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	345184	A. BUILDING _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE & REHAB-ELIZABETH CITY	901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909

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F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for	F 585		8/29/18

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

Electronically Signed | 08/24/2018

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completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be

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F 585	Continued From page 2 taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, resident interviews and staff interviews the facility failed to issue a written decision regarding action taken by the facility to resolve grievances for 2 of 2 residents reviewed for grievances. (Resident #138 and #17.) The findings included: Review of the facility's undated grievance policy, titled, Complaints/Grievances, read in part, under "Procedure: #7. Complaints/grievances are promptly acknowledged, investigated, and the complainant apprised of progress toward a resolution. #10. The facility ensures that all written grievance decisions includes, in part: D. A summary of the pertinent findings or conclusions regarding the resident's concerns, E. A statement as to whether the grievance was confirmed or not confirmed, F., Any corrective action taken or to be taken by the facility as a result of the grievance and G. The date the written decision was issued."	F 585	1. Resident #138 is no longer in the facility. Resident #17 grievance was written, completed, and the resident was given a copy of the grievance resolution. 2. The Director of Nursing, Staff Development Coordinator, the Executive Director, and or Department Manager performed a one-time 8/23/2018 audit with current resident population to ensure that any concerns have been properly documented, resolved, and resolution given to resident and/or resident representative according to the grievance policy. 3. The Staff Development Coordinator, Executive Director and/or Department Manager re-educated all staff 8/23/2018 to the center's policy and procedures regarding the resident right to voice grievances to the facility and the facilities responsibility to make prompt efforts to	

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F 585	Continued From page 3 1. Resident #138 was originally admitted to the facility on 8/31/17 with diagnoses including Hypertension, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Type 2 Diabetes Mellitus, Cognitive Communication Deficit and Alzheimer's Disease. According to the most recent Discharge Minimum Data Set (MDS) dated 2/15/18 revealed Resident #138 was cognitively impaired and required extensive supervision in most areas of activities of daily living. Review of Hospital report dated 2/10/18, read in part, "According to family patient pulled out his oxygen because he was not in his right mind due to his dementia and this was attributed to his Exelon patch last replaced on 2/6/18 in addition to other patches for the past 3 days. We will admit patient for acute on chronic systolic exacerbation. No further cardiac workup is warranted at this time." Reviewed of hospital discharge medication orders dated 2/6/18, read in part, "Exelon 9.5 mg./24 hr. Pt 24- Use 9.5 mg. to affected area once a day. Generic: Rivastigmine." Resident #138 was readmitted to the hospital again on 2/10/18, when it was determined the exelon patch was last replaced on 2/6/18 and other patches were not placed for three days. During an interview on 8/1/18 at 1:00 PM, the Director of Nursing (DON) revealed Resident #138 was discharged to the hospital from 2/2/18 through 2/6/18. She revealed when he was readmitted back to the facility on 2/6/18, he had a order for an Exelon patch which was supposed to be applied, removed and replaced every 24 hrs. She explained Resident #138 was discharged to the hospital again on 2/10/18 and an Exelon	F 585	resolve grievances. Staff not available for re-education by set date will be educated before next working shift. 4. The Director of Nursing, Staff Development Coordinator, Executive Director and/or Department Manager will audit 5 residents 2 times a week for 4 weeks and audit 5 residents once a week for 4 weeks, then monthly for 3 months to ensure all resident concerns have been documented and resolved according to the grievance policy. 5. Data results will be reviewed and analyzed at the center's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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patch dated 2/6/18 had not been removed and replaced. The DON revealed the discharge orders from the hospital were not followed. She stated she did not know why the patch was not removed and replaced daily. The DON explained that a meeting was held with Resident #138's family member on 2/16/18 who voiced concerns and filed a grievance about the facility's failure to remove and replace the Exelon patch. The DON stated she did inservices and audits on patches. She revealed a grievance was completed but Resident #138's family member never returned to sign or get a copy of the written grievance.

During another interview on 8/3/18 at 10:50 AM, the Director of Nursing (DON) revealed she was not aware she was supposed to send a written decision to the resident/resident representative regarding resolution of the grievance.

During an interview on 8/3/18 at 11:27 AM, the Administrator revealed her expectation would be for staff to follow-up with grievances and send a copy of the written decision to the resident/resident representative regarding resolution of the grievance.

2. Resident #17 was admitted to the facility on 5/7/2018 with diagnoses to include paralytic syndrome following stroke, after care for joint replacement and difficulty walking. Her admission Minimum Data Set (MDS) assessment dated 5/17/2018 revealed her cognition was intact, and she required extensive assistance from staff from staff for activities of daily living (ADL).

A review of the grievance logs from June 2018 to

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July 2018 revealed no documentation of grievances filed by Resident #17.

On 7/31/2018 at 12:15 PM, an interview was conducted with Resident #17. The Resident stated on 7/18/2018, she put her call light on to have someone move a stationary chair out of the way so she could maneuver her wheelchair to the bathroom. A 3:00 PM to 11:00 PM nursing assistant (NA), came to her room and turned off the call light and asked her if she couldn't do anything for herself. The Resident stated she was annoyed by this statement and put her call light on again, and a nurse came in and moved the chair for her. The resident stated she filed a grievance about the NA with the Director of Nursing (DON) on 7/23/2018. The resident stated she had not heard anything about the outcome from anyone at the facility.

On 8/1/2018 at 4:21 PM, an interview was conducted with Nurse #9, who stated she had gone to the Resident #17s room when answering her call light and moved a chair out of the way so the resident could move her wheelchair. The nurse stated she did not know about the NA not moving the chair.

On 8/1/2018 at 4:09 PM, an interview was conducted with the Director of Nursing (DON), who stated she had spoken with Resident #17 about the NA on 7/23/2018, but had not written up a grievance form because she had spoken with her in person. The DON stated the grievance was settled because she told the resident she would handle it as she left the room.

Attempts made to interview the NA were unsuccessful.

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F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interviews the facility failed to provide a written bed hold policy to 1 of 1 residents upon discharge to the hospital. (Resident #70). The findings included:	F 625	1. Resident #70 has received the bed hold policy 8/09/2018. 2. The Director of Nursing, and or the Staff Development Coordinator performed a one-time audit 8/17/2018 with current resident population to validate that each	8/29/18

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F 625	Continued From page 7 Review of the facility's Bed-Hold & Readmission policy, dated 11/28/17, read in part, "Policy: The bed-hold policy is given to the resident and resident representative at admission, when any changes occur under the state plan, and at time of transfer, therapeutic leave or temporary discharge. 2. When an emergency transfer is initiated, the notice is provided to the resident, surrogate, and representative upon transfer. The written notice may be included in the papers sent with the resident to the hospital." Resident #70 was originally admitted to the facility on 7/11/18, with diagnoses including Obstructive sleep apnea and Type 2 diabetes mellitus. According to the most recent Admission Minimum Data Set (MDS) dated 7/18/18, Resident #70 was cognitively impaired and required extensive supervision in most areas of activities of daily living. Review of a nurse's note dated 8/1/18 at 4:44 PM, read in part, "7/30/18, 3:10 PM, Resident was sent to emergency room this shift for lethargy and abdominal distention per medical doctor." During an interview on 8/2/18 at 1:26 PM, Staff Nurse #8 revealed in preparation to send Resident #70 to the hospital she sent a copy of his orders, Medication Administration Record (MAR), Face Sheet, Vitals and history and physical. She stated a bed hold policy was not included in the information sent to the hospital with the resident. During an interview on 8/2/18 at 3:11 PM, the Director of Nursing (DON) revealed when residents were discharged to the hospital, the Business Office Manager and the Admission	F 625	resident received the bed hold policy upon transfer to a hospital or the resident goes on therapeutic leave. 3. The Staff Development Coordinator re-educate Licensed Nurses 8/15/2018 to the center's policy and procedures in regards to providing the resident and resident representative written notice which specifies the duration of the bed hold policy. Staff not available for training by set date will be educated before next working shift. 4. The Director of Nursing, Staff Development Coordinator and or Administrative Nurse will audit transferred residents 2 times a week for 4 weeks, and then weekly for 4 weeks and monthly for 3 months to ensure each resident received the bed hold policy upon transfer to a hospital or the resident goes on therapeutic leave. 5. Data results will be reviewed and analyzed at the center's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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F 625	Continued From page 8 Coordinator usually handled the bed hold policy. She said during morning meetings they talked about bed holds and contacting the family. She stated residents signed the bed hold policy on admission to the hospital. During an interview on 8/3/18 at 11:16 PM, the Administrator revealed she was not aware that the bed hold policy had to be sent to the hospital with the resident upon discharge to the hospital. She revealed her expectation going forward would be that the bed hold policy will be sent with the resident to the hospital.	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a	F 655		8/29/18

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F 655	Continued From page 9 comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide evidence that a written summary baseline care plan was given to 1 of 1 residents (Resident #70) and/or resident's representative. The findings included: Resident #70 was originally admitted to the facility on 7/11/18, with diagnoses including Obstructive sleep apnea and Type 2 diabetes mellitus. According to the most recent Admission Minimum Data Set (MDS) dated 7/18/18, Resident #70 was cognitively impaired and required extensive supervision in most areas of activities of daily living.	F 655	1. Resident #70's baseline care plan was reviewed on 8/09/2018 with the resident's representative, signed copy placed in resident's chart. 2. The Director of Nursing and or Staff Development Coordinator performed a one-time audit 8/24/2018 with current resident population for all residents admitted in the last 21 days to validate that the baseline care plan has been reviewed with the resident and/or resident's representative. 3. The Director of Nursing and/or Staff Development Coordinator re-educated all Licensed Nursing and Interdisciplinary	

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F 655	Continued From page 10 Review of Resident #70's undated baseline care plan revealed the care plan was not signed by Resident #70 or a representative of Resident #70. During an interview on 8/3/18 at 9:00 AM the Minimum Data Set (MDS) Coordinator revealed she was not responsible for reviewing the baseline care plan with family members or residents. She revealed the Director of Nursing (DON) was responsible. During an interview on 8/3/18 at 9:30 AM, the Corporate Nurse revealed he could provide a signed copy of the baseline care plan by the nurse but he did not have it signed by Resident #70 or the resident's family member. During an interview on 8/3/18 at 10:53 AM, the Director of Nursing (DON) revealed the admitting nurse or nurse manager completed the initial assessment and baseline care plans and she said nurse managers are now aware that the resident and/or representative must sign the baseline care plan. During an interview on 8/3/18 at 11:16 AM, the Administrator revealed her expectation would be that baseline care plans will be signed by the resident and/or representative.	F 655	Team 8/24/2018 to review the summary of baseline care plan with the resident and/or resident's representative and place a signed copy in the resident's chart. Staff not available for training by set date will be educated before next working shift. All new admissions will be reviewed in clinical morning meeting to ensure baseline care plan summary is reviewed with the resident and/or resident representative. 4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit all new admissions 3 times weekly for one month, then weekly for one month, and then monthly for one month to ensure baseline care plan summary is reviewed with the resident and/or resident representative. 5. Data results will be reviewed and analyzed at the center's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	
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	F 656		8/29/18

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F 656	Continued From page 11 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to implement care plan interventions by not applying a hand splint or	F 656	1. Resident #33's supplement order was corrected and given on 8/02/2018 by charge nurse, splint, ted hose applied,	

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providing passive range of motion, not providing dietary supplements and not applying compression hose for 1 of 20 residents reviewed for care plans (Resident #33).

The findings included:

1. Resident #33 was admitted to the facility on 3/10/15 with diagnoses including Diabetes Mellitus, Chronic Ischemic Heart disease, Hemiplegia and Hemiparesis following a Cerebrovascular Accident and Dementia.

Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 6/14/18 identified Resident #33 as moderately cognitively impaired. He did not exhibit behaviors. He was an extensive two person assist with bed mobility and transferring and required extensive one person assistance with eating. Resident #33 had both upper and lower extremity range of motion impairment to one side. He was not receiving Speech, Physical or Occupational therapy. He was not in a Restorative nursing program or receiving splint or brace assistance.

a. Review of the Care Area Assessment dated 3/16/18 documented Resident #33 required Activities of Daily Living (ADL) assistance and had contractures.

Review of the Physician's Order dated 4/3/18 read Resident #33 was discharged from Occupational Therapy services. The resident was to receive passive range of motion (PROM) to the left shoulder, elbow, wrist and digits daily prior to putting on a hand splint with built up digit support.

and PROM performed by Certified Nursing Assistant on 8/02/2018.

2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse completed a one-time audit 8/17/2018 with current resident population to validate that residents receiving splints and ted hose has an appropriate care plan, physician order(s) in place, and device applied to residents. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse completed a one-time audit 8/17/2018 with current population to ensure that residents with supplements and PROM to validate care plan is appropriate.

3. The Staff Development Coordinator and/or Administrative Nurse re-educated all nursing staff 8/24/2018 to provide splint, ted hose, and supplements per physician order and item is care planned. The Rehabilitation Manager re-educated all Certified Nursing Assistants 8/24/2018 on PROM. Staff not available for training by set date will be educated before next working shift. The Director of Nursing and Interdisciplinary Team will review care plans for any revisions in weekly Standards of Care meetings to ensure care plans are implemented.

4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit 5 residents with splints, ted hose, supplements, and PROM 3 times a week for 4 weeks, then

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F 656	Continued From page 13 Review of the Care Plan, revision date 5/21/15, documented a Focus area for Resident #33 having an ADL Self-care performance deficit related to his Cerebrovascular Accident with hemiparesis (left sided weakness). Interventions in meeting the goal of improving the current level of function included a left-hand splint as ordered. Review of the March 2018 Occupational Therapy assessment documented Resident #33's elbow was at 86 degrees to 65 degrees with passive range of motion. Review of the August 2018 Occupational Therapy assessment documented Resident #33's elbow was at 72 degrees to 62 degrees with passive range of motion prior to pain. The assessment documented the resident was a candidate for elbow splint. Observations of Resident #33 on 7/31/18 at 11:54 AM he was up in his wheelchair for lunch. He was observed with a contracture to the left hand and there was no visible hand splint in place. Observations on 7/31/18 at 1:35 PM revealed Resident #33 in his wheelchair with no splint in place in his contracted left hand. Observations on 7/31/18 at 3:52 PM revealed Resident #33 in bed with no hand splint in place in his contracted left hand. Observations on 8/1/18 at 7:51 AM revealed Resident #33 in bed with no hand splint in place in his contracted left hand. Observations on 8/1/18 at 11:28 AM revealed Resident #33 was in bed with no hand splint in	F 656	once a week for two months to ensure residents care plans are followed. 5. Data results will be reviewed and analyzed at the center's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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place in his contracted left hand.

Observations on 8/2/18 at 8:06 AM revealed Resident #33 in bed with no hand splint in place in his contracted left hand.

During an interview on 8/01/18 at 9:08 AM with Nursing Assistant (NA #1), who frequently worked with Resident #33, she stated the resident did not wear wrist splits and had never placed hand splints on the resident. She further stated he could not use his left hand at all.

During an interview with the Occupational Therapist (O.T.), who had completed both the March 2018 and August 2018 assessment, on 8/02/18 at 8:42 AM she stated Resident #33 had always had a hand splint and in March 2018 a new one was ordered. She stated she worked for approximately two weeks with the resident doing passive range of motion and using the hand splint. She further stated at the end of two weeks she informed the nurse and the nursing assistant of the splint and how and when to use it. She stated there was no restorative program at the facility and this meant the nursing assistants were responsible for doing the passive range of motion and applying the splint. She stated she had placed the splint in the top dresser drawer. The O.T. and State Agency (SA) walked down to Resident #33's room and the O.T. pulled the splint out of the top dresser drawer and showed the SA and NA#3, who was in the room, how it was to be used. NA #3 stated, "ok." The O.T. then looked at the resident's left elbow and stated "I smell skin". She attempted to move the left elbow and the muscle was tight. She stated she would do an evaluation and most likely place an elbow splint on the left elbow to keep the elbow from

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further contracture. She stated it was very important to do the PROM exercises to keep the muscles from getting tight. She then stated she had given instructions in March 2018 to the nursing staff that the resident was to wear the splint 4-6 hours per day during the 7am-3pm shift after PROM had been completed during his morning care. She further documented on the August 2018 evaluation that upon arrival on 8/2/18, the resident presented supine in bed with his left elbow in a guarded position on his chest. In March 2018, the resident did not exhibit this resting position or pain after 10 degrees of passive range of motion, displaying increase contracture and hypertonicity (tightness). She documented the resident would benefit from a full OT evaluation for these concerns.

During an interview on 8/02/18 at 1:32 PM with Resident #33 he stated he had not had a splint on all day.

During an interview with NA #3 on 8/02/18 at 1:32 PM she stated she did not have the resident on her shift today that NA #2 had him.

During an interview with NA #2 on 8/02/18 at 1:34 PM she stated she had not worked with the resident before today and had no idea he was to wear a splint. She did not state if PROM had been done with morning care.

During a follow up interview with NA #3 on 8/02/18 at 1:34 PM she stated she had worked with the resident before and there had never been a splint in the room to place on him.

During an interview with the Nurse Consultant on 8/02/18 at 2:14 PM he stated the resident's

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left-hand splint did not get on the Medication Administration Record because the nurse keyed it in wrong, so it never showed up to be done.

During an interview on 8/2/17 at 2:48 PM with the Director of Nursing she stated the order for the hand splint was not transferred correctly to the Medication Administration Record but it was on the Kardex. She stated the Kardex was created from the care plan and the nursing assistants could see this in point of care, either at the nursing station, on the wall station or their hand-held device. She stated passive range of motion should have been completed during the bath time and the hand splint should have been in place as ordered.

During an interview with the Administrator on 8/3/18 at 10:40 AM she stated the hand splint should have been on and the care plan followed.

b. Review of the Physician's Order dated 10/18/16 documented an order for a Glucose control nutritional supplement one container three times per day at 8AM, 12PM and 4PM.

Review of the Medication Administration Record (MAR) for 2/2018 through 8/2018 documented an order for a Glucose Control nutritional supplement one container three times a day and was documented as given.

Review of the Care Plan, revised on 10/11/17, documented a focus area for Resident #33 being at a nutritional risk related to skin integrity. Interventions listed in meeting the goal of no significant weight change included

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diet/supplement as ordered.

Review of Resident #33's weight record documented a 2/12/18 weight of 220 pounds and his recorded weight on 8/2/18 was 200.5 pounds. This reflects an 8.9% weight loss in six months.

Observations on 8/1/18 at 8:49 AM did not reveal any supplement on the resident's bedside table or meal tray.

Observations on 8/1/18 at 1:03 PM of lunch did not reveal any supplement on the resident's bedside table or meal tray.

During an interview with Nurse #1 on 8/1/18 at 9:07 AM she stated the resident received a Glucose Control supplement three times daily, but she did not know who was responsible for giving this to the resident and stated it must come from dietary.

During an interview with Nursing Assistant (NA) # 1 on 8/1/18 at 9:10 AM she stated the resident did not have a supplement on his meal tray and she thought the nurse gave that to him.

During an interview with the Dietary Manager on 8/02/18 at 9:22 AM she stated dietary was not responsible for supplements on the meal trays that nursing provided supplements.

During an interview with the Registered Dietician on 8/2/18 at 9:49 AM she stated Resident #33 should be getting supplements with med pass.

During an interview with the Director of Nursing on 8/2/18 at 10:01 AM she stated all supplements are given by the nurses and are on the

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medication cart. The nurses are expected to give the supplements and chart as such. If the supplement isn't given the nurse should not chart it as given.

During a follow up interview with Nurse #1 on 8/02/18 at 10:15 AM she stated that she documented the Glucose Control supplement as given on the MAR because typically the supplements come through dietary on the meal tray and she assumed he received the supplements. She stated she was informed today that nurses are responsible for providing the supplements. She stated she went to get Glucose control from the supply room and the facility did not have the type of supplement ordered.

During a follow up interview with the Registered Dietician on 8/02/18 at 10:35 AM she stated that about six months ago the facility stopped carrying the glucose control supplement that Resident #33 had been ordered. She stated she did not know why this was not addressed on any notes and stated the resident probably had not received the glucose control nutritional supplement since the facility did not carry that any longer.

During an interview with the Nurse Consultant on 8/02/18 at 2:14 PM he stated the facility switched supplements about 6 months ago and it was not changed on the MAR. He did not know if the resident had received an alternative supplement.

During an interview with the Administrator on 8/3/18 at 10:40 AM she stated the nutritional supplements should have been given as ordered.

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c. Review of the Care Plan, revised on 3/27/18, documented a Focus area of resident having impaired circulation and/or edema to the lower extremities related to Diabetes and diet. The interventions in place to meet the goal of being free from signs/symptoms of the complications of edema through the next review date included anti-embolism stockings as ordered.

Review of the Physician's Order dated 2/8/16 revealed an order for anti-embolism stockings knee high stockings - Apply in AM (morning) and removed QHS (evening) one time a day for Edema.

Review of the Treatment Administration Record (TAR) for 2/2018 through 8/2018 documented the knee high stockings as being applied daily.

Observations on 7/31/18 at 11:42 AM Resident #33 was sitting up in his wheelchair at his bedside table for lunch. His ankles were observed to be swollen. He was not wearing anti-embolism stockings.

During an observation on 7/31/18 at 1:35 PM Resident #33 was sitting in his wheelchair. His ankles were noted to be swollen. He was not wearing anti-embolism stockings.

During an observation on 7/31/18 at 3:52 PM Resident #33 was in bed sleeping. He was not wearing anti-embolism stockings.

During observations on 8/1/17 at 2:28 PM with NA #1 she lifted the bed sheets to observe Resident #33's legs/feet. There were no anti-embolism stockings observed on his legs.

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F 656	Continued From page 20 During an interview with Nursing Assistant (NA) #1 on 8/1/18 at 2:28 PM she stated she had never been told the resident needed anti-embolism stockings. She stated he does not have any swelling in his ankles unless he is up in his chair. During an interview on 8/2/17 at 2:48pm the Director of Nursing stated the anti-embolism stockings should have been on the resident. During an interview with the Administrator on 8/3/18 at 10:40 AM she stated the anti-embolism stockings should have been on Resident #33 as ordered.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		8/29/18

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F 657	Continued From page 21 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to revise a Care Plan for 1 of 1 residents reviewed for significant weight loss. (Resident #50). The findings included: Resident #50 was originally admitted to the facility on 3/29/17, with diagnoses including Muscle Weakness (Generalized), Alzheimer's Disease, Hypertension and Dysphagia Oropharyngeal phase. According to the most recent Quarterly Minimum Data Set (MDS) dated 7/4/18, Resident #50 was cognitively impaired and required extensive assistance in most areas of activities of daily living, including eating. Review of a Dietician's Nutrition Assessment dated 6/29/18, read in part, "Medical Nutrition therapy review completed. See assessment for details. Summary of review: Weight stable. Intake by mouth greater than 50%. Does best with verbal prompts during meals. Current diet being tolerated. Continue with Plan of Care. Do not proceed to Care Plan." The RD's Assessment did not address that Resident #50 had experienced a recent weight loss from April 2018 to May 2018. Review of the facility Dietician's progress note	F 657	1. Resident #50 care plan was revised 8/17/2018 to reflect resident's current weight loss and intervention by Minimum Data Set Nurse (MDS). 2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 with current resident population to ensure care plans have been updated appropriately. 3. The Staff Development Coordinator and/or Administrative Nurse re-educate Licensed Nurses 8/24/2018 on care plan revision for weight change. Staff not available for training by set date will be educated before next working shift. The Director of Nursing and Interdisciplinary Team will review weight changes in clinical morning meeting and will be reviewed weekly in Standards of Care meeting to validate compliance. 4. The Director of Nursing and/or Administrative Nurse will audit all residents with weight changes weekly for 3 months to ensure care plans are revised regarding any weight changes.	

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F 657	Continued From page 22 dated 7/10/18, revealed Resident #50's weight was 152.4 pounds. She had a weight loss in April, 2018 of unknown etiology. Weight has been stable for past three months. Resident #50's body mass index was 27.9 and the resident was overweight as her ideal body weight was 110 pounds. The resident's intake by mouth was 76-100% with total dependence on feeding per staff. Speech Language Pathologist evaluation -appropriate food texture being given. Regular mechanical soft texture, Ensure three times daily should continue to provide for needs. The RD's progress note did not address that Resident #50 had experienced a recent weight loss specifically between April 2018 and May 2018. Review of Resident #50's Care Plan dated 7/12/18, which continued from 7/12/17 revealed she had a nutritional risk as her intake by mouth varied. She had a goal for no significant weight change with intake by mouth no greater than 75%. The interventions included daily weights times three weeks, then weekly weights times 4 weeks. Diet supplements as ordered. Monitor weights, intake by mouth and labs as available. Review of Resident #50's weights for a six month period revealed the resident had experienced the following weight loss: 1/3/18 163 2/12/18 165 3/10/18 164 3/14/18 163 4/10/18 165 5/1/18 152.8 (note a 7.4 % weight loss since 4/10/18) 6/27/18 153 7/9/18 152 pounds	F 657	5. Data results will be reviewed and analyzed at the center's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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During an interview on 8/2/18 at 1:30 PM, the facility Dietician stated she knew Resident #50 lost weight and she said she must have missed it by not updating the resident's care plan to address the weight loss. She revealed Resident #50 had been fine for several years and the speech therapist had evaluated her for texture. She stated they were concerned about her weight loss and she didn't know why she did not document it. She revealed she did not know about updating the care plan when a resident experienced weight changes.

During an interview on 8/2/18 at 1:52 PM, the MDS Coordinator revealed the last time Resident #50's Care Plan was updated was 7/12/18. She stated if Resident #50 had weight loss, the Dietician would look at any weight changes and would make a note if there was a weight change.

During an interview on 8/2/18 at 3:17 PM, the Director of Nursing (DON) revealed Resident #50 gained a lot of weight when she was initially admitted to the facility and she gained a few pounds here and there. She stated it would be up to the Dietician to make a note about Resident #50's weight loss. She stated it would have benefited her to lose weight because her thyroid level was abnormal. She revealed the Dietician should have addressed the weight loss at the time of the weight loss and even if it was a good thing for Resident #50 to lose weight, the Dietician should have documented it. The DON further stated she would have expected the Dietician to update Resident #50's Care Plan.

During an interview on 8/3/18 at 11:22 AM the Administrator revealed her expectation would be

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F 657	Continued From page 24 that the Dietician would update the resident's Care Plan.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to order a urinalysis for 1 of 1 residents who had physician's orders for a urinalysis (Resident # 11) and failed to follow discharge orders from the hospital to remove and replace Exelon patches for 1 of 1 residents reviewed. (Resident#138). The findings included: 1. Resident # 11 was admitted to the facility on 1/4/13 with diagnoses of Dementia, End Stage Renal Disease, Arteriosclerosis and Anxiety. The quarterly review Minimum Data Set (MDS) dated 5/11/18 identified the resident as severely cognitively impaired. Resident # 11 required extensive assistance with bed mobility, transfers, dressing, eating, and toilet use. Review of the nurse note dated 6/19/18 revealed the resident complained of burning sensation when urinating. The note documented staff would call the physician for a possible Urinary tract infection (UTI).	F 658	1. Resident #138 is no longer in the facility. Resident #11, Medical Doctor discontinued order 8/03/2018 for urinalysis related to absence of symptoms. 2. The Director of Nursing, and or the Staff Development Coordinator performed a one-time audit 8/17/2018 with current resident population to ensure new physician orders on all residents within the last 30 days were followed. 3. The Staff Development Coordinator re-educated all Licensed Nurses 8/24/2018 on following physician orders. Staff not available for training by set date will be educated before next working shift. The Director of Nursing and Interdisciplinary Team will review new physician orders in daily clinical morning meeting to ensure orders are followed. 4. The Director of Nursing and/or Administrative Nurse will audit all physician orders 5 times a week for one	8/29/18

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F 658	Continued From page 25 Review of the nurse note on 6/19/18 revealed the physician had confirmed a urinalysis on 6/20/18, to check for possible UTI. A review of the physician ' s order dated 6/19/18 revealed an order for urinalysis on 6/20/18. During an interview on 8/3/18 at 8:51 AM the nurse unit manager stated that normally the physician's orders were placed on the lab sheet and the labs were drawn. She stated she did not know why the urinalysis not been done. During an interview on 8/3/18 at 9:05 AM the Director of Nursing (DON) stated their process was to place the physician ' s order in the lab book to be drawn. She expected staff should have followed through with the order or told someone else the lab needed to be drawn. The DON revealed staff had put the physician ' s note into the computer so they should have followed through. The DON stated staff were calling the physician to see if he still wanted the urinalysis. 2. Resident #138 was originally admitted to the facility on 8/31/17 with diagnoses including Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Hypertension, Alzheimer's Disease, Type 2 Diabetes Mellitus and Cognitive Communication Deficit. According to the most recent Minimum Data Set (MDS) dated 2/15/18, Resident # 138 was independent in decision making and he required extensive assistance in most areas of activities of daily living. Review of hospital discharge medication orders dated 2/6/18, read in part, "Exelon 9.5 mg/24 hr. Pt 24- Use 9.5 mg. to affected area once a day." Resident #138 was readmitted to the hospital	F 658	month, then 2 times a week for 2 months to ensure physician orders are followed per professional standards. 5. Data results will be reviewed and analyzed at the center's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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F 658	Continued From page 26 again on 2/10/18, when it was determined the Exelon patch was last replaced on 2/6/18 and other patches were not placed for three days. During an interview on 8/1/18 at 1:00 PM, the Director of Nursing (DON) revealed Resident #138 was discharged to the hospital from 2/2/18 through 2/6/18. She revealed when he was readmitted back to the facility on 2/6/18, he had a order for an Exelon patch which was supposed to be applied, removed and replaced every 24 hrs. She explained Resident #138 was discharged to the hospital again on 2/10/18 and an Exelon patch dated 2/6/18 had not been removed and replaced. The DON revealed the discharge orders from the hospital were not followed. She stated she did not know why the patch was not removed and replaced daily. The DON explained that a meeting was held with Resident #138's family member and she did in services and audits on patches. During an interview on 8/3/18 at 11:27 AM, the Administrator revealed her expectation would be to follow doctor's orders.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		8/29/18

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F 684	Continued From page 27 by: Based on observations, record review and resident and staff interviews, the facility failed to provide compression stockings as ordered by the physician to treat lower extremity edema for 1 of 1 resident reviewed with compression stockings (Resident #33) and failed to provide care in a timely manner for a resident exhibiting signs of pain for 1 of 1 resident with a change in condition (Resident #7). The findings included: 1. Resident #33 was admitted to the facility on 3/10/15 with diagnoses including Diabetes Mellitus, Chronic Ischemic Heart disease, Hemiplegia and Hemiparesis following a Cerebrovascular Accident and Dementia. Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 6/14/18 identified Resident #33 as moderately cognitively impaired. He did not exhibit behaviors. He was an extensive two person assist with bed mobility and transferring and required extensive one person assistance with eating. Resident #33 had both upper and lower extremity range of motion impairment to one side Review of the Care Plan, revised on 3/27/18, documented a Focus area of resident having impaired circulation and/or edema to the lower extremities related to Diabetes and diet. The interventions in place included compression stockings as ordered. Review of the Physician's Order dated 2/8/16 revealed an order for compression stockings - knee high stockings - Apply in AM (morning) and removed QHS (evening) one time a day for	F 684	1. Resident #33's ted hose was applied 8/03/2018 and checked daily, resident was assessed for pain on 8/03/2018 with no pain indicated. 2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 with current resident population to ensure those with ted hose have proper placement and residents that have physician orders for pain medication to assure medication is given timely. 3. The Staff Development Coordinator and/or Administrative Nurse re-educate all Licensed Nurses 8/24/2018 on applying ted hose as ordered and administering medication in a timely manner for residents as per physician orders. Staff not available for training by set date will be educated before next working shift. The Director of Nursing and Interdisciplinary Team will review residents with physician orders to apply ted hose and pain medication weekly in Standards of Care meeting to ensure ongoing compliance. 4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit 5 residents pain assessments and Medical Administration Record (MAR) for residents that have physician order for pain medication 5 times a week for 1 month, then 2 times a week for 2 months	

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F 684	Continued From page 28 Edema. Review of the Treatment Administration Record (TAR) for 2/2018 through 8/2018 documented the knee high stockings as being applied daily. Observations on 7/31/18 at 11:42 AM Resident #33 was sitting up in his wheelchair at his bedside table for lunch. His ankles were observed to be swollen. He was not wearing compression stockings. During an observation on 7/31/18 at 1:35 PM Resident #33 was sitting in his wheelchair. His ankles were noted to be swollen. He was not wearing compression stockings. During an observation on 7/31/18 at 3:52 PM Resident #33 was in bed sleeping. He was not wearing compression stockings. During observations on 8/1/17 at 2:28 PM with NA #1 she lifted the bed sheets to observe Resident #33's legs/feet. There were no compression stockings observed on his legs. During an interview with NA #1 on 8/1/18 at 2:28 PM she stated she had never been told the resident needed compression stockings. She stated he did not have any swelling in his ankles unless he was up in his chair. During an interview on 8/2/17 at 2:48pm the Director of Nursing stated the compression stockings should have been on the resident. During an interview with the Administrator on 8/3/18 at 10:40 AM she stated the compression stockings should have been on Resident #33 as ordered.	F 684	to ensure pain medication is given in a timely manner. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit 5 residents physician orders for ted hose 3 times a week for one month, then once a week for 2 months to assure care plan is appropriate, physician order in place, and ted hose being applied. 5. Data results will be reviewed and analyzed at the center's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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2. Resident #7 was admitted to the facility on 1/29/18 with diagnoses including Atrial Fibrillation, Atherosclerotic Heart disease, Dysphagia, Acute and Chronic Respiratory Failure and Gastrostomy status.
Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 5/7/18 identified Resident #7 as cognitively intact.
Review of the Nursing Note dated 8/1/18 showed no documentation from Nurse #1 related to an assessment done by this nurse on 8/1/18 at 12:30 PM.

Review of the Nursing Note dated 8/1/18 showed an entry at 3:00 PM from Nurse #1 reflecting resident having generalized complaints of pain. His temperature was 98.6, pulse 54, respirations 18 and blood pressure 127/77. Tylenol had been given for a fever.

Review of the Nursing Note, written by the Director of Nursing, dated 8/1/18 at 3:37 PM documented Resident #7 was diaphoretic, oxygen saturation level was 99% on 2 liters of oxygen via nasal cannula, BP 128/80 and his temperature was 100.8 degrees Fahrenheit. The note documented the resident was not his usual self and was lethargic but arousable. The Nurse Practitioner was in the building and was notified. New orders were written for a Urinalysis/Culture and Bactrim (antibiotic) for 10 days. The family was notified.

During an observation of Resident #7 on 8/1/18 at 12:16 PM he was observed lying in his bed with the head of the bed up 60 degrees. His gastrostomy feeding was running at 60 cc (cubic centimeters) per hour. He was noted to be

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F 684	Continued From page 30	F 684		

diaphoretic and was pale in color. His eyes were noted to be rolling in an upwards direction. The air conditioner was observed on at a setting of 72 degrees and Resident #7 was under his blanket.

During an observation on 8/1/18 at 12:30 PM Nurse #1 entered Resident #7s room to assess the resident. Resident #7 was heard telling the nurse he hurt all over. His blood pressure was 125/76, pulse 54, axillary temperature was 98.6 degrees Fahrenheit, his Oxygen was on via nasal cannula at 2 liters, his gastrostomy was running at 60 cc and hour and Nurse #1 stated his lungs had some wheezing and he felt a little clammy and was sweaty. Nurse #1 was observed to give Tylenol for the fever.

During an interview with Resident #7 on 8/1/18 at 12:16 PM he stated he did not feel well and was having pain in his legs. He stated he had told someone earlier but did not recall who.

During an interview with Nurse #1 on 8/1/18 at 12:18 PM she stated she had seen the resident during medication pass earlier in the morning and he never complained of any pain. She stated maybe he told the Nursing Assistant about the pain. She further stated she was not used to taking care of Resident #7 and really did not know him. She stated Resident #7's roommate had told her that Resident #7 had not been feeling well for a couple of days. She stated when NA #4 came to her earlier about the resident and told her he was not looking right, she had NA #4 take his vital signs and his vital signs looked good. She stated clinically nothing was wrong, but "he didn't look right." She stated she had not done a physical assessment such as listening to lung sounds or anything yet because his vital

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F 684	Continued From page 31 signs looked good. She stated she really did not know the resident well and she would assess the resident. During an interview with NA #4 at 8/1/18 at 1:02 PM she stated she gave morning care, bathed Resident #7 and washed his hair. She stated his eyes looked a little funny so she told the nurse, who asked her to get vital signs. She stated she got vitals and told the nurse. During a follow-up interview with Nurse #1 on 8/1/18 at 1:11 PM she stated she had not taken another nurse in to look at the resident because she didn't know who to tell. She stated she did not know who the unit supervisor was. During an interview with Resident #7's primary care physician on 8/3/18 at 9:09 AM he stated that the resident should have been assessed by the nurse when the NA informed her of changes. She should have documented an assessment and called me if necessary. During an interview with the Administrator on 8/3/18 at 10:40 AM she stated Resident #7 should have been assessed when the Nursing Assistant came to the nurse about a change. She stated taking vital signs isn't enough. Following the assessment the nurse should have entered information related to her assessment in the computer. The nurse knew who was in charge and could have had the Unit Manager or Director of Nursing go in to assess the resident with her.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a	F 688		8/29/18

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F 688	Continued From page 32 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 observation, record review and staff interviews, the facility failed to provide splinting services and passive range of motion for contracture management for 1 of 1 residents (Resident #33) reviewed for range of motion and mobility. The findings included: Resident #33 was admitted to the facility on 3/10/15 with diagnoses including Diabetes Mellitus, Chronic Ischemic Heart disease, Hemiplegia and Hemiparesis following a Cerebrovascular Accident and Dementia. Review of the Care Area Assessment dated 3/16/18 documented Resident #33 required Activities of Daily Living (ADL) assistance and had contractures. Review of the March 2018 Occupational Therapy	F 688	1. Resident #33's splint was applied on 8/03/2018 by Certified Nursing Assistant and checked daily; PROM given to resident on 8/03/2018 by Certified Nursing Assistant and ongoing. 2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 with current resident population to ensure residents with splints have proper placement and residents with PROM orders are being followed. 3. The Staff Development Coordinator and/or Administrative Nurse re-educate all nursing staff 8/24/2018 on applying splint as per physician order and providing PROM as per physician order. Staff not available for training by set date will be	

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F 688	Continued From page 33 assessment documented Resident #33's elbow was at 86 degrees to 65 degrees with passive range of motion. Review of the Physician's Order dated 4/3/18 read Resident #33 was discharged from Occupational Therapy services. The resident was to receive passive range of motion (PROM) to the left shoulder, elbow, wrist and digits daily prior to putting on a hand splint with built up digit support. Review of the Care Plan, revision date 5/21/15, documented a Focus area for Resident #33 having an ADL Self-care performance deficit related to his Cerebrovascular Accident with hemiparesis (left sided weakness). Interventions in meeting the goal of improving the current level of function included a left-hand splint as ordered. Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 6/14/18 identified Resident #33 as moderately cognitively impaired. He did not exhibit behaviors. He was an extensive two person assist with bed mobility and transferring and required extensive one person assistance with eating. Resident #33 had both upper and lower extremity range of motion impairment to one side. He was not receiving Speech, Physical or Occupational therapy. He was not in a Restorative nursing program or receiving splint or brace assistance. Review of the August 2018 Occupational Therapy assessment documented Resident #33's elbow was at 72 degrees to 62 degrees with passive range of motion prior to pain. The assessment documented the resident was a candidate for elbow splint.	F 688	educated before next working shift. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will ensure splint application and PROM are completed by observation and reviewing audit in Clinical Morning meeting. 4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit 5 residents with splints for placement and PROM being performed 3 times a week for 1 month, then once a week for 2 months. 5. Data results will be reviewed and analyzed at the center's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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Observations of Resident #33 on 7/31/18 at 11:54 AM he was up in his wheelchair for lunch. He was observed with a contracture to the left hand and there was no visible hand splint in place.

Observations on 7/31/18 at 1:35 PM revealed Resident #33 in his wheelchair with no splint in place in his contracted left hand.

Observations on 7/31/18 at 3:52 PM revealed Resident #33 in bed with no hand splint in place in his contracted left hand.

Observations on 8/1/18 at 7:51 AM revealed Resident #33 in bed with no hand splint in place in his contracted left hand.

Observations on 8/1/18 at 11:28 AM revealed Resident #33 was in bed with no hand splint in place in his contracted left hand.

Observations on 8/2/18 at 8:06 AM revealed Resident #33 in bed with no hand splint in place in his contracted left hand.

During an interview on 8/01/18 at 9:08 AM with Nursing Assistant (NA #1), who frequently worked with Resident #33 on the 7:00 AM to 3:00 PM shift, she stated the resident did not wear wrist splits and had never placed hand splints on the resident. She further stated he could not use his left hand at all.

During an interview with the Occupational Therapist (O.T.), who had completed both the March 2018 and August 2018 assessment, on 8/02/18 at 8:42 AM she stated Resident #33 had always had a hand splint and in March 2018 a

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new one was ordered. She stated she worked for approximately two weeks with the resident doing passive range of motion and using the hand splint. She further stated at the end of two weeks she informed the nurse and the nursing assistant of the splint and how and when to use it. She stated there was no restorative program at the facility and this meant the nursing assistants were responsible for doing the passive range of motion and applying the splint. She stated she had placed the splint in the top dresser drawer. The O.T. and State Agency (SA) walked down to Resident #33's room and the O.T. pulled the splint out of the top dresser drawer and showed the SA and NA#3, who was in the room, how it was to be used. NA #3 stated, "Ok." The O.T. then looked at the resident's left elbow and stated "I smell skin". She attempted to move the left elbow and the muscle was tight. She stated she would do an evaluation and most likely place an elbow splint on the left elbow to keep the elbow from further contracture. She stated it was very important to do the PROM exercises to keep the muscles from getting tight. She then stated she had given instructions in March 2018 to the nursing staff that the resident was to wear the splint 4-6 hours per day during the 7am-3pm shift after PROM had been completed during his morning care. She further documented on the August 2018 evaluation that upon arrival on 8/2/18, the resident presented supine in bed with his left elbow in a guarded position on his chest. In March 2018, the resident did not exhibit this resting position or pain after 10 degrees of passive range of motion, displaying increase contracture and hypertonicity (tightness). She documented the resident would benefit from a full OT evaluation for these concerns.

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During an interview on 8/02/18 at 1:32 PM with Resident #33 he stated he had not had a splint on all day.

During an interview with NA #3 on 8/02/18 at 1:32 PM she stated she did not have the resident on her shift today that NA #2 had him.
During an interview with NA #2 on 8/02/18 at 1:34 PM she stated she had not worked with the resident before today and had no idea he was to wear a splint. She did not state if PROM had been done with morning care.

During a follow up interview with NA #3 on 8/02/18 at 1:34 PM she stated she had worked with the resident before and there had never been a splint in the room to place on him. She did not mention when she did PROM with Resident #33.

During an interview with the Nurse Consultant on 8/02/18 at 2:14 PM he stated the resident's left-hand splint did not get on the Medication Administration Record because the nurse keyed it in wrong, so it never showed up to be applied to the resident's left hand.

During an interview on 8/2/17 at 2:48 PM with the Director of Nursing she stated the order for the hand splint was not transferred correctly to the Medication Administration Record but it was on the Kardex. She stated the Kardex was created from the care plan and the nursing assistants could see this in point of care, either at the nursing station, on the wall station or their hand-held device. She stated passive range of motion should have been completed during the bath time and the hand splint should have been in place as ordered.

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F 688	Continued From page 37 An attempt to contact Resident #33's physician was unsuccessful during the survey. During an interview with the Administrator on 8/3/18 at 10:40 AM she stated the hand splint should have been on, passive range of motion performed and the care plan followed.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to assess and address weight loss for 2 of 2 residents reviewed for nutritional status (Resident #50, Resident #33) and failed to provide the nutritional supplement as ordered by the physician for 1 of 2 residents	F 692	1. Resident #33's weight loss reviewed by Registered Dietitian on 8/02/2018 with new supplement ordered; supplement order was corrected on 8/02/2018 by charge nurse and resident has since received proper order.	8/29/18

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F 692	Continued From page 38 reviewed for nutrition (Resident #33). The findings included: 1. Resident #50 was originally admitted to the facility on 3/29/17, with diagnoses including Muscle Weakness (Generalized), Alzheimer's disease, Hypertension and Dysphagia Oropharyngeal phase. According to the most recent Quarterly Minimum Data Set (MDS) dated 7/4/18, Resident #50 was cognitively impaired and required extensive assistance in most areas of activities of daily living, including eating. Review of a Dietician's (RD) Nutrition Assessment dated 6/29/18, read in part, "Medical Nutrition therapy review completed. See assessment for details. Summary of review: Weight stable. Intake by mouth greater than 50%. Does best with verbal prompts during meals. Current diet being tolerated. Continue with Plan of Care. Do not proceed to Care Plan." The RD's Assessment did not address that Resident #50 had experienced a recent weight loss from April 2018 to May 2018. Review of the facility Dietician's progress note dated 7/10/18, revealed Resident #50's weight was 152.4 pounds. She had a weight loss in April, 2018 of unknown etiology. Weight has been stable for past three months. Resident #50's body mass index was 27.9 and the resident was overweight as her ideal body weight was 110 pounds. The resident's intake by mouth was 76-100% with total dependence on feeding per staff. Speech language Pathologist evaluation -appropriate food texture being given. Regular mechanical soft texture, Ensure three times daily should continue to provide for needs. The RD's	F 692	2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 with current resident population in the last 30 days to ensure they have been addressed with interventions. In addition to auditing all residents with supplement orders to ensure residents have correct supplement and are receiving per physician orders. 3. The Staff Development Coordinator and/or Administrative Nurse re-educated all Licensed Nurses 8/24/2018 on providing supplements as per physician order and addressing weight changes with Registered Dietitian. Staff not available for training by set date will be educated before next working shift. The Director of Nursing and Interdisciplinary Team will review weight changes weekly in Standards of Care meeting. 4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit 5 residents receiving supplements to assure supplements are being given as per physician order and all residents with weight changes are addressed with interventions 3 times a week for 1 month, then once a week for 2 months. 5. Data results will be reviewed and analyzed at the center's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as	

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progress note did not address that Resident #50 had experienced a recent weight loss specifically between April 2018 and May 2018.

Review of Resident #50's Care Plan dated 7/12/18, which continued from 7/12/17 revealed the resident had a nutritional risk as her intake by mouth varied. Resident #50 had a goal for no significant weight change with intake by mouth no greater than 75%. The interventions included daily weights times three weeks, then weekly weights times 4 weeks. Diet supplements as ordered. Monitor weights, intake by mouth and labs as available.

Review of Resident #50's weights for a six month period revealed the resident had experienced the following weight loss:

1/3/18 163
2/12/18 165
3/10/18 164
3/14/18 163
4/10/18 165
5/1/18 152.8 (note a 7.4 % weight loss since 4/10/18)
6/27/18 153
7/9/18 152 pounds

During a breakfast observation and interview on 8/2/18 at 8:53 AM, Nursing Assistant (NA#5) revealed a week to a week and a half, Resident #50 was not eating as good. She revealed Resident #50 was eating 50 to 75% and she was doing much better now.-She stated Resident #50 did not get supplements during meals because she would not eat anything else. She revealed Resident #50 would stop eating if she was not prompted to eat.

needed.

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During an interview on 8/2/18 at 1:30 PM, the facility Dietician stated she knew Resident #50 lost weight and she said she must have missed it by not updating the resident's care plan to address the weight loss. She revealed Resident #50 had been fine for several years and the speech therapist had evaluated her for texture. She stated they were concerned about her weight loss and she didn't know why she did not document it. The Dietician confirmed she did not put intervention(s) in place to address Resident 50's recent weight loss.

During an interview on 8/2/18 at 1:52 PM, the MDS Coordinator revealed the last time Resident #50's Care Plan was updated was 7/12/18. She stated if Resident #50 had weight loss, the Dietician would look at any weight changes and would make a note if there was a weight change.

During an interview on 8/2/18 at 3:17 PM, the Director of Nursing (DON) revealed Resident #50 gained a lot of weight when she was initially admitted to the facility and she gained a few pounds here and there. She stated it would be up to the Dietician to make a note about Resident #50's weight loss. She stated it would have benefited her to lose weight because her thyroid level was abnormal. She revealed the Dietician should have addressed the weight loss at the time of the weight loss and even if it was a good thing for Resident #50 to lose weight, the Dietician should have documented it. She stated she would have expected the Dietician to update Resident #50's Care Plan.

During an interview on 8/3/18 at 11:22 AM the Administrator revealed her expectation would be

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that the Dietician would address weight loss and note the reason for weight loss and implement measures to address the weight loss.

2. Resident #33 was admitted to the facility on 3/10/15 with diagnoses including Diabetes Mellitus, Chronic Ischemic Heart disease, Hemiplegia and Hemiparesis following a Cerebrovascular Accident and Dementia.

Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 6/14/18 identified Resident #33 as moderately cognitively impaired. He did not exhibit behaviors. He was an extensive two person assist with bed mobility and transferring and required extensive one person assistance with eating. Resident #33 had both upper and lower extremity range of motion impairment to one side. He was not receiving Speech, Physical or Occupational therapy. He was not in a Restorative nursing program or receiving splint or brace assistance.

Review of the Physician's Order dated 10/18/16 documented an order for a Glucose control nutritional supplement one container three times per day at 8AM, 12PM and 4PM.

Review of the Medication Administration Record (MAR) for 2/2018 through 8/2018 documented an order for a Glucose Control nutritional supplement one container three times a day and was documented as given.

Review of the Care Plan, revised on 10/11/17, documented a focus area for Resident #33 being at a nutritional risk related to skin integrity.

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Interventions included supplement as ordered.

Review of Resident #33's weight record documented a 2/12/18 weight of 220 pounds and his recorded weight on 8/2/18 was 200.5 pounds. This reflects an 8.9% weight loss in six months.

Review of Resident #33's Nutritional note dated 3/13/18 documented no significant weight change. His current weight was 218 pounds. His intake was 50-100%. He was receiving supplements three times per day. No nutritional changes were recommended.

Review of Resident #33's Nutritional Therapy review dated 6/12/18 documented at the resident had chewing difficulty and swallowing problems, which included coughing or choking during meals. Physical findings were noted as obesity. His current weight was 207 pounds. No new recommendations were made. There was no documentation related to weight loss.

Observations on 8/1/18 at 8:49 AM during the breakfast meal did not reveal any supplement on the resident's bedside table or meal tray.

Observations on 8/1/18 at 1:03 PM of lunch did not reveal any supplement on the resident's bedside table or meal tray.

During an interview with Nurse #1 on 8/1/18 at 9:07 AM she stated the resident received a Glucose Control supplement three times daily, but she did not know who was responsible for giving this to the resident and stated it must come from dietary.

During an interview with Nursing Assistant (NA) #

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1 on 8/1/18 at 9:10 AM she stated the resident did not have a supplement on his meal tray and she thought the nurse gave that to him.

During an interview with the Dietary Manager on 8/02/18 at 9:22 AM she stated dietary was not responsible for supplements on the meal trays that nursing provided supplements.

During an interview with the Registered Dietician on 8/2/18 at 9:49 AM she stated Resident #33 should be getting supplements with med pass.

During an interview with the Director of Nursing on 8/2/18 at 10:01 AM she stated all supplements are given by the nurses and are on the medication cart. The nurses are expected to give the supplements and chart as such. If the supplement isn't given the nurse should not chart it as given.

During a follow up interview with Nurse #1 on 8/02/18 at 10:15 AM she stated that she documented the Glucose Control supplement as given on the MAR because typically the supplements come through dietary on the meal tray and she assumed Resident #33 received the supplements. She stated she was informed today that nurses are responsible for providing the supplements. She stated she went to get a Glucose control supplement from the supply room and the facility did not have the type of supplement ordered.

During a follow up interview with the Registered Dietician on 8/02/18 at 10:35 AM she stated that about six months ago the facility stopped carrying the glucose control supplement that Resident #33 had been ordered. She stated she did not know

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F 692	Continued From page 44 why this was not addressed or the weight loss on any notes and stated the resident probably had not received the glucose control nutritional supplement since the facility did not carry that any longer. She further stated he did drop weight during the last six months; however, she stated she probably would not have made any changes because Resident #33 was still above his ideal weight. During an interview with the Nurse Consultant on 8/02/18 at 2:14 PM he stated the facility switched supplements about 6 months ago and it was not changed on Resident #33's MAR. He did not know if the resident had received an alternative supplement. During an interview with the Administrator on 8/3/18 at 10:40 AM she stated the nutritional supplements should have been given as ordered.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and	F 693		8/29/18

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F 693	Continued From page 45 §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interviews, the facility failed to administer nutrition through a gastrostomy tube as ordered, for 24 hours, and failed to document the correct amount given for 1 of 2 residents (Resident # 46) observed for tube feeding. The findings included: Resident # 46 was re-admitted to the facility on 7/14/2017 with diagnoses to include multiple sclerosis, and gastrostomy status with percutaneous endoscopic gastrostomy tube (PEG). Her annual Minimum Data Set (MDS) assessment dated 6/27/2018 revealed her cognition to be severely impaired and she required extensive to total assistance from staff for activities of daily living. She required over 50% of food and nutrition thru the PEG tube. Resident #46s electronic medical record revealed her weight for the previous 6 months to be as follows: 2/12/2018 - 115 pounds (#) 3/6/2018 - 115 # 4/9/2018 - 113.5 # 5/2/2018 115.5 # 6/27/2018 121.5# 7/18/2018 119.5 #	F 693	1. Resident #46's feeding bottle and tubing was changed and pump settings re-programed by Director of Nursing on 7/31/2018 at 1:00 pm; then feeding continued as per physician order. 2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 with current resident population on all residents with eternal feedings to ensure feedings are given as per physician order. 3. The Staff Development Coordinator and/or Administrative Nurse re-educated all Licensed Nurses 8/24/2018 on eternal feeding administration. Staff not available for training by set date will be educated before next working shift. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will ensure eternal feedings are given as ordered during observation and audits that will be reviewed in Clinical Morning meeting. 4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit 5 residents receiving eternal feeding to assure	

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F 693	Continued From page 46 Physician Orders dated for July 2018 included orders as follows: Enteral nutrition: 150 cubic centimeters (cc) bolus of Jevity (nutrition) 1.5 every 4 hours for a total of 900 cc in 24 hours. Flush feeding tube with 100 milliliters (ml) of water every 4 hours. Resident #46s Medication Administration Record (MAR) for July 2018 recorded on the date of 7/30/2018 and 7/31/2018 the following: 7/30/2018: Day 360 ml nutrition feeding (MLF) 300 ml water (MLW) Evening 360 MLF 300 MLW Night 360 MLF 300 MLW 7/31/2018: Day 360 MLF 300 MLW On 7/31/2018 at 9:03 AM, an observation was conducted of a tube feeding for Resident # 46. The front of the bottle was written on with a black marker and dated as 7/30 start 1330 (1:30 PM). The bottle appeared full and was connected to tubing which ran thru an electronic programmable pump. The face of the pump showed flush 100 ml every 4 hours and was running with 501 ml recorded, and 150 ml/hour bolus, with 0 bolus	F 693	supplements are being given as per physician orders are being followed and infusing properly 3 times a week for 1 month, then once a week for 2 months. 5. Data results will be reviewed and analyzed at the center's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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CONCORDIA TRANSITIONAL CARE & REHAB-ELIZABETH CITY	901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909

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recorded. Another full unopened bottle was lying on the resident's chest of drawers across from the resident's bed.

On 7/31/2018 at 1:59 PM, an observation was conducted of Resident #46s tube feeding bottle, which was the same bottle dated as 7/30 start 1:30 PM and appeared full.

On 7/31/2018 at 2:22 PM, an interview was conducted with Nurse #5 at the bedside of Resident #46, who stated the pump must have been erased because she was unable to see how much feeding had been recorded. The nurse requested to get some help and returned with Nurse #3. Nurse #3 measured the full bottle hanging with an unopened full bottle and stated the bottle was full and was good for 48 hours. Nurse #5 stated she sometimes fed the resident manually with syringe, but she did not do that today as there was no other bottle of feeding in the room, and she used the pump to deliver the feeding today. The nurse stated she documented the feeding was given on the MAR because she knew that was the amount of feeding the resident was supposed to get.

On 7/31/2018 at 2:42 PM, an interview was conducted with the Director of Nursing (DON) at the bedside of Resident # 46 and stated the feeding bottle was full and it appeared the pump had only delivered water and not the feeding. The DON stated if the tubing had not been changed the bottle would be good for 48 hours, but since there was no date on the tubing the whole set up would be changed now.

On 8/1/2018 at 7:48 AM, an interview was conducted with Nurse #10. The nurse stated she

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worked the 3:00 PM to 11:00 PM shift on 7/30/2018 and she documented Resident # 46s feeding had been delivered because when she observed the bottle dated 7/30 at 1:30 PM, there was 600 to 700 ml left in the bottle. The nurse stated she figured up what the amount should be given during her shift and that is what she documented on the MAR. The nurse stated the bottle was full enough that it did not need to be changed on her shift.

On 8/1/2018 at 7:59 AM, an interview was conducted with Nurse #11. The nurse stated she worked on the 11:00 PM to 7:00 AM shift on the night of 7/30/2018. The Nurse stated she gave Resident #46 medication at midnight and 6:00 AM, and she noticed the bottle was dated as 7/30, but did not look at the time. The nurse stated she would admit that she did not look closely at the bottle to make sure the feeding was being delivered.

The nurse who hung the bottle on 7/30/2018 at 1:30 PM was an agency nurse and was unavailable for interview.

On 8/3/2018 at 8:07 AM, an interview was conducted with Nurse #9, with the DON present. The nurse stated she had documented the feeding amount as 360 ml, and water as 300 ml because she had the choice on the electronic MAR to click a button for the previous amount documented and did not have to figure up what the amount should be.

On 8/3/2018 at 8:07 AM, an interview was conducted with the DON who stated she expected the nurses to document the correct amount of tube feeding given and expected the

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F 693	Continued From page 49 nurses to look at the tube feeding pump and bottle to sign off what amount of tube feeding was actually given.	F 693		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth 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	F 756		8/29/18

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F 756	Continued From page 50 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 observations, record review, staff interview, staff physician and Pharmacy Consultant interview, the Pharmacy Consultant failed to identify and address the long-term use of an antibiotic eye drop for 1 of 1 resident reviewed for antibiotic usage (Resident #41). The findings included: Resident #41 was admitted to the facility on 9/12/17 and re-admitted on 10/17/17 with diagnoses including Alzheimer's Dementia and Atrial Fibrillation. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated 6/22/18 identified Resident #41 as being severely cognitively impaired. The MDS did not document antibiotic usage. Review of the Medication Administration Records dated 10/17/17 through 8/3/18 documented Resident #41 was receiving Gentamycin Sulfate Solution 0.3% (eye drops), one drop to both eyes each evening at bedtime for redness. According to the package insert Gentamicin sulfate ophthalmic solution 3% is indicated in the topical treatment of ocular bacterial infections. During an observation on 8/2/18 at 11:20 AM, Resident #41 was in her room sitting up in her	F 756	1. Resident #41, charge nurse received order to discontinue medication on 7/31/2018; medication discontinued 7/31/2018. 2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 with current resident population who receive anti-biotic medication to ensure stop date. 3. The Staff Development Coordinator and/or Administrative Nurse re-educated all Licensed Nurses 8/24/2018 on obtaining stop dates for anti-biotics ordered. Staff not available for training by set date will be educated before next working shift. The Director of Nursing and Interdisciplinary Team will review new anti-biotic orders in Clinical Morning meeting. 4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit all anti-biotic orders for stop dates 3 times a week for 1 month, then once a week for 2 months. 5. Data results will be reviewed and analyzed at the center's monthly Quality	

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F 756	Continued From page 51 wheelchair. She was wearing glasses and no drainage or redness was noted in her eyes. During an interview with the Unit Manager on 8/2/18 at 1:28 PM she stated she would need to research why the resident was receiving the medication. The Unit Manager did not return with a diagnosis for the medication. During an interview with the Regional Nurse Consultant on 8/2/18 at 3:43 PM he stated the medication had been discontinued as of today. During an interview with Resident #41's primary care physician on 8/3/18 at 9:07 AM he stated sometimes folks come in with chronic Blephritis and need the medications. He further stated the medication was discontinued yesterday. During an interview with the Administrator on 8/3/18 at 10:40 AM she stated the eye drops were discontinued. She further stated the pharmacist should have made a recommendation for an appropriate diagnosis for the use of the drops and addressed when the medication should have been discontinued. Attempts to contact the Pharmacy Consultant during survey were made and unsuccessful. During an interview with the Pharmacy Consultant on 8/6/18 at 2:47 PM by telephone she stated that the Pharmacy Consultant at the time should have addressed the usage of the medication and why it was being used. The Pharmacy Consultant should have also addressed an appropriate stop date for the medication's usage.	F 756	Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	
F 757	Drug Regimen is Free from Unnecessary Drugs	F 757		8/29/18

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F 757 SS=D	Continued From page 52 CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview, physician interview and Pharmacy Consultant interview, the facility administered an antibiotic eye drop without the presence of a diagnosis for 1 of 1 resident reviewed for antibiotic usage (Resident #41). The findings included: Resident #41 was admitted to the facility on 9/12/17 and re-admitted on 10/17/17 with diagnoses including Alzheimer's Dementia and Atrial Fibrillation.	F 757	1. Resident #41, charge nurse received order to discontinue medication on 7/31/2018. Pharmacy Consultant instructed by Nurse Consultant on 7/31/2018 to review all medications during each regular scheduled visit. 2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 with current resident population who receive anti-biotic medication to have a diagnosis.	

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F 757	Continued From page 53 Review of the most recent quarterly Minimum Data Set (MDS) assessment dated 6/22/18 identified Resident #41 as being severely cognitively impaired. The MDS did not document antibiotic usage. Review of the Medication Administration Records dated 10/17/17 through 8/3/18 documented Resident #41 was receiving Gentamycin Sulfate Solution 0.3% (eye drops), one drop to both eyes each evening at bedtime for redness/dry eye. According to the package insert Gentamicin sulfate ophthalmic solution 3% is indicated in the topical treatment of ocular bacterial infections. During an observation on 8/2/18 at 11:20 AM, Resident #41 was in her room sitting up in her wheelchair. She was wearing glasses and no drainage or redness was noted in her eyes. During an interview with the Unit Manager on 8/2/18 at 1:28 PM she stated she would need to research why the resident was receiving the medication. The Unit Manager did not return with a diagnosis for the medication. During an interview with the Regional Nurse Consultant on 8/2/18 at 3:43 PM he stated the medication had been discontinued as of today. During an interview with Resident #41's primary care physician on 8/3/18 at 9:07 AM he stated sometimes folks come in with chronic Blephritis and need the medications. He did not confirm a diagnosis. He further stated the medication was discontinued yesterday.	F 757	3. The Staff Development Coordinator and/or Administrative Nurse re-educated all Licensed Nurses 8/24/2018 on obtaining a diagnosis for anti-biotics ordered. Staff not available for training by set date will be educated before next working shift. The Director of Nursing will review all anti-biotic orders monthly with pharmacist to ensure diagnosis. 4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit all anti-biotic orders for diagnosis 3 times a week for 1 month, then once a week for 2 months. 5. Data results will be reviewed and analyzed at the center's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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F 757	Continued From page 54 During an interview with the Administrator on 8/3/18 at 10:40 AM she stated the eye drops were discontinued. She further stated the pharmacist should have made a recommendation for an appropriate diagnosis for the use of the drops and addressed when the medication should have been discontinued. Attempts to contact the Pharmacy Consultant during survey were made and unsuccessful. During an interview with the Pharmacy Consultant on 8/6/18 at 2:47 PM by telephone she stated that the Pharmacy Consultant at the time should have addressed the usage of the medication and why it was being used. The Pharmacy Consultant should have also addressed an appropriate stop date for the medication's usage.	F 757		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews, the facility failed to maintain a medication error of less than 5%, with 5 medication errors from 25 opportunities, resulting in a medication error rate of 20% for 3 of 4 residents (Resident #5, #35 and #7) reviewed for medication administration. The findings included:	F 759	1. Resident's #5 and #35 were assessed by the charge nurse on 7/31/2018 with no negative outcomes. 2. The Staff Development Coordinator completed medication competencies including medication test on nurse #4 and #5 on 7/31/2018 and 8/01/2018. 3. The Staff Development Coordinator	8/29/18

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F 759	Continued From page 55 1. During a medication administration observation on 7/31/2018 at 8:10 AM, Nurse #4 was observed passing medications to Resident #5. The nurse was observed to dispensed 8 tablets one at a time into a small plastic cup including a vitamin D 1000 (international units) IU tablet. The nurse was asked to verify the number of medications in the plastic cup and she counted and answered that she had 8 medications. The nurse stated she needed to crush the medications, and mix them with applesauce. The nurse dispensed the medications with the applesauce to Resident #5 and then gave the resident 1 spray into each nostril of Fluticasone suspension nasal spray. During medication reconciliation (medications given are compared to what was ordered), it was discovered the Physician order was written for Vitamin D 2000 IU one time per day for supplement. The Fluticasone suspension nasal spray was written on the Physician orders as 2 sprays in both nostrils one time a day for nasal congestion. On 7/31/2018 at 8:39AM, an interview was conducted with Nurse #4, who stated she gave the Resident 2 tablets of Vitamin D to make 2000 IU. The nurse stated she said she had 8 tablets in her cup, but she had 9. The Nurse stated she had given Resident #5 2 sprays in both nostrils as the order was written. The nurse then stated she was nervous. 2. On 7/31/2018 at 8:46 AM, a medication administration pass with Nurse #5 was observed for Resident #35. The nurse stated Resident #35's blood pressure was 103/62 and she was to hold the Coreg 12.5 milligram (mg) and Norvasc	F 759	and/or Administrative Nurse re-educated all Licensed Nurses 8/24/2018 on using medication competencies and medication test. Staff not available for training by set date will be educated before next working shift. The Director of Nursing and Interdisciplinary Team will ensure medication error rate below 5% by reviewing audits and observation results in Clinical Morning meeting. 4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit medication pass on all shifts 3 times a week for 1 month, then once a week for 2 months. 5. Data results will be reviewed and analyzed at the center's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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5mg tablets for a blood pressure of less than 110/75. The nurse readied and dispensed 8 other medications to Resident #35.

During a medication reconciliation, it was discovered that the nurse had documented she had also dispensed on 7/31/2018 Diclofenac Gel 1% at 8:46 AM, and Lasix 20mg at 8:47 AM.

Physician orders for the missed medications were listed as follows:
Diclofenac Sodium gel 1%, apply 4 grams transdermally 4 times a day for pain.
Lasix tablet, give 20 mg one time per day related to essential hypertension.

The Medication Administration Record (MAR) noted times for Diclofenac Gel 1% to be administered at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM.

On 7/31/2018 at 12:04 PM, an interview was conducted with Nurse #5, who stated she held the Lasix because she held the blood pressure medications, and she did not notify the Physician the medication was held. The nurse stated she put the Diclofenac Gel on the resident when she arrived at work at 7:00 AM, because that was when she conducted her treatments.

On 7/31/2018 at 3:50 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she expected the nurses to read the Medication Administration Record (MAR) and give what was ordered. The DON stated it was wrong to document that a medication was given when it wasn't given, and she expected the Lasix to be given if there were no parameters to hold it, and the physician should have been notified.

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3. Resident #7 was admitted to the facility on 4/23/17 and re-admitted on 1/29/18 with diagnoses including Hypertension, Atrial Fibrillation, Chronic Respiratory Failure, Dysphagia and Gastrostomy status.

Review of the Physician's Order dated 1/29/18 documented an order for Acetaminophen (Tylenol) Suppository 650 milligrams, insert 1 suppository rectally every 4 hours as needed for elevated temperature; not to exceed 3 grams Acetaminophen in 24 hours.

During an observation of an assessment of Resident #7 on 8/1/18 at 12:30 PM he was noted with an axillary temperature of 98.6 degrees Fahrenheit and pain.

During an observation of a medication pass on 8/1/18 at 12:40 PM with Nurse #1, she placed 650 milligrams of Acetaminophen into a medication cup and crushed the medication. She entered Resident #7's room. The resident's gastrostomy tube (GT) placement was checked for patency. The GT was flushed with 120 cc (cubic centimeters) of water. The Acetaminophen was administered via GT.

During a medication reconciliation, it was discovered that the nurse had documented as given Tylenol suppository 650 milligrams, insert 1 suppository rectally every 4 hours as needed for elevated temperature.

During an interview with Nurse #1 on 8/1/18 at 1:00pm when asked why she gave the Tylenol per GT when the order was written for

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F 759	Continued From page 58 suppository she stated, "really, why would I do that?" She then stated she would delete that entry and get an order for Tylenol per GT, unless there was already a standing orders for this. During an interview with the Director of Nursing on 8/1/18 at 1:15 PM she stated the nurse should have administered the medication as it was ordered, as a suppository. During an interview with the Administrator on 8/03/18 at 10:40 AM she stated the medication should have been given as ordered and documented it was given.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		8/29/18

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F 761	Continued From page 59 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to dispose/discard out of date medications and supplements for 2 of 4 medications carts reviewed for medication storage. The findings included: 1. An inspection of the 100-hall medication cart was conducted on 8/1/2018 at 9:19 AM with the nurse standing beside the medication cart. A bottle labeled as Vitamin E 400 IU had as an expiration date 2/2018. A bottle labeled as Vitamin B 1 100 mg had as an expiration date of 7/2018. A bottle labeled as turmeric curcumin 500 mg had a pharmacy sticker over the expiration date. An interview was conducted with Nurse # 8 immediately following the inspection. The nurse stated the Minimum Data Set (MDS) nurse checked the medication cart all the time, so she was surprised to see the expired medication. The nurse tried to peel the pharmacy sticker that was covering the expiration date off the bottle of turmeric, but only succeeded in tearing up the label, and stated she was unable to say what the expiration date was on the medicine. On 8/2/2018 at 8:43 AM, an interview was conducted with the MDS nurse, who stated she never checked the medication carts for expired medication, and thought the nurse on the cart	F 761	1. All medication carts and medication room were checked for expired medications on 8/01/2018 by the Director of Nursing and Unit Manager(s); no other expired medications were found. 2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 on all medication carts, the medication room, and the central supply room for expired medication. 3. The Staff Development Coordinator and/or Administrative Nurse re-educated all Licensed Nurses 8/24/2018 on checking medication expiration date and removing expired medication from medication cart. 4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit all medication carts for expired medication(s) 3 times a week for 1 month, then once a week for 2 months. 5. Data results will be reviewed and analyzed at the center's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as	

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F 761	Continued From page 60 would be responsible for checking the cart. On 8/2/2018 at 3:04 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the pharmacist checked the carts when she came to the facility and the last check was on 7/25/2018. The DON stated she expected the nurses to check the cart and removed expired medications. 2. An inspection of the 200-hall medication cart was conducted on 8/1/2018 at 9:24 AM with the nurse standing beside the cart. A bottle labeled as Rena-Vite supplement had as an expiration date 5/2018. An interview was conducted with Nurse #1 immediately following the inspection. The nurse stated she was an agency nurse and was not sure who checked the cart for expired medication. On 8/2/2018 at 3:04 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the pharmacist checked the carts when she came to the facility and the last check was on 7/25/2018. The DON stated she expected the nurses to check the cart and removed expired medications.	F 761	needed.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		8/29/18

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agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

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

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

§483.70(i)(4) Medical records must be retained

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F 842	Continued From page 62 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility staff inaccurately documented medications, nutritional supplements and protein supplements as given on the electronic Medication Administration Record for 3 of 3 residents who were observed during a medication pass (Resident #33, #35, and #7), and the facility staff inaccurately documented on the electronic Treatment Administration Record the application of a hand splint for 1 of 1 resident observed for the application of hand splint (Resident #33). The findings included: 1. Resident # 35 was admitted to the facility on 6/9/2017, with diagnoses to include hypertension. Her Minimum Data Set (MDS) assessment dated	F 842	1. Proper documentation updated on 7/31/2018 for enteral feedings given, splint placement, and medications on hold. 2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 with current resident population who receive eternal nutrition, splint application, and physician made aware if any medication were held. 3. The Staff Development Coordinator and/or Administrative re-educated all Licensed Nurses 8/24/2018 on recording correct documentation on eternal feeding amounts, splints, and medications being	

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F 842	Continued From page 63 6/15/2018 revealed her cognition was moderately impaired. Physician orders dated 7/2018 included as orders the following: Coreg (an anti-hypertension) 12.5 milligrams (mg) 2 times per day, hold for a systolic blood pressure (SBP) less than 110, diastolic blood press (DBP) less than 75, heart rate (HR) less than 65. Norvasc (an anti-hypertension) 5 mg tablet 1 time per day, hold for SBP less than 110, DBP less than 75, HR less than 65. Lasix (a diuretic) 20 mg one time per day related to hypertension. Diclofenac Sodium (a topical anti-inflammatory) gel 1%, apply 4 grams transdermally 4 times a day for pain. Ensure (nutritional supplement) 120 milliliters (ml) 1 time per day with medication pass, document percentage consumed. Protein modular powder two times per day for supplement. On 7/31/2018 from 8:46 AM until 8:55 AM, a medication administration pass with Nurse #5 was observed for Resident #35. The nurse stated Resident #35's blood pressure was 103/62 and she was to hold the Coreg 12.5 mg and Norvasc 5mg tablets for a blood pressure of less than 110/75. The nurse readied and dispensed 8 other medications to Resident #35.	F 842	held. Staff not available for training by set date will be educated before next working shift. The Director of Nursing and Interdisciplinary Team will review documentation in Clinical Morning meeting to ensure ongoing compliance. 4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will audit all Licensed Nurses on accurate documentation with eternal nutrition, splints, and Medical Doctor made aware of medication being held and the reason. 3 times a week for 1 month, then 2 times a week for 2 months. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will ensure accurate documentation is complete during audits. 5. Data results will be reviewed and analyzed at the center's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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During the medication reconciliation (medications given are compared to what was ordered) it was discovered that the nurse had documented she had also dispensed Lasix 20 mg at 8:47 AM on 7/31/2018, Ensure nutritional supplement at 8:46 AM with 100% was consumed, Protein powder at 8:46 AM with 100% consumed, and Diclofenac Gel 1% at 8:46 AM, all of which were not observed during the medication administration.

On 7/31/2018 at 12:04 PM, an interview was conducted with Nurse #5, who stated she held the Lasix because she held the blood pressure medications, and she did not notify the Physician the medication was held. The nurse stated she never gave Resident # 35 her ensure because she always refused it, and that is why she didn't ask her if she wanted it. The nurse stated she put the Diclofenac Gel on the resident when she arrived at work at 7:00 AM, because that was when she conducted her treatments. The nurse stated the only mistake she made was the protein powder and it was an honest mistake in that she just forgot to give it. The nurse stated she knew what it meant to document medications that weren't given.

On 7/31/2018 at 3:50 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she expected the nurses to read the medication administration record (MAR) and give what was ordered. The DON stated it was wrong to document that a medication was given when it wasn't given, and she expected the Lasix to be given if there were no parameters to hold it, and the physician should have been notified.

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2. Resident #7 was admitted to the facility on 4/23/17 and re-admitted on 1/29/18 with diagnoses including Hypertension, Atrial Fibrillation, Chronic Respiratory Failure, Dysphagia and Gastrostomy status.

Review of the electronic Medication Administration record (MAR) for August 2018 documented an order for Acetaminophen (Tylenol) Suppository 650 milligrams, insert 1 suppository rectally every 4 hours as needed for elevated temperature; not to exceed 3 grams Acetaminophen in 24 hours.

During an observation of an assessment of Resident #7 on 8/1/18 at 12:30 PM he was noted with an axillary temperature of 98.6 degrees Fahrenheit.

During an observation of a medication pass on 8/1/18 at 12:40 PM, Nurse #1 placed 650 milligrams of Acetaminophen into a medication cup and crushed the medication. She entered Resident #7's room. The resident's gastrostomy tube (GT) placement was checked for patency. The GT was flushed with 120 cc (cubic centimeters) of water. The Acetaminophen was administered into the GT. The nurse was observed to sign the Acetaminophen suppository order as given in the electronic MAR.
During an interview with Nurse #1 on 8/1/18 at 1:00pm, when asked why she gave the Tylenol per GT when the order was written for suppository, she stated, "really, why would I do that?" She then stated she would delete that entry and get an order for Tylenol per GT. She was then observed to enter the computer system and delete the entry for Tylenol suppository.
During an interview with the Director of Nursing

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on 8/1/18 at 1:15 PM she stated the nurse should have administered the medication as it was ordered, as a suppository. The nurse should not have deleted the entry on the Medication Administration Record.

During an interview with the Administrator on 8/03/18 at 10:40 AM she stated the medication should have been given as ordered and documented it was given.

3. Resident #33 was admitted to the facility on 3/10/15 with diagnoses including Diabetes Mellitus, Chronic Ischemic Heart disease, Hemiplegia and Hemiparesis following a Cerebrovascular Accident and Dementia.

Review of the Physician's Order dated 10/18/16 documented an order for a Glucose control supplement, one container three times per day at 8AM, 12PM and 4PM.

Review of the Care Plan, revision dated of 10/11/17, revealed Resident #33 was at nutritional risk related to skin integrity and Diabetes. Interventions to prevent significant weight change included supplements as ordered.

Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 6/14/18 identified Resident #33 as moderately cognitively impaired.

Review of the Medication Administration Record (MAR) for 2/2018 through 8/2018 documented an order for a Glucose Control supplement, one container three times a day and was documented as given.

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Observations on 8/1/18 at 1:03 PM of lunch did not reveal any supplement on the resident's bedside table or meal tray.

During an interview with Nurse #1 on 8/1/18 at 9:07 AM she stated the resident received a Glucose Control supplement three times daily but she did not know who was responsible for giving this to the resident and stated it must come from dietary.

During an interview with Nursing Assistant (NA) # 1 on 8/1/18 at 9:10 AM she stated the resident did not have a supplement on his meal tray and she thought the nurse gave the supplement to the resident.

During an interview with the Dietary Manager on 8/02/18 at 9:22 AM she stated dietary was not responsible for providing supplements on the meal trays that nursing provided supplements.

During an interview with the Registered Dietician on 8/2/18 at 9:49 AM she stated Resident #33 should be getting supplements with med pass.

During an interview with the Director of Nursing on 8/2/18 at 10:01 AM she stated all supplements were given by the nurses and were on the medication cart. The nurses were expected to give the supplements and chart as such. If the supplement isn't given the nurse should not chart it as given.

During a follow up interview with Nurse #1 on 8/02/18 at 10:15 AM she stated that she documented the Glucose Control supplement as given on the MAR because typically the supplements came through dietary on the meal

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tray and she assumed he received the supplements. She stated she was informed today that nurses were responsible for providing the supplements. She stated she went to get the Glucose control supplement from the supply room and the facility doesn't even have this type of supplement.

During a follow up interview with the Registered Dietician on 8/02/18 at 10:35 AM she stated that about six months ago the facility stopped carrying the glucose control supplement that the resident was receiving. She stated she did not know why this was not addressed on any notes and stated the resident probably had not received the supplement since the facility did not carry that any longer.

During an interview with the Nurse Consultant on 8/02/18 at 2:14 PM he stated the facility switched supplements about 6 months ago and it was not changed on the MAR.

During an interview with the Administrator on 8/3/18 at 10:40 AM she stated the supplements should have been given as ordered.

4. Resident #33 was admitted to the facility on 3/10/15 with diagnoses including Diabetes Mellitus, Chronic Ischemic Heart disease, Hemiplegia and Hemiparesis following a Cerebrovascular Accident and Dementia.

Review of the Care Plan, revision date 5/21/15, revealed Resident #33 as having an ADL Self-care performance deficit related to his Cerebrovascular Accident with hemiparesis (left sided weakness). Interventions for improving the current level of function included a left hand splint

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as ordered.

Review of the Care Area Assessment dated 3/16/18 documented Resident #33 required Activities of Daily Living (ADL) assistance and had contractures.

Review of the Physician's Order dated 4/3/18 read Resident #33 was discharged from Occupational Therapy services. The resident was to receive passive range of motion (PROM) to the left shoulder, elbow, wrist and digits daily prior to putting on a hand splint with built up digit support.

Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 6/14/18 identified Resident #33 as moderately cognitively impaired with a Brief Interview for Mental Status score of 8 (on a scale of 00-15 with 15 being cognitively intact). He did not exhibit behaviors.

Observations of Resident #33 on 7/31/18 at 11:54 AM revealed he was up in his wheelchair for lunch. He was observed with a contracture to the left hand and there was no visible hand splint in place.

Observations on 7/31/18 at 1:35 PM revealed Resident #33 in his wheelchair with no left hand splint in place.

Observations on 7/31/18 at 3:52 PM revealed Resident #33 in bed with no hand splint in place.

Observations on 8/1/18 at 7:51 AM revealed Resident #33 in bed with no hand splint in place.

Observations on 8/1/18 at 11:28 AM revealed

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Resident #33 was in bed with no hand splint in place.

Observations on 8/2/18 at 8:06 AM revealed Resident #33 in bed with no hand splint in place.

During an interview on 8/01/18 at 9:08 AM with NA #1 she stated the resident did not wear wrist splits. She further stated he could not use his left hand at all.

During an interview with the Occupational Therapist (O.T.) on 8/02/18 at 8:42 AM she stated Resident #33 had always had a hand splint and in March 2018 a new one was ordered. She stated she worked for approximately two weeks with the resident doing passive range of motion and using the hand splint. She further stated at the end of two weeks she informed the nurse and the nursing assistant of the splint and how and when to use it. She stated there was no restorative program at the facility and this meant the nursing assistants were responsible for doing the passive range of motion and applying the splint. She stated she had placed the splint in the top dresser drawer. The O.T.walked down to Resident #33's room. NA#3 was in the room. The O.T. pulled the splint out of the top dresser drawer and showed the NA#3 how it was to be used. NA #3 stated, "Ok." The O.T. then looked at the resident's left elbow and stated "I smell skin". She attempted to move the left elbow and the muscle was tight. She stated she would do an evaluation and most likely place an elbow splint on the left elbow to keep the elbow from further contracture. She stated it was very important to do the PROM exercises to keep the muscles from getting tight.

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F 842	Continued From page 71 During an interview on 8/02/18 at 1:32 PM with Resident #33 he stated he had not had a splint on all day. During an interview with NA #3 on 8/02/18 at 1:32 PM she stated she did not have the resident on her shift today that NA #2 had him. During a follow up interview with NA #3 on 8/02/18 at 1:34 PM she stated she had worked with the resident before and there had never been a splint in the room. During an interview with NA #2 on 8/02/18 at 1:34 PM she stated she had not worked with the resident before today and had no idea he was to wear a splint. During an interview with the Nurse Consultant on 8/02/18 at 2:14 PM he stated the splint did not get on the Medication Administration Record because the nurse keyed it in wrong so it never showed up to be done. During an interview on 8/2/17 at 2:48 PM with the Director of Nursing she stated the order for the splint was not transferred correctly to the Medication Administration Record but it was on the Kardex. She stated the Kardex was created from the care plan and the nursing assistants could see this in point of care, either at the nursing station, on the wall station or their hand-held device. She stated the hand splint should have been in place as ordered and the TAR should have been documented as done if the splint were on.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/29/18

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	345184	A. BUILDING _____ B. WING _____	C 08/03/2018

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F 880	Continued From page 72 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 73 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to disinfect glucometers per the manufacturer's recommendations after use to check blood sugars for 2 of 2 residents (resident #45, and resident #78) observed for blood sugar checks. The findings included: The facility's policy titled Cleaning and Disinfecting Glucometer, dated as revised on	F 880	1. All blood glucose machines were disinfected by Staff Development Coordinator on 8/01/2018. 2. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse performed a one-time audit 8/17/2018 on competency of all Licensed Nurses for blood glucose machines disinfecting procedure per policy and procedure.	

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F 880	Continued From page 74 10/30/17 read: "Step 9: Wipe the entire surface of the meter 3 times horizontally and 3 times vertically to remove blood-borne pathogens. Step 10: Dispose of the used towelette in a trash bin. Step 11: allow exteriors to remain wet for the appropriate contact time and then wipe the meter using a dry cloth." Glucometers manufacturer's recommendations for cleaning and disinfecting were reviewed, and the facility used one of the recommended disinfectant cloths. The disinfecting instructions read: "Step 8: Allow exteriors to remain wet for the appropriate contact time and then wipe the meter using a dry cloth." The manufacturer recommended wipe instructions were visible on the wipe container as follows: "Allow treated surface to remain wet for a full two minutes. Let air dry." The non-recommended germicidal/disinfectant wipe instructions were visible on the wipe container as follows: "Treated surface must remain visibly wet for a full 4 minutes. Use additional wipe(s) if needed to assure continuous 4 minutes wet contact time." An observation of a blood sugar check was conducted on 8/1/2018 at 10:59 AM with Nurse #6, and Nurse #7, for Resident # 45. Nurse #6 gathered supplies and put them in a plastic cup. The Nurse wiped the glucometer for 10 seconds at 11:08 AM with the non-recommended wipes, and threw the wipe away. Nurse #7 stated, "according to the instructions on the wipe container, we have to let the glucometer air dry for 4 minutes." The glucometer was placed in a cup. At 11:11 the nurses agreed the glucometer was dry, but stated they needed to wait the 4 minutes before they could use it. The blood sugar was obtained by Nurse #6, and then she	F 880	3. The Staff Development Coordinator and/or Administrative Nurse re-educated all Licensed Nurses 8/24/2018 on disinfecting glucometers per policy and procedure. Staff not available for training by set date will be educated before next working shift. The Director of Nursing and Interdisciplinary Team will review audits in Clinical Morning meeting to ensure ongoing compliance. 4. The Director of Nursing, Staff Development Coordinator, and/or Administrative Nurse will observe all Licensed Nurses on proper cleaning of glucometers 3 times a week for 1 month, then 2 times a week for 2 months. 5. Data results will be reviewed and analyzed at the center's monthly Quality Assurance and Performance Improvement meeting for three months with a subsequent Plan of Correction as needed.	

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F 880	Continued From page 75	F 880		

wiped the glucometer for 10 seconds with a disinfectant wipe at 11:18 AM. The nurse set the glucometer in a cup to air dry. A request was made of Nurse #7 to read the instructions on the wipe container, to which she replied the label said visibly wet for 4 minutes. The nurse stated the glucometer was not wet for 4 minutes. The nurses could not decide if the glucometer was disinfected or not.

A second observation of a blood sugar check was conducted on 8/1/2018 at 11:56 AM with Nurse #1 for the Resident #78. The nurse stated she needed to clean her machine and wiped the glucometer for 10 seconds with a recommended wipe, and then folded the wipe and set the glucometer on the wipe. The nurse obtained the blood sugar and then used the same folded wiped and swiped across the top of the glucometer 2 times and set the glucometer on the medication cart and threw the wipe away. The nurse stated the resident needed insulin and she did not have needles on her cart, so she dropped the glucometer in the medication cart and left to get a needle.

On 8/1/2018 at 12:08 PM, an interview was conducted with Nurse #1. The nurse stated she cleaned the glucometer before and after the blood sugar check, but the glucometer had not remained wet for 2 minutes as indicated on the wipe container.

On 8/1/2018 at 12:24 PM, an interview was conducted with the Staff Development Coordinator (SDC). The SDC nurse stated the wipes should be used for a couple of minutes to clean the glucometer. She stated the 4-minute wipes were generally used for someone in

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F 880	Continued From page 76 isolation. On 8/2/2018 at 2:52 PM, an interview was conducted with the Director of Nursing (DON). The DON stated her expectations for glucometer cleaning was the 2-minute wipes should be used for 2 minutes and the 4 minutes wipes should be used for 4 minutes for cleaning before the glucometers were used on the next resident.	F 880		