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	345421	A. BUILDING _____ B. WING _____	C 01/24/2020

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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E 000	Initial Comments An unannounced Recertification survey was conducted on 1/21/2020 through 1/24/2020. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #8LLV11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted on 1/21/20 to 1/24/20. There were 6 complaint intakes with a total of 21 allegations. None of the allegations were substantiated. See Event #8LLV11.	F 000		
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free	F 604		2/21/20

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

Electronically Signed | 02/13/2020

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F 604	Continued From page 1 from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and physician interview, the facility utilized a helmet with a chin strap for Resident #70, that he was unable to remove independently, without considering it as a restraint and without a medical diagnosis for 1 of 4 residents reviewed for physical restraints. The findings included: Resident #70 was admitted to the facility on 4/25/19 with diagnoses that included dementia with behavioral disturbance, epilepsy, and unsteadiness on feet. The plan of care for Resident #70 included the problem area of the risk for fall related injury and falls related to confusion/dementia, wandering, and a history of falls. Resident was noted to be unaware of danger, he would lay down on the ground for 10 to 15 minutes and then get back up. He laid down on the floor in the halls, day room, and dining room. This focus area was initiated on 5/7/19 and last revised on 5/14/19. The interventions included, in part, Resident #70 to wear a helmet when out of bed. This intervention was initiated on 5/22/19. A physician ' s order dated 6/3/19 indicated a	F 604	The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is 2-21-2020 Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F604 Right to be free from Physical Restraints Corrective Action: Resident #70 has been reassessed by the MDS (minimum data set) Care Plan nurse, and has had a device evaluation completed on 1-23-20. A clarification order has been written on 1-23-2020, to include the medical diagnosis/symptom for the usage of the device and at what the time it is to be applied and when it is to be removed. The device will be reviewed quarterly to determine if the helmet is still a restraint and if so, if it is considered the lease restrictive device.	

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F 604	Continued From page 2 helmet was to be applied to Resident #70 ' s head during daytime hours and when out of bed. This order was entered by Unit Manager (UM) #2. A Psychiatric Nurse Practitioner ' s note dated 7/2/19 indicated Resident#70 was non-verbal and he had the behavior of pacing and placing himself on the floor, rolling back and forth, and then standing up. A safety helmet was applied to prevent head injury. The quarterly Minimum Data Set (MDS) assessment dated 11/26/19 indicated Resident #70 had short-term and long-term memory problems and severely impaired decision making. He had physical behaviors and rejection of care on 1 to 3 days during the 7-day MDS review period. Resident #70 was assessed as supervision with set up help only for walking in room and corridor. He had no falls since his previous MDS (8/26/19). This assessment indicated he had no physical restraints (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body). The Nursing Assistant (NA) care guide dated 12/22/19 indicated that Resident #70 was to have his helmet on when out of bed. An observation was conducted of Resident #70 on 1/21/20 at 12:17 PM on the facility ' s secured unit. He was wearing a helmet. The helmet had a chin strap and was clasped in the closed position on Resident #70. The resident was walking independently throughout the halls and common area of the unit.	F 604	Identification of others potentially at risk: Any resident that has the need for a device for safety, that prevents access to one□s body, has the potential to be affected. This will be identified through continuous review of new orders and changes of the residents by the nursing team and communicate changes found to the MDS team for any updates as needed. An audit of all residents that were using a device that prevents access to one□s body, was conducted 1-27-2020, by the DON, (Director of Nurses) and her nurse managers. No other resident was found to be affected. Systemic Changes: The MDS nurses will be re-educated on 2-17-2020, by the Regional MDS consultant, as to what constitutes a restraint, how and when to code it as a restraint, when a device and/or a restraint evaluation must be conducted, and how to update the care guide for staff. Licensed nurses will be re-educated on 2-17-2020 by the DON/ADON of how to complete the physical device evaluation and the frequency of the evaluation, with updates to the MDS staff as needed. Any staff not completing the in-service will not be able to work until educated. This includes all shifts and weekend staff. Monitoring: Residents with assistive devices that meet the criteria as a restraint will be identified on admission with the physical device evaluation. Resident whose physical	

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F 604	Continued From page 3 A review of the active physician ' s orders on 1/21/20 indicated the order for the helmet (initiated on 6/3/19) continued to be active. A review of the medical record on 1/21/20 revealed no physical device or physical restraint evaluation was completed for the use of Resident #70 ' s helmet. An interview was conducted with NA #3 on 1/22/20 at 3:15 PM. She indicated that Resident #70 had no helmet in place when he was first admitted, but that it had now been in use for several months. She stated that staff put the helmet on him when he wakes up and takes it off when he goes to bed or when he was assisted with showering. NA #3 reported that the helmet was in place to protect Resident #70 ' s head. She explained that he has a behavior of laying himself on the ground, so they wanted something in place to keep his head safe when he laid on the ground. NA #3 revealed that Resident #70 was not able to take the helmet off himself. She further revealed that the helmet had restricted his ability to touch his head. During an interview with NA #4 on 1/23/20 at 10:10 AM she confirmed NA #3 ' s report that the Resident #70 was not able to independently take his helmet off and that it had restricted his ability to touch his head. She stated that the helmet was in place for safety as he had a behavior of laying down on the ground in the halls and the common areas. On 1/23/20 at 11:25 AM the Director of Nursing (DON) was asked what the normal process was	F 604	device has been identified as being a restraint will have the order for the device reviewed to ensure that the medical diagnosis/symptom is included in the order as well as frequency of application and removal. New admission physical device evaluations will be audited weekly by the DON (Director of Nurses) and/or her nurse managers, to ensure that any physical device evaluation is done correctly and if any restraint has been identified. Any new physician orders regarding devices will be audited to determine if the physical device has an evaluation. If a restraint is identified, the order will be audited to determined if a consent has been signed, as well to determine if the order has the medical diagnosis/symptom and frequency. Audits will be done weekly for 2 months and then monthly times 3 month, and then will be discussed in the monthly QAPI (Quality Assurance and Performance Improvement) meeting for 3 months. The Director of Nurses will be responsible to ensure any further recommendations are carried out. Staff found to not be accurately completing device evaluations will be re-educated as necessary.	

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for the completion of physical device/restraint assessments. She stated that the UMs were responsible for completing the physical device evaluations on initiation of physical device and then quarterly thereafter as long as the device was in use. The use of Resident #70 ' s helmet was reviewed with the DON. She stated that this helmet was put on to protect his head as he had a behavior of laying on the ground. She reported that a physical device evaluation should have been completed for the helmet when it was initiated in June. The medical record was reviewed with the DON and she confirmed no physical device evaluation was completed for Resident #70 ' s helmet.

A physical device evaluation dated 1/23/20 at 1:06 PM was completed by UM #2 for Resident #70. This evaluation indicated a helmet was in use for Resident #70, the device was attached or adjacent to the resident, and could not be easily removed by the resident. UM #2 answered "no" to the question that asked if the device restricted the resident's freedom of movement or normal access to his /her body. Based on UM #2 ' s responses to these questions, the helmet was assessed as an enabler and not a physical restraint.

An interview was conducted with UM #2 on 1/23/20 at 2:20 PM. She reported that she was responsible for completing physical device use evaluations for the past year. She revealed she had no recollection of being trained on how to complete these evaluations, so she did them to the best of her ability. UM #2 stated that the evaluations were to be completed on initiation of a physical device. She reported she was unsure how often they were to be completed after the

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initial evaluation. She additionally reported that she was unaware that physical restraint use reduction attempts were required to be completed when a restraint was in use.

This interview with UM #2 continued. She indicated she was familiar with Resident #70 and that he had a helmet in place to protect his head from injury. She stated that when he was first admitted to the facility he laid on the floor frequently, he had no orientation to space, and no awareness of danger. She revealed she had not completed a physical device evaluation for Resident #70 when the helmet was initiated in June 2019. She further revealed that she had not completed any attempts to reduce and/or eliminate the use of the helmet in the 7.5 months it had been in use. UM #2 explained that she had not thought of the helmet as a physical restraint because it was implemented for his safety.

She indicated the DON asked her to complete a physical device evaluation for the use of Resident #70 ' s helmet today (1/23/20). This physical device evaluation was reviewed with UM #2. The question that asked if the device restricted resident ' s freedom of movement or normal access to his body was reviewed with UM #2. UM #2 revealed she had not understood how to accurately answer this question. She acknowledged that the helmet prevented Resident #70 from normal access to his head.

An interview was conducted with the physician on 1/24/20 at 2:00 PM. He stated that Resident #70 ' s helmet was in place for safety reasons. He explained that the resident had the behavior of sitting down on the floor and then rolling around and the helmet protected his head if it hit the

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F 604	Continued From page 6 floor. During an interview with the Administrator and DON on 1/24/20 at 2:55 PM the use of Resident #70 ' s helmet was reviewed. They both agreed that the helmet was attached to the resident ' s body, that he was not able to remove it, and that it restricted normal access to his head. The Administrator and DON reported that they expected an accurate evaluation to be completed when a physical device was initiated to determine if it met the definition of a physical restraint. The Administrator further reported that he expected physical restraints to have a medical symptom to justify their use, and for ongoing assessments and restraint reduction attempts to be completed regularly.	F 604		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to accurately code the Minimum Data Set in the areas of Activities of Daily Living (Residents #5, #70, #75,and #100), active diagnosis (Resident #5), discharge (Resident #126), restraints (Residents #70 and #83), behaviors (Resident #45), medications (Resident #17) and bowel and bladder (Resident #76) for 9 or 31 sampled residents reviewed. The findings included:	F 641	F641 Accuracy of Assessments Corrective Action: Resident #75 has had a correction to the MDS by the MDS nurse on 2-5-2020, to accurately reflect bathing occurrences. Resident #100 has had a correction to the MDS by the MDS nurse on 2-10-2020,to reflect the accurate amount of assistance required for transfer and range of motion of extremities. Resident #70 has had a correction to the MDS on 1-31-2020 by the MDS nurse, to reflect the assessment of his helmet as a	2/21/20

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1) Resident #75 was originally admitted to the facility on 8/6/19 with the most recent readmission date of 11/29/19. His diagnoses included chronic obstructive pulmonary disease (COPD), chronic pain syndrome and diabetes.

A quarterly Minimum Data Set (MDS) dated 11/13/19 indicated Resident #75 was cognitively intact. He received setup assistance for meals; extensive assistance with dressing, bed mobility, toileting, personal hygiene and was dependent on staff for transfers and bathing.

The most recent quarterly MDS dated 12/3/19 revealed Resident #75 to have mild cognitive impairment but was able to make needs known and understood others. He was coded as activity did not occur for bathing during the 7 day look back period.

On 1/23/2020 at 8:30am an interview occurred with Resident #75, who explained a sponge bath was provided every morning before he got dressed. He further stated he had been in the hospital at the end of November 2019 but remembered receiving sponge baths every morning as he does now when he returned to the facility.

On 1/23/2020 at 10:50am nurse aide #5 was observed providing a sponge bath to Resident #75.

An interview occurred with Nurse Aide #5 on 1/23/2020 at 11:10am and indicated all residents are to receive a sponge bath prior to getting up every morning.

The MDS Nurse #3 was interviewed on 1/23/2020

restraint/device. In addition to coding for a restraint/device, resident #70 has had a correction to amount of assistance for locomotion that was required for both in the room and on the unit. Resident #5, having a stable weight for the past 6 months, has had the diagnosis updated by the MDS nurse on 1-24-2020, to include a history of abnormal weight loss. In addition, for resident #5, a correction has been completed for the bathing section to reflect an accurate bathing assessment. Resident #76□s assessment has been corrected by the MDS nurse on1-31-2020, to accurately reflect the condom catheter, and not an indwelling one. Resident #17□s MDS has been corrected by the MDS nurse on 2-11-2020, to accurately reflect the gradual dose reduction trial of the Seroquel. Resident #83□s MDS has been corrected by the MDS nurse on 1-22 -2020, to accurately reflect the use of a limb restraint. Resident #45 MDS assessment has been corrected by the Social Worker on 1-27-2020 to reflect his refusal behaviors. Resident #126□s MDS has been corrected by the MDS nurse on 1-23-2020 to reflect accurate location of discharge.

Identification of others potentially at risk: All residents in our facility require an accurate MDS assessment and have the potential to be affected. An audit of MDS□s completed in the past 3 months, looking at bathing occurrences, transfer assistance and range of motion, use of assistive devices, assistance for locomotion, active diagnosis□s, type of

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F 641	Continued From page 8 at 2:45pm. After reviewing the quarterly MDS dated 12/3/19 the MDS Nurse #3, stated she couldn't find documentation from the nurse aides that a bath was provided and coded the bathing portion of the assessment as activity did not occur. She further stated she failed to speak with the aides to see if a sponge bath or bed bath was provided during the look back period. During an interview on 1/24/2020 at 8:00am, the Director of Nursing indicated it was her expectation for the MDS to be coded accurately. 2) Resident #100 was originally admitted to the facility on 9/20/19 with diagnoses which included contracture of the right and left leg, right elbow and left wrist and adhesive capsulitis of the left and right shoulders (constant severe limitation of the range of motion to the shoulder). A review of Resident #100's admission Minimum Data Set (MDS) dated 9/27/19 revealed the resident with severe cognitive impairment and required total assistance from staff for transfers. Limited range of motion was present to all extremities. The Quarterly MDS dated 12/20/19 indicated Resident #100 had severe cognitive impairment and received limited assistance of staff for transfers. She was coded with limited range of motion to all extremities. Review of the Nursing Care Card dated 1/20/2020 indicated Resident #100 required total assistance of 2 people for transfers via a mechanical lift. On 1/23/2020 at 1:55pm an interview was	F 641	catheter, coding for gradual dose reduction, use of restraints, and refusal behaviors, was conducted from the time of survey and completed on 2-14-2020 , by the DON, (Director of Nurses) and her nurse managers. No other resident was found to be affected by this alleged deficient practice. Systemic Changes: The MDS nurses and social services will be re-educated on 2-17-2020, by the Regional MDS consultant to include expectations on gathering correct information for accuracy in coding MDS Monitoring: MDS□s audits will be done weekly by the DON and/or the nurse managers for 2 months and then monthly times 3 months and then will be discussed in the monthly QAPI meeting by the DON, to ensure proper and accurate coding. Staff found to not be accurately completing the MDS will be re-educated as necessary. The Director of Nurses will be responsible to ensure any further recommendations are carried out.	

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conducted with nurse aide #7 who was familiar with the resident. She indicated Resident #100 was dependent on a mechanical lift and 2 to 3 staff members to transfer to and from the bed and gerichair.

Nurse #1 was interviewed on 1/23/2020 at 2:15pm and stated Resident #100 was dependent on a mechanical lift and at least 2 to 3 staff members for transfers and was not able to assist with the task.

A phone interview was conducted with MDS Nurse #2 on 1/23/2020 at 3:51pm. She stated she completed Section G of the MDS by the coding on the aide flow record. Since there were 2 total assists and 1 limited assist she coded as limited assistance and could not recall speaking with any staff members when completing Section G of the MDS assessment. The MDS Nurse #2 added she visualized the resident but thought she had to code by what was documented from the aides.

During an interview with the Administrator and Director of Nursing on 1/24/2020 they both indicated it was their expectation for the MDS to be coded accurate.

3a. Resident #70 was admitted to the facility on 4/25/19 with diagnoses that included dementia with behavioral disturbance, epilepsy, and unsteadiness on feet.

A physician ' s order dated 6/3/19 indicated a helmet was to be applied to Resident #70 ' s head during daytime hours and when out of bed. This order was entered by Unit Manager (UM) #2.

The quarterly Minimum Data Set (MDS)

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assessment dated 11/26/19 indicated Resident #70 had short-term and long-term memory problems and severely impaired decision making. This assessment indicated he had no physical restraints (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body). The restraints section of this MDS was coded by MDS Nurse #2.

An observation was conducted of Resident #70 on 1/21/20 at 12:17 PM on the facility ' s secured unit. He was wearing a helmet. The helmet had a chin strap and was clasped in the closed position on Resident #70.

A review of the active physician ' s orders on 1/21/20 indicated the order for the helmet (initiated on 6/3/19) continued to be active.

An interview was conducted with UM #2 on 1/23/20 at 2:20 PM. She stated that Resident #70 ' s helmet was attached to his body, that he was not able to remove it, and that it restricted his normal access to his head. UM #2 acknowledged the helmet met the definition of a physical restraint for Resident #70.

A phone interview was conducted on 1/23/20 at 4:00 PM with MDS Nurse #2. She stated that she used observations, physical device evaluations, and staff interviews to code the MDS in the area of restraints. Resident #70 ' s helmet use and the 11/26/19 MDS that indicated he had no restraints was reviewed with MDS Nurse #2. She reported that she had not thought of the helmet as a physical restraint because it was used for safety.

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(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
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MDS Nurse #2 acknowledged that the helmet met the definition of a physical restraint as it was attached to the resident ' s body, he was not able to remove it, and it restricted his normal access to his head.

During an interview with the Administrator and DON on 1/24/20 at 2:55 PM the use of Resident #70 ' s helmet was reviewed. They both agreed that the helmet was attached to the resident ' s body, that he was not able to remove it, and that it restricted normal access to his head. The Administrator indicated that he expected the MDS to be coded accurately.

3b. Resident #70 was admitted to the facility on 4/25/19 with diagnoses that included dementia with behavioral disturbance.

A review of the Nursing Assistant (NA) documentation of locomotion on the unit for the 7-day period of 11/20/19 through 11/26/19 revealed Resident #70 was coded 4 times as extensive assistance of 1. The remaining documentation indicated he was independent with no set up help for locomotion on the unit.

The quarterly Minimum Data Set (MDS) assessment dated 11/26/19 indicated Resident #70 had short-term and long-term memory problems and severely impaired decision making. Resident #70 was assessed as requiring supervision with set up help only for walking in room/corridor and extensive assistance of 1 physical assist for locomotion on the unit. Resident #70 used no mobility devices. The Activities of Daily Living (ADLs) section of this MDS was coded by MDS Nurse #2.

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A phone interview was conducted on 1/23/20 at 4:00 PM with MDS Nurse #2. She stated that she used the NA electronic documentation of locomotion on the unit to complete the MDS section about locomotion on the unit and walking in room/corridor. The 11/26/19 MDS for Resident #70 that had extensive assist of 1 for locomotion on the unit and supervision with set up help only for walking in room/corridor was reviewed with MDS Nurse #2. MDS Nurse #2 acknowledged that Resident #70 ' s method of locomotion on the unit was walking as he had no mobility devices. She revealed that locomotion on the unit and walking in room/corridor should have been coded the same for Resident #70. She indicated that utilizing the rule of three, locomotion on the unit should have been coded as extensive assistance of 1.

During an interview with the Administrator on 1/24/20 at 2:55 PM he indicated he expected the MDS to be coded accurately.

4a. Resident #5 was initially admitted to the facility on 8/30/17 and most recently readmitted on 3/6/18 with diagnoses that included dementia.

A dietary note dated 1/2/20 indicated Resident #5 ' s weight was within normal limits and was stable over the last 6 months.

The quarterly Minimum Data Set (MDS) assessment dated 1/3/20 indicated Resident #5 ' s cognition was severely impaired. He was assessed with no significant weight loss. His active diagnoses included abnormal weight loss.

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The active diagnoses section of this MDS was coded by MDS Nurse #1.

An interview was conducted on 1/24/20 at 11:20 AM with MDS Nurse #1. The 1/3/20 MDS that indicated Resident #5 had an active diagnosis of abnormal weight loss was reviewed with MDS Nurse #1. She stated that this was an error. She reported that the diagnoses pull through from the previous assessment and she must have forgotten to remove it as an active diagnosis.

During an interview with the Administrator on 1/24/20 at 2:55 PM he indicated he expected the MDS to be coded accurately.

4b. Resident #5 was initially admitted to the facility on 8/30/17 and most recently readmitted on 3/6/18 with diagnoses that included dementia.

A review of the electronic Nursing Assistant (NA) documentation on 9/29/19 through 10/5/19 revealed no documentation of a shower/bath for Resident #5.

A review of the hard copy shower sheets indicated Resident #5 received a shower on 9/30/19.

The quarterly MDS assessment dated 10/5/19 indicated Resident #5 ' s cognition was severely impaired. This assessment indicated that bathing (full body bath, shower, or sponge bath) had not occurred during the 7-day MDS review period. The bathing section of this 10/5/19 MDS was coded by MDS Nurse #1.

An interview was conducted on 1/24/20 at 11:20 AM with MDS Nurse #1. She stated that she

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used the electronic NA documentation of showers/baths when she completed this section of the MDS. She stated that she also used the hard copy shower sheets if she was able to find them. She explained that the hard copy shower sheets were not always kept in the same place. The 10/5/19 MDS for Resident #5 that indicated no bathing had occurred during the review period (9/29/19 through 10/5/19) was reviewed with MDS Nurse #1. The hard copy shower sheet that indicated a shower was given to Resident #5 on 9/30/19 was reviewed with MDS Nurse #1. She stated that she must not have been able to locate the hard copy shower sheets when she completed this MDS for Resident #5. She acknowledged that this MDS was inaccurate for bathing.

During an interview with the Administrator on 1/24/20 at 2:55 PM he indicated he expected the MDS to be coded accurately.

5. Resident #76 was originally admitted to the facility on 9/5/10 and was readmitted on 11/27/19 with multiple diagnoses including quadriplegia.

Resident #76's care plan initiated on 11/12/19 and was revised on 12/4/19 revealed that Resident #76 was using a condom catheter.

The readmission nursing note dated 11/27/19 indicated that Resident #76 was readmitted to the facility with a condom catheter.

A nursing note dated 12/2/19 at 11:22 AM revealed that Resident #76 had a condom catheter in place.

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The quarterly Minimum Data Set (MDS) assessment dated 12/3/19 indicated that Resident #76 had an indwelling urinary catheter.

On 1/23/20 at 10:05 AM, Resident #76 was observed and interviewed. Resident #76 was observed to have a condom catheter in placed and when interviewed, he stated that he had been using a condom catheter since he was readmitted to the facility.

On 1/23/20 at 4:05 PM, MDS Nurse # 2 was interviewed. She verified that she had completed the MDS assessment dated 12/3/19 for Resident #76. She reported that she based her assessment on the November 2019 Treatment Administration Record (TAR) indicating that the resident had an indwelling urinary catheter. MDS Nurse #2 stated that she didn't observe the resident and she didn't review the nursing notes.

On 1/24/20 at 8:10 AM, Unit Manager (UM) #2, assigned on the hall where Resident #76 resided, was interviewed. She stated that Resident #76 had been using condom catheter since admission to the facility and not an indwelling urinary catheter.

On 1/24/20 at 10:25 AM, MDS Nurse #1 (MDS Coordinator) was interviewed. She stated that she expected MDS Nurse #2 to review the nurse's notes including the admission notes and not only the TAR and if any discrepancies noted, to verify from the nurses the accuracy of the notes. MDS Nurse #1 reported that the quarterly MDS assessment dated 12/3/19 for Resident #76 was coded wrong, the resident had an external catheter (condom catheter) and not an indwelling urinary catheter.

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On 1/24/20 at 2:55 PM, the Director of Nursing (DON) and the Administrator were interviewed. They stated that they expected the MDS assessments to be coded accurately.

6. Resident #17 was admitted to the facility on 10/8/18 with multiple diagnoses including psychosis.

Resident #17 was admitted to the facility on Seroquel (an antipsychotic medication) 25 milligrams (mgs) by mouth twice a day for psychosis.

In October 2019, the pharmacy consultant had requested a gradual dose reduction (GDR) for the Seroquel for Resident #17.

On 10/21/19, Resident #17 had a doctor's order to decrease the dose of Seroquel to 25 mgs by mouth at bedtime.

The quarterly Minimum Data Set (MDS) assessment dated 1/4/20 revealed that Resident #17 had received an antipsychotic medication for 7 days during the assessment period and a GDR for the use of the antipsychotic had not been attempted.

On 1/24/20 at 10:25 AM, MDS Nurse #1 was interviewed. She verified that she had completed the quarterly MDS assessment dated 1/4/20 for Resident #17. After reviewing the records, MDS Nurse #1 reported that Resident #17 had received a GDR for the Seroquel in October 2019 and should have been coded on the quarterly MDS dated 1/4/20 but it was not. She added that

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she would make a correction to the MDS to reflect that GDR had been attempted.

On 1/24/20 at 2:55 PM, the Director of Nursing (DON) and the Administrator were interviewed. They stated that they expected the MDS assessments to be coded accurately.

7. Resident #83 was admitted on 6/19/19 with cumulative diagnoses of Cerebral Vascular Accident (CVA), respiratory failure with a tracheostomy (temporary or permanent surgical opening in the neck for tube insertion to aide in breathing).

Review of a Physical Order dated 10/2/19 read Resident #83 required the use of a left-hand mitten to prevent the removal of her tracheostomy tube.

Review of a Physical Device Evaluation completed 10/2/19 read she required the use of a hand mitten and assessed as a physical restraint.

Resident #83 was care planned on 10/2/19 for the use a left-hand mitten restraint due to removing her tracheostomy tube.

Review of Resident #83's quarterly Minimum Data Set (MDS) dated 12/19/19 revealed she was not coded for the use of a limb restraint.

In an observation on 1/22/20 at 2:00 PM, Resident #83 was sleeping without evidence of respiratory distress. She had an oxygen attached to her tracheostomy tube and a mitten on her left hand.

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In an interview on 1/23/20 at 3:21 PM, MDS Nurse #1 stated she was out of work for 3 ½ weeks in December 2019 and during that time MDS Nurse #2 covered for her while she was out of work.

In an interview on 1/23/20 at 3:30 PM, Nursing Assistant (NA) #1 stated Resident #83 required close observation. She stated Resident #83 wore a left-hand mitten because she pulled out her tracheostomy tube and had a cardiac arrest last fall.

In an observation on 1/24/20 at 6:30 AM Resident #83 was lying in bed with oxygen attached her to her tracheostomy tube. She was wearing a left-hand mitten and lifting her left hand to her face and neck.

In another interview on 1/24/20 at 11:18 AM, MDS Nurse #1 stated she completed a modification MDS on 1/22/20 to reflect the use of the hand mitten.

In a telephone interview on 1/24/20 at 11:57 AM, MDS Nurse #2 stated she neglected to code the hand mitten as a restraint of Resident #83's quarterly MDS dated 12/19/19 and that it was an oversight.

In an interview on 1/24/20 at 2:53 PM, the Administrator and Director of Nursing stated it was their expectation that Resident #83's quarterly MDS dated 12/19/19 should have been coded for the use of a restraint.

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8. Resident #45 was admitted on 8/27/17 with cumulative diagnoses of paraplegia, a stage 4 pressure ulcers (PU) to his left buttock and a stage 4 PU to his right buttock.

Review of a nursing note stated 11/5/19 read Resident #45 refused to allow the treatment nurse to assess his wound. He also refused to have the PU's evaluated by the Wound Clinic.

Review of Resident #45's care plan dated 11/6/19 read he had actual impaired skin integrity with a stage 4 PU's to his left and right ischium. The care plan read Resident #45 preferred to do his own treatments, remain in bed, refused supplements and refused to allow the facility and Wound Physician to assess his wounds.

Review of Resident #45's annual modified Minimum Data Set dated 11/6/19 read he was cognitively intact and exhibited no behaviors. He was coded for 2 stage 4 PU's.

In an interview on 1/23/20 at 8:45 AM, Unit Manager (UM) #1 stated Resident #83 refused assistance with the completion of his wound care and assessment.

In an interview on 1/23/20 at 9:30 AM, the Treatment Nurse stated Resident #45 earlier agreed to allow for a wound observation this morning but she just spoke with him and he stated he had already completed his wound care for the day and refused to allow surveyor to assess the wounds.

In an interview on 1/23/20 at 9:47 AM, Resident #45 confirmed he completed his wound care earlier this morning and did not want surveyor to

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assess his wounds.

In an interview on 1/23/20 at 12:10 PM, Nursing Assistant (NA) #2 stated Resident #45 refused most of his activities of daily living (ADLs) staff assistance.

In an interview on 1/23/20 at 3:21 PM, MDS Nurse #1 confirmed that Social Worker (SW) #1 completed the behaviors section of the annual MDS dated 11/6/19.

In a telephone interview on 1/24/20 at 11:52 AM, SW #1 confirmed she completed the cognition and behaviors section of Resident #45's annual MDS dated 11/6/19. She stated as part of her assessment, she interviewed staff and reviewed the medical record. She stated she must have missed the nursing note regarding Resident #45's refusal when completing her 7 day look back for behaviors. She stated it was an oversight.

In an interview on 1/24/20 at 2:53 PM, the Administrator and Director of Nursing stated it was their expectation that Resident #45 annual MDS dated 11/6/19 was coded for his refusal behaviors.

9. Resident #126 was admitted to the facility on 9/23/2019 with diagnoses that included type 2 diabetes mellitus, chronic kidney disease, and osteomyelitis.

The most recent Minimum Data Set (MDS) for Resident #126 was dated 11/12/2019. Section

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F 641	Continued From page 21 A2000 indicated the resident was discharged on 11/12/2019 and section A2100 indicated the resident was discharged to acute hospital setting. Record review revealed a nursing progress note dated 11/12/2019 that indicated the resident was discharged home on 11/12/2019 with home health services. Resident #126's discharge summary dated 11/12/2019 indicated the resident was discharged to the community with home health services. On 01/23/20 at 2:36pm an interview was conducted with MDS nurse #1, identified as the person who coded the discharge MDS for Resident #126. MDS nurse #1 stated she was not certain why the discharge MDS was coded to indicate the resident discharged to an acute hospital setting. MDS nurse #1 confirmed resident #126 was discharged home and the MDS for Resident #126 was coded in error. An interview was conducted on 1/24/2020 at 2:55pm with the facility's administrator and Director of Nursing (DON), they acknowledged MDS coding as an area needing improvement and stated they expect MDS to be coded correctly in the area of discharge.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		2/21/20

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F 656	Continued From page 22 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to develop comprehensive care plans in the areas of	F 656	F656 Development Comprehensive Care Plans	

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F 656	Continued From page 23 physical restraints (Resident #70) and contractures (Resident #80) for 2 of 27 residents reviewed. The findings included: 1. Resident #70 was admitted to the facility on 4/25/19 with diagnoses that included dementia with behavioral disturbance, epilepsy, and unsteadiness on feet. A physician ' s order dated 6/3/19 indicated a helmet was to be applied to Resident #70 ' s head during daytime hours and when out of bed. This order was entered by Unit Manager (UM) #2. The quarterly Minimum Data Set (MDS) assessment dated 11/26/19 indicated Resident #70 had short-term and long-term memory problems and severely impaired decision making. This assessment indicated he had no physical restraints (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body). An observation was conducted of Resident #70 on 1/21/20 at 12:17 PM on the facility ' s secured unit. He was wearing a helmet. The helmet had a chin strap and was clasped in the closed position on Resident #70. The resident was walking independently throughout the halls and common area of the unit. A review of the active physician ' s orders for Resident #70 on 1/23/20 indicated the order for the helmet (initiated on 6/3/19) continued to be	F 656	Corrective Action: For resident #70, a care plan has been developed by the MDS care plan coordinator 1-31-2020, to include the use of the helmet as a restraint. For resident #80, care plans have been added by the MDS nurse on 1-24-2020, to include contracture treatment for the right leg and both hands, and for range of motion. Identification of others potentially at risk: All residents require an accurate and thoroughly developed care plan and have the potential to be affected. An audit of MDS□s completed in the past 3 months was conducted from the end of the survey and completed on 2-14-2020, by the DON, (Director of Nurses) and her nurse managers to ensure residents that were coded correctly for contractures, assistance with range of motion and the use of assistive devices that are a restraint, have a care plan that these areas. Any resident identified as being potential affected by this alleged deficient practice had a correction made to the MDS and the care plan updated to reflect the update to the MDS. No other resident was found to be affected. Systemic Changes: The MDS nurses will be re-educated on 2-17-2020, by the Regional MDS consultant to include expectations on gathering correction information for MDS Coding and resultant care planning that reflects the resident and the resident care. Monitoring: Care plans audits will be done	

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(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
F 656	Continued From page 24 active. An interview was conducted with UM #2 on 1/23/20 at 2:20 PM. She indicated that Resident #70 ' s helmet was attached to his body, that he was not able to remove it, and that it restricted his normal access to his head. UM #2 acknowledged that the helmet met the definition of a physcial restraint. A review on 1/23/20 of the active care plan for Resident #70 revealed there was no care plan developed to address the physical restraint in use for Resident #70. A phone interview was conducted on 1/23/20 at 4:00 PM with MDS Nurse #2. She reported that she had not thought of the helmet as a physical restraint because it was used for safety. MDS Nurse #2 acknowledged that the helmet met the definition of a restraint as it was attached to the resident ' s body, he was not able to remove it, and it restricted his normal access to his head. An interview was conducted with MDS Nurse #1 on 1/24/20 at 11:20 AM. She stated she never thought of Resident #70 ' s helmet as a physical restraint because it was used for safety. She acknowledged that the helmet met the definition of physical restraint and that the restraint use should have been incorporated into his care plan. During an interview with the Administrator and DON on 1/24/20 at 2:55 PM the use of Resident #70 ' s helmet was reviewed. They both agreed that the helmet was attached to the resident ' s body, that he was not able to remove it, and that it restricted normal access to his head. They indicated they expected a care plan to be	F 656	weekly for 2 month and then monthly times 3 month and then will be discussed in the monthly QAPI meeting by the DON and the Regional MDS consultant, to ensure proper and accurate coding of physical devices and contracture and appropriately reflected on the care plans. Staff found to not be accurately completing the MDS will be re-educated as necessary. Results of the audits will be taken to the QAPI meeting by the DON. The DON will be responsible to carry out any recommendations from the QAPI meeting.	

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developed to address the use of a physical restraint.

2) Resident #80 was readmitted to the facility on 12/5/19 after an extended hospital stay, with diagnoses that included a history of multiple Cerebrovascular Accident (CVA-stroke) with paralysis to both sides of her body and Multiple Sclerosis.

Review of the hospital and long-term acute care records dated 10/14/19 through 12/5/19 revealed Resident #80 to have contractures present in all extremities.

The Admission Minimum Data Set (MDS) dated 12/12/19 indicated Resident #80 had severe cognitive impairment and received total assistance from staff for all Activities of Daily Living. Limited range of motion was coded in all extremities.

The care plan dated 12/31/19 was reviewed and there was no care plan that addressed any contractures or her limited range of motion.

Review of the Nursing Care Card dated 1/8/2020 indicated Resident #80 had contractures to her right leg and partial contractures to her left and right hand.

On 1/21/2020 at 9:55am an observation was made of Resident #80 lying in bed. She was noted to have a contracture to her right leg with the inability to straighten it out and to her bilateral hands which were curled into a fists.

An interview occurred with the MDS Nurse #3 on 1/24/2020 at 10:20am. She reviewed the care

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F 656	Continued From page 26 plan dated 12/31/19 and acknowledged there was no care plan developed for the right leg and bilateral hand contractures, stating it was an oversight. MDS Nurse #3 indicated residents with contractures should have a care plan developed. On 1/24/2020 at 3:00pm an interview occurred with the Administrator and Director of Nursing who stated it was their expectation for care plans to be developed for residents with contractures.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		2/21/20

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F 657	Continued From page 27 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and revise a care plan in the area of medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #64) The findings included: Resident #64 was initially admitted to the facility on 7/22/19 and most recently readmitted on 12/18/19 with diagnoses that included osteomyelitis of the sacral region, diabetes and hypertension. The quarterly Minimum Data Set (MDS) assessment dated 11/19/19 indicated Resident #64's cognition was fully intact. He was noted with intravenous (IV) medications during the MDS review period. A review of the December 2019 Medication Administration Record (MAR) revealed Resident #64 did not receive any IV medications. Resident #64's active care plan was reviewed on 1/21/2020 and revealed a problem/need area of at risk for complications due to IV medications. This problem/need was initiated on 11/27/19 and most recently reviewed on 12/20/19. On 1/24/2020 at 10:20am an interview occurred with the MDS Nurse #3. After reviewing Resident #64's medical record she confirmed he received an IV medication from 11/27/19 through 12/1/19 and the IV medication care plan should have	F 657	F657 Care Plan Timing and Revision Corrective Action: For resident #64, the IV therapy care plan has been resolved by the Care Plan nurse on 1-6-2020. Identification of others potentially at risk: All resident who have an acute episode that has required medications and or treatments will have the potential to be affected. All residents with acute episodes with medication and or treatments in the past 3 months that has been resolved have been audited from the end of the survey till completed on 2-14-2020 by the MDS nurse, to ensure the care plan reflects this. Any identified issue was corrected on the care plan by the MDS nurse. No others were found to be affected. Systemic Changes: The MDS nurses have been re-educated on 2-17-2020, by the Regional MDS consultant to include resolving care plans for residents with acute episodes requiring medication and or treatment. Monitoring: Care plans audits will be completed by the DON and/or her nurse managers, done weekly for 2 months and then monthly times 3 month and then will be discussed in the monthly QAPI meeting by the DON, to ensure care plans are resolved when medications or	

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F 657	Continued From page 28 been resolved when the review was completed on 12/20/19. An interview occurred with the Administrator and Director of Nursing on 1/24/2020 at 3:00pm. They both indicated it was their expectation for the care plan to be an accurate representation of the resident.	F 657	treatments are discontinued. Staff found to not be accurately completing Care Plans will be re-educated as necessary. The DON will be responsible to ensure any further recommendations are carried out.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately transcribe physician orders for diabetic ulcers and a surgical wound for 1 of 6 residents reviewed with pressure ulcers. (Resident #54) The findings included: Resident #54 was originally admitted to the facility on 6/14/19 and most recently readmitted to the facility on 1/9/2020. His diagnoses included diabetes with foot ulcers, amputation of right great toe and other areas to right foot and peripheral vascular disease. The most recent Minimum Data Set (MDS) dated 11/18/19 indicated Resident #54 was cognitively intact and had limited range of motion to both lower extremities. He was coded with 1 Stage 3 (involving the entire thickness of the skin)	F 658	F658 Services Provided Meet Professional Standards Corrective Action: The treatment order for resident #54 was clarified on 1-23-2020 by the treatment nurse and re-written and she updated it on the treatment record. Identification of others potentially at risk: All residents who have mixed treatments have the potential for being affected. An audit of treatment orders resulting from outside consultations, ordered in the past 3 months, was conducted on 1-23-2020, by the DON, (Director of Nurses) and her nurse managers to ensure that treatment order recommendations were written correctly and that they were transcribed to the treatment record accurately. No other issues identified.	2/21/20

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F 658	Continued From page 29 pressure ulcer and 2 venous/arterial ulcers (develop as a result of lack of blood flow) present on admission as well as diabetic foot ulcers and surgical wounds. A wound clinic progress note dated 12/4/19 revealed an order, in part, for 1 teaspoon of Hibiclens (a solution used to cleanse the skin to prevent infection) mixed with 2 cups of distilled water to spray over wounds. A wound clinic progress note dated 12/18/19 indicated to use 1 teaspoon of Hibiclens mixed with 2 cups of distilled water to spray over wounds. The December 2019 Treatment Administration Record (TAR) revealed, in part, the following skin treatments: -Left heel wound- mix 1 cup of Hibiclens with 2 cups of distilled water and spray over wound. -Left first metatarsal wound (the part of the foot that includes the bones between the ankle and toes)- mix 1 cup of Hibiclens with 2 cups of distilled water and spray over wound. -Right heel wound- mix 1 cup of Hibiclens with 2 cups of distilled water and spray over wound. The wound clinic progress note dated 12/30/19 revealed an order to use 1 teaspoon of Hibiclens mixed with 2 cups of distilled water to spray over wounds. Resident #54's active care dated 12/31/19 revealed care plans in place for amputation of the right big toe and actual impairments to the skin. Interventions included to provide treatments as	F 658	The nurse responsible for transcribing the order has been re-educated the week of 2/3/2020 by the Director of Nurses Systemic Changes: Licensed nurses have been in serviced the week of 2-3-2020, regarding correctly transcribing orders by the Director of Nurses /ADON/SDC. Any nurses that were not able to attend will not be able to work until the education takes place. This includes all shifts and includes weekends. Orders that are received from consultations, will be reviewed in the next clinical-ops meeting, on an on-going basis, by the nurse managers, to ensure accuracy. Monitoring: Transcription of orders audits will be done weekly for 2 months and then monthly times 3 months by the DON and/or her nurse managers. Results will be discussed in the monthly QAPI meeting by the DON. Staff found to not be documenting orders accurately will be re-educated as necessary. The Administrator will be responsible to ensure any further recommendations are carried out.	

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F 658	Continued From page 30 ordered. The January 2020 TAR revealed, in part, the following skin treatments: Left heel wound- mix 1 cup of Hibiclens with 2 cups of distilled water and spray over wound. An interview occurred with the Treatment Nurse on 1/24/2020 at 10:20am. She reviewed the wound clinic orders from December 2019 that read in part to mix 1 teaspoon of Hibiclens with 2 cups of distilled water, as well as the December 2019 and January 2020 TARS that read in part to mix 1 cup of Hibiclens with 2 cups of distilled water. The treatment nurse further stated the orders had been transcribed incorrectly. Resident #54's nursing progress notes indicated on 1/24/2020 at 11:00 am, the wound clinic physician was informed the wounds had been cleansed with 1 cup of Hibiclens to the 2 cups of distilled water instead of 1 teaspoon of Hibiclens. The physician stated there would be no harm from the extra Hibiclens. On 1/24/2020 at 2:00 pm, an interview occurred with the Medical Director and explained there should be no detrimental effects from the use of extra Hibiclens. During an interview with the Administrator and Director of Nursing on 1/24/2020 at 3:00pm, both stated it was their expectation for the orders to be transcribed correctly for wound care.	F 658		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails.	F 700		2/21/20

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F 700	Continued From page 31 The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to assess for the continued use of ½ side rails for 2 (Resident #104 and Resident #117) of 2 residents reviewed for side rails. The findings included: 1. Resident #104 was admitted on 2/22/16 with a diagnosis of Alzheimer's Disease. Review of a Physician Order dated 3/26/19 read Resident #104 required the use of side rails as an enabler while in bed. Review of a Physical Device Evaluation form dated 3/26/19 indicated Resident #104 required	F 700	F700 Bedrails Corrective Action: A device audit was completed 1-23-2020 for Resident□s #104 and #117. The bed rails have been removed 2-11-2020, and the plan of care has been updated. Identification of others potentially at risk: All resident who have beds with side rails have the potential to be affected. Initiated at the time of survey, an audit of all residents who have beds with side rails was completed by the DON, and nurse managers on 1-27-2020, to ensure that side rails have an appropriate physical	

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F 700	Continued From page 32 the use of side rails. The facility was unable to provide any evidence of any other side rail assessments since 3/26/19. Review of the undated Kardex read Resident #104 had ½ side rails and extensive assistance with bed mobility. Review of the facility's Restraint Management policy that included side rails last revised October 2019 read a Physical Device Evaluation would be completed quarterly, annually and with any significant change of condition. Review of Resident #104's significant change Minimum Data Set (MDS) dated 1/7/20 indicated severe cognitive impairment with no behaviors. She was coded for extensive assistance of two staff with bed mobility, no falls and not coded for the use of bed rails. Review of Resident #104's care plan revised on 1/22/20 read bilateral ½ side rails for safety during the provision of care to assist with bed mobility. Interventions included staff observation for injury or entrapment related to side rail use. In an observation on 1/23/20 at 8:30 AM, Resident #104 was sitting up in bed eating breakfast. Both ½ side rails were engaged. Resident #104 was noted to be leaning to her right. In an interview on 1/23/20 at 8:45 AM, Unit Manager (UM) #1 stated Resident #104 was unable to get up out of her bed unassisted. She stated Resident #104 was recently moved out of the locked unit due to a decline in her condition. In an interview on 1/23/20 at 9:10 AM, Nurse #4	F 700	device assessment. Any identified issues have been addressed as indicated. No other resident using bed rails was found to be affected. Systemic Changes: Licensed nurses have been in serviced by 2-3-2020, on expectations of completing physical device evaluation for all side rails by the ADON . Both licensed nurses and certified nursing assistants have been in serviced on the proper use of side rails by the ADON by 2-3-2020. Any staff that are not in-serviced by that date have not been able to work until in-serviced, including both all shifts and weekends. Monitoring: Beds will be reviewed by the DON and her nurse managers weekly for 2 months, then monthly for 3 months by the DON and/or her nurse managers, to ensure that bed rails are not available to be used unless the resident has been assessed to require and a device assessment has been completed. Results of the audits will be taken to the monthly QAPI meeting by the DON, for any further recommendations. The Director of Nurses will be responsible to ensure any further recommendations are carried out.	

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stated Resident #104 was unable to get out of bed unassisted. She stated Resident #104 has had an overall health decline in the past few months and was moved out of the locked unit.

In an interview on 1/23/20 at 3:30 PM, Nursing Assistant (NA) #1 stated Resident #104 made no attempts to get out of bed on her own and she had not had any falls.

In an interview on 1/24/20 at 6:05 AM, NA #8 stated Resident #104 doesn't try to get out of bed unassisted. Resident #104 was observed at 6:05 AM sleeping in bed with her ½ side railed engaged and her bed was in the low position.

In an interview on 1/24/20 at 11:18 AM, MDS Nurse #1 stated it was the responsibility of the UM and the Unit Coordinator's (UC) to complete the Physical Device Evaluations. She stated she does not complete the side rail assessment at the time of completing an MDS assessment.

In an interview on 1/24/20 at 12:00 PM, UC #1 stated if a Physical Device Evaluation was scheduled in the electronic medical record, it would populate for her or the UM to complete when it was due. She stated it was not done because apparently the Physical Device Evaluation form was not programed on a quarterly schedule.

In an interview on 1/24/20 at 2:53 PM, the Administrator and Director of Nursing stated it was their expectation that Resident #104 have ongoing assessment for the continued use of side rails.

2. Resident #117 was admitted on 8/1/13 with a

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diagnosis of Alzheimer's Disease.

Review of a Physician Order dated 9/18/17 read Resident #117 required the use of side rails as an enabler while in bed.

Review of a Physical Device Evaluation form dated 2/8/19 indicated Resident #117 required the use of side rails. The facility was unable to provide any evidence of any other side rail assessments since 2/14/19.

Review of Resident #117's care plan last revised 10/17/19 read she was at risk for falls with the interventions of a low bed , floor mats and bilateral ½ side rails.

Review of the undated Kardex read Resident #117 had ½ side rails and extensive assistance with bed mobility.

Review of Resident #117's annual Minimum Data Set (MDS) dated 1/2/20 indicated severe cognitive impairment and she exhibited no behaviors. Resident #117 was coded for one staff extensive assistance with bed mobility, no falls and she was not for the use of side rails.

In an observation on 1/22/20 at 3:00 PM, Resident #117 was lying in bed with her bilateral ½ side rails engaged. Her bed was low with fall mats on the floor.

In an interview on 1/23/20 at 8:45 AM, Unit Manager (UM) #1 stated Resident #117 was unable to get up out of her bed unassisted.

In an interview on 1/23/20 at 9:10 AM, Nurse #4 stated Resident #117 was unable to get out of

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bed unassisted.

In an interview on 1/23/20 at 1:30 PM, Nursing Assistant (NA) #9 stated when she laid Resident #117 down for her nap, she lowered the bed, engaged the side rails and put the mats on the floor. NA #9 stated she was not aware of any attempts by Resident #117 to get out of the bed unassisted.

In an interview on 1/23/20 at 3:30 PM, Nursing Assistant (NA) #1 stated Resident #117 made no attempts to get out of bed on her own and she had not had any falls.

In an interview on 1/24/20 at 6:00 AM, NA #10 stated Resident #117 did not attempt to get out of bed unassisted and she was not aware of any recent falls. Resident #117 was observed at 6:00 AM sleeping in bed with her ½ side railed engaged, floor mats on the floor and her bed was in the low position.

In an interview on 1/24/20 at 11:18 AM, MDS Nurse #1 stated it was the responsibility of the UM's and the Unit Coordinator's (UC) to complete the Physical Device Evaluations. She stated she does not complete the side rail assessment at the time of completing an MDS assessment.
In an interview on 1/24/20 at 12:00 PM, UC #1 stated if a Physical Device Evaluation was scheduled in the electronic medical record, it would populate for her or the UM to complete when it was due. She stated it was not done because apparently the Physical Device Evaluation form was not programed on a quarterly schedule.

In an interview on 1/24/20 at 2:53 PM, the

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

(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
F 700	Continued From page 36 Administrator and Director of Nursing stated it was their expectation that Resident #117 have ongoing assessment for the continued use of side rails.	F 700		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 755		2/21/20

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F 755	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on record review, pharmacist and staff interviews, the facility failed have a system in place for the accurate reconciling of controlled medications administered to residents (Residents #45, #15) for 2 of 2 residents reviewed for the use of narcotics. The findings included: 1. Resident # 45 was admitted to the facility 8/27/2017 with diagnoses including hypertension, neurogenic bladder, and stage 4 pressure ulcers. The resident's most recent annual Minimum Data Set (MDS) dated 11/6/2019 indicated the resident was cognitively intact and had no behaviors. Resident # 45 was coded as receiving both scheduled pain medication as well as pain medication on an as needed basis. The resident was coded as reporting his pain level as a 5 out of 10 (with 0 being no pain and 10 being the worst pain). The resident did not experience a disruption in sleep or daily activities due to pain. a. Resident #45's Medication Administration Record (MAR) revealed he received diazepam 5 milligrams (mg) four times a day. Review of the resident's January 2020 MAR indicated the resident received 24 tablets of 5mg diazepam between 1/1/2020 and 1/7/2020. The declining narcotic sheet for 5mg diazepam indicated the resident received 28 tablets between 1/1/2020 and 1/7/2020. The discrepancies occurred on 1/1/20 at 7:00 am, 1/2/20 at 4:00 am, 1/3/20 at 4:00 am, and on 1/4/2020 at 4:00am where the declining narcotic count sheet indicated the narcotics were removed by Nurse # 7, but the	F 755	F755 Pharmacy Corrective Action: Resident□s #45 and 15 is receiving narcotics as prescribed according to the declining inventory sheets and as reported by the resident. The nurses identified as not signing both the declining inventory sheet and the MAR have been re-educated by the DON on 1-24-2020 to sign both sheets. Identification of others potentially at risk: All residents that receive narcotics have the potential to be affected. An audit of medication orders ordered in the past 3 months was conducted after the completion of the survey and by 1-27-2020, by the DON, (Director of Nurses) and her nurse managers to ensure that the declining inventory sheet for narcotics are reconciled with the Medication Administration Record (MAR). No other issues identified. Systemic Changes: Nurses have been in serviced the week of 2-3-2020. by the Assistant Director of Nurses (ADON), regarding documentation of narcotics on both the declining inventory sheet, as well as the MAR. New nurses will also get this in service during the introductory period. Any nurse not in-serviced will not be able to work until receiving the education. This includes both all shifts and weekends staff. Monitoring: Documentation of narcotics on	

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F 755	Continued From page 38 MAR did not indicate the medication was administered to Resident #45. b. Resident #45's Medication Administration Record (MAR) also revealed he received 30mg oxycodone four times a day. Review of the resident's January 2020 MAR indicated the resident received 28 tablets of 30mg oxycodone between 1/1/2020 and 1/7/2020. The declining narcotic sheet for 30mg oxycodone indicated the resident received 24 tablets of between 1/1/2020 and 1/7/2020. The discrepancies occurred on 1/1/20 at 7:00am, on 1/2/20 at 4:00 am, 1/3/20 at 4:00 am, and on 1/4/20 at 4:00 am where the declining count sheet indicated the narcotics were removed by Nurse # 7 but the MAR did not indicate the medication was administered to Resident #45. In an interview with the resident on 1/23/2020 at 8:45am he stated his pain was well controlled on his current regimen. He stated he did believe he had been getting all of his scheduled pain medications. On 01/23/20 at 04:00 PM during an interview with Nurse #7, she stated she did give both medications at 4:00 am on 1/1/20, 1/2/20, 1/3/20 and 1/4/20 to Resident #45 as indicated by the declining narcotic count sheet. However, she did not document the administration on the MAR. She further stated she pulled the medication from the narcotics box, documented it in the narcotics declining count log, administered the medication to the resident, then failed to document it in the computer MAR. She further stated on those days she must have gotten busy and forgot to go back and document administration on the MAR.	F 755	both the declining inventory sheets and the MAR will be audited weekly for 2 months, then monthly for 3 months by the DON and/or her nurse managers. Staff found to not be documenting accurately will be re-educated as necessary regarding expectations. Results of the audits will be taken to the monthly QAPI meeting by the DON and be reviewed for any further recommendations. The DON will be responsible to ensure any further recommendations are carried out.	

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F 755	Continued From page 39	F 755		

On 1/24/20 at 10:22 AM In an interview with the consultant pharmacists. She stated they do not reconcile narcotics as part of their services for the facility. It is up to the facility reconcile the narcotics declining count sheets by comparing them to the medication administration sheet.

On 1/23/2020 at 4:39 PM an interview was conducted with the Director of Nursing (DON) where she stated she was aware of the missing documentation in the resident's MARs and it was something the facility's Quality Assurance committee was working on.

2. Resident #15 was admitted to the facility on 9/27/2019 with diagnoses including cerebral infarct, aphasia, and type 2 diabetes.

The resident's most recent significant change Minimum Data Set (MDS) was dated 10/26/2019 and indicated the resident was cognitively impaired and total dependent with all aspects of care. Additionally, the MDS indicated the resident received opioids for pain 5 out 7 days during the assessment period. The MDS also indicated the resident was receiving hospice care.

The resident's January 2020 Medication administration Record (MAR) indicated the resident received both scheduled morphine 1 milliliter (ml) every 6 hours as well as morphine 1ml every hour as needed for breakthrough pain. On 1/1/20 the declining count narcotic sheet for Resident #15 indicated morphine, 20mg/ml, was removed at 12:00 am, 6:00 am, 12:00 pm, 6:00 pm, and 8:00 pm. The resident's MAR for January 1, 2020 indicated the resident only received 4 doses with the 8:00 pm dose not being accounted for on the resident's MAR. The

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F 755	Continued From page 40 declining count log indicated the 8:00 pm dose was removed by Nurse #6. An interview was conducted on 01/23/20 at 4:15pm with Nurse #6 in which she reviewed her documentation on 1/1/20 and determined that she did not document the administration of the 1ml dose of morphine to Resident #15 at 8:00 pm in the residents MAR. On 1/23/2020 at 4:39 PM an interview was conducted with the Director of Nurses where she stated she was aware of the missing documentation in the resident's MARs and it is something the facility's Quality Assurance committee has been working on.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		2/21/20

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F 758	Continued From page 41 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with the resident, staff, and physician, the facility failed to have an adequate clinical indication for the use of an antipsychotic medication for 1 of 4 residents (Resident #1) reviewed for psychotropic medication use. The findings included: Resident #1 was admitted to the facility on 1/4/20	F 758	F758 Free from Unnecessary Psychotropic Meds/PRN use Corrective Action: Resident #1 has had the antipsychotic medication discontinued on 1-20-2020 by the physician. Identification of others potentially at risk: All new admissions with antipsychotic medications have the potential to be	

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F 758	Continued From page 42 with diagnoses that included orthopedic aftercare, anxiety, depression, and Post Traumatic Stress Disorder (PTSD). A review of Resident #1 ' s hospital discharge summary dated 1/4/20 indicated Resident #1 was on Seroquel (antipsychotic medication) 25 milligrams (mg) twice daily as needed (PRN). A physician ' s order dated 1/4/20 indicated Seroquel 25 mg every 12 hours PRN. There was no diagnosis indicated for this Seroquel order. A physician ' s order dated 1/6/20 indicated a discontinuation of the 1/4/20 PRN Seroquel order for Resident #1. A review of the Medication Administration Record (MAR) for Resident #1 revealed no administrations of the PRN Seroquel order. A physician ' s order for Resident #1 dated 1/7/20 indicated Seroquel 25 mg once daily at bedtime for PTSD with psychotic features. The admission Minimum Data Set (MDS) assessment dated 1/11/20 indicated Resident #1 ' s cognition was intact. He had no signs or symptoms of psychosis, no behaviors, and no rejection of care. Resident #1 received antipsychotic medication on 5 of 7 days during the MDS review period. A Psychiatric Nurse Practitioner (PNP) note dated 1/13/20 indicated Resident #1 was referred for depression. He was assessed with no psychotic symptoms. Resident #1 was noted with had a history of depression, anxiety, PTSD, insomnia, and neuropathy. The PNP reported that per staff	F 758	affected. An audit of antipsychotic medications ordered in the past 3 months was conducted by 1-27-2020, by the DON, (Director of Nurses) and her nurse managers to ensure that all guests with antipsychotic medication orders have an adequate clinical indication for the use of the medication. No other issues identified. Systemic Changes: Nurses have been in serviced the week of 2-3-2020. by the Assistant Director of Nurses (ADON), regarding antipsychotic medication and having adequate clinical indication for the use of the medication. New nurses will also get this in service during the introductory period. Any nurses not able to attend the in-service will not be able to work until they do so. This includes all shifts and weekends. Monitoring: All new admissions with Antipsychotic medications orders will be audited for appropriate clinical indication 5 times weekly for 2 months, then monthly for 3 months by the DON and/or her nurse managers, to ensure there is appropriate clinical indication for the use of the antipsychotic medication. Results of the audits will be taken to the QAPI meeting by the DON to be reviewed for any further recommendations. The DON will be responsible to ensure any further recommendations are carried out.	

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F 758	Continued From page 43	F 758		

and nursing notes he had no acute issues. This note indicated that Resident #1 denied mental health problems and denied mood issues.

A physician ' s order for Resident #1 dated 1/20/20 indicated a discontinuation of the Seroquel 25 mg once daily at bedtime.

A review of the Nursing Assistant (NA) electronic behavior monitoring documentation from 1/4/20 through 1/20/20 revealed Resident #1 had no behaviors.

A review of the Skilled Care Nursing Assessment Notes from 1/4/20 through 1/20/20 revealed Resident #1 had no behaviors, delusions, or hallucinations.

An interview and observation was conducted with Resident #1 on 1/21/20 at 4:04 PM. The resident was alert and oriented to person, place, time, and situation. He was noted with no behavioral issues and no signs or symptoms of psychosis. Resident #1 reported that prior to his hospitalization he was on Seroquel when he was at home. He was unsure what the Seroquel was ordered to treat.

During an interview with Nurse #5 on 1/24/20 at 9:20 AM she reported that she was familiar with Resident #1 and that he had no signs or symptoms of psychosis. She was unable to explain why Resident #1 had a routine order for Seroquel in place from 1/7/20 to 1/20/20.

An interview was conducted with the physician on 1/24/20 at 2:00 PM. He stated that he tried not to utilize PRN antipsychotic medications and that if a

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F 758	Continued From page 44 resident was admitted with a PRN order for an antipsychotic then it was normally changed to a routine order if the medication was needed. Resident #1 ' s 1/4/20 order for PRN Seroquel 25 mg every 12 hours that was in place until 1/6/20 was reviewed with the physician. Resident #1 ' s 1/7/20 order for routine Seroquel 25 mg once daily at bedtime that replaced the PRN Seroquel order and was in place until 1/20/20 was reviewed with the physician. Resident #1 ' s MAR that indicated the PRN Seroquel was not administered on 1/4/20, 1/5/20, or 1/6/20 was reviewed with the physician. The physician was unable to provide information on what clinical indication was present that required routine Seroquel for Resident #1. He revealed there were no signs or symptoms of psychosis which was why the Seroquel was discontinued completely on 1/20/20. During an interview with the Administrator and Director of Nursing on 1/24/20 at 2:55 PM they both indicated that they expected a clinical indication to be identified to justify the use of an antipsychotic medication.	F 758		
F 842 SS=B	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.	F 842		2/21/20

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F 842	Continued From page 45 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained 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	F 842		

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F 842	Continued From page 46 (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 and resident interviews, the facility failed to have complete medical records in the areas of treatments, showers, accu-checks and sliding scale insulin. The facility also failed to have accurate medical records in the area of nursing assessment. This was for 4 (Resident #45, Resident #88, Resident #24, and Resident #1) of 27 residents reviewed for complete and accurate medical records. The findings included: 1. Resident #45 was admitted on 8/27/17 with cumulative diagnoses of paraplegia, a stage 4 pressure ulcers (PU) to his left buttock and a stage 4 PU to his right buttock. Review of Resident #45's care plan dated 11/6/19 read he had actual impaired skin integrity with a stage 4 PU's to his left and right ischium. Resident #45 was also care planned on 11/6/19 for an indwelling urinary catheter. The care plan read Resident #45 preferred to do his own	F 842	F842 Resident Records-Identifiable Information Corrective Action: Since the time of notification during the survey, for Resident #45, his refusal of wound care and catheter care is being documented on the treatment record, as well as when completed and by whom. Resident #88□s showers are being documented as they are given or refused. Resident #24□s blood sugars are being drawn as ordered and are being documented on the MAR. Resident# 24□s sliding scale blood sugars and coverage is being documented as ordered and performed. Resident #1□s skilled care nursing assessments notes are being recorded accurately. Identification of others potentially at risk: All residents that require documentation of	

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F 842	Continued From page 47 treatments, remain in bed, refused supplements and refused to allow the facility and Wound Physician to assess his wounds. Review of Resident #45's annual modified Minimum Data Set dated 11/6/19 read he was cognitively intact and exhibited no behaviors. He was coded for 2 stage 4 PU's and an indwelling urinary catheter. Review of Resident #45's December 2019 Treatment Administration Record (TAR) revealed no documented evidence of his catheter care on multiple shifts. Review of Resident #45's January 2020 TAR from 1/1/20 to 1/22/20 revealed no documented evidence of his catheter care on multiple shifts. The TAR also revealed multiple omissions of his PU care as ordered. In an interview on 1/22/20 at 11:22 AM, the Treatment Nurse stated Resident #45 refused to allow her or the Wound Physician to assess and treat his PU's. She stated he made his own appointments to go out to a Wound Clinic when he wanted an assessment. The Treatment Nurse stated provided daily wound care to all PU's stage 3 or higher. She also stated he provided his own catheter care daily In another interview on 1/22/20 at 12:04 PM, the Treatment Nurse stated they facility started using a phone to document wound assessments about 4 months ago. She stated when using the phone to document wound assessments, it did not have the option to document refusals. The Treatment Nurse stated she would have to go into the electronic medical record to document his	F 842	treatments, or documentation of personal care, documentation of blood sugars, and/or accurate skilled care nursing notes, have the potential to be affected. An audit of the MAR□s (Medication Administration Record) and treatment and shower sheets, was conducted on 1-27-2020, by the DON, (Director of Nurses) and her nurse managers to ensure there were no further issues of documentation. Any identified issue was addressed at the time as appropriate. Systemic Changes: Licenses Nurses have been in-serviced the week of 2-3-2020. by the Assistant Director of Nurses (ADON), regarding accurate and complete documentation of medications, treatments, and refusals. New nurses will also get this in-service during the introductory period. Any nurse not able to attend the in-service will not be able to work until they are re-educated. This includes weekend and all shifts. Monitoring: Documentation of MAR□s, Treatment Sheets, and Skilled Nursing Assessments, will be audited 5 times weekly for 2 months, then monthly for 3 months by the DON and/or her nurse managers, to ensure care being provided is accurately documented in the medical record. Staff found to not be documenting accurately will be re-educated as necessary. Results of the audits will be taken to the QAPI meeting by the DON to be reviewed for any further recommendations. The DON will be responsible to ensure any further	

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F 842	Continued From page 48 refusals. She stated she had not been documenting refusals on the TAR's. In an interview on 1/23/20 at 8:45 AM, Unit Manager (UM) #1 stated Resident #83 refused assistance with the completion of his wound care and catheter care. In an interview on 1/23/20 at 9:10 AM, Nurse #4 stated she offered to assist with catheter care but Resident #45 refused assistance. She stated she did not always document his refusals on the TAR. In an interview on 1/23/20 at 9:47 AM, Resident #45 confirmed he completed his wound care and catheter care and asked for assistance if he required it. In an interview on 1/23/20 at 12:10 PM, Nursing Assistant (NA) #2 stated Resident #45 refused most of his activities of daily living (ADLs) staff assistance. In an interview on 1/24/20 at 2:53 PM, the Administrator and Director of Nursing stated it was their expectation that Resident #45's medical record be complete and refusals of care be documented. 2. Resident #88 was admitted on 3/30/16 with a diagnosis of Rheumatoid Arthritis. Review of Resident #88's quarterly Minimum Data Set (MDS) dated 1/6/20 indicated she was cognitively intact, exhibited no behaviors and she was coded for limited assistance with bathing. Review of Resident #45's care plan revised	F 842	recommendations are carried out.	

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1/22/20 indicated she required bathing assistance. Interventions included offering a sponge bath if desired rather than a shower. She was also care planned for refusals of activities of daily living (ADLs) assistance. Interventions included negotiation for a time for ADLs and return at the stated time.

Review of the electronic and hard copy shower documentation for December 2019 and January 2020 revealed Resident #88 did not receive 2 scheduled showers in December 2019 and 2 showers in January 2020.

In an interview on 1/24/20 at 10:10 AM, Resident #88 stated she only needed set up assistance for bed baths but she missed some showers this month. She stated her showers were scheduled for 2nd shift on Tuesday's and Saturday's.

In an interview on 1/24/20 at 10:30 AM, the Director of Nursing (DON) stated Nursing Assistant (NA) #6 worked 12 hours shifts on the days in question.

In an interview on 1/24/20 at 10:50 AM, NA #6 stated she worked the days there was no documented evidence of Resident #88's showers. She stated she worked 7:00 AM to 7:00 PM and her practice was to go to Resident #88 at the beginning of her shift to ask if she wanted her shower earlier rather than waiting until 2nd shift. NA #6 stated the days where there was missing documentation of Resident #88's showers, she left the electronic medical record blank for the NA coming in at 7:00 PM to document the shower. She was not aware that the 2nd shift aide was not documenting the shower. NA#6 stated Resident #88's shower would populate in the electronic

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medical record after 3:00 PM but she left it blank since she would be doing the documentation for both shifts. NA #6 stated showers were very important to Resident #88 so she offered to schedule a time at the beginning of her shift and went back at the stated time. She stated Resident #88 did refuse a shower on once and she documented the refusal on a Shower/Skin Observation sheet that was kept at the nursing station. NA #6 stated she was unsure if the DON was aware, she was not charting in the medical record on 2nd shift. She stated she should either complete a Shower/Skin Observation sheet or chart in the electronic medical record when she completed Resident #88's shower.

In an interview on 1/24/20 at 12:20 PM, the DON stated it was her expectation that Resident #88's shows be documented when she received it regardless of the shift.

3a) Resident #24 was originally admitted to the facility on 1/12/19 with diagnoses which included diabetes, congestive heart failure and hypertension.

The quarterly Minimum Data Set (MDS) assessment dated 11/5/19 indicated Resident #24 to be cognitively intact and received supervision to limited assistance for all Activities of Daily Living.

The active care plan revealed a problem area for fluctuations in blood sugar levels due to diabetes.

The January 2020 physician orders revealed an order dated 1/12/19 for accuchecks before meals and at bedtime.

Review of the January 2020 Medication

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Administration Record (MAR) revealed accuchecks were not documented as obtained by the nurse or refused by the resident for 6 out of 22 days (1/1/20, 1/4/20, 1/7/20, 1/9/20, 1/15/20 and 1/21/20) at 6:30 am.

Review of the facility's Nursing Report Sheets for 1/1/20 through 1/21/20 revealed accucheck values written for Resident #24 each day at 6:30am.

A telephone interview was conducted with Nurse #1 on 1/23/2020 at 3:30pm, who was on the 3rd shift schedule for 1/9/20 and 1/21/20. He explained he always obtained Resident #24's blood sugars at the time ordered but could not recall why the accuchecks were not documented on the MAR.

On 1/23/2020 at 4:05pm an interview was held with Nurse #3, who was on the 3rd shift schedule for 1/1/20, 1/4/20, 1/7/20 and 1/15/20. She stated she obtained the blood sugars as ordered for Resident #24 and always wrote them on the facility's nursing report sheets but often forgot to write the value on the MAR.

The Director of Nursing (DON) was interviewed on 1/24/2020 at 8:00am. She reviewed the missing values for Resident #24's accuchecks on the January 2020 MAR and stated it was her expectation for the blood sugar result to be recorded on the MAR after the accucheck was obtained.

3b) Resident #24 was originally admitted to the facility on 1/12/19 with diagnoses which included

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diabetes, congestive heart failure and hypertension.

The quarterly Minimum Data Set (MDS) assessment dated 11/5/19 indicated Resident #24 to be cognitively intact and received supervision to limited assistance for all Activities of Daily Living. She was coded to have received 7 days of insulin injections during the look back period.

The active care plan revealed a problem area for fluctuations in blood sugar levels due to diabetes. The interventions included to administer medications as ordered.

The January 2020 physician orders revealed an order dated 12/27/19 for Humalog Mix 75/25 KwikPen inject as per sliding scale: If 80-150 give 18 units; 151-250 give 22 units; 251-350 give 25 units; 351-400 give 28 units; subcutaneously (under the skin) two times a day for diabetes at 6:30 am and 4:30 pm.

Review of the January 2020 Medication Administration Record (MAR) revealed sliding scale insulin was not documented as provided by the nurse or refused by the resident for 7 out of 22 days (1/1/20, 1/4/20, 1/7/20, 1/9/20, 1/15/20, 1/17/20 and 1/21/20) at 6:30am.

A telephone interview was conducted with Nurse #1 on 1/23/2020 at 3:30pm, who was on the 3rd shift schedule for 1/9/20 and 1/21/20. He explained he always obtained Resident #24's blood sugars at the time ordered and could not recall why the sliding scale insulin was not documented as given or refused by the resident on the MAR.

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On 1/23/2020 at 4:05pm an interview was held with Nurse #3, who was on the 3rd shift schedule for 1/1/20, 1/4/20, 1/7/20, 1/15/20 and 1/17/20. She stated she obtained the blood sugars as ordered for Resident #24 but often forgot to document if the sliding scale insulin was provided or refused by Resident #24 on the MAR.

The Director of Nursing (DON) was interviewed on 1/24/2020 at 8:00am. She reviewed the missing documentation for Resident #24's sliding scale insulin at 6:30am on the January 2020 MAR and stated it was her expectation for the nurses to document on the MAR how much sliding scale insulin was provided or if the resident refused.

4. Resident #1 was admitted to the facility on 1/4/20 with diagnoses that included anxiety, depression, and Post Traumatic Stress Disorder (PTSD).

A physician ' s order dated 1/4/20 indicated Seroquel 25 (antipsychotic medication) milligrams (mg) every 12 hours as needed (PRN).

A physician ' s order dated 1/6/20 indicated a discontinuation of the 1/4/20 PRN Seroquel order for Resident #1.

A physician ' s order dated 1/6/20 indicated Trazodone (antidepressant medication) 300 mg at bedtime and Lorazepam (antianxiety medication) 0.5 mg every 24 hours PRN for Resident #1.

A physician ' s order dated 1/7/20 indicated Seroquel 25 mg once daily at bedtime for

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Resident #1.

The admission Minimum Data Set (MDS) assessment dated 1/11/20 indicated Resident #1 ' s cognition was intact. He received antipsychotic and antidepressant medication on 5 of 7 days and antianxiety medication on 1 of 7 days during the MDS review period.

A physician ' s order dated 1/17/20 indicated a discontinuation of Lorazepam 0.5 mg PRN for Resident #1.

A physician ' s order dated 1/20/20 indicated a discontinuation of Seroquel 25 mg once daily at bedtime for Resident #1.

A review of the active physician ' s order on 1/24/20 indicated the physician ' s order for Trazodone 300 mg once daily at bedtime remained in place for Resident #1.

A review of the Skilled Care Nursing Assessment Notes from 1/4/20 through 1/24/20 all indicated Resident #1 was on no psychoactive medications.

A phone interview was conducted with Nurse #6 on 1/24/20 at 12:05 PM. A review of the Skilled Care Nursing Assessment Notes completed by Nurse #6 that indicated Resident #1 was on no psychoactive medications were reviewed (1/7, 1/11, 1/14, 1/15, 1/17, 1/18, 1/19, 1/20, 1/23, and 1/24). Nurse #6 stated that she thoroughly reviewed the physician ' s orders and Medication Administration Records (MARs) to determine if the resident was on any psychoactive medications. She revealed she made an error on all of these Skilled Care Nursing Assessment

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F 842	Continued From page 55 notes for Resident #1 as he was on one or more psychoactive medications at the time of each note. During an interview with the Administrator and Director of Nursing on 1/24/20 at 2:55 PM they both indicated they expected nursing documentation to be accurate.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility's Quality Assurance Committee (QA) failed to maintain procedures and monitor interventions that the committee put into to place following the annual recertification survey dated 2/14/19. This was for three recited deficiencies in the areas of Accuracy of Assessments at F641-not accurately coding the Minimum Data Set (MDS) in the areas of active diagnoses previously cited on 2/14/19, Bedrails at F700-assessment for the use of side rails previously cited 2/14/19, and Antibiotic Stewardship Program at F881-the use of prophylaxis antibiotics previously cited 2/14/19. The findings included: This citation is cross referenced to: F641-Based on observations, record reviews,	F 867	F867 Improvement Activities Corrective action: Resident #75 has had a correction to the MDS by the MDS nurse on 2-5-2020, to accurately reflect bathing occurrences. Resident #100 has had a correction to the MDS by the MDS nurse on 2-10-2020,to reflect the accurate amount of assistance required for transfer and range of motion of extremities. Resident #70 has had a correction to the MDS on 1-31-2020 by the MDS nurse, to reflect the assessment of his helmet as a restraint/device. In addition to coding for a restraint/device, resident #70 has had a correction to amount of assistance for locomotion that was required for both in the room and on the unit. Resident #5, having a stable weight for the past 6	2/21/20

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resident and staff interviews, the facility failed to accurately code the MDS in the areas of Activities of Daily Living (Residents #70, #75, #5 and #100), active diagnosis (Resident #5), discharge (Resident #126), restraints (Residents #70 and #83), behaviors (Resident #45), medications (Resident #17) and bowel and bladder (Resident #76) for 9 or 31 sampled residents reviewed for MDS accuracy.

F700-Based on observations, staff interviews and record review, the facility failed to assess for the continued need for ½ side rails for 2 (Resident #104 and Resident #117) of 2 residents reviewed for side rails.

F881-Based on record review, Physician and staff interview, the facility failed to implement its antibiotic stewardship program as evidenced by administration of an antibiotic without the presence of active infection and without adequate indication for use for 1 of 1 sampled resident reviewed for antibiotic therapy (Resident #17).

In an interview on 1/24/20 at 2:45 PM, the Administrator and Director of Nursing (DON) stated when MDS Nurse #1 went out on medical leave in December 2019, MDS Nurse #2 filled in and some of the MDS inaccuracies could be related to that. The DON stated she was unsure why the assessments for the use of side rails were recited. She stated she was under the impression that the Unit Managers were completing the assessments but there had been some staffing changes that could have contributed to the problem. The Administrator and DON stated the Medical Director felt the use of antibiotics in the absence of infection was

months, has had the diagnosis updated by the MDS nurse on 1-24-2020, to include a history of abnormal weight loss. In addition, for resident #5, a correction has been completed for the bathing section to reflect an accurate bathing assessment. Resident #76□s assessment has been corrected by the MDS nurse on 1-31-2020 to accurately reflect the condom catheter, and not an indwelling one. Resident #17□s MDS has been corrected by the MDS nurse on 2-11-2020, to accurately reflect the gradual dose reduction trial of the Seroquel. Resident #83□s MDS has been corrected by the MDS nurse on 1-22 -2020, to accurately reflect the use of a limb restraint. Resident #45 MDS assessment has been corrected by the Social Worker on 1-27-2020, to reflect his refusal behaviors. Resident #126□s MDS has been corrected by the MDS nurse on 1-23-2020 to reflect accurate location of discharge.
A device audit was completed 1-23-2020 for Resident□s #104 and #117. The bed rails have been removed 2-11-2020 and the plan of care has been updated.
Resident number #17 was reviewed in July of 2019 to have the antibiotic discontinued. The Physician had discontinued the antibiotic and the resident developed another urinary tract infection. A culture and sensitivity was obtained and the resident was resistant to the medication and a new antibiotic started that the organism was susceptible to. The physician has documented in the record this will be indefinite. It is reordered every 14 days after his review to ensure

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F 867	Continued From page 57 necessary for some residents.	F 867	prophylaxis is still necessary. A culture and sensitivity will be obtained by a physician order if clinically indicated. Identification of others potentially at risk: All residents in our facility require an accurate MDS assessment and have the potential to be affected. An audit of MDS□s completed in the past 3 months, looking at bathing occurrences, transfer assistance and range of motion, use of assistive devices, assistance for locomotion, active diagnosis's, type of catheter, coding for gradual dose reduction, use of restraints, and refusal behaviors, was conducted from the time of survey and completed on 2-14-2020 , by the DON, (Director of Nurses) and her nurse managers. No other resident was found to be affected by this alleged deficient practice. Identification of others potentially at risk: All resident who have beds with side rails have the potential to be affected. Initiated at the time of survey, an audit of all residents who have beds with side rails was completed by the DON, and nurse managers on 1-27-2020, to ensure that side rails have an appropriate physical device assessment. Any identified issues have been addressed as indicated. No other resident using bed rails was found to be affected. Corrective action for those who have the potential to be affected Any resident that requires an antibiotic has the potential to be affected and can	

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be identified by reviewing the weekly antibiotic reports generated from our pharmacy. Audit was completed on 1-27-2020 by the DON and her nurse managers. No other person was found to be on prophylactic antibiotics.

Systemic changes The QAPI committee will be in-serviced on 2-12-2020 by the Regional Director of Operations on the procedure for developing and implementing appropriate plans of action to correct identified quality concerns. Education will include determining the root cause of the identified concern, identifying, implementing and monitoring the corrective action plan and recognizing when an action plan may need to be revised. A Root Cause Analysis will be developed at that education session for the three identified issues.

Monitoring: MDS□s audits will be done weekly by the DON and/or the nurse managers for 2 months and then monthly times 3 months and then will be discussed in the monthly QAPI meeting by the DON, to ensure proper and accurate coding. Staff found to not be accurately completing the MDS will be re-educated as necessary. The Director of Nurses will be responsible to ensure any further recommendations are carried out.

Monitoring: Beds will be reviewed by the DON and her nurse managers weekly for 2 months, then monthly for 3 months by the DON and/or her nurse managers, to ensure that bed rails are not available to

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F 867	Continued From page 59	F 867	be used unless the resident has been assessed to require and a device assessment has been completed. Results of the audits will be taken to the monthly QAPI meeting by the DON, for any further recommendations. The Director of Nurses will be responsible to ensure any further recommendations are carried out. Monitoring The Director of Nurses/ Unit Managers, will review the weekly antibiotic reports generated from our pharmacy, to ensure there are stop orders in place or to determine why there is not a stop order, weekly for the next 2 months, and then monthly for 3 months. The results will be reported by the DON, to the monthly QAPI meeting for any further recommendations or root cause analysis. The DON will be responsible to follow-up on any recommendation from the committee and additional training is indicated. Root cause analysis will be determined in the next QAPI meeting the week of 2-17-2020.	
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.	F 881		2/21/20

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F 881	Continued From page 60 This REQUIREMENT is not met as evidenced by: Based on record review, Physician and staff interview, the facility failed to implement it's antibiotic stewardship program as evidenced by administration of an antibiotic without the presence of active infection and without adequate indication for use for 1 of 1 sampled resident reviewed for antibiotic therapy (Resident #17). Findings included: The facility's protocol/criteria (name of the criteria) dated 9/2019 used for antibiotic stewardship program was reviewed. The protocol revealed that the criteria for UTI (without a catheter), the resident must have acute dysuria or acute pain or fever and must have at least 1 of the following, acute costovertebral angle pain or tenderness, suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in urgency, and new or marked increase in frequency. The protocol further revealed that in the absence of fever, 2 or more of the following must be present, suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in urgency, and new or marked increase in frequency and at least 1 of the following, 10 CFU/ml of more than 2 species of microorganism in a voided urine sample or 10 CFU/ml of any number of organism in a specimen collected by in and out catheter. Resident #17 was admitted to the facility on 10/8/18 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 1/4/20 indicated that Resident #17 had severe cognitive impairment, had received an antibiotic medication for 7 days	F 881	F881 Antibiotic Stewardship Program Corrective Action: Resident number #17 was reviewed in July of 2019 to have the antibiotic discontinued. The Physician had discontinued the antibiotic and the resident developed another urinary tract infection. A culture and sensitivity was obtained and the resident was resistant to the medication and a new antibiotic started that the organism was susceptible to. The physician has documented in the record this will be indefinite. It is reordered every 14 days after his review to ensure prophylaxis is still necessary. A culture and sensitivity will be ordered by the physician if symptomatic and indicated. Corrective action for those who have the potential to be affected Any resident that requires an antibiotic has the potential to be affected and can be identified by reviewing the weekly antibiotic reports generated from our pharmacy. Audit was completed on 1-27-2020 by the DON and her nurse managers. No other person was found to be on prophylactic antibiotics. Systemic Changes The consultant pharmacist will address all antibiotics on a monthly basis for all residents. Reviews will be reviewed by the DON and Administrator as well. Any antibiotics that do not meet the criteria for antibiotic stewardship will be reviewed	

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F 881	Continued From page 61 during the assessment period and had no UTI in the last 30 days. The nurse's notes from September 2019 through January 2020 were reviewed and there was no documentation to indicate that Resident #17 had signs/symptoms of UTI except the note dated 9/21/19. The nurse's note dated 9/21/19 at 3:30 PM revealed that Resident #17 had hematuria in the disposable brief. The on-call physician was called to request for urinalysis and urine culture and sensitivity (C & S). The urine C & S result dated 9/24/19 revealed >100,000 colony forming units per milliliter (CFU/ml) of Proteus Mirabilis. Resident #17's care plan dated 9/27/19 was reviewed. One of the care plan problem was at risk for urinary tract infection (UTI) related to history of UTI. Another care plan problem initiated on 10 22/19 was at risk for discomfort or adverse side effects due to antibiotic therapy related to chronic UTI. The doctor's progress note dated 9/27/19 indicated that Resident #17 has been on prophylactic antibiotic for frequent UTI. It was decided to stop the antibiotic for a trial about a month ago. The resident has now developed a culture documented UTI. The plan was to treat the resident with Ceftin and after the treatment was completed, to restart prophylaxis with Ceftin 250 mgs daily. Resident #17 had the following doctor's orders written by Unit Manager (UM) #2:	F 881	with the Medical Director, by the Director of Nurses to ensure appropriate reasoning and documentation is available. Monitoring The Director of Nurses/ Unit Managers, will review the weekly antibiotic reports generated from our pharmacy, to ensure there are stop orders in place or to determine why there is not a stop order, weekly for the next 2 months, and then monthly for 3 months. The results will be reported by the DON, to the monthly QAPI meeting for any further recommendations or root cause analysis. The DON will be responsible to follow-up on any recommendation from the committee and additional training is indicated. Root cause analysis will be determined in the next QAPI meeting the week of 2-17-2020.	

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F 881	Continued From page 62 9/27/19 - Ceftin (an antibiotic medication) 500 milligrams (mgs) 1 tablet by mouth daily for UTI x (for) 7 days. The Medications Administration Record (MARs) revealed that Resident #17 had received Ceftin 500 mgs from 9/27/19 through 10/2/19. 10/2/19 - Ceftin 250 mgs 1 tablet by mouth daily for UTI prophylaxis, to start on 10/5/19. The MARs revealed that Resident #17 had received Ceftin 250 mgs from 10/5/19 through 10/18/19. 10/21/19 - Ceftin 250 mgs 1 tablet by mouth daily for UTI prophylaxis for 14 days. The MARs revealed that Resident #17 had received Ceftin 250 mgs from 10/21/19 through 11/3/19. 11/5/19 - Ceftin 250 mgs 1 tablet by mouth daily for chronic UTI for 14 days. The MARs revealed that Resident #17 had received Ceftin 250 mgs from 11/5/19 through 11/18/19. 11/25/19 - Ceftin 250 mgs 1 tablet by mouth daily for chronic UTI for 14 days. The MARs revealed that Resident #17 had received Ceftin 250 mgs from 11/25/19 through 12/8/19. 12/9/19 - Ceftin 250 mgs 1 tablet by mouth daily for chronic UTI for 14 days. The MARs revealed that Resident #17 had received Ceftin 250 mgs from 12/9/19 through 12/22/19. 12/24/19 - Ceftin 250 mgs 1 tablet by mouth daily for chronic UTI for 14 days. The MARs revealed that Resident #17 had received Ceftin 250 mgs from 12/24/19 through 1/6/20. 1/7/20 - 12/24/19 - Ceftin 250 mgs 1 tablet by mouth daily for chronic UTI for 14 days. The MARs revealed that Resident #17 had	F 881		

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F 881	Continued From page 63	F 881		

received Ceftin 250 mgs from 1/7/20 through 1/20/20.
1/22/20- Ceftin 250 mgs 1 tablet by mouth daily for chronic UTI for 14 days.

On 1/23/20 at 10:05 AM, the Director of Nursing (DON) was interviewed. The DON stated that the facility used the (name of the criteria) protocol/criteria for their infection surveillance including UTI and for the use of the antibiotic therapy.

On 1/23/20 at 4:36 PM, UM #2 was interviewed. She verified that she was the UM assigned on the hall where Resident #17 resided. She stated that Resident #17 had a chronic UTI and was on prophylactic antibiotic in the past. The UM indicated that she was aware that antibiotic should only be used if there was an active infection like fever, burning on urination, abdominal pain and if there was a positive urine C & S. She reported that the physician had ordered a prophylactic antibiotic for Resident #17 for chronic UTI in September 2019. The UM further indicated that the facility had been cited for the use of indefinite antibiotic, so she had written the order for the antibiotic to be given for 14 days and to stop for 2 days and then reinstated again for 14 days. The UM stated that she had evaluated the resident prior to writing the order for the antibiotic and had called the doctor. She verified that Resident #17 had no signs/symptoms of infections or had no positive urine C & S after 9/24/19.

On 1/24/20 at 12:25 PM, the facility's Infection Control (IC) Nurse was interviewed. She stated that she just started as Infection Control Nurse last week. She reported that she was aware that

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Resident #17 was on antibiotic for prophylaxis and this was against the facility's antibiotic stewardship program, however, the resident's physician wanted to continue the use of the antibiotic for the resident. The IC Nurse indicated that she was aware that chronic UTI was not an indication for the use of antibiotic.

On 1/24/20 at 2:00 PM, Resident #17's Physician was interviewed. He stated that he was aware that Resident #17 was on prophylactic antibiotic for chronic UTI. He added that the use of the antibiotic for Resident #17 supports her condition being debilitated elderly with serious UTI in the past. The Physician reported that Resident #17 was on prophylactic antibiotic in the past and that was stopped, and she developed a serious UTI in September 2019 and the antibiotic was restarted. He also stated that he only ordered urine C & S if symptomatic.

On 1/24/20 at 2:55 PM, the Director of Nursing (DON) and the Administrator were interviewed. They stated that they expected the facility's antibiotic stewardship program to be followed.