STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification and Complaint survey was conducted on 01/13/20 through 01/16/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 507411.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification and Complaint survey was conducted on 01/13/20 through 01/16/20. A total of 7 allegations were investigated and none were substantiated. Event ID # 507411.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response.	F 565		

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

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(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.

§483.10(f)(6) The resident has a right to participate in family groups.

§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interviews, the facility failed to record, resolve and communicate the facility's efforts to address resident concerns and/or suggestions voiced during 11 of 11 Resident Council meetings.

Findings included:

During a Resident Council group interview conducted on 01/08/20 at 11:00 AM, residents present voiced an ongoing issue with the resolution of concerns voiced during Resident Council meetings.

The Resident Council minutes for the period February 2019 through December 2019 were reviewed and revealed the following:

Resident Council minutes dated 02/21/19 indicated residents voiced concerns related to missing laundry and the noise level at night.

Resident Council minutes dated 03/02/19 noted under Old Business, "noise at night not fixed, asking for 8:00 PM ordinance ..."

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Resident Council minutes dated 04/18/19 indicated residents voiced dietary concerns related to being served dry, tough and overcooked meat.

Resident Council minutes dated 05/16/19 indicated residents voiced ongoing concerns related to the noise level at night. It was noted residents voiced a new concern related to noise level in the dining room and suggested curtains to cut down on the noise.

Resident Council minutes dated 06/20/19 indicated residents voiced ongoing concerns related to the noise level at night. It was noted residents voiced new concerns regarding laundry not being returned to the right residents and dietary not getting meals out on time.

Resident Council minutes dated 07/18/19 indicated residents voiced ongoing concerns related to laundry not being returned to the right residents, timing of food and noises level at night. It was noted residents voiced new concerns regarding call lights not being answered timely by staff.

Resident Council minutes dated 08/15/19 indicated residents voiced ongoing concerns related to laundry not being returned to the right residents and noise level at night.

Resident Council minutes dated 09/19/19 indicated residents voiced repeated concerns related to laundry not being returned to the right residents. A notation under 'New Business' read, "residents feel things are getting worse."

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Resident Council minutes dated 10/18/19 indicated under 'Old Business' that residents wanted to know who responded to grievances. It was noted residents voiced a new concern that dietary staff were not following meal tickets carefully.

Resident Council minutes dated 11/25/19 indicated residents voiced ongoing concerns with meal tickets not being followed correctly and laundry not being returned to the right residents.

Resident Council minutes dated 12/26/19 indicated residents voiced ongoing concerns with laundry not being returned to the right residents. It was noted residents voiced a new concern related to housekeeping not cleaning the rooms thoroughly.

There was no evidence the facility's response to the concerns and/or suggestions voiced during the meetings was provided or discussed during the subsequent meetings.

The facility's grievance/concern logs for the period February 2019 through December 2019 were reviewed. There were no concerns recorded for the Resident Council or residents who attended the meetings except for the month of August 2019 which indicated the 2 concerns dated 08/16/19 related to missing laundry and noise level at night were investigated and the facility's response would be provided to the residents at the next scheduled Resident Council meeting.

During an interview on 01/15/20 at 3:50 PM, the Activity Director (AD) confirmed he attended and recorded the minutes for the Resident Council

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monthly meetings. The AD explained when residents voiced concerns and/or issues during the monthly meetings, he wrote them on a concern form and delivered the form to the Social Worker or Administrator. He added there were some concerns voiced during the meetings that he did not write down on a concern form because he discussed the issue directly with the Department Supervisor (DS), such as missing laundry. He shared the concerns brought up by the residents were also discussed in the morning administrative meetings with the other DS. He stated once the resolution to the concerns was provided to him, he reported it back to the Resident Council at the next scheduled meeting. The AD shared he did not write down the resolution on the minutes but did verbally discuss with the residents what had been done to address their concerns. The AD admitted the residents reported during the meetings that they were not happy their concerns did not appear to be getting addressed. The AD stated he felt the Administrator tired to address the concerns voiced but the issues often took time to resolve and the residents were left feeling nothing was being done because they voiced the same concerns month-to-month.

During an interview on 01/15/20 at 3:20 PM, the Administrator confirmed he was the Grievance Officer for the facility. He explained when concerns were voiced during the Resident Council meetings, staff were instructed to document the concerns on a concern form, he reviewed the concerns and then discussed the concerns with the DS during the morning administrative meetings to develop a plan of action. He added during the discussions with the DS, he made notes to ensure the residents'

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F 565	Continued From page 5 concerns were addressed and followed up on. The Administrator stated he felt the concerns voiced by the residents were always addressed and verbal communication was always provided; however, the process for resolution often took time. The Administrator confirmed there was no written documentation to support the facilities efforts to address the concerns voiced by residents during the Resident Council meetings.	F 565		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 582		

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Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to provide a CMS-10055 SNF ABN (Centers for Medicare and Medicaid Services Skilled Nursing Facility Advanced Beneficiary Notice) prior to discharge from Medicare Part A skilled services to 2 of 3 residents reviewed for beneficiary protection notification review (Residents #50 and #71).

Findings included:

1. Resident #50 was admitted to the facility on 10/17/19.

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A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #50 on 12/11/19 which indicated Medicare Part A coverage for skilled services would end on 12/13/19. Resident #50 remained in the facility after the NOMNC was issued with Medicare Part A benefits remaining.

A review of the medical record revealed a CMS-10055 SNF ABN was not provided to Resident #50.

During an interview on 01/15/20 at 10:20 AM, the Social Worker (SW) indicated she was responsible for issuing the NOMNC to the resident or their Responsible Party (RP) once notified the resident's Medicare Part A coverage for skilled services was ending. The SW added she was aware a SNF ABN was also required when the resident remained in the facility with Medicare Part A benefits remaining. The SW was unable to explain why Resident #50 was not issued a CMS-10055 SNF ABN prior to Medicare Part A services ending.

During an interview on 01/16/20 at 4:10 PM, the Administrator stated he would expect for staff to issue the required notices to residents and/or their RP when Medicare Part A skilled services were ending.

2. Resident #71 was admitted to the facility on 09/30/19.

A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #71 on

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F 582	Continued From page 8 12/11/19. The notice indicated that Medicare Part A coverage for skilled services would end on 12/13/19. Resident #71 remained in the facility after the NOMNC was issued with Medicare Part A benefits remaining. A review of the medical record revealed a CMS-10055 SNF ABN was not provided to Resident #71. During an interview on 01/15/20 at 10:20 AM, the Social Worker (SW) indicated she was responsible for issuing the NOMNC to the resident or their Responsible Party (RP) once notified the resident's Medicare Part A coverage for skilled services was ending. The SW added she was aware a SNF ABN was also required when the resident remained in the facility with Medicare Part A benefits remaining. The SW was unable to explain why Resident #71 was not issued a CMS-10055 SNF ABN prior to Medicare Part A services ending. During an interview on 01/16/20 at 4:10 PM, the Administrator stated he would expect for staff to issue the required notices to residents and/or their RP when Medicare Part A skilled services were ending.	F 582		
F 585 SS=C	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	F 585		

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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 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;

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F 585	Continued From page 10 (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 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	F 585		

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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 and staff interviews, the facility failed to develop a grievance policy that included: the residents' right to receive a written summary of the grievance resolution, the name and contact information of the facility's designated grievance official, the contact information of independent entities with whom grievances may also be filed such as pertinent State agency, State Long Term Care Ombudsman or Quality Improvement Organization, and a statement that evidence demonstrating the results of all grievances would be maintained for a period of 3 years.

Findings included:

A review of the facility's grievance policy, with a revised date of 12/20/16 and provided by the Administrator, specified in part the facility documented, investigated, and attempted to resolve all concerns submitted orally or in writing without fear of threat or reprisal in any form. The policy further stated the Executive Director would designate a Grievance Officer at the facility and a copy of the resolution would be provided to the resident upon request.

During an interview on 01/15/20 at 3:20 PM, the Administrator shared he was the Grievance Officer for the facility and personally followed up with the individual voicing the concern to verbally

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F 585	Continued From page 12 discuss the resolution and ensure the issue was resolved to their satisfaction. He confirmed the grievance policy retrieved from the corporate website, with a revised date of 12/20/16, was the most current policy. The Administrator explained the corporate office updated policies as needed to ensure regulatory requirements were met and acknowledged the facility's current grievance policy did not contain all the required components as outlined in the grievance regulation.	F 585		
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 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	F 655		

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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 develop a baseline care plan within 48 hours of admission to address the immediate needs for 1 of 4 sampled residents reviewed for baseline care plan (Resident #31).

Findings included:

Resident #31 was admitted to the facility on 10/30/19 with diagnoses included dysphagia, status post gastrostomy, neurogenic bladder, cortical blindness, and muscle spasm.

Review of care area assessment revealed Resident #31 had a percutaneous endoscopic gastrostomy (PEG) tube in place due to dysphagia.

Review of the admission Minimum Data Set (MDS) dated 11/06/19 revealed Resident #31 was

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coded with severely impaired short-term and long-term memory problems as well as daily decision-making skill. She required extensive to total assist with 1 to 2 plus person physical assist for most of her activities of daily living.

Review of electronic records and the hard chart revealed baseline care plans that included the minimum healthcare information necessary to properly care for the immediate needs of Resident #31 was not in place within the 48 hours after admission. The comprehensive care plan for Resident #31 was not developed until more than one week after admission on 11/07/19.

During an interview conducted with the Assistant Director of Nursing (ADON) on 01/16/20 at 3:03 PM, she acknowledged that the facility had failed to develop the baseline care plan for Resident #31 within 48 hours after admission. The ADON stated whenever a new resident admitted to the facility, the hall nurse who was admitting the resident had to initiate the baseline care plan during the shift. The Unit Manager (UM) of the shift was responsible to follow through and to ensure the completion of the baseline care plan within 48 hours. She attributed the incident as a lack of follow through by the UM on duty.

An interview was conducted with the Director of Nursing (DON) on 01/16/20 at 3:08 PM. She stated the hall nurse who admitted Resident #31 was responsible to initiate the baseline care plan and the UM had to follow through and ensure the completion of the baseline care plan within 48 hours after admission. The DON reported her expectation was for the nurse and the UM to complete the baseline care plan accurately based on Resident #31's immediate needs within 48

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F 655	Continued From page 15 hours after admission. Interview with the Administrator conducted on 01/16/20 at 3:23 PM revealed that his expectation was for all the residents to have a baseline care plan in place within 48 hours after admission. A phone interview was attempted on 01/16/20 at 4:34 PM with the former UM who was on duty during Resident #31 admission. She was not available to answer the call. A message with call back phone number was left in her voicemail box. No return calls were received.	F 655		
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, staff, and physician interviews the facility failed to administer medication per physician's order for 2 of 5 sampled residents reviewed for unnecessary medication (Resident #65 and Resident #22). Findings included: 1. Resident #65 was admitted to the facility on 12/06/19 with diagnosis of progressive neurological condition. A review of a physician's order dated 12/07/19 indicated Resident #65 was to receive Testosterone Cyplonate (steroid medication)	F 658		

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Solution 200 milligram (mg) per milliliter (ml) and inject 1 dose intramuscularly (IM) one time a day every 14 days for chronic inflammatory demyelinating polyneuritis (rare neurological disorder).

A review of the Medication Administration Record (MAR) for the month of December 2019 and January 2020 revealed per staff documentation on the MAR that Resident #65 received an initial dose of Testosterone Cyplonate on 12/13/19 at 9:00 AM. Resident #65 per absence of documentation on the MAR did not receive the 9:00 AM dose of scheduled Testosterone Cyplonate on 12/27/19 and 01/10/20.

On 01/15/20 at 8:14 AM an interview was conducted with Nurse #1 who stated she was responsible to administer steroid medication 200 mg per ml on 12/27/19 and 01/10/20 at 9:00 AM. Nurse #1 stated the medication was not available on the medication cart or in the medication storage room on 12/27/19 and 01/10/20 so she did not administer the medication. Nurse #1 shared that she did not notify the physician that the medication was not available to be administered on 12/27/19 and 01/10/20 to receive further instructions or orders from the physician and further stated she did not notify the Director of Nursing (DON) that the medication was not available to be administered. Nurse #1 stated she did not contact the pharmacy regarding the missing steroid medication on 12/27/19 and 01/10/20 for Resident #65. Nurse #1 stated she was new to the facility and did not know the protocol to follow if medication was not available on the medication cart.

On 01/15/20 at 8:23 AM an interview was

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conducted with the DON who stated her expectation was that Nurse #1 would have administered the steroid medication to Resident #65 as per physician's order. The DON stated Nurse #1 should have notified the physician that the medication was not available and determined if the physician wanted to change the order or change the time for the medication administration for Resident #65. The DON stated if the medication was not available on the medication cart or in the facility to be administered then the nurse should have called the pharmacy to get the medication sent to the facility. The DON shared that the reason why Resident #65's steroid medication was not available in the facility was because the pharmacy required a paper prescription and Nurse #1 had not called the pharmacy to determine a paper prescription was required.

0n 01/15/20 at 08:30 AM an interview was conducted with the Physician who stated his expectation was that Resident #65 would have been administered Testosterone Cyplonate per his orders. The physician shared that he should have been notified by the facility that the medication was not available for administration so that he could have provided further orders. The Physician stated he was unaware that Resident #65 had missed 2 doses of Testosterone Cyplonate, one dose on 12/27/19 and one dose on 01/10/20. The physician shared that no harm resulted to Resident #65 because the medication was not administered on 12/27/19 and 01/10/20.

On 01/15/20 at 9:53 AM an interview was conducted with the Administrator who stated his expectation was that steroid medication would have been administered as ordered by the

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physician to Resident #65. The Administrator stated his expectation was that Nurse #1 would have informed the physician that the steroid medication was not available to be administered and the physician could have provided further orders. The Administrator shared Nurse #1 should have informed the DON that Resident #65's steroid medication was not available to be administered. The Administrator stated he felt that the breakdown of why the steroid medication was not administered to Resident #65 was lack of communication by Nurse #1 not informing the physician and the DON that the medication was not available to be administered.

2. Resident #22 was admitted to the facility on 03/26/19 with diagnosis included multiple sclerosis (MS), anxiety, fibromyalgia, and chronic pain.

Review of care area assessment dated 04/03/19 revealed Resident #22 had chronic pain related to fibromyalgia and MS.

Review of care plan for pain initiated on 04/03/19 revealed part of the interventions included administered analgesia as per orders; monitored and documented for the side effects of pain medication.

Review of the quarterly Minimum Data Set (MDS) assessment dated 11/01/19 indicated Resident #22 was cognitively intact and required supervision with most of her activities of daily livings except independent with transfers. Further review of MDS revealed Resident #22 was receiving opioid daily in the 7-day look back period.

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A review of the physician's order dated 03/26/19 indicated Resident #22 was to receive one half tablet of 5 milligram (mg) Oxycodone by mouth once every 12 hours as needed for pain.

A review of Controlled Medication Utilization Records (CMUR) for January 2020 revealed Resident #22 had received one half tablets of the "as needed" (PRN) Oxycodone 5 mg on the following dates and times and they were all administered by Nurse #1:
01/07/20 at 7:00 AM
01/07/20 at 9:00 AM
01/14/20 at 6:00 AM
01/14/20 at 7:00 AM

On 01/15/20 at 10:48 AM an interview was conducted with Resident #22 who stated sometimes when the pain occurred earlier than the scheduled once every 12 hours, she would request the PRN pain medication sooner. In most cases, the nurse would tell her it was not time yet.

On 01/15/20 at 10:58 AM an interview was conducted with the Consultant Pharmacist who acknowledged that Nurse #1 had administered the PRN Oxycodone too soon on 01/07/20 and 01/14/20 respectively. She stated Nurse #1 should have checked the actual time of previous PRN narcotic administration before given Resident #22 the next PRN dose. It was her expectation for all the nurses to follow physician's order when administrating PRN pain medication with specified interval.

On 01/15/20 at 2:09 PM an interview was conducted with Nurse #1 who stated she would normally check the physician's order in the electronic Medication Administration Records

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(eMAR) before administering the PRN pain medications with specified interval. She would chart the time of administration of the PRN pain medication in CMUR after she had administered the medication. Nurse #1 added the times she charted in the CMUR were as closed to the actual time of administration as possible. She acknowledged that she had a couple occasions that she had given the PRN pain medication sooner than the order as she had forgotten to check the previous administration time before administering the next dose. Nurse #1 stated she should have checked the CMUR to find out when Resident #22 had received the last dose of PRN pain medication before administering the next dose.

On 01/15/20 at 2:32 PM an interview was conducted with Assistant Director of Nursing (ADON) who acknowledged that Nurse #1 had administered the PRN Oxycodone to Resident #22 sooner than the order in at least 2 separate occasions. The ADON stated per facility protocol, whenever a nurse received request for PRN narcotic with a specific interval, they had to check the CMUR to find out the actual time of last PRN narcotic administration before administering the next dose. It was her expectation for all the nurses to follow the facility protocol and physician's order.

On 01/15/20 at 2:48 PM an interview was conducted with the Director of Nursing (DON) and the Administrator (AD) who stated Nurse #1 should have checked the time of the last PRN narcotic administration before giving Resident #22 the next dose. The DON and AD expected all the nurses in the facility to follow physician's order during medication administration.

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F 658	Continued From page 21 On 01/16/20 at 1:01 PM a phone interview was conducted with the Physician who stated no harm would result to Resident #22 for receiving the PRN Oxycodone two times sooner than it was specified in the order. It was his expectation for all the nurses to follow physician's orders when administering PRN medication with specified time interval.	F 658		
F 814 SS=B	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep the dumpster area free of debris for 2 of 2 dumpsters. The findings included: During a tour of the dumpster area on 01/15/20 at 2:10 PM with the Food Service Director (FSD), observations revealed that beside dumpster #1 there were 2 wet napkins, 1 plastic cup lid with a straw inside and 1 disposable glove. Behind dumpster #1 there were approximately 3 muddy and wet paper fragments, 1 disposable glove, 2 ketchup packets, 2 soda bottle lids with mud filling them and at least 25 cigarette butts. In front of dumpster #2 there were approximately 4 paper fragments soaked into the mud and at least 10 cigarette butts. A second observation of the dumpster area took place on 01/15/20 at 2:27 PM with the Maintenance Director (MD) during which 2 wet	F 814		

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F 814	Continued From page 22 napkins remained to the side of the dumpster #1, 1 disposable glove, 2 ketchup packets and at least 25 cigarette butts were observed behind dumpster #1. In front of Dumpster #2 were approximately 4 wet, muddy paper fragments and at least 10 cigarette butts. A third observation of the dumpster area took place on 01/16/20 at 10:08 AM, approximately 5 cigarette butts remained behind dumpster #1 along with 1 soda bottle lid. The remainder of debris observed prior had been removed. An interview was completed with the MD 01/15/20 at 2:27 PM who reported that he did not think that any department was solely responsible for routinely cleaning the dumpster area and instead it was expected that all team members keep the area clean. The MD reported that it was his expectation that the area remain clean and free of trash and debris. On 01/16/20 an interview was completed with the Administrator at 3:37 PM who reported that the dumpsters were emptied daily and during that process it was not uncommon for trash to fall onto the ground which he explained as the reason trash was found outside of the dumpsters during the observations. The Administrator reported that the dumpster area was expected to remain free of trash and debris.	F 814		
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	F 842		

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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, 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.

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F 842	Continued From page 24 §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 accurately document the provision of catheter care for 1 of 1 resident reviewed for urinary catheter (Resident #65). Findings included: Resident #65 was admitted to the facility on 12/06/19 with diagnosis of progressive neurological condition and neurogenic (lack control) bladder. A review of a physician's order dated 12/08/19 indicated Resident #65 was to receive catheter care every shift and as needed.	F 842		

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Admission Minimum Data Set (MDS) assessment dated 12/13/19 indicated Resident #65 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene and had an indwelling catheter.

Care Area Assessment dated 12/13/19 indicated Resident #65 had an indwelling catheter for neurogenic bladder.

Care plan initiated on 12/16/19 indicated resident #65 had an indwelling catheter for neurogenic bladder.

A review of the Treatment Administration Record (TAR) for the month of January 2020 revealed on the day shift for the dates of 01/02/20, 01/07/20, 01/09/20, and 01/13/20 and on the evening shift 01/08/20 there was no documentation to indicate that catheter care had been provided as ordered by the physician.

On 01/16/20 at 11:41 AM a telephone interview was conducted with Nurse #1 who stated she was responsible to document that catheter care had been provided on the day shift for Resident #65 on 01/02/20, 01/07/20, 01/09/20, and 01/13/20. Nurse #1 shared that the catheter care had been provided per physician's order. Nurse #1 explained that she was a new nurse to the facility and was not used to the computer system and did not document on Resident #65's TAR that catheter care was provided.

On 01/16/19 at 2:35 PM a telephone interview was conducted with Nurse #2 who stated she was responsible to document that catheter care had been provided on the evening shift for

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resident #65 on 01/08. Nurse #2 shared that catheter care had been provided per physician's order. Nurse #2 explained that she forgot to document on Resident #65's TAR that catheter care was provided.

On 01/16/20 at 2:59 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that Nurse #1 would have documented on Resident #65's TAR that catheter care was provided on the day shift on 01/02/20, 01/07/20, 01/09/20, and 01/13/20. The DON shared that lack of knowledge to document on the TAR in the computer system was probably the reason why Nurse #1 had not documented catheter care was provided for Resident #65. The DON stated it was her expectation that Nurse #2 would have documented that Resident #65 received catheter care on the evening shift on 01/08/20. The DON shared that lack of time management was probably the reason why Nurse #2 did not document on the TAR that Resident #65 had received catheter care on the evening shift on 01/08/20.

On 01/16/20 at 3:45 PM an interview was conducted with the Administrator who stated his expectation was that catheter care for Resident #65 would have been documented by Nurse #1 and Nurse #2 when completed.