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	345049	A. BUILDING _____ B. WING _____	C 02/28/2019

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E 000	Initial Comments An unannounced Recertification/Complaint Investigation suvey was conducted on 02/24/19 through 2/28/19. The facility was found in compliance with the required CFR 483.73, Emergency Preparedness. Event ID# QN9Y11.	E 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a Significant Change Minimum Data Set (MDS) within the 14 days required for 1 of 29 residents (Resident #95) whose MDSs were reviewed. Findings included: Review of the annual MDS dated 01/06/19 revealed Resident #95 was severely cognitively impaired. He had no behaviors and did not reject care. Resident #95 needed the assistance of staff for bed mobility, dressing, hygiene, eating and toilet use. Review of the Entry Tracking Record MDS	F 637	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged, or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. F 637 1. Resident #95 had expired and the discharge return not anticipated assessment had been completed and	3/18/19

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

Electronically Signed | 03/15/2019

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F 637	Continued From page 1 revealed Resident #95 was re-admitted to the facility on 01/14/19 following a hospital stay. Review of the MDS records from 01/14/19-02/08/19 revealed no Significant Change MDS for Resident #95. Review of the Physician's Orders dated 01/15/19 revealed Resident #95 was re-admitted to hospice for end of life care. Resident #95 had previously been admitted to hospice on 01/08/19 prior to his most recent hospitalization. In an interview on 02/27/19 at 12:15 PM the MDS Nurse stated that she did not know Resident #95 had been re-admitted to the facility or that he had been re-admitted to hospice. She indicated that residents were discussed in the facility's morning meetings, which she attended, but that Resident #95's status had not been discussed. The MDS Nurse indicated that a resident being placed on hospice necessitated a Significant Change MDS and that the facility had 14 days to submit the change. She stated that since Resident #95 had gone out to the hospital and then had been re-admitted the Significant Change MDS should have been submitted by 01/29/19 and it was not. In an interview on 02/28/19 at 11:45 AM the Director of Nursing (DON) stated he expected Significant Change MDSs to be done as required according to the RAI (Resident Assessment Instrument) manual.	F 637	accepted so no other corrective action can be competed for this resident. 2. An audit of Minimum Data Set (MDS) was completed by the Clinical Reimbursement Director (CRD) on 2/28/19 of all residents identified with orders for hospice to ensure the MDSs correctly reflected their hospice status. If the MDS did not reflect the hospice status, a significant change assessment was completed and submitted to remain in compliance with the Resident Assessment Instrument (RAI) Manual. 3. The Clinical Reimbursement Director (CRD) and the Clinical Reimbursement Staff (CRS) were in-serviced by the Regional Clinical Process Analyst on 2/28/19 regarding accurately coding of the MDS. Any resident admitted with or acquire new orders for hospice will be reported in the Daily Clinical Meeting as a means for informing the CRD and CRS of hospice orders, so they can be accurately reflected on the MDS. Section O of all MDSs of residents identified with hospice orders will be audited by the CRD for the next two months, or until 100% compliance is achieved for two consecutive months, to ensure the MDSs are accurately coded. The results of the audits will be presented to the monthly Quality Assurance Performance Improvement Committee (QAPI) by the DON and the quality monitoring schedule will be modified	

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F 637	Continued From page 2	F 637	based on findings.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (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	F 656		3/18/19

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F 656	Continued From page 3 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 and staff interviews the facility failed to develop a Hospice Care Plan for 1 of 29 residents (Resident #95) whose Care Plans were reviewed. Findings included: Review of the facility care plans revealed that no hospice care plan had been developed for Resident #95. Review of the annual Minimum Data Set (MDS) dated 01/06/19 revealed Resident #95 was severely cognitively impaired. He had no behaviors and did not reject care. Resident #95 needed the assistance of staff for bed mobility, dressing, hygiene, eating and toilet use. Review of the Entry Tracking Record MDS revealed Resident #95 was re-admitted to the facility on 01/14/19 following a hospital stay. Review of the Physician's Orders dated 01/15/19 revealed Resident #95 was re-admitted to hospice for end of life care. Resident #95 had previously been admitted to hospice on 01/08/19 prior to his most recent hospitalization. In an interview on 02/27/19 at 12:15 PM the MDS Nurse stated that she did not know Resident #95 had been re-admitted to the facility or that he had been placed on hospice. She indicated that residents were discussed in the facility's morning	F 656	F656 1. Resident #95 has expired so no other corrective action can be completed for this resident. 2. An audit of Care Plans was completed by the Director of Nursing (DON) on 2/28/19 of all residents identified with orders for hospice to ensure a plan of care is in place for hospice services. If the Care Plan did not reflect the hospice status, the care plan was updated at that time. 3. The Interdisciplinary Team was in-serviced by Regional Clinical Director on 3/13/18 regarding the regulation pertaining to the development and implementation of a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident□s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment to attain or maintain the resident□s highest practicable physical, mental and psychosocial well being. Any resident admitted with or acquire new orders for hospice will be reported in the	

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F 656	Continued From page 4 meetings, which she attended, but that Resident #95's status had not been discussed. In an interview on 02/28/19 at 11:45 AM the Director of Nursing (DON) stated he expected care plans to be developed as required according to the RAI (Resident Assessment Instrument) manual. In a follow-up interview on 02/28/19 at 12:51 PM the MDS Nurse indicated that a resident being placed on hospice necessitated the development of a hospice care plan. She stated that since Resident #95 had gone out to the hospital and then had been re-admitted to the facility and re-admitted to hospice a care plan should have been developed and it was not.	F 656	Daily Clinical Meeting as a means for informing the Interdisciplinary Team of hospice orders, so they can be accurately reflected on the Care Plan. 4. The care plans of all residents identified with hospice orders will be audited by the DON for the next two months, or until 100% compliance is achieved for two consecutive months, to ensure the MDSs are accurately coded. The results of the audits will be presented to the monthly Quality Assurance Performance Improvement Committee (QAPI) by the DON and the quality monitoring schedule will be modified based on findings.	
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 observations, physician interview, staff and resident interviews, and record review the facility failed to: 1) provide physician ordered nutritional snacks to 1of 5 residents (Resident #80) reviewed for unnecessary medications, and 2) failed to administer a prescribed as needed diuretic medication to 1 of 29 residents whose orders were reviewed (Resident #160). Findings included:	F 658	F658 1. A. On February 27, 2018 resident # 80 was provided two yogurt cups per her request. A plastic tub was also placed in the resident□s room with snacks of her choice for her consumption. B. The resident was admitted on February 21, 2019 through February 26, 2019 for respite care. Unable to correct due to discharge.	3/18/19

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1) Resident #80 was admitted to the facility on 05/10/16. Diagnoses included, in part, Lung cancer, anxiety, chronic pain, depression, chronic kidney disease, and viral Hepatitis C.

The Minimum Data Set (MDS) significant change assessment dated 01/25/19 revealed the resident was cognitively aware. Resident #80 required supervision with one staff physical assistance with bed mobility, transfers, toileting, and personal hygiene, and was independent with set up only with dressing and meals. She had no impairments, used a walker and a wheelchair and was always continent of bowel and bladder.

A review of the care plan revealed an updated plan of care on 02/14/19 to include at risk for a nutritional/dehydration problem related to diagnosis and weight fluctuations due to new diagnosis of metastatic cancer with good oral intake.

A review of the dietary recommendations written on 02/14/19 revealed recommendations for a fortified diet, weekly weights for 4 weeks, and nutritional treats three times a day for supplement.

A review of the Medication Administration Record (MAR) revealed the resident had an order for nutritional treats three times a day for supplement starting on 02/14/19. The MAR indicated on 02/14/19 through 02/27/19 the resident received a nutritional treat at 9:00 AM, 1:00 PM and 5:00 PM as evidenced by the nursing initials.

An interview was conducted with Resident #80 on 02/24/19. Resident #80 stated she was not

2. On February 27, 2018 the residents were interviewed to determine the type of snack they would like to have included in the pantry on each floor. On February 28, 2019 these snacks are always available in each unit. Snacks that are ordered by the attending physician are delivered to the nursing units at 10 am, 14:00 and 20:00. The nurses ensure these snacks are passed to the specific residents.
3. On March15, 2019 an audit was completed by the Administrative Nursing Team of all admissions for the past 30 days to ensure all medications indicated on the transfer sheets is entered into the electronic system as ordered and all admissions have a recorded height and weight entered into the system.
The Administrator, Assistant Administrator and Director of Nursing or Assistant Director of Nursing will meet with the resident council weekly for 4 weeks to ensure the snacks of choice are being passed. Any identified areas of concern will be addressed upon identification.
On March 15, 2019 through March 18, 2019 the RN Staff Development Coordinator completed an in service to all licensed nurses on ensuring medication ordered by the physician are transcribed and administered to the residents as well as monitoring parameters are transcribed and admission heights and weights are obtained.
The Administrative Nursing Team will audit 10 charts per week until 100% compliance is maintained for 2 consecutive months, of the resident

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F 658	Continued From page 6 feeling well and she was receiving radiation due to a recent diagnosis of lung cancer. Resident #80 stated she ate all her meals in her room and did not require any assistance with feeding. Resident #80 stated she had been losing weight due to her cancer. An interview was conducted with Resident #80 on 02/26/19 at 9:00 am. Resident #80 stated no staff member has ever offered her a snack. Resident #80 stated "I get my breakfast, lunch and dinner, but no snacks were offered." Resident #80 reported sometimes her family and friends would bring her a snack. An observation of Resident #80 ' s room revealed there were no snacks available to the resident. An interview was conducted with Resident #80 on 02/26/19 at 4:30 PM. The resident reported she was not offered a snack this morning or this afternoon. Resident #80 reported she was not offered a snack all day on 02/25/19 either. An observation was conducted on Resident #80 on 02/27/19 at 9:00 AM. The resident was alert and oriented and sitting upright in bed. There was no food visible in her room including the side table and bedside table. An interview with Resident #80 on 02/27/198 at 9:00 AM revealed she was waiting for her breakfast. Resident #80 stated "I ' m hungry! I don ' t know why it is taking so long to get my breakfast." Resident #80 stated she had not been offered a snack today. An interview was conducted with NA #1 on 02/27/19 at 9:15 AM. NA #1 stated she was in the process of passing out the trays at this time.	F 658	orders to ensure they are transcribed, administered, and monitored per the MD order. The Director of Nursing will follow up with the licensed nurses as necessary. The Administrative Nursing Team will audit the charts of new admissions to ensure admission heights and weights are obtained until 100% compliance is maintained for 2 consecutive months. 4. The results of the audits will be presented to the monthly Quality Assurance Performance Improvement Committee (QAPI) by the DON and the quality monitoring schedule will be modified based on findings.	

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NA #1 was observed bringing Resident #80 ' s tray to her room. NA #1 reported the resident was alert and oriented and could make her needs known. NA #1 stated she has never brought a snack to the resident.

An observation of the kitchenette on the floor Resident #80 resided on on 02/27/19 at 9:30 AM revealed there were 4/4 oz. juice containers in the refrigerator.

An observation of Resident #80 ' s breakfast tray revealed she had fortified foods listed on her dietary slip. The meal consisted of cold cereal, scrambled eggs, 1 piece of toast, oatmeal, milk and coffee. The resident was noted to have consumed all of the eggs, one piece of toast and the milk and coffee.

An interview with Resident #80 on 02/27/19 at 10:10 AM revealed she ate all of her eggs and toast and some of her oatmeal. Resident #80 reported she had not been offered any kind of snack today.

An interview was conducted with the Registered Dietician (RD) on 02/27/19 at 11:05 AM. The RD reported if there was an order for snacks written for a specific resident, the expectation was the Dietary Manager would provide a variety of nutritional snacks to the assigned floor. The RD stated the snacks were prepared in the kitchen and brought to each kitchenette at 10:00 am for the am snack and the afternoon snack, and at 7:00 PM, additional snacks were brought to each kitchenette for PM snacks. The RD reported she was aware of Resident #80 ' s weight loss and confirmed she ordered the snacks to aid in supplementation. The RD reported due to her

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diagnosis, she was expected to have fluctuations in her weight with the side effects of the cancer treatment therapy. The RD stated it was her expectation of the nursing staff to administer the recommended nutritional treats as ordered and if she was refusing the snacks, then the nurses should be documenting the refusal so that her weight could be monitored closely.

An observation of the kitchenette at 11:15 AM revealed there was a clear plastic bag filled with a variety of snacks including pudding, yogurt, apple juice, apple sauce, animal crackers and goldfish crackers.

An observation of the kitchenette at 2:50 PM revealed the same clear plastic bag filled with a variety of snacks including pudding, yogurt, apple juice, apple sauce, animal crackers and goldfish crackers. The bag had not been moved nor were any items removed since the observation at 11:15 AM.

An interview was conducted with Resident #80 on 02/27/19 at 2:50 PM. The resident reported she ate about 75% of her lunch when she returned from her appointment today. The resident reported she was not offered a snack today. The resident reported she liked yogurt and berries and she also enjoyed cottage cheese and pineapples. The resident reported the staff has not asked her what her likes and dislikes were that she could recall. The resident reported no one has ever offered her a yogurt.

An interview was conducted with Nurse #2 on 02/27/19 at 2:50 PM. Nurse #2 stated if there was a check mark and initials on the MAR under a prescribed order, it meant that the task was

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completed or the medication was given. Nurse #2 stated she offered the resident a snack this morning, but the resident refused. Nurse #2 could not recall the time, but said "I think it was about 9:00 AM." Nurse #2 stated she offered her applesauce from her medication cart. Nurse #2 stated she signed off the MAR even though the resident refused because she offered it. Nurse #2 stated she offered the resident an afternoon snack of applesauce from her medication cart on 02/27/19, but the resident refused. Nurse #2 stated, again, she signed it off on the MAR because she offered it, but the resident refused it. Nurse #2 stated if a resident refused a medication she would not put a check mark on the MAR to indicate it was given.

An interview was conducted with Nursing Supervisor (NS) on 02/27/19 at 3:00 PM. The NS stated if a nurse gave a medication or completed a task she should sign the MAR to indicate the medication and or task was completed or given. If a resident refused the task or the medication, the nurse should not sign off on the MAR that it was given.

An interview was conducted with the Dietary Manager (DM) on 02/27/19 he reported if a resident had specific orders for snacks at specific times, those snacks were included in the snack bag that was brought to the kitchenettes each day and evening. The DM stated it was the nurse ' s responsibilities to ensure the ordered snack was delivered to the resident.

An interview was conducted with the Resident on 02/28/19 at 9:00 AM. Resident #80 reported "Look what I have!" The resident pointed to a bin full of multiple snacks and stated "I ate 3 of my

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snacks and they gave me yogurt two times yesterday, and I ' m going to have another one!"

An interview was conducted with the Administrator on 02/28/19 at 2:00 PM. The Administrator stated his expectation of the nursing staff was to administer the snacks as ordered and to not sign off on the task if it was refused. The Administrator added, in order to better monitor the resident ' s weight loss, the nurse should be documenting in the eMAR why it was refused, and if it continued to be refused, to let the physician know.

2. Resident #160 was admitted to the facility on 02/21/19. The resident's documented diagnoses included congestive heart failure, chronic kidney disease, and diabetes.

The resident's 02/19/19 FL2 form documented she was receiving regularly schedule Bumex (a diuretic medication) 2 milligrams (mg) daily, but was also supposed to receive as needed (prn) Bumex 1 mg daily for weight gains of 3 or more pounds.

The resident's hospice Client Medication Report, available to the facility upon admission, also documented the resident was to receive prn Bumex "every morning for wt (weight) gain of 3 lbs (pounds) or more."

Review of Resident #160's orders in the facility's electronic medical record revealed there was an order for the resident's regularly scheduled Bumex, but not for her prn Bumex.

Review of Resident #160's nursing admission assessment revealed there was no height or weight recorded in the document. Review of

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Resident #160's electronic weight history revealed no weights had been obtained for the resident during her nursing home stay.

A 02/21/19 8:32 PM admission progress note documented Resident #160 had 4+ pitting edema and discoloration to her bilateral lower extremities. The note also documented the resident was alert and oriented to person, place, and time. The resident had no complaints of pain or discomfort.

A 02/26/19 5:32 PM progress note documented Resident #160 was discharged home with family, and at the time of discharge her respirations were even and unlabored.

During an interview with the Assistant Director of Nursing (ADON) on 02/27/19 at 3:28 PM she stated when residents were admitted to the facility the medications that were entered into the electronic medical record system were the ones listed on the FL2 form. However, she reported she thought she recalled on the day of admission a family member informing the staff that Resident #160 did not need her prn Bumex.

During a telephone interview with Nurse #11, the nurse who admitted Resident #160 to the facility on 02/21/19, she stated the resident entered the facility by herself on a stretcher. She reported she talked with family on the phone the day of admission, but she commented she did not remember the family making any comments about the resident not needing a medication. According to Nurse #9, she put an X by each medication listed on the hospice Client Medication Report as she placed an order for it into the electronic medical record system. (There

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was a X by the prn Bumex, but the order for it was not found in the resident's electronic medical record). Nurse #9 commented this was the first time she had to put a new admit into the electronic record.

During an interview with the Director of Nursing (DON) on 02/27/19 at 4:48 PM he stated the facility would administer medications as ordered by hospice. He reported he would expect the responsible party (family member) and the physician to have a conversation and reach a joint decision if there were medications the family thought were unnecessary. He commented if there was a hospice order for medication administration based on the resident's weight then he would expect the resident to be weighed daily.

During an interview with Nurse #4 on 02/28/19 at 9:27 AM she stated the facility administered the medications listed on the admitting FL2 form unless the family or facility had some concerns and approached the primary physician who could decide to discontinue medications or change their dosage or time of administration. She reported if such occurred, a progress note should document the decision and the rationale behind it.

During an interview with Nurse #5 on 02/28/19 at 9:45 AM she stated the facility administered medications as they were documented on the FL2 form. She reported family did not have the right to dictate what medications the resident did and did not receive. She explained that if family disagreed with medication documentation on the FL2 form then they needed to meet with the primary physician to discuss their concerns.

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F 658	Continued From page 13 During an interview with Physician #1 on 02/28/19 at 11:13 AM he stated the facility would honor the medication orders on the FL2. If modifications were sought to the FL2 medication regimen, he reported family of Resident #160 should have contacted hospice. He commented weight was only one indicator of increased congestive heart failure risk, but he remarked he thought a good description of signs and symptoms from the nurse daily was a better assessment tool. According to the physician, one of his physician assistants (PAs) would make a decision daily about the need for prn Bumex. However, he stated not gathering daily weights as a tool for prn diuretic use increased the chance that Resident #160 could have gone into congestive heart failure.	F 658		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		3/18/19

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F 690	Continued From page 14 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, staff interview, and record review the facility failed to collect urine in order that an urinalysis (UA) and culture and sensitivity (C & S) could be completed as ordered by the physician for 2 of 2 sampled residents (Resident #30 and #90) reviewed for urinary concerns. Findings included: 1. Resident #30 was admitted to the facility on 03/29/18. The resident's documented diagnoses included vascular dementia with behavioral disturbances, pseudobulbar affect (an emotional/neurological condition characterized by uncontrollable emotional episodes of crying, laughing, etc), anxiety and depression disorders, and cerebrovascular accident (CVA). Record review revealed a 06/13/18 physician order started Resident #30 on Buspar (anti-anxiety medication) 10 milligrams (mg) twice daily for the management of anxiety.	F 690	F690 1. The physician was notified on 2/25/19 of the missed lab, and an order was obtained for a Urinalysis with Culture and Sensitivity (UA, C&S) to be completed on 2/26/19. The lab was completed as ordered, however, the resident was hospitalized due to a pathological hip fracture prior to the C&S results being sent to the facility. The Physician Assistant (PA) was notified of the C&S results and determined that antibiotic treatment was not appropriate due to the fact the resident had not exhibited an elevated temperature, the white blood cell count was within normal limits, the urine was negative for nitrites and the resident had not exhibited burning, frequency, and there was no blood in the urine, etc.	

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F 690	Continued From page 15 Lab results from a 09/30/18 urinalysis (UA) documented Resident #30 had 75,000 colony forming units (CFU) of yeast in her urine, and she was started on medication for yeast control/eradication. A 10/28/18 physician order documented, "Collect urine sample" This order was given by an on-call physician who was also helping the facility address Resident #30's elevated blood sugar level. Review of labs revealed there were no UA, C & S results associated with this order. A 11/23/18 physician order requested Resident #30 be sent to the emergency room (ER) for a psychiatric evaluation due to being argumentative, combative with residents and staff, and being difficult to redirect. Record review revealed the resident was given Zyprexa (anti-psychotic medication) at the ER. A 11/23/18 physician order started Resident #30 on as needed (prn) Ativan 0.5 mg every 4 hours x 14 days. A 11/28/18 physician order requested a UA and culture and sensitivity (C & S) be obtained for Resident #30 due to increased confusion. Review of labs revealed there were no UA, C & S results associated with this order. A 11/28/18 physician order implemented a psychiatric consult recommendation to discontinue Resident #30's Buspar and start her on Klonopin (benzodiazepine medication that can used for anxiety and behavior control) 0.125 mg twice daily (BID) for anxiety control.	F 690	2. Any resident with ordered labs has the potential to be affected. A 30 day look back of 100% of charts was completed by the Administrative Nursing Team to ensure ordered labs were completed as ordered and results were received for the correct labs ordered. If any lab was determined not to be completed, the physician was notified to obtain orders for further direction. 3. The Administrative Nursing Team was in-serviced by the RCD regarding the clinical process of reviewing labs in the morning clinical meeting to ensure the correct lab is drawn and correct results are received. The licensed nurses were in-serviced by the Staff Development Coordinator (SDC) regarding utilizing the Lab Requisition Log to ensure lab results are checked against the provider lab orders the ensure the correct lab results are received. 4. The Lab Requisition Log will be audited in the daily clinical meeting by checking it against the provider orders to determine if the correct lab was drawn. When results are received, the results will be checked against the provider order the ensure the results are for the ordered lab. The audit will be completed daily for four weeks, then weekly until 100% compliance is met for two consecutive months. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	

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F 690	Continued From page 16 Resident #30's 12/21/18 quarterly minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors including resistance to care, she required extensive assistance from staff to being dependent on staff for all her activities of daily living except for requiring only supervision with eating, and was frequently incontinent of bowel and bladder. Review of Resident #30's 01/09/19 complete blood count (CBC) revealed her white blood cell (WBC) level was 5.3 with normal being 4 - 11. A 01/31/19 physician order requested a UA and C & S be obtained for Resident #30 due to increased lethargy. Review of labs revealed there were no UA, C & S results associated with this order. Review of Resident #30's 02/06/19 CBC revealed her white blood cell (WBC) level was 8.2 with normal being 4 - 11. A 02/25/19 physician order requested a CBC and UA, C & S be obtained on the morning of 02/26/19. During an interview with Assistant Director of Nursing (ADON) on 02/26/19 at 4:25 PM she stated Unit Managers were responsible for making sure labs get drawn/collected and were responsible for making sure results were obtained. Review of Resident #30's 02/26/19 CBC revealed her WBC level was 5.1 with normal being 3.6 - 11.2. 02/27/19 UA final results documented Resident	F 690	1. The UA was obtained for Resident #90 1/27/19 after his return from his hospitalization due to a critical hemoglobin. The C&S results were received on 1/30/19, the physician was notified, and the treatment was initiated on that date. Nurse #3 and nurse #2 were in-serviced by the Staff Development Coordinator (SDC) regarding the policy and procedure for obtaining a lab sample from an indwelling catheter, to ask another nurse if unsure of the procedure for obtaining a sample, the lab tracking process, documentation of obtaining the lab and notification of the physician if unable to obtain a lab sample. Nurse #2□s in-service also included the anatomy of, and the reasons for, where a supra pubic catheter is placed and why one would not try to place a secondary catheter in the penis if a supra pubic catheter is present. 2. Any resident with ordered UA, C&S and has a suprapubic catheter has the potential to be affected. A 30 day look back of 100% of charts of residents with suprapubic catheters was completed by the Administrative Nursing Team to ensure ordered labs were completed as ordered and results were received for the correct labs ordered. If any lab was determined not to be completed, the physician was notified to obtain orders for further direction. 3. The licensed nurses were in-serviced by the SDC 3/4/19-3/14/19 regarding the policy and procedure for obtaining a lab	

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F 690	Continued From page 17 #30's urine specimen was negative for nitrites , her WBC level was elevated at 6 with normal being 0 - 2 and many bacteria were identified. C & S results were still pending. During a follow-up interview with the ADON on 02/27/19 at 1:23 PM she stated the nurse who received the physician order for a UA, C & S was supposed to place the order in the electronic order system and complete a lab requisition sheet. She reported facility staff collected the urine, and if staff had problems collecting the urine the Unit Manager was notified and made attempts to collect. If the Unit Manager was unsuccessful she stated the physician was contacted about how to proceed, and a progress note was written to document the outcome. The ADON commented the floor on which Resident #30 resided was without a Unit Manager. According to the ADON, the lab company placed lab results in the facility's electronic medical record system, and they called the facility when lab results involved critical values. She stated there was no flag currently in the electronic medical record system for lab results which had not been obtained. However, she reported Unit Managers tried to monitor labs to make sure results were received in a timely manner. The ADON commented she thought UA, C & S lab requisitions were completed for Resident #30 on 10/28/18, 11/28/18, and 01/31/19 but she was not sure what happened from there. She explained the phlebotomist may not have picked up the refrigerated urine samples, the lab company may have misplaced the samples, but she was just not sure exactly what caused the problem. According to the ADON, unobtained UAs had the potential to result in sepsis and death for residents that had urinary tract infections (UTIs).	F 690	sample from an indwelling catheter, to ask another nurse if unsure of the procedure for obtaining a sample, the lab tracking process, documentation of obtaining the lab, and notification of the physician if unable to obtain a lab sample. The in-service also included the anatomy of, and the reasons for, where a supra pubic catheter is placed and why one would not try to place a secondary catheter in the penis if a supra pubic catheter is present. This in-service will be added to the orientation process of all newly hired licensed nurses. 4. The Physician Orders will be audited in the daily clinical meeting to check if an order for a UA/C&S was written for any resident with an indwelling catheter. The chart will be audited to ensure the lab was obtained and if the physician was notified if it was not. The nurse will be followed up with if the lab was not obtained to determine the reason why. Education/discipline will be provided as needed. The audit will be completed daily for four weeks, then weekly until 100% compliance is met for two consecutive months. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings. The results of the audits will be presented to the monthly Quality Assurance Performance Improvement Committee (QAPI) by the DON and the quality monitoring schedule will be modified	

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F 690	Continued From page 18 During an interview with Nurse #4 on 02/28/18 at 9:27 AM she stated when she received an order for a UA, C & S she put the order in the facility's electronic system, and attempted to collect the urine on her shift. If unable to do so, she commented she passed the responsibility to the on-coming nurse at shift change. She commented if the urine could not be collected, the physician was notified, and a progress note was written documenting how he/she wanted to proceed. She stated a lab slip was completed when the urine was collected, and this slip was placed with the refrigerated urine. According to Nurse #4, it was the responsibility of the Unit Managers to monitor for missing or unobtained lab results. During an interview with Nurse #5 on 02/28/19 at 9:45 AM she stated she put UA, C & S orders into the electronic system, and documented these lab requests on her 24-hour report. She reported once the urine was collected she printed off the lab requisition and placed it with the urine in the lab refrigerator. She commented that she called the lab if she did not have a UA result the next day or she did not have a C & S result in a couple of days after receiving the UA. According to Nurse #5, this practice helped to avoid missing lab results. During an interview with Nurse #6, an agency nurse, on 02/28/19 at 10:08 AM she stated she was not sure how to enter an order into the facility's electronic system and had not had to do so since working in this facility. She reported in this facility the staff collected the urine and placed it in refrigeration so the lab phlebotomist could pick it up. She commented she would call the lab	F 690	based on findings.	

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if she did not have UA results 24 hours after the phlebotomist collected the sample.

During an interview with Nurse #7, who worked on an as needed basis (prn), on 02/28/19 at 10:12 AM she stated she put UA, C & S orders into the electronic medical record system, collected the urine using a hat or in and out catheter, printed off the lab requisition, attached the requisition to the refrigerated specimen, and the lab phlebotomist collected the sample. She commented if she did not have UA results within 24 hours of the sample pick-up she called the lab.

During an interview with Physician #1 on 02/28/19 at 11:13 AM he stated if there were physician orders to obtain UA, C & S results then the lab work should have been completed. He reported he would expect facility staff to make contact with the lab 48 hours after urine specimens were collected if no results were sent to the facility. He commented not having UA, C & S results available in multiple months increased the chance residents could become septic.

A hospital discharge summary documented Resident #30 was hospitalized from 03/01/19 until 03/05/19 for a pathological fracture of the left hip. UTI was not one of her discharge diagnoses, and the summary documented, "UA could not be obtained due to incontinence."

During a telephone interview with the facility's Physician Assistant (PA) on 03/06/19 at 11:34 AM she stated urine was collected for Resident #30 on 02/26/19, and based on the final UA results alone she probably would not have pursued antibiotic treatment since the urine was negative for nitrites and CBC results in both January 2019

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and February documented WBC levels within the normal range. She reported the facility did not receive C & S results until 03/01/19 after Resident #30 was already hospitalized. She commented that the resident received an IV cephalosporin antibiotic as a precaution during hip surgery. According to the PA, she thought some of the changes in Resident #30's behaviors and energy level were caused by the pathological hip fracture. She explained she usually treated residents with an antibiotic when they had greater than 100, 000 CFUs of a specific bacteria, but she reported in the case of Resident #30 she was not sure she would have done so because the resident was exhibiting no elevated temperatures, no burning upon urination, no frequent urination, no blood in the urine, etc, and she thought the fracture could explain the other symptoms (behaviors and lethargy).

2) Resident #90 was admitted to the facility on 01/26/19. Diagnoses included, in part, weakness due to stroke, chronic kidney disease, anemia, neuromuscular dysfunction of bladder, cognitive communication deficit, and reflux Uropathy (kidney damage due to urine flowing backward from the bladder toward the kidneys).

The Minimum Data Set (MDS) dated 02/12/19 14-day assessment revealed Resident #90 was mildly cognitively impaired. Resident #90 was sent out to the hospital on 01/23/19 and returned on 01/26/19. Resident #90 required extensive assistance with one staff physical assistance with bed mobility, transfers, dressing, toileting, and

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personal hygiene. Resident #90 had an impairment to one side to upper and lower extremities, used a wheelchair, had an indwelling catheter and was always incontinent of bowel.

A review of the care plan updated on 02/14/19 revealed a plan of care for a Suprapubic (S/P) catheter (a catheter surgically created for a connection between the urinary bladder and the skin used to drain urine from the bladder in individuals with obstruction of normal urinary flow) for neurogenic bladder. Interventions for the catheter included, in part, to monitor labs as ordered and report results to the physician and to monitor, record, and report to physician any signs or symptoms of a Urinary Tract Infection (UTI) such as pain, burning, blood tinged urine, and no output.

A review of a physician order revealed an order written on 01/19/19 at 2:49 PM to obtain a urine analysis and culture and sensitivity (U/A & C&S) to rule out UTI due to change in mental status.

A nursing note written on 01/19/19 at 4:36 PM revealed Nurse #3 documented several attempts to collect urine and was unsuccessful.

A nursing note written on 01/20/19 at 10:00 PM revealed Nurse #3 was unable to collect urine.

A nursing note written on 01/21/19 at 5:58 AM by Nurse #3 revealed several attempts were made to collect urine, but it was unsuccessful.

An interview was conducted with Nurse #3 on 02/25/19 at 4:00 PM. Nurse #3 stated Resident #90 was admitted with the S/P catheter and has had it since admission. She stated there were no

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concerns with the catheter and it functioned properly. Nurse #3 stated if she had to obtain a UA/C&S on a resident with a S/P catheter she would disconnect the current catheter, disinfect the port and reconnect a clean catheter with clean tubing and when the urine drained into the bag, she would obtain it for the U/A. Nurse #3 demonstrated this procedure on Resident #90. Nurse #3 stated she was unable to obtain the urine on 01/19/19 because there was no urine. Nurse #3 stated the catheter had output but it had sediment in it so she could not use it. Nurse #3 was asked if a new catheter was in place and she responded, "Yes." The nurse was asked if the new catheter had urine output, but she would not provide an answer. Nurse #3 confirmed that she made a nursing note on 01/19/19 that she documented at 4:36 PM that no urine was obtained. Nurse #3 stated she did not notify the physician regarding not obtaining the urine. Nurse #3 also confirmed that she documented on 01/20/19 at 10:00 PM that no urine was obtained. Nurse #3 could not provide an answer as to why the urine was not obtained or whether or not the resident had any urine output on 01/20/19 and she did not notify the physician to report the urine was unable to be obtained. Nurse #3 reported on the morning of 01/21/19 at 5:58 AM she documented unsuccessful attempts for urine. Nurse #3 stated she passed it on to the oncoming nurse she was unable to obtain a urine.

An interview was conducted with Nurse #2 on 02/26/19 at 2:45 PM. Nurse #2 indicated she was the nurse that obtained the order to get a UA/C&S due to his confusion. Nurse #2 stated to obtain a U/A, she used a 16 French catheter inserted into the resident ' s penis to obtain the urine, but she could not get any urine. Nurse #2

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F 690	Continued From page 23	F 690		

was questioned as to why she would insert a Foley catheter into a resident who had a functioning S/P catheter and she stated because he could void from his penis. Nurse #2 stated there was no urine output from the S/P catheter at the time she inserted the Foley catheter into the resident ' s penis. Nurse #2 reported she did not call the physician assistant (PA) or the physician to notify them there was no output from the penis or the suprapubic catheter and stated she was giving the catheter time to work and passed it on to the next shift (Nurse #3) to obtain the urine on 01/19/19.

An interview was conducted with the Nursing Supervisor (NS) on 02/26/19 at 3:36 PM. The NS stated she would not have expected Nurse #2 to have inserted another catheter into a resident who had a functioning S/P catheter. The NS stated a resident who had a S/P catheter usually had an obstruction and there was a reason why they would have a S/P catheter. She stated she would have expected the nurses to call the PA or the physician if the resident was not voiding during the shift and if they were unable to obtain a U/A.

An interview was conducted with the facility physician on 02/28/19 at 10:58 AM. The physician reported he would not expect nursing staff to insert a Foley catheter into a resident with an existing suprapubic catheter. Additionally, he reported he would expect if staff were unsure on how to do a procedure, they should ask for help. The physician reported he would have expected the nursing staff to contact him if the resident had no urine output in an 8 hour shift.

An interview was conducted with the Director of

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F 690	Continued From page 24 Nursing (DON) on 02/28/19 at 11:25 AM. The DON reported his expectation of the nurses would have been to notify the physician on 01/19/19 that they were not able to obtain the urine. Additionally, he reported that if nurses do not have an understanding of what they are supposed to do when obtaining a urine from suprapubic catheter, they should let the appropriate staff know so that they can be educated.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident, staff and physician interviews the facility failed to provide physician ordered tracheostomy care for 1 of 1 sampled residents (Resident #54). Findings included: Resident #54 was re-admitted to the facility on 10/17/18 and had diagnoses of end stage renal disease (ESRD), chronic obstructive pulmonary disease (COPD), and muscle weakness. Resident #54 had a tracheostomy. Review of the quarterly Minimum Data Set (MDS) dated 01/15/19 revealed Resident #54 was	F 695	F695 Resident #54 was evaluated on February 26, 2019 by the Registered Nurse and the tracheostomy orders were clarified to include the size of the change of inner cannula, q shift care, and prn suctioning. The others identified with tracheostomy care were reviewed by the registered nurse on February 26, 2019 to determine the orders were written correctly and the care and services were being provided for tracheostomy care and subsequent admissions. No other areas of concern	3/18/19

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F 695	Continued From page 25 cognitively intact, had no behaviors and did not reject care. Resident #54 needed the extensive assistance of one person for dressing, the limited assistance of one person for transfers, toilet use and hygiene, and the supervision of one person for bed mobility and bathing. Review of the Order Summary Report revealed an order dated 01/24/19 for tracheostomy care every shift and as needed. There was also an order dated 01/24/19 to change the tracheostomy and/or the tracheostomy collar as needed. The size was listed as 16. Review of the 01/24/19-01/31/19 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no order for tracheostomy care for Resident #54 and no order to change the tracheostomy and/or the tracheostomy collar as needed using a size 16. Review of the Tracheostomy Care Plan revised on 01/28/19 revealed that nursing was to perform Resident #54's tracheostomy care. There was no mention that Resident #54 could perform the task herself. Review of the 02/01/19-02/24/19 MAR and TAR revealed no order for tracheostomy care for Resident #54 and no order to change the tracheostomy and/or the tracheostomy collar as needed using a size 16. In an interview on 02/24/19 at 4:37 PM Resident #54 stated she was out of the cleanser, the inner cannulas, and the ties for her tracheostomy. She indicated she had informed the nurses and the person who ordered the supplies multiple times that she needed these items. She indicated the	F 695	were identified upon the completion of tracheostomy care audit completed on 02/26/19. The licensed respiratory therapist completed an in-service on March 4, 2019 for the licensed nurses to educate on developing and writing the proper tracheostomy care orders, procedures in the care of tracheostomies and q shift documentation. Any discrepancies found that would require physician notified will be relayed and orders obtained and transcribed. This education will be added to the orientation process for licensed nurses. Re-education will be provided for any nurse that has not followed the written orders for tracheostomy care up to include disciplinary action and/or termination. Resident that have been identified and requiring tracheostomy care will be reviewed the RN-Director of Nursing, RN-Assistant Director of Nursing, Unit Manager RN Staff development director RN weekly to ensure the tracheotomy care is provided as order by the Physician and the care and service meet professional standard. The results of the audits will be presented to the monthly Quality Assurance Performance Improvement Committee (QAPI) by the DON and the quality monitoring schedule will be modified based on findings.	

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facility had not provided supplies to her in 2-3 weeks and that she had been performing her own tracheostomy care.

In an observation and interview on 02/25/19 at 11:35 AM Resident #54 was sitting up on the side of the bed. There was a tracheostomy kit on the over bed table and the tracheostomy ties had been changed. Resident #54 indicated the nurse had been in to change the ties.

In an observation on 02/25/19 at 11:45 AM Nurse #8 performed tracheostomy care using sterile procedure. She removed Resident #54's disposable inner cannula, cleansed it with peroxide and normal saline, and reinserted the inner cannula. The tracheostomy kit did not contain a new disposable cannula.

In an interview on 02/25/19 at 12:00 PM Nurse #8 indicated she had been working with Resident #54 for about 3 weeks. She stated that before today she had not provided tracheostomy care for Resident #54. She indicated the order had never "popped" on the computer as a task that needed to be completed.

In an interview on 02/25/19 at 12:40 PM the Central Supply Manager stated that Resident #54 was admitted with 3 boxes of inner cannulas and that she was never told the resident needed more. She indicated she had been told by the Respiratory Therapist (RT) that the size 60XLTIN disposable inner cannulas the facility had in stock were the equivalent of the size 16 that was ordered. She indicated that she did not know how the nursing staff would know to use the 60XLTIN cannulas instead of a size 16 because the box did not reference a size 16.

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In an interview on 02/25/19 at 4:25 PM the 4th floor Nursing Supervisor stated tracheostomy care had been provided to Resident #54 and that the order was on the January 2019 and the February 2019 MAR or TAR. The Nursing Supervisor reviewed the January and February 2019 MAR/TAR and verified the order to provide tracheostomy care every shift was not there. She stated the order had been received from the physician on 01/24/19 and that she had noted it and input the order in the electronic medical record. She stated that for some reason the order was not carried over to the MAR/TAR so the tracheostomy care did not "pop" on the computer as a task for the nurses to perform.

In an interview on 02/25/19 at 4:40 PM Nurse #9 stated if the task did not show up on the electronic MAR/TAR she would not know that it needed to be done. She indicated that tracheostomy supplies were kept in the resident's rooms. She indicated if she needed an inner cannula and the size listed on the order was unavailable she would call central supply to get one. She indicated she would not know what an acceptable substitution would be if it was not listed on the order.

In an interview on 02/25/19 at 4:50 PM the Director of Nursing (DON) stated he expected tracheostomy care to be done according to the physician order and the facility policy to prevent respiratory issues and infections. He indicated he expected a clear order and that the situation would be corrected immediately.

In an interview on 02/26/19 at 7:35 AM Resident #54 indicated the nurses had provided

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F 695	Continued From page 28 tracheostomy care for her the night before. In an interview on 02/26/19 at 7:40 AM Nurse #10, who was assigned to Resident #54 and had worked with her during January and February 2019, stated she had not performed tracheostomy care for the resident during that time. She indicated that Resident #54 did her own tracheostomy care. Nurse #10 stated that Resident #54 had never informed her that she did not have the necessary supplies to do her own tracheostomy care. In an interview on 02/26/19 at 3:40 PM the Respiratory Therapist (RT) stated that Resident #54 had not been signed off to do her own tracheostomy care. She indicated that the nurses should be providing the tracheostomy care for Resident #54. In an interview on 02/28/19 at 11:20 AM a facility physician indicated that if a resident had a tracheostomy then tracheostomy care should be provided as ordered by the physician. He indicated that since there were no signs of infection, increased mucus production or difficulty breathing no harm had come to the resident.	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs 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	F 757		3/18/19

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F 757	Continued From page 29 §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 record review and staff interviews, the facility failed to monitor Prothrombin Time and International Normalized Ratio (PT/INR) labs ordered for 1 of 6 residents reviewed for unnecessary medications (Resident #103). Findings included: Resident #103 had been admitted on 2/6/19. Her admission diagnoses included Atrial Fibrillation (an irregular heart rhythm), Diabetes and Hypertension. A physician note dated 2/7/19 indicated Resident #103 had a history of atrial fibrillation and that she received warfarin for anticoagulation. Resident #103's Admission Minimum Data Set (MDS) assessment dated 2/13/19 indicated she was cognitively intact, had a diagnosis of atrial fibrillation, and she received anticoagulant medication daily. A physician order dated 2/6/19 for warfarin (blood	F 757	F757 1. The Physician Assistant (PA) was notified on 2/22/19 and an order was written to obtain a PT/INR on 2/25/15. The PT/INR was completed on 2/25/19 and a Anticoagulant Therapy Flow Record was initiated, and the resident has been receiving the PT/INRs as ordered. 2. Any resident receiving Coumadin has the potential to be affected. A 30 day look back of all residents receiving Coumadin was completed by the DON on 2/25/19 and a Anticoagulant Therapy Flow Record was initiated to ensure all residents receiving Coumadin has PT/INRs as ordered and are currently receiving the correct dose ordered. 3. The licensed nurses were in-serviced placement of the Anticoagulant Therapy Flow Records in the front of the narcotic	

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F 757	Continued From page 30 thinner) 2 milligrams (mg) every evening and to check Resident #103's PT/INR (this test is used to monitor the therapeutic use of warfarin, the PT measures how many seconds it takes the blood to clot and the INR is a ratio calculated from the PT result, and is used to monitor how well the blood thinning medication is working) every Monday and Thursday starting on 2/11/19. PT/INR lab dated 2/11/19 (Monday) revealed results of 28/2.58. A physician order dated 2/12/19 (Tuesday) to continue warfarin 2 mg every evening. A physician order dated 2/19/19 (Tuesday) to obtain a PT/INR on 2/20/19, and noted a previous order had been written for a PT/INR to be completed every Monday and Thursday. PT/INR lab dated 2/20/19 (Wednesday) revealed results of 45.5/4.05. A physician order dated 2/20/19 to discontinue the use of warfarin. PT/INR lab dated 2/21/19 (Thursday) revealed results of 43.5/3.84. A physician order dated 2/21/19 to discontinue the use of warfarin. A physician order dated 2/22/19 to start warfarin 1 mg every evening and to recheck the PT/INR on 2/25/19. PT/INR lab dated 2/25/19 (Monday) revealed results of 33.2/2.99. Review of Resident #103's February 2019 Medication Administration Record (MAR) indicated she had received warfarin 2 mg from	F 757	book, documentation of the PT/INR results, physician notification and new orders obtained on the Flow Record. An Anticoagulant Therapy Flow Record was initiated for each resident on Coumadin. The orders for new admissions will be reviewed in the Daily Clinical Meeting for orders for Coumadin and to ensure Anticoagulant Therapy Flow Record have been initiated for each resident. 4. Any resident on Coumadin will be reviewed in the Daily Clinical Meeting and a Coumadin Audit Worksheet will be completed by the Unit Managers to ensure PT/INRs are completed as ordered and the orders are correct on the Medication Administration Record. The results of the audits will be presented to the monthly Quality Assurance Performance Improvement Committee (QAPI) by the DON and the quality monitoring schedule will be modified based on findings.	

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2/7/19 through 2/19/19, no warfarin on 2/20/19 or 2/21/19, and warfarin 1 mg 2/22 through 2/26/19.

On 02/28/19 at 9:58 AM an interview with the Director of Nursing (DON) was conducted. The DON stated while transcribing the order, a step had been missed and the labs had not been put into the laboratory computer program. The DON also stated it was his expectation of the nurse to transcribe orders according to facility guidelines and to be consistent. He also stated it was his expectation that if the nurse had any questions, they should talk with their immediate supervisor.

On 2/28/19 at 11:00 AM and interview with Nurse #1 was conducted. The nurse stated when an order for labs needed to be transcribed, the order would be typed into the facility computer physician orders program to appear on the computer generated orders. The lab work order would then be typed into the laboratory web site so the laboratory would be aware of the needed lab work. A copy of the laboratory work order would then be placed into the laboratory notebook. The nurse also stated the night shift nurse did chart reviews and stated it appeared these laboratory orders had been missed.

On 2/28/19 at 11:53 AM a telephone interview with the Physician Assistant (PA) was conducted. The PA stated she was unsure why the labs had been missed on 2/14/19 and 2/18/19. The PA stated that on 2/19/19 she had noticed Resident #103's PT/INR had not been completed and she had requested that the labs be done. She stated Resident #103's INR should be 2.50-3.50 for her diagnosis of Atrial Fibrillation. She stated Resident #103 did not suffer any harm or injury, and also stated she would expect the nurses to

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F 757	Continued From page 32 follow orders.	F 757		
F 761 SS=E	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 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to store medications at recommended temperatures for 2 of 3 medication refrigerators. Findings included:	F 761	F761 No individual residents were named in the deficiency. All medications identified in the medication refrigerators were removed and discarded. The identified medication was replaced from the pharmacy.	3/18/19

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F 761	Continued From page 33 Review of 2 of 3 Raleigh Rehab refrigerator Medication Room Records for February 2019 showed 22 out of 26 recorded temperatures below 24 degrees Fahrenheit (F.) from the 3rd floor medication refrigerator, and 6 out of 11 (February 17 through February 27) recorded temperatures below 32 degrees (F.). The 2nd floor Medication Room Refrigerator log had no documented temperatures from February 01 through February 16. Review of the United States Food and Drug Administration literature revealed "According to the product labels from all three U.S. insulin manufacturers, it is recommended that insulin be stored in a refrigerator at approximately 36°F to 46°F. Avoid freezing the insulin. Do not use insulin that has been frozen." Review of the Levemir Storage Temperatures showed Levemir should be, "stored at 35-46 degrees", and to "not freeze". Review of the Humalog Storage Temperatures showed Humalog should be, "stored at 35-46 degrees", and to "not freeze". Review of the Lantus Storage Temperatures showed Lantus should be, "stored at 35-46 degrees", and to "not freeze". Review of the Novolog Storage Temperatures showed Novolog should be, "stored at 35-46 degrees", and to "not freeze". Review of the Tuberculin Storage Temperatures showed Tuberculin should be, "stored at 35-46 degrees", and to "not freeze". Review of the Influeza Storage Temperatures showed Influeza should be, "stored at 35-46 degrees", and to "not freeze". Review of the Latanoprost Storage Temperatures showed Latanoprost should be, "stored at 35-46	F 761	All residents have the potential to be affected by deficient practice of inappropriately stored medications. All medication refrigerators were inspected by the administrator and director of nursing and the dial thermometers were replaced with digital thermometers. The issues with the storage temperature was resolved on February 28, 2019. All nurses were re-educated by the RN Staff Development Director on the process of medication refrigerator storage on 2/27/19 through 3/12/19. The 11-7 nurses will be responsible for inspecting the medication refrigerator temperatures to ensure they are maintained between 36-46 degrees Fahrenheit and sign the medication and vaccination refrigerator temperature log. The Registered Nurse-Unit managers or licensed nurse supervisor will audit the medication room refrigerators weekly to ensure the temperature remains between 36-46 degrees Fahrenheit. Any discrepancies will be reported to the Director of Nursing, Administrator and Maintenance Director where appropriate. Unit managers will immediately address the issues. The results of the audits will be presented to the monthly Quality Assurance Performance Improvement Committee (QAPI) by the DON and the quality monitoring schedule will be modified based on findings.	

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degrees", and to "not freeze".
Review of the Actemra Storage Temperatures showed Actemra should be, "stored at 35-46 degrees", and to "not freeze".
Review of the Performist Storage Temperatures showed Performist should be, "stored at 35-46 degrees", and to "not freeze".
Review of the Levamin Storage Temperatures showed Levamin should be, "stored at 35-46 degrees", and to "not freeze".
Review of the Lorazepam Storage Temperatures showed Lorazepam should be, "stored at 35-46 degrees", and to "not freeze".
Review of the Vancomycin Storage Temperatures showed Vancomycin should be, "stored at 35-46 degrees", and to "not freeze".
Review of the Infuvite Storage Temperatures showed Infuvite should be, "stored at 35-46 degrees", and to "not freeze".
Review of the Novolin Storage Temperatures showed Novolin should be, "stored at 35-46 degrees", and to "not freeze".
Review of the Acetylcysteine Storage Temperatures showed Acetylcysteine should be, "stored at 35-46 degrees", and to "not freeze".

Review of the 5.3 - 2017 Storage and Expiration of Medication, Biologicals, Syringes and Needles Policy revealed, "Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges. Facility staff should monitor the temperature of vaccines twice a day. Refrigeration: 36 - 46 degrees Fahrenheit."

In an observation on 02/26/19 at 8:45 AM with the Director of Nursing (DON) revealed the thermometer in the 3rd floor medication

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refrigerator read 9 degrees F. The medication refrigerator contained multiple Lantus, Novolog, and Lantus injectable pens, multiple vials of different insulins (Novolog, and Lantus), Influenza/Tuberculin vaccinations, Latanoprost vial, Actemra vials, multiple Preformist vials, and multiple Levamin vials.

In an interview and observation on 02/26/19 at 8:45 AM with the DON revealed the 3rd floor medication refrigerator temperature was 9 degree F. The DON confirmed the refrigerator temperature should have been between 36 degrees F. and 46 degrees F., and was not. The DON also stated that all of the 3rd floor medication refrigerator temperatures from February 01 through February 25 were all reading 24 degree F. The DON stated it was the responsibility of the 11-7 nurses to record the medication refrigerator temperatures. The DON stated if temperature registered below 36 degree F. or above 46 degree F., for staff to immediately notify maintenance department or Administrator, notify manager, and to retake temperature in 1 hour. And if temperature (after 1 hour) registers below 36 degree F. or above 46 degree F., to initiate product removal/relocation procedure, which was not done.

In an interview on 02/26/19 at 10:40 AM and 02/27/19 at 11:38 AM the Corporate Consultant Pharmacist explained to the Facility Director, Corporate Nurse, DON, Assistant Director of Nursing (ADON), and the Maintenance Assistant that the February/2019 the 3rd floor medication refrigerator temperatures should have been kept between 36 degrees F. and 46 degrees F., and if it was not, the medications stored in it needed to be replaced.

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In an observation on 02/27/19 at 10:28 AM with the Corporate Consultant Nurse revealed the thermometer in the 2nd floor medication refrigerator read 32 degrees F. The medication refrigerator contained multiple Novolin and Humalog vials, Novolog injectable pens, Influenza vaccinations, Vancomycin antibiotics, Preformist vials, and Acetylcysteine.

In an interview on 02/27/19 at 10:28 AM with the Corporate Consultant Nurse stated the February/2019 2nd floor medication refrigerator temperatures should have been kept between 36 degrees F. and 46 degrees F., and was not. The nurse stated it was the responsibility of the 11-7 nurses to record the medication refrigerator temperatures. The Corporate Nurse said the nurses who signed off on 9 of the 11 days on the 2nd floor medication refrigerator temperature log from February 17 through February 27 (which read from 28 degree F. to 34 degrees F.) failed to follow the facility ' s policy to immediately notify maintenance department, notify their manager, and to retake the temperature in 1 hour.

In an interview on 02/27/19 at 10:30 AM the Facility Director, DON, Facility Pharmacist, Corporate Nurse stated the February/2019 2nd and 3rd floor medication refrigerators temperatures should have been kept consistently between 36 degrees F. and 46 degrees F., and was not.

In interviews on 02/26/18 at 10:40 AM and 02/27/19 at 11:38 AM the Corporate Consultant Pharmacist stated she had been in contact with the Administrator and DON today and reviewed with her the 3rd and 2nd floor medication

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F 761	Continued From page 37 refrigerators February temperatures as well as reviewed the medications that were stored in both refrigerators. She indicated she told the DON that 32 degrees was considered freezing. She indicated medications should be kept between 36-46 degrees. The Consultant Pharmacist stated medications that had been frozen or could not confirm that they had not frozen, should not be used. The Consultant Pharmacist stated: that all medications stored in the 2nd and 3rd floor medication refrigerators were discarded and replaced. The Consultant Pharmacist stated she was not aware of any Adverse Drug Reactions (ADRs) as a result of the 2nd and 3rd floor refrigerator temperatures for February 2019 not being within 36 degrees F. and 46 degrees F. In a written statement on 02/26/19 the Facility Director stated the February/2019 3rd floor medication refrigerator temperatures should have been kept consistently between 38 degrees F. and 43 degrees F., and was not.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		3/18/19

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F 812	Continued From page 38 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to air dry items of kitchenware prior to stacking them on top of one another in storage. The facility also failed to monitor food and utensil storage areas which resulted in opened food items not being labeled and dated, in food items not being refrigerated after opening according to labeling instructions, and in an utensil drawer having dried food debris inside of it. Findings included: 1. During initial tour of the kitchen on 02/24/19, beginning at 10:25 AM, 12 of 18 tray pans were stacked on top of one another in storage with moisture trapped inside. During an interview with the Dietary Manager (DM) on 02/27/19 at 4:18 PM he stated he thought the tray pans were stacked wet the night before being found on 02/24/19. He explained he had a new pot washer at night that might not have understood the procedure for cleaning and drying kitchenware. However, he reported dietary staff were previously in-serviced that kitchenware should be completely air dried before stacking it in storage. The DM commented bacteria could grow in moisture that was trapped between pieces of kitchenware. During an interview with Dietary Employee #1 on 02/28/19 at 10:56 AM she stated she was	F 812	F 812 The utensil drawer was cleaned, the wet pans were removed and rewashed, the unlabeled cheese was discarded along with the food items above the two-bowl sink, and the unlabeled chicken nuggets were discarded by the Dietary Manager at the time of survey. The kitchen was deep cleaned and inspected by the kitchen staff, Administrator, and Dietary Manager on February 28, 2019 to include all areas listed above. The dietary staff was in-serviced on February 27, 2019 on the following: Food Safety/Sanitation, Foodborne illness to include storage of items wet and not refrigerated, Importance of clean sanitary kitchen to include utensil drawers, and cleaning Schedules. Administrator, assistant administrator or guardian angel will tour the dietary kitchen and review the cleaning logs to validate cleaning has occurred and monitor the storage and labeling of items. Any concerns will be addressed as discovered. This monitoring will continue	

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F 812	Continued From page 39 educated that kitchenware was supposed to be dry, clean, and free from grease build-up before being placed in storage. She commented that kitchenware run through the 3-compartment sink system was dried on the draining board and then transferred to an air drying rack if need be so that there was no moisture at all left on kitchenware before it was placed in storage. She reported bacteria and mold could grow in trapped moisture, potentially making residents sick. 2. During initial tour of the kitchen on 02/24/19, beginning at 10:25 AM, 1 of 2 utensil drawers containing assorted utensils had dried food debris in it. In the reach-in refrigerator a storage container of orange shredded cheese did not have a label and date on it. On a shelf above the 2-compartment sink system opened food items did not have labels and dates on them. These items included a 16-ounce box of corn starch, a 12-ounce box of gluten free elbow macaroni, and a 42-ounce box of quick grits. On this same shelf there were opened containers of hot sauce (128 fluid ounce) and barbeque sauce (9.87 pound). The labels on both items documented, "Refrigerate After Opening." In the walk-in freezer an opened bag of chicken nuggets did not have a label and date on it. On 02/26/19 at 10:03 AM, during a follow-up tour of the kitchen, 1 of 2 utensil drawers containing assorted utensils had dried food debris in it. An opened 128 fluid ounce container of hot sauce and an opened 9.87 pound container of barbeque sauce above the 2-compartment sink system both had labels which documented, "Refrigerate After Opening." During an interview with the Dietary Manager	F 812	until 4 consecutive weeks of zero negative findings is achieved. Afterwards, the monitoring will occur weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur ongoing. The results of the audits will be presented to the monthly Quality Assurance Performance Improvement Committee (QAPI) by the Dietary Manager and the quality monitoring schedule will be modified based on findings.	

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(DM) on 02/27/19 at 4:18 PM he stated in mid-December 2018 the dietary staff was in-serviced about the need to label and date opened and repackaged food items. He also reported staff had been told to read and follow the labels on food packaging. The DM commented residents had the potential of becoming sick if opened food items were left out at room temperature when their labeling specified "Refrigerate After Opening." He also stated the sauces/condiments found above the 2-compartment sink could begin to separate if they were not refrigerated per labeling instructions. According to the DM, it was the responsibility of all dietary staff to label and date food items if they were the ones who opened, but did not use all of them. He stated that he and his assistant tried to monitor storage areas twice daily to make sure labeling and dating were in place. He reported that he expected the utensil drawers to be wiped out with sanitizing solution before every meal. If not, he commented that food debris in the drawers could cross-contaminate utensils used in food preparation tasks.

During an interview with Dietary Employee #1 on 02/28/19 at 10:56 AM she stated leftovers, opened, and repackaged food items in all storage areas should have labels and dates on them. She reported this practice helped reduce spoilage and supported the FIFO (first in, first out) principle which the facility had adopted. She commented that mold and bacteria could begin to form in opened food items that were not refrigerated when their labels documented refrigeration was necessary after opening. According to the employee, utensil drawers were cleaned as needed, but should be kept free from

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F 812	Continued From page 41 food residue which could contaminate the whole drawer and the utensils stored in it.	F 812		
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 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,	F 842		3/18/19

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F 842	Continued From page 42 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening 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 record review and staff interviews the facility failed to maintain complete and accurately documented medical records for 1 of 4 residents (Resident #95) whose bathing and shower records were reviewed. Findings included: Resident #95 was readmitted to the facility on	F 842	F842 1. Resident #95 has expired so no other corrective action can be completed for this resident. 2. Any resident receiving a bath or	

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F 842	Continued From page 43 10/30/18 with diagnoses of atrial fibrillation, aphasia, and hemiplegia. Review of the annual Minimum Data Set (MDS) dated 01/06/19 revealed Resident #95 was severely cognitively impaired, had no behaviors and did not reject care. Resident #95 required the limited assistance of one person for bed mobility, the extensive assistance of one person for dressing and hygiene, and was dependent on one person for eating and toilet use. Resident #95 was coded as an 8/8 for bathing during the look back period which meant that the activity did not occur or a family member or non-family member provided care 100% of the time for that activity. Review of the medical record revealed that Resident #95 was discharged to the hospital on 01/11/19 and was re-admitted on 01/14/19. Review of the ADL (Activities of Daily Living) Look Back Report for January 2019 revealed one entry on 01/03/19 coded 8/8 which meant the resident was not available, the resident refused, or that it was not applicable. On 01/25/19 there was one entry that Resident #95 was dependent on one person for the bathing activity that day. The rest of the bathing activity documentation was blank. Review of the January 2019 hospice Visit History Information revealed Resident #95 received a total bed bath on 01/18/19, 01/22/19, 01/23/19 01/26/19, 01/29/19 and 01/30/19. In an interview on 02/27/19 at 9:19 AM the Administrator indicated he did not expect staff to document bathing on days that hospice provided that care. He stated that he did expect	F 842	shower has the potential to be affected. The computerized documentation for each resident was updated to allow the Certified Nursing Assistants (CNAs) to specifically document when a shower is given. The nursing staff were in-serviced 3/14/19 through 3/18/19 regarding the update to the system for documentation of showers and the in-service will be added to the orientation process of nursing staff. 3. The computerized documentation for each resident was updated to allow the Certified Nursing Assistants (CNAs) to specifically document when a shower is given. The nursing staff were in-serviced 3/14/19 through 3/18/19 regarding the update to the system for documentation of showers and the in-service will be added to the orientation process of nursing staff. 4. The Director of Nursing will audit the documentation of two residents from each floor daily for four weeks to ensure that showers are given and documented as scheduled. The audit will be completed daily for four weeks, then weekly until 100% compliance is met for two consecutive months. The results of the audits will be presented to the monthly Quality Assurance Performance Improvement Committee (QAPI) by the DON and the quality monitoring schedule will be modified based on findings.	

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documentation on the other days of the week for showers and baths that the staff in the facility performed.

In an interview on 02/27/19 at 9:20 AM the facility Nurse Consultant indicated she expected that residents would receive a bath or shower every day and that the NAs document bathing in the medical record.

In an interview on 02/27/19 at 10:07 AM Nursing Assistant (NA) #3 stated she knew she provided a shower to Resident #95 on a Saturday but could not remember the date. She indicated that showers were not documented in the electronic record and only baths were recorded.

In an interview on 02/27/19 at 10:22 AM NA #4 stated that showers and baths were both recorded in the computer. She indicated that showers "popped up" on the computer screen on the day they were due.

In an interview on 02/27/19 at 10:28 AM NA #5 stated showers were documented in the computer and not on paper.

In an interview on 02/27/19 at 10:50 AM NA #6 indicated that showers and baths were recorded in the computer. She indicated residents could refuse baths and showers but that information would also need to be documented and the nurse would need to be informed.

In a telephone interview on 02/28/19 at 8:04 AM NA #7 stated she had provided a bed bath to Resident #95 on 01/04/19 but did not document it and she should have. She indicated baths and showers were documented in the computer and

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F 842	Continued From page 45 not on paper. In an interview on 02/28/19 at 10:13 AM the Nursing Supervisor of the 4th floor stated she expected baths and showers to be documented. She stated that the documentation should not be blank as baths and/or showers were provided daily. In an interview on 02/28/19 at 11:45 AM the Director of Nursing (DON) stated he expected documentation to be completed consistently, completely and accurately.	F 842		