/18).

There was no evidence in Resident #18 ' s medical record of the Pharmacy Consultant identifying and addressing that an AIMS

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assessment or any other involuntary movement assessment had not been completed for Resident #18 after the new antipsychotic medication Risperdal was initiated (4/3/18) or when the Risperdal ' s dosage was increased (4/18/18).

An observation was conducted of Resident #18 on 8/6/18 at 10:30 AM with no involuntary movements noted.

A phone interview was conducted with the Pharmacy Consultant on 8/9/18 at 1:05 PM. She stated that her expectation for the completion of AIMS assessments was on initiation of a new antipsychotic medication and annually thereafter unless there was a change in the dosage or a change in the resident ' s symptoms. She confirmed that she expected a new AIMS to be completed if any new antipsychotic medication was initiated. The Pharmacy Consultant explained that it was important to complete a new AIMS for each antipsychotic medication ' s initiation because each medication had the potential to cause different side effects. Resident #18 ' s most recent AIMS completed on 3/13/18 was reviewed with the Pharmacy Consultant. Resident #18 ' s physician ' s orders that indicated the initiation Risperdal on 4/3/18 as well as the increase in the Risperdal ' s dosage on 4/18/18 were reviewed with Pharmacy Consultant. She verified she expected a new AIMS to be completed when the Risperdal had been initiated and when it was increased. She revealed she had not identified that an AIMS was not completed when the Risperdal was initiated on 4/3/18 or when it was increased on 4/18/18.

An interview was conducted with the Administrator on 8/9/18 at 4:10 PM. She stated

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F 756	Continued From page 56 she expected the Pharmacy Consultant to review AIMS assessments during the monthly drug regimen reviews and to request a new AIMS assessment for any resident who was initiated on a new antipsychotic medication or had a change in the dosage of their antipsychotic medication.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		9/5/18

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F 758	Continued From page 57 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, Physician, Physician Assistant (PA) and staff interview, the facility failed to have adequate indication for the use of duplicate therapy for insomnia for 1 of 6 sampled residents reviewed for unnecessary medications (Resident #90). Findings included: Resident #90 was originally admitted to the facility on 1/6/16 and was readmitted on 4/30/18 with multiple diagnoses including dementia with behaviors. The significant change in Minimum Data Set (MDS) assessment dated 7/20/18 indicated that Resident #90 had severe cognitive impairment and had no behaviors. Resident #90's doctor's orders were reviewed. On 4/30/18, he had orders for Trazodone (an antidepressant) 150 milligrams (mgs) - ½ tablet	F 758	The facility failed to have adequate indication for the use of duplicate therapy for insomnia on Resident #90. Nurse #1 failed to notify the prescribing physician of Resident #90's current medications when she contacted the physician regarding insomnia. At the time of the phone call to the physician, Resident #90 was currently prescribed and being administered Trazadone and Melatonin for insomnia. The physician ordered for Restoril to be administered at bedtime for insomnia. Nurse #1 also failed to document that the resident was suffering from increased insomnia and that the current medication regimen was ineffective. Current physician orders for Resident #90	

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F 758	Continued From page 58 by mouth at bedtime for insomnia and Melatonin (used as a sleep aide) 3 mgs by mouth at bedtime for insomnia. Resident #90's care plan dated 7/19/18 was reviewed. One of the care plan problems was resident was on psychotropic medications related to diagnoses of depression, dementia and insomnia. The goal was for the resident to have no signs and symptoms of adverse reaction from the medications through the next review date. The approaches included psychiatry to evaluate and follow as needed/indicated, pharmacy and doctor to monitor for continued need for drug and review for the continued need for the medication per facility protocol. The June, July and August 2018 Medication Administration Records (MARs) were reviewed and revealed that Resident #90 had received the Trazodone and the Melatonin every night as ordered. The July and August 2018 nurse's notes were reviewed. The notes did not indicate that Resident #90 was not sleeping at night. The nurse's notes (written by Nurse #1) dated 8/4/18 at 12:46 PM, revealed that Resident #90 had a fall and sustained a skin tear to his left elbow and knee and a small abrasion to his left forehead. The physician was informed and he gave new orders for Restoril (a benzodiazepine) 7.5 mgs by mouth at bedtime for insomnia and Ativan 1 mgs by mouth every 8 hours as needed (PRN) for agitation. On 8/8/18 at 10:25 AM, Nurse #1 was interviewed. She verified that she was the nurse	F 758	were reviewed by the physician assistant and Restoril was discontinued on 8/9/18. A 100% audit of all active physician orders for psychotrophics was completed on 8/21/18 by the Consultant Pharmacist to identify residents' currently prescribed duplicate therapy. Five residents were identified as being prescribed duplicate anti-depressant therapy. The Pharmacy Consultant made recommendations to the prescribing provider for any residents identified to have duplicate therapy. An in-service was initiated by the Assistant Director of Nursing on August 21, 2018 for all licensed nursing staff regarding review of current medication orders with the physician when requesting new orders and complete documentation including the reason for contacting the physician to obtain an order. All newly hired licensed nursing staff will receive the appropriate education during orientation. Staff will not be allowed to work until they have received the in-service. During clinical meeting, Monday through Friday, all carbon copies of orders received on the previous day will be reviewed with the Director of Nursing, Assistant Director of Nursing, MDS Coordinator, and Unit Managers x 2. During this review, any orders for psychotropic drugs will be reviewed to ensure that the resident is not receiving duplicate therapy. Any incidents of duplicate therapy will be discussed with the prescribing provider (Medical Director,	

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F 758	Continued From page 59 assigned to Resident #90 on 8/4/18. She had called and informed the Physician about the fall and the Physician had ordered Restoril and PRN Ativan. Nurse #1 indicated that the Restoril was ordered because Resident #90 was not sleeping at night. Nurse #1 was unable to find documentation that the resident was not sleeping at night. On 8/8/18 at 10:20 AM, Clinical Manager #2 was interviewed. She stated that she didn't know why the Restoril was ordered when the resident was already on two drugs for insomnia. She revealed that she had already discussed it with the Physician Assistant (PA) and the PA would discontinue the Restoril. On 8/8/18 at 12:20 PM, the PA was interviewed. The PA stated that she was not aware that Resident #90 was not sleeping at night. She further indicated that if she was made aware she would increase the dose of the Trazodone or refer him to Psychiatry but she would not order another drug especially Restoril. On 8/9/18 at 3:14 PM, the Physician, who ordered the Restoril, was interviewed. He stated that he remembered that he received a call from the facility that Resident #90 or his family member was requesting additional sleeping pill and he gave an order for Restoril. He was not aware that the resident was already on Trazodone and Melatonin for insomnia, if he had known he would just increase the Trazodone and not order the Restoril. On 8/9/17 at 4:07 PM, the Administrator and the	F 758	Physician Assistant, or Nurse Practitioner) for recommendations. The Pharmacy Consultant will continue to review medication orders monthly to identify and address any duplicate therapy and make necessary recommendations to the prescribing physician. In order to provide Quality Assurance, the Director of Nursing will audit all active orders for psychotropic medications weekly for 4 weeks, then monthly for 2 months to identify any instances of duplicate therapy. Any incidents of duplicate therapy will be discussed with the prescribing provider (Medical Director, Physician Assistant, or Nurse Practitioner) for recommendations. The Director of Nursing will present the results of these audits to the Quality Assurance Performance Improvement Committee for a minimum of three consecutive meetings to identify trends, concerns, and recommendations for any modification of the process. The Director of Nursing will be responsible for implementing the plan of correction.	

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F 758	Continued From page 60 Director of Nursing (DON) were interviewed. The Administrator stated that she expected her nurses to inform the doctor the medications the resident was on to prevent duplicate therapy.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard opened, expired food items in 1 of 2 kitchen refrigerators and failed to date frozen food items with their opened date and discard an expired food product in 1 of 1 kitchen freezers. The findings included: 1. An observation of kitchen food storage areas was conducted on 8/6/18 at 9:30 AM with the Dietary Manager (DM) revealed:	F 812	The facility failed to discard opened, expired food items in 1 of 2 refrigerators and failed to date frozen food items with their opened date and discard an expired food product in 1 of 1 freezer. Items noted during survey to be expired and/or opened without a date were discarded on 8/6/18.	9/5/18

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F 812	Continued From page 61 a. Observed in the kitchen's walk-in refrigerator was an opened package of turkey with an expired expiration date of 7/7/18, a 5-pound container of cottage cheese with an expired expiration date of 8/4/18, a container of opened tuna salad with an expired expiration date of 8/4/18, a container of opened egg salad with an expired expiration date of 8/4/18. b. Observation of foods stored in the walk-in freezer revealed an opened, undated package of chicken, an opened, undated package of chicken patties, an opened, undated package of potatoes tots and an unopened carton of frozen heavy cream with an expired use by date of 6/4/18. In an interview on 8/6/18 at 9:30 AM, the DM stated all items identified should have been dated when opened and discarded at the time of expiration. The DM stated she assumed the DM position about 6 weeks ago after the previous DM resigned unexpectantly and she was still in the process of learning her new role. She stated it was ultimately her responsibility to ensure there was no expired food and any staff who opened an item was responsible to write the date opened on the item.	F 812	Dietary staff failed to discard expired food items and failed to label items appropriately. A 100% audit of all food items in the kitchen was completed on 8/21/18 by the Dietary Manager to ensure all expired food was discarded appropriately and all items are labeled with an open date. During this audit, a bag of chicken filets and French fries were identified in the freezer as not labeled or dated and a container of left over ribs were not stored air tight per policy. The cook responsible was issued disciplinary action per policy by the Dietary Manager. An in-service was initiated by the Dietary Manager on 8/17/18 all dietary employees regarding storage of food in accordance with professional standards for food safety. All newly hired dietary staff will receive the appropriate education during orientation. Staff will not be allowed to work until they have received the in-service. When food, food products or beverages are delivered to the nursing home, dietary staff will inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all foods stored in the refrigerator or freezer as indicated. Dietary staff will manage the receipt and storage of dry food, removing foods not safe for consumption, keeping dry food products in closed containers,	

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F 812	Continued From page 62	F 812	and rotating supplies. In order to provide Quality Assurance, utilizing a Food Storage Audit tool the Dietary Manager will audit all food storage areas to ensure food is stored in accordance with professional standards for food safety weekly for 8 weeks, then monthly for 1 month to identify any instances of noncompliance. Any expired or opened unlabeled items will be discarded upon identification. The Dietary Manager will present the results of these audits to the Quality Assurance Performance Improvement Committee for a minimum of three consecutive meetings to identify trends, concerns, and recommendations for any modification of the process. The Dietary Manager will be responsible for implementing the plan of correction.	
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the	F 865		9/5/18

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F 865	Continued From page 63 requirements of this section. §483.75(i) Sanctions. 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 review, observation, resident interview, and staff interview, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 8/17/17 recertification survey in the area of Accuracy of Assessments (483.20), following the 10/11/17 and 3/15/18 complaint investigation surveys in the area of Abuse and Neglect (483.12), following the 2/15/18 complaint investigation survey in the area of Pressure Ulcers (483.25), and following the 3/15/18 complaint investigation survey in area of Accident Hazards (483.25). These 4 deficiencies were cited again on the current recertification survey of 8/9/18. The continued failure of the facility during 2 or more federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 1. 483.20 Accuracy of Assessments: Based on record review, observation, and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of active diagnosis and antipsychotic medication review (Resident #18), falls (Resident #72), and dental status (Resident #2) for 3 of 27 residents reviewed.	F 865	The facility's Quality Assurance Committee failed to maintain implemented procedures and monitor the interventions the facility put in place following the recertification survey on 8/17/17 in the area of Accuracy of Assessments, following the 10/11/17 and 3/15/18 complaint investigation surveys in the area of Abuse and Neglect, following the 2/15/18 complaint investigation survey in the area of Pressure Ulcers, and following the 3/15/18 complaint investigation survey in the area of Accident Hazards. A plan of correction for F641, F600, F689, and F686 cited during the annual survey on 8/9/18 were submitted to CMS on 8/28/18. Plans of correction were put into place at the time of each deficiency cited during the surveys on 8/17/17, 10/11/17, 3/15/18, and 2/15/18. Each plan of correction included monitoring tools and review of monitoring tools during monthly Quality Assurance Performance Improvement meetings for a defined amount of time. Monitoring of each plan of correction was presented to the Quality Assurance Performance Improvement Committee. No further issues were identified throughout monitoring period and	

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F 865	Continued From page 64 During the recertification survey of 8/17/17 the facility was cited at 483.20 Accuracy of Assessments for failing to code the MDS assessment accurately in the areas of active diagnosis and behaviors. 2. 483.12 Abuse and Neglect: Based on record review, observation, staff and resident interview, the facility failed to protect a cognitively impaired resident (Resident #62) from unwanted advances from a cognitively intact resident (Resident #60) and also neglected to provide incontinent care to a resident who needed extensive assist with toileting (Resident #65) for 2 of 2 sampled residents reviewed for abuse and neglect. During the complaint investigation survey of 10/11/17 the facility was cited at 483.12 Abuse and Neglect for failing to protect residents from staff who willfully neglected to provide medications and tube feeding as ordered. During the complaint investigation survey of 3/15/18 the facility was cited at 483.12 Abuse and Neglect for neglecting to use 2 staff members to provide incontinence care resulting in a fall, failing to report the fall, failing to assess the resident for injury prior to moving the resident, and then failing to use two staff to move the resident with a mechanical lift. 3. 483.25 Pressure Ulcers: Based on record review, observation and Wound Care Specialist, Registered Dietician (RD), and staff interview, the facility failed to provide preventative measures to prevent pressure ulcer development to a resident at risk for pressure ulcer which resulted to the development of 4 additional pressure ulcers for 1 of 3 sampled residents reviewed for pressure	F 865	monitoring was discontinued. The facility failed to maintain compliance for areas previously cited and then recited, specifically in the areas of Accuracy of Assessments, Abuse and Neglect, Pressure Ulcers, and Accident Hazards. The Administrator initiated an in-service to all Administrative staff on August 28, 2018 regarding Quality Assurance Performance Improvement processes including identifying and prioritizing quality deficiencies, systemically analyzing causes of systemic quality deficiencies, developing and implementing corrective action or performance improvement activities, and monitoring and evaluating the effectiveness of corrective action/performance improvement activities. This in-service included ensuring accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary. All newly hired Administrative staff will receive the appropriate education during orientation. No staff will work until they have received the appropriate education. To ensure quality assurance, the Administrator will review the facility Quality Assurance Committee Master Checklist and scheduled audits monthly to ensure that those areas noted to be deficient are systemically analyzed and corrective	

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F 865	Continued From page 65 ulcers (Resident #90). During the complaint investigation survey of 2/15/18 the facility was cited at 483.25 Pressure Ulcers for failing to obtain physician orders to immediately initiate the treatment of a pressure ulcer on admission, failing to obtain physician orders before starting treatment of a pressure ulcer, failing to assess for worsening of a pressure ulcer, failing to prevent the worsening of a pressure ulcer, failing to follow Wound Nurse Consultant orders of a resident admitted with a pressure ulcer, and failing to consistently provide treatment to the pressure ulcer. 4. 483.25 Accident Hazards: Based on record review, observation, and staff interview, the facility failed to provide supervision to prevent a resident who required the extensive assistance of 1 person for toileting from having an unsupervised fall in the bathroom for 1 of 7 sampled residents reviewed for accidents. Resident #57 experienced an unsupervised fall in the bathroom and sustained a right femur fracture requiring open reduction internal fixation (ORIF) surgery (a surgical procedure to fix a severe broken bone. During the complaint investigation survey of 3/15/18 the facility was cited at 483.25 Accident Hazards for failing to provide two staff members during the provision of incontinence care to prevent a resident from falling from bed and sustaining an injury. An interview was conducted with the Administrator 8/9/18 at 4:20 PM. The Administrator indicated she was the head of the facility ' s QAA Committee. She indicated she	F 865	action implemented. The Administrator will responsible for the plan of correction.	

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F 865	Continued From page 66 was not the Administrator during the previous recertification survey of 8/17/17 or the complaint investigation survey of 10/11/17. She stated she was the Administrator at the time of 2/15/18 and 3/15/18 complaint investigation surveys. She reported she was aware of the citations from these previous surveys. The Administrator indicated there had been no identified concerns in the recent months with MDS accuracy and she was unable to say why this was a repeat citation. When asked about the previous citations in the area of Abuse/Neglect the Administrator indicated that these citations led the facility to develop a no tolerance policy as well as a change in leadership from top level management staff to direct care staff. She reported this change included the recent hiring of a new Director of Nursing and a Staff Development Coordinator that was scheduled to start this month (August 2018). The Administrator spoke about their previous citation in the area of Accident/Hazards reporting that the facility had recently implemented a new performance improvement plan related to falls as they had identified during QAA that there had been an increase in the number of falls at the facility. She stated that this performance improvement plan was still in the early stages of implementation. She reported that in regard to the repeat citation related to Pressure Ulcers that the facility had not had a steady Treatment Nurse over the past 6 months reporting 4 changes in this position since she had been the Administrator (February 2018). She stated she believed these changes contributed to the repeat deficiency.	F 865		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control	F 881		9/5/18

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F 881	Continued From page 67 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Pharmacy Consultant, Physician's Assistant, and Medical Director, the facility failed to follow its Antibiotic Stewardship Program as evidenced by the failure to identify and address the use of prophylactic (preventative) antibiotic prescribed on an indefinite basis of 3 of 5 residents (Resident #4, #44, and #45) reviewed. The findings included: A review of the facility's Antibiotic Stewardship Program's policy, last revised 12/2016, indicated appropriate indications for use of antibiotics included: "a. Criteria met for clinical definition of active infection or suspected sepsis; and b. Pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending)." The policy additionally stated that if an antibiotic was ordered that a start and stop date or number of days of therapy was to be indicated on the order. 1. Resident #4 was admitted to the facility on 2/21/17 with diagnoses that included ectropion of left and right lower eyelids (lower eyelid turns or sags outward, away from your eye, exposing the surface of your inner eyelid).	F 881	The facility failed to follow its Antibiotic Stewardship Program as evidenced by the failure to identify and address the use of prophylactic antibiotic prescribed on an indefinite basis for Resident #4, #44, and #45. Resident #4 was prescribed Erythromycin eye ointment on 10/19/17 for ectropion with no stop date. Resident #45 was prescribed prophylactic Keflex related to a history of urinary tract infections on 3/15/18 with no stop date. Resident #44 was prescribed prophylactic Trimethoprim related to a history of urinary tract infections on 3/21/18 with no stop date. Prescribing providers were not aware of the facility's Antibiotic Stewardship Program. The facility failed to accurately track use of antibiotics. The Consultant Pharmacist failed to track antibiotic usage or make timely recommendations to the prescribing provider regarding antibiotic use in the absence of active infection. The antibiotic prescribed for Resident #4 was discontinued on 8/10/18.	

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F 881	Continued From page 68 A physician's order for Resident #4 dated 10/19/17 indicated Erythromycin (antibiotic) 0.5 percent (%) eye ointment apply 1-centimeter (cm) ribbon onto lower conjunctival sac at night related to ectropion. There was no stop date for this order. The quarterly Minimum Data Set (MDS) assessment dated 11/6/17 indicated Resident #4's cognition was severely impaired. She was administered antibiotics on 7 of 7 days during the MDS review period. Her active diagnoses included ectropion of left and right lower eyelids. Resident #4 was assessed with no active infections. A Pharmacy Consultant recommendation dated 1/16/18 indicated Erythromycin eye ointment was ordered 10/19/17 and no stop date was issued. The recommendation was to check with the physician to see if it was able to be discontinued as it was usually ordered with a 10 to 14-day duration. This recommendation was reviewed and signed by the Physician ' s Assistant (PA) on 1/30/18 and indicated to refer to the optometry follow up appointment. The quarterly MDS assessment dated 5/1/18 indicated Resident #4 ' s cognition was severely impaired. She was administered antibiotics on 7 of 7 days during the MDS review period. Her active diagnoses included ectropion of left and right lower eyelids. Resident #4 was assessed with no active infections. A review of Resident #4 ' s current physician ' s orders was conducted on 8/7/18. The orders included the Erythromycin eye ointment order that	F 881	The Responsible Representative for Resident #45 was contacted on 8/7/18 by the Director of Nursing regarding the currently prescribed antibiotic. The Responsible Representative was educated on the risks versus benefits of antibiotic use in the absence of an active infection. The Responsible Representative verbalized an understanding of education; however, requests that the antibiotic not be discontinued citing that each time this medication has been discontinued in the past, her mother has experienced pain related to urinary tract infections. Resident #45 is currently on hospice services and Responsible Representative states she wishes to keep her mother comfortable and pain free. The Medical Director and Hospice were consulted on 8/7/18 regarding the use of prophylactic antibiotics and agreed that the benefits outweigh the risks of use in this individual case as resident is on hospice services and has not had any side effects or adverse reactions to the antibiotic. The resident has not experienced a urinary tract infection since initiation of the prophylactic antibiotic. Residents care plan updated on 8/7/18 by the MDS Coordinator. The antibiotic prescribed for Resident #44 was discontinued on 8/7/18. A 100% audit of all active physician orders was completed on 8/21/18 by the Pharmacy Consultant to identify residents currently prescribed antibiotics in the	

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F 881	Continued From page 69 was initiated on 10/19/17. A further review of Resident #4 ' s record revealed there continued to be no stop date for the Erythromycin eye ointment. A review of the monthly drug regimen reviews and pharmacy recommendations for Resident #4 revealed no further mention of the Erythromycin eye ointment after the 1/16/18 recommendation to discontinue the medication. An interview was conducted with the Director of Nursing (DON) on 8/7/18 at 3:40 PM. She indicated she was responsible for monitoring the Antibiotic Stewardship Program (ASP) at the facility. The DON was asked what the ASP ' s policy stated about the use of antibiotics without the presence of an active infection. She reported she was not sure what the policy stated, but that she was aware the facility tried to deter from the use of prophylactic (preventative) antibiotics. The DON was asked what the ASP ' s policy stated about the use of antibiotics prescribed on an indefinite basis. She stated she was not sure. She explained that she had just taken over responsibility of the ASP about a month and a half ago. The DON stated she needed to follow up with the previous responsible staff member to provide additional information. An interview was conducted with the Admissions Coordinator on 8/7/18 at 3:50 PM. She stated she was responsible for the ASP up until about a month and a half ago. She stated that antibiotics were expected to have an adequate clinical indication for use and were also expected to have a specified duration. She revealed that an antibiotic ordered prophylactically was not an adequate clinical indication for use. She	F 881	absence of an active infection. One resident was noted to have an active order for antibiotic eye drops without a stop date. Recommendations were made to the prescribing provider on 8/22/18 for the discontinuation of this medication and the medication was discontinued on 8/23/18 per provider orders. The Pharmacy Consultant was in-serviced by the Pharmacy Manager on 8/21/18 regarding antibiotic stewardship policies and procedures. This in-service included the requirement for the Pharmacy Consultant to identify and address/readdress any antibiotic prescribed on an indefinite basis and/or without clinical indication for use. The Director of Nursing provided an in-service to the Assistant Director of Nursing and all providers including the Medical Director and in-house physician assistant on 8/22/18 regarding the facility's Antibiotic Stewardship Program. This in-service included ensuring that antibiotics are not prescribed in the absence of an active infection and that all antibiotic orders have a stop date. The Assistant Director of Nursing initiated an in-service to all licensed nursing staff and providers on 8/22/18 regarding the facility's Antibiotic Stewardship Program. This in-service included ensuring that antibiotics are not prescribed in the absence of an active infection and that all antibiotic orders have a stop date. All newly hired licensed nursing staff will	

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F 881	Continued From page 70 additionally revealed that an antibiotic prescribed on an indefinite basis was not in accordance with the ASP ' s policy. A follow up interview was conducted with Admission ' s Coordinator on 8/8/18 at 3:00 PM. The Erythromycin eye ointment order for Resident #4 that had been in place since 10/19/17 was reviewed with the Admission ' s Coordinator. She confirmed that this order was received during the timeframe that she was responsible for the ASP. She was unable to explain why the long-term use of this prophylactic antibiotic had not been addressed. An interview was conducted with the PA on 8/9/18 at 12:20 PM. The PA was asked what the facility ' s Antibiotic Stewardship Program ' s policy stated about the use of prophylactic antibiotics prescribed indefinitely. She stated she was not involved in the facility ' s ASP and she was unaware of the ASP ' s policy. She reported she was not in the practice of initiating orders for prophylactic antibiotics. She stated if an order for a prophylactic antibiotic came from another provider and there were no adverse consequences of that antibiotic that she would not usually recommend a discontinuation of the medication. The order for Resident #4 ' s Erythromycin eye ointment that had been in place since 10/19/17 was reviewed with the PA. The 1/16/18 pharmacy recommendation to discontinue Resident #4 ' s Erythromycin eye ointment was reviewed with the PA. She stated that this was an instance in which the prophylactic antibiotic was prescribed by an optometrist and she had seen no adverse consequences, so she had not discontinued the antibiotic.	F 881	receive the appropriate education during orientation. Staff will not be allowed to work until they have received the in-service. The Pharmacy Consultant will identify and address/readdress any antibiotic prescribed on an indefinite basis and/or without clinical indication and make necessary recommendations to the prescribing physician. The Pharmacy Consultant will complete an exit conference with the Administrator and Director of Nursing monthly and provide a complete list of all residents on antibiotics and recommendations for review. All antibiotic orders will be verified by the Unit Managers x 2, Assistant Director of Nursing, and Director of Nursing 5 x weekly to ensure diagnosis and stop dates. In order to provide Quality Assurance, utilizing an Antibiotic QI Audit Tool the Assistant Director of Nursing will audit all active antibiotic orders weekly x 4 weeks then monthly x 2 months to ensure each antibiotic prescribed has a clinical indication and a stop date. The Assistant Director of Nursing will notify the prescribing provider of any concerns upon identification. The Director of Nursing will be responsible for the plan of correction.	

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A phone interview was conducted with the Pharmacy Consultant on 8/9/18 at 1:05 PM. The Pharmacy Consultant was asked what the facility ' s Antibiotic Stewardship Program ' s policy stated about the use of prophylactic antibiotics prescribed indefinitely. She stated she was not sure what the ASP ' s policy stated about prophylactic antibiotics, but that generally prophylactics were prescribed with no stop date because they were for infection prevention. She was asked if she identified and addressed prophylactic antibiotics that were prescribed indefinitely during her monthly drug regimen reviews. The Pharmacy Consultant stated she normally waited 4 to 6 months after admission and/or initiation of the antibiotic and would then make a recommendation to discontinue it if no infections had occurred. The pharmacy recommendation dated 1/16/18 to discontinue the Erythromycin eye ointment for Resident #4 was reviewed with the Pharmacy Consultant. She stated that this was an instance in which she identified Resident #4 was on a prophylactic antibiotic and had no infections, so she recommended its discontinuation. She revealed she had made no further recommendations related to Resident #4 ' s Erythromycin eye ointment after 1/16/18.

A phone interview was conducted with the facility ' s Medical Director/Resident #4 ' s physician on 8/9/18 at 3:05 PM. The Medical Director was asked what the facility ' s Antibiotic Stewardship Program ' s policy stated about the use of prophylactic antibiotics prescribed indefinitely. He revealed he was unsure of the facility ' s Antibiotic Stewardship Program ' s policy. He stated that neither himself or his PA were in the practice of prescribing prophylactic antibiotics as

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there was no evidence to support the benefit of their use. He explained that if a resident was admitted on a prophylactic antibiotic or if a specialist prescribed the medication that he sometimes didn ' t know why the medication was originally initiated. He stated that without knowing why the medication was initiated that he would not discontinue the medication unless there was some adverse consequence.

An interview was conducted with the Administrator on 8/9/18 at 4:10 PM. She stated she expected the facility ' s staff and providers to be aware of the Antibiotic Stewardship Program ' s policy, for the policy to be followed, for antibiotics to be administered only when the criteria for an active infection was met, and for all antibiotic orders to have a specified duration.

2. Resident #45 was admitted to the facility on 3/14/18 with diagnoses that included chronic kidney disease stage 3, heart failure, and palliative care.

A physician ' s order dated 3/14/18 indicated Keflex (antibiotic) 250 milligrams (mg) once daily for prophylaxis (prevention).

A Physician ' s Assistant (PA) note dated 3/15/18 indicated Resident #45 was on prophylactic Keflex related to a history of Urinary Tract Infections (UTIs). The PA noted that she advised for discontinuation if Resident #45 ' s Responsible Party (RP) agreed.

A nursing note dated 3/15/18 indicated Resident #45 was on a prophylactic antibiotic related to UTIs.

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A physician ' s note dated 3/21/18 indicated Resident #45 was on prophylactic Keflex related to a history of UTIs.

The quarterly Minimum Data Set (MDS) assessment dated 6/19/18 indicated Resident #45 ' s cognition was severely impaired. She was administered antibiotics on 7 of 7 days during the MDS review period. Resident #45 was assessed with no active infections.

A review of Resident #45 ' s current physician ' s orders was conducted on 8/7/18. The orders included the Keflex 250 mg once daily for prophylaxis that was initiated on 3/14/18. A further review of Resident #45 ' s record revealed there continued to be no stop date for the prophylactic Keflex.

There was no evidence in Resident #44 ' s medical record of the Pharmacy Consultant identifying and addressing the use of prophylactic Trimethoprim prescribed indefinitely.

An interview was conducted with Clinical Manager #2 on 8/7/18 at 1:08 PM. She reported Resident #45 had been on prophylactic Keflex since her admission on 3/14/18. She stated Resident #45 had no active infection and that the Keflex was prescribed with no stop date.

An interview was conducted with the Director of Nursing (DON) on 8/7/18 at 3:40 PM. She indicated she was responsible for monitoring the Antibiotic Stewardship Program (ASP) at the facility. The DON was asked what the ASP ' s policy stated about the use of antibiotics without the presence of an active infection. She reported

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she was not sure what the policy stated, but that she was aware the facility tried to deter from the use of prophylactic antibiotics. The DON was asked what the ASP ' s policy stated about the use of antibiotics prescribed on an indefinite basis. She stated she was not sure. She explained that she had just taken over responsibility of the ASP about a month and a half ago. The DON stated she needed to follow up with the previous responsible staff member to provide additional information.

An interview was conducted with the Admissions Coordinator on 8/7/18 at 3:50 PM. She stated she was responsible for the ASP up until about a month and a half ago. She stated that antibiotics were expected to have an adequate clinical indication for use and were also expected to have a specified duration. She revealed that an antibiotic ordered prophylactically was not an adequate clinical indication for use. She additionally revealed that an antibiotic prescribed on an indefinite basis was not in accordance with the ASP ' s policy.

An interview was conducted with the PA on 8/9/18 at 12:20 PM. The PA was asked what the facility ' s Antibiotic Stewardship Program ' s policy stated about the use of prophylactic antibiotics prescribed indefinitely. She stated she was not involved in the facility ' s ASP and she was unaware of the ASP ' s policy. She reported she was not in the practice of initiating orders for prophylactic antibiotics. She explained that if a resident was admitted on a prophylactic antibiotic or if a specialist prescribed the antibiotic and there had been no adverse consequences/side effects of it that she would not usually recommend a discontinuation of the medication.

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The order for Resident #45 ' s prophylactic Keflex that had been in place since 3/14/18 was reviewed with the PA. Her note dated 3/15/18 that advised a discontinuation of Resident #45 ' s Keflex if the RP was agreeable was reviewed with the PA. She stated she had advised for the Keflex ' s discontinuation because Resident #45 was on hospice and she had not seen a benefit of the medication. She indicated the RP was not agreeable to its discontinuation. She stated she had not seen any adverse consequences of the prophylactic Keflex, so she had not discontinued it.

A phone interview was conducted with the Pharmacy Consultant on 8/9/18 at 1:05 PM. The Pharmacy Consultant was asked what the facility ' s Antibiotic Stewardship Program ' s policy stated about the use of prophylactic antibiotics prescribed indefinitely. She stated she was not sure what the ASP ' s policy stated about prophylactic antibiotics, but that generally prophylactics were prescribed with no stop date because they were for infection prevention. She was asked if she identified and addressed prophylactic antibiotics that were prescribed indefinitely during her monthly drug regimen reviews. The Pharmacy Consultant stated she normally waited 4 to 6 months after admission and/or initiation of the antibiotic and would then make a recommendation to discontinue it if no infections had occurred. The order for Resident #45 ' s prophylactic Keflex that had been in place since 3/14/18 was reviewed with the Pharmacy Consultant. She confirmed she had made no recommendations related to Resident #45 ' s prophylactic Keflex.

A phone interview was conducted with the facility '

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s Medical Director/Resident #45 ' s physician on 8/9/18 at 3:05 PM. The Medical Director was asked what the facility ' s Antibiotic Stewardship Program ' s policy stated about the use of prophylactic antibiotics prescribed indefinitely. He revealed he was unsure of the facility ' s Antibiotic Stewardship Program ' s policy. He stated that neither himself or his PA were in the practice of prescribing prophylactic antibiotics as there was no evidence to support the benefit of their use. He explained that if a resident was admitted on a prophylactic antibiotic or if a specialist prescribed the medication that he sometimes didn ' t know why the medication was originally initiated. He stated that without knowing why the medication was initiated that he would not discontinue the medication unless there was some adverse consequence.

An interview was conducted with the Administrator on 8/9/18 at 4:10 PM. She stated she expected the facility ' s staff and providers to be aware of the Antibiotic Stewardship Program ' s policy, for the policy to be followed, for antibiotics to be administered only when the criteria for an active infection was met, and for all antibiotic orders to have a specified duration.

3. Resident #44 was admitted to the facility on 3/21/18 with diagnoses that included Alzheimer ' s and hypertension.

Resident #44 ' s history and physical dated 3/21/18 completed prior to her admission to the facility indicated she had a history of recurrent Urinary Tract Infections (UTIs) and was on prophylactic (preventative) antibiotics. Resident #44 was noted with no signs of UTI.

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A physician ' s order dated 3/21/18 indicated Trimethoprim (antibiotic) 100 milligrams (mg) once daily for Resident #44. There was no stop date for this order.

A Physician ' s Assistant (PA) note dated 3/22/18 indicated Resident #44 was on prophylactic Trimethoprim for a history of UTIs.

A physician ' s note dated 3/26/18 indicated Resident #44 was on Trimethoprim for recurrent UTIs.

The quarterly Minimum Data Set (MDS) assessment dated 6/26/18 indicated Resident #44 ' s cognition was severely impaired. She was administered antibiotics on 7 of 7 days during the MDS review period. Resident #44 was assessed with no active infections.

A review of Resident #44 ' s current physician ' s orders was conducted on 8/7/18. The orders included the Trimethoprim 100 mg once daily for UTI prophylaxis that was initiated on 3/21/18. A further review of Resident #44 ' s record revealed there continued to be no stop date for the prophylactic Trimethoprim.

There was no evidence in Resident #44 ' s medical record of the Pharmacy Consultant identifying and addressing the use of prophylactic Trimethoprim prescribed indefinitely.

An interview was conducted with Clinical Manager #2 on 8/7/18 at 11:53 AM. She reported Resident #44 had been on prophylactic Trimethoprim since her admission on 3/21/18. She stated Resident #44 had no active infection

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and that the Trimethoprim was prescribed with no stop date.

An interview was conducted with the Director of Nursing (DON) on 8/7/18 at 3:40 PM. She indicated she was responsible for monitoring the Antibiotic Stewardship Program (ASP) at the facility. The DON was asked what the ASP ' s policy stated about the use of antibiotics without the presence of an active infection. She reported she was not sure what the policy stated, but that she was aware the facility tried to deter from the use of prophylactic antibiotics. The DON was asked what the ASP ' s policy stated about the use of antibiotics prescribed on an indefinite basis. She stated she was not sure. She explained that she had just taken over responsibility of the ASP about a month and a half ago. The DON stated she needed to follow up with the previous responsible staff member to provide additional information.

An interview was conducted with the Admissions Coordinator on 8/7/18 at 3:50 PM. She stated she was responsible for the ASP up until about a month and a half ago. She stated that antibiotics were expected to have an adequate clinical indication for use and were also expected to have a specified duration. She revealed that an antibiotic ordered prophylactically was not an adequate clinical indication for use. She additionally revealed that an antibiotic prescribed on an indefinite basis was not in accordance with the ASP ' s policy.

An interview was conducted with the PA on 8/9/18 at 12:20 PM. The PA was asked what the facility ' s Antibiotic Stewardship Program ' s policy stated about the use of prophylactic antibiotics

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prescribed indefinitely. She stated she was not involved in the facility ' s ASP and she was unaware of the ASP ' s policy. She reported she was not in the practice of initiating orders for prophylactic antibiotics. She explained that if a resident was admitted on a prophylactic antibiotic or if a specialist prescribed the antibiotic and there had been no adverse consequences/side effects of it that she would not usually recommend a discontinuation of the medication. The order for Resident #44 ' s prophylactic Trimethoprim that had been in place since 3/21/18 was reviewed with the PA. She stated that this was an instance in which Resident #44 was on the prophylactic antibiotic prior to her admission and she had seen no adverse consequences, so she had not discontinued the antibiotic.

A phone interview was conducted with the Pharmacy Consultant on 8/9/18 at 1:05 PM. The Pharmacy Consultant was asked what the facility ' s Antibiotic Stewardship Program ' s policy stated about the use of prophylactic antibiotics prescribed indefinitely. She stated she was not sure what the ASP ' s policy stated about prophylactic antibiotics, but that generally prophylactics were prescribed with no stop date because they were for infection prevention. She was asked if she identified and addressed prophylactic antibiotics that were prescribed indefinitely during her monthly drug regimen reviews. The Pharmacy Consultant stated she normally waited 4 to 6 months after admission and/or initiation of the antibiotic and would then make a recommendation to discontinue it if no infections had occurred. The order for Resident #44 ' s prophylactic Trimethoprim that had been in place since 3/21/18 was reviewed with the

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Pharmacy Consultant. She confirmed she had made no recommendations related to Resident #44 ' s prophylactic Trimethoprim.

A phone interview was conducted with the facility ' s Medical Director/Resident #44 ' s physician on 8/9/18 at 3:05 PM. The Medical Director was asked what the facility ' s Antibiotic Stewardship Program ' s policy stated about the use of prophylactic antibiotics prescribed indefinitely. He revealed he was unsure of the facility ' s Antibiotic Stewardship Program ' s policy. He stated that neither himself or his PA were in the practice of prescribing prophylactic antibiotics as there was no evidence to support the benefit of their use. He explained that if a resident was admitted on a prophylactic antibiotic or if a specialist prescribed the medication that he sometimes didn ' t know why the medication was originally initiated. He stated that without knowing why the medication was initiated that he would not discontinue the medication unless there was some adverse consequence.

An interview was conducted with the Administrator on 8/9/18 at 2:23 PM. She stated she expected the facility ' s staff and providers to be aware of the Antibiotic Stewardship Program ' s policy, for the policy to be followed, for antibiotics to be administered only when the criteria for an active infection was met, and for all antibiotic orders to have a specified duration.