STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345015	A. BUILDING _____ B. WING _____	04/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPPS CONVALESCENT NH	500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203

(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 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157		5/17/17

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

Electronically Signed | 05/10/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to notify the physician or the responsible party (RP) of a skin tear for 1 (Resident #141) of 2 residents reviewed for accidents. The findings included: Resident # 141 was admitted 1/5/17 with cumulative diagnoses of diabetes, sepsis and long term anticoagulant use. His admission MDS dated 1/12/17 indicated Resident #141 was cognately intact and required extensive assistance with bed mobility, transfers, dressing and toileting. He was coded for limited assistance with locomotion on and off the unit, and non-ambulatory in the hall but extensive assistance with ambulation in his room. He was coded with no skin issues on admission. There was no care plan for any skin issues but Resident #141 was care planned for activities of daily living (ADL) assistance as needed on 4/12/17. In an observation on 4/17/17 at 4:03 PM, Resident #141 had a dry gauze dressing to his left outer forearm. He stated he bumped it on his	F 157	F157 1. Corrective actions taken for those residents found to have been affected by the deficient practice: " On 4/20/17 Resident #141□s skin tear was examined by the Director of Nursing. The attending physician was notified of the skin tear by the Director of Nursing and order for treatment was received. Accident/Incident report was completed and the responsible party was notified on 4/20/17 of the skin tear by the DON. 2. Residents having the potential to be affected by the same deficient practice were identified and the following action taken: " All resident with skin tears were evaluated by the DON and Assistant Director of Nursing to ensure the Physician/resident/family were notified of the skin tear and any new treatment orders. Residents that were found to have had no documentation supporting	

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F 157	Continued From page 2 bedside table. The dressing was clean and dry but there was no date as to when the dry dressing was applied. Resident #141 was unable to state when the dressing was last changed. In a review of the facility incident log from October 2016 to present did not include any incidents involving Resident #141. A review of the Resident #141 ' s electronic medical record included a Wound Assessment Report dated 4/11/17 that identified a skin tear to the left upper forearm. It was assessed as a new wound measuring 3.0 centimeter (cm) x 2.5 cm. The report completed by Nurse #6 indicated there was not treatment required. The physician and the responsible party were not documented as having been notified. In a telephone interview on 4/19/17 at 11:45 AM, Nurse #6 stated she thought the skin tear to Resident #141 ' s left forearm happened over an existing area therefore she did not do incident report or notified the physician or RP. Nurse #6 stated she may have told Resident #141 ' s RP when she came in since she was at the facility every day. A review of the undated policy titled Accidents and Incidents Investigation read all incidents occurring to a resident must be reported and documented. The attending physician should be notified along with the resident RP. In an interview on 4/19/17 at 12:10 PM, the DON stated it was the expectation of the facility notify the physician for orders to treat a new skin tear since there was no facility protocol for skin tears.	F 157	the family had been notified of new skin tear. All were found to have had the physician notified and treatment started. " ADON notified family members by phone of those residents who were found not to have documentation in place of new skin Completed: 5/3/17 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur: The DON and Administrator reviewed the facility policy for Change in Resident Condition or Status to ensure all the requirements were met in the current policy relating to F157 regulation 483.10(b)(11) Notification of Changes. The current facility policy does meet the requirement and was used for the in-service education for the licensed nurses. In-Service training was initiated on 4/26/17 by the ADON for all nurses concerning requirements for immediate physician notification when an accident with injury to the resident occurs and has the potential for requiring physician intervention and notifying the responsible party of incidents and new Physician orders. All licensed nurses were required to receive and acknowledge the Physician notification in-service training prior to beginning his/her next scheduled work shift.	

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F 157	Continued From page 3	F 157	4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: " The Director of Nursing or the Assistant Director of Nursing will monitor all Accidents/Incidents on a daily basis for one week; weekly basis for 4 weeks; every 2 weeks for 30 days and the monthly for 3 months to assure compliance with the Change in Resident Condition or Status policy. " The DON will take the audits to the QA Committee and results of that monitoring will be reviewed and discussed in the monthly QA Committee meeting. The QA committee will assess and modify the action plan as needed to ensure continual compliance. Completed: 5/15/17	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to follow the care plan and provide nail care to one of one sampled	F 282	F282 Services by Qualified Persons/Per Care Plan	5/17/17

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F 282	Continued From page 4 residents who required extensive assistance with ADL (activities of daily living) care (Resident #111). The findings included: 1. Resident #111 was admitted to the facility 12/23/11. Cumulative diagnoses included Alzheimer ' s disease. A Quarterly Minimum Data Set (MDS) dated 3/2/17 indicated Resident #111 was severely impaired in cognition. Resident #111 required extensive assistance of one person for personal hygiene. Rejection of care was not indicated as having occurred during the assessment period. A care plan dated 3/7/17 indicated Resident #111 required extensive assistance with personal hygiene. Approaches included, in part, assist her with personal hygiene daily. Make sure hands and face are clean and hair is combed. On 4/17/17 at 3:30PM, Resident #111 was observed to have brown material under all of her fingernails on both hands. On 4/18/17 at 9:00AM, Resident #111 was observed lying in bed. She continued to have brown material under each nail on both hands. On 4/18/17 at 11:06AM, an observation revealed Resident #111 dressed and lying in bed. She continued to have brown material under each nail on both hands. On 4/18/17 at 2:42PM, an interview was conducted with NA #1. She stated she had provided care for Resident #111 on day shift. She said Resident #111 helped with putting on her upper body clothing and washing her face and	F 282	1. Corrective actions taken for those residents found to have been affected by the deficient practice: " On 4/18/17 The Director of Nursing instructed the Nursing Assistant to complete nail care for Resident #111. 2. Residents having the potential to be affected by the same deficient practice were identified and the following action taken: " On 4/18/17 DON evaluated all Residents nails to ensure nail care had been provided and found all Resident□s to have had appropriate nail care delivered. 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur: " The DON and or Assistant Director of Nursing will provide education to all Licensed Nurses on checking and addressing nail care on weekly skin assessment. All Licensed Nurses will have received education prior to returning to work. " The DON and or ADON will provide education to all NA□s on providing nail care during ADL care. Completed on: 5/17/17 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance	

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F 282	Continued From page 5 was dependent on staff for all other areas of care. NA #1 said morning care included making sure that Resident #111 ' s fingernails were clean. She stated Resident #111 had times when she was resistive to nail care. If that happened, she returned later and encouraged her to let staff clean her nails. NA #1 said Resident #111 had resisted nail care this morning but she had not informed anyone and had not gotten a chance to tell the nurse. Nursing notes were reviewed from March 1, 2017 through present. There was no documented episodes of resistance to care. Resident #111 ' s care plan was reviewed and there was not a care plan for resistance to care. On 4/18/17 at 3:37PM, an observation of Resident #111 was conducted with the Director of Nursing. She stated she expected nursing staff to follow the care plan and nursing staff should have monitored, cleaned and inspected Resident #111 ' s fingernails daily during morning care, when giving a bath and on shower days. The Director of Nursing observed Resident #111 ' s fingernails and said the fingernails should have been cleaned and free from the dark material. When asked if she would let staff clean her nails, Resident #111 stated "Yes".	F 282	measures implemented: " The Director of Nursing or the Assistant Director of Nursing will monitor 10 random residents on a daily basis for one week; weekly basis for 4 weeks; every 2 weeks for 30 days and the monthly for 3 months to assure compliance. " The DON will take the audits to the QA Committee and results of that monitoring will be reviewed and discussed in the monthly QA Committee meeting. The QA committee will assess and modify the action plan as needed to ensure continual compliance. Completed on: 5/17/17	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and	F 309		5/17/17

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F 309	Continued From page 6 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to initiate a treatment to skin tear for 1 (Resident #141) 1 of residents reviewed for accidents. The findings included: Resident # 141 was admitted 1/5/17 with	F 309	F309 1. Corrective actions taken for those residents found to have been affected by the deficient practice: " On 4/20/17 Resident #141□s skin tear was examined by the Director of	

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F 309	Continued From page 7 cumulative diagnoses of diabetes, sepsis and long term anticoagulant use. His admission MDS dated 1/12/17 indicated Resident #141 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing and toileting. He was coded for limited assistance with locomotion on and off the unit, and non-ambulatory in the hall but extensive assistance with ambulation in his room. He was coded with no skin issues on admission. There was no care plan for any skin issues but Resident #141 was care planned for activities of daily living (ADL) assistance as needed on 4/12/17. In an observation on 4/17/17 at 4:03 PM, Resident #141 had a dry gauze dressing to his left outer forearm. He stated he bumped it on his bedside table. The dressing was clean and dry but there was no date as to when the dry dressing was applied. Resident #141 was unable to state when the dressing was last changed. A review of Resident #141 ' s treatment administration record (TAR) for April 2017 revealed there were no orders present for the area to Resident #141 ' s left outer forearm. A review of the Resident #141 ' s electronic medical record included a Wound Assessment Report dated 4/11/17 that identified a skin tear to the left upper forearm. It was assessed as a new wound measuring 3.0 centimeter (cm) x 2.5 cm. The report indicated there was no treatment required. In a second observation on 4/19/17 at 8:45 AM, Resident #141 was observed self-propelling in his wheelchair. There was a new gauze dressing	F 309	Nursing. The attending physician was notified of the skin tear by the Director of Nursing and order for treatment was received. Accident/Incident report was completed and the responsible party was notified on 4/20/17 of the skin tear by the Director of Nursing. 2. Residents having the potential to be affected by the same deficient practice were identified and the following action taken: " All resident with skin tears were evaluated to ensure the Physician/resident/family were notified of the skin tear and any new treatment orders. Requirements were met for appropriate notifications and treatment orders. Completed on:5/3/17 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur: " In-Service training was initiated on 4/26/17 by the ADON for all nurses concerning requirements for immediate physician notification when an accident with injury to the resident occurs and has the potential for requiring physician intervention and notifying the responsible party of incidents and new Physician orders. All licensed nurses were required to receive and acknowledge the Physician notification in-service training prior to beginning his/her next scheduled work shift.	

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F 309	Continued From page 8 covered with a clear adhesive dressing to his left outer forearm. The gauze was red tinged under the clear covering. The dressing was dated 4/18/17. Resident #141 stated a nurse put a new dressing on his arm last night. A review of the hard copy chart revealed a handwritten order dated 4/17/17 to clean the skin tear with normal saline and apply a post-operative Opsite dressing and change the dressing every three days. The order was written and signed by the DON. In a telephone interview on 4/19/17 at 11:45 AM, Nurse #6 stated if she remembered correctly, she told the Assistant Director of Nursing (ADON) about the skin tear and the ADON told her to clean the area with normal saline and to apply a dry gauze dressing. Nurse #6 stated the facility did not have a skin tear protocol so anytime there was a newly identified skin tear, it was her practice to ask the ADON or call the physician for treatment orders. She did not recall contacting the physician on 4/11/17. The ADON was unavailable to interview on 4/19/17. In an interview on 4/19/17 at 12:10 PM, the DON stated it was her expectation that Resident #141 ' s skin tear would be been treated as ordered by the physician at the time of the incident on 4/11/17.	F 309	4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: " The Director of Nursing or the Assistant Director of Nursing will monitor all Accidents/Incidents on a daily basis for one week; weekly basis for 4 weeks; every 2 weeks for 30 days and the monthly for 3 months to assure compliance with the Change in Resident Condition or Status policy. " The DON will take the audits to the QA Committee and results of that monitoring will be reviewed and discussed in the monthly QA Committee meeting. The QA committee will assess and modify the action plan as needed to ensure continual compliance. Completed: 5/17/17	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 312		5/17/17

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F 312	Continued From page 9 services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interviews, the facility failed to provide nail care to one of one resident who required extensive assistance and/or and were was dependent on staff for personal hygiene (Resident #111). The findings included: Resident #111 was admitted to the facility 12/23/11. Cumulative diagnoses included Alzheimer ' s disease. A Quarterly Minimum Data Set (MDS) dated 3/2/17 indicated Resident #111 was severely impaired in cognition. Resident #111 required extensive assistance of one person for personal hygiene. Rejection of care was not indicated as having occurred during the assessment period. A care plan dated 3/7/17 indicated Resident #111 required extensive assistance with personal hygiene. Approaches included, in part to assist her with personal hygiene daily and make sure hands and face are clean and hair is combed. On 4/17/17 at 3:30 PM, Resident #111 was observed to have brown material under all of her fingernails on both hands. On 4/18/17 at 9:00 AM, Resident #111 was observed lying in bed. She continued to have brown material under each fingernail on both hands. On 4/18/17 at 11:06 AM, an observation revealed Resident #111 dressed and lying in bed. She	F 312	F312 ADL Care Provided for Dependent Resident 1. Corrective actions taken for those residents found to have been affected by the deficient practice: " On 4/18/17 The Director of Nursing instructed the Nursing Assistant to complete nail care for Resident #111. Follow up by DON found Resident #111 nails to be clean. 2. Residents having the potential to be affected by the same deficient practice were identified and the following action taken: " On 4/18/17 DON evaluated all Residents nails to ensure nail care had been provided and found all Resident□s to have had appropriate nail care delivered. 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur: " The DON and or Assistant Director of Nursing will provide education to all Licensed Nurses on checking and addressing nail care on weekly skin assessment. " The DON and or ADON will provide	

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F 312	Continued From page 10 continued to have brown material under each fingernail on both hands. On 4/18/17 at 2:42 PM, an interview was conducted with NA #1. She stated she had provided care for Resident #111 on day shift. She said Resident #111 helped with putting on her upper body clothing and washing her face and was dependent on staff for all other areas of care. NA #1 said morning care included making sure that Resident #111 ' s fingernails were clean. She stated Resident #111 had times when she was resistive to nail care. If that happened, she returned later and encouraged her to let staff clean her nails. NA #1 said Resident #111 had resisted nail care this morning but she had not informed anyone and had not gotten a chance to tell the nurse. Nursing notes were reviewed from March 1, 2017 through present. There was were no documented episodes of resistance to care. On 4/18/17 at 3:37 PM, an observation of Resident #111 was conducted with the Director of Nursing. She stated she expected nursing staff to monitor, clean and inspect Resident #111 ' s fingernails daily during morning care, when giving a bath and on shower days. The Director of Nursing observed Resident #111 ' s fingernails and said the fingernails should have been cleaned and free from the dark material. When asked if she would let staff clean her nails, Resident #111 stated "Yes". On 4/19/17 at 10:40 AM, an observation of Resident #111 revealed all of her fingernails on both hands were trimmed and clean under every nail.	F 312	education to NA□s on providing nail care during ADL care. Completed on: 5/17/17 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: " The Director of Nursing or the Assistant Director of Nursing will monitor 10 random residents on a daily basis for one week; weekly basis for 4 weeks; every 2 weeks for 30 days and the monthly for 3 months to assure compliance. " The DON will take the audits to the QA Committee and results of that monitoring will be reviewed and discussed in the monthly QA Committee meeting. The QA committee will assess and modify the action plan as needed to ensure continual compliance " Completed on: 5/17/17	

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F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. 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. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to evaluate and monitor the safe continued use of a mechanical standing lift for a resident who sustained a fall during the use of the standing lift for a transfer for 1 (Resident #70) of 1 residents reviewed for accidents. The findings included:	F 323	F323 1. Corrective actions taken for those residents found to have been affected by the deficient practice. " 4/25/17 Physical Therapy re-evaluated Resident # 70 to confirm the use of Stand Lift as safe means of transfer. The Stand Lift was determined to	5/17/17

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A review of the facilities ' policy dated 12/19/07 titled Mechanical Lift/+2 Assistance Transfer Policy read the standing lift required the assistance of one staff member and the sling lift required 2 person assistance.

Resident #70 was admitted 10/23/14 with cumulative diagnoses of osteoporosis, scoliosis, and a history of falls.

Resident #70 ' s last documented Rehabilitation Screen was dated 2/27/17 which read she was non-ambulatory and was to be transferred using the standing lift.

The most recent quarterly Minimum Data Set (MDS) dated 3/1/17 indicated Resident #70 had moderate cognitive impairment with no behaviors. She required extensive assistance with her transfers with two person assistance. She was coded as non-ambulatory and as having no falls.

Resident #70 was care planned as a fall risk on 3/6/17 with interventions to include the notification of therapy for a fall and nonskid foot wear. She was care planned for staff assistance with transfers.

A review of the facility incident log from October 2016 to present included one fall recorded for Resident #70 on 3/18/17.

A review of the incident report dated 3/18/17 at 11:35 AM specified Resident #70 was assisted to the ground from the standing lift. Resident #70 was assessed for injuries then was lifted from the ground and placed in her wheelchair using a sling lift. Nurse #3 instructed the Nursing Assistant (NA) #2 to use the sling lift over the weekend until

be an appropriate mechanical lift to be used for the residents transfers to and from surfaces.

2. Residents having the potential to be affected by the same deficient practice were
identified and the following action taken:
" All falls for the last month were reviewed to determine if a therapy referral/evaluation was necessary. No falls due to mechanical lift were noted. Completed:5/5/17

" Review of all residents requiring the use of a mechanical lift will be completed by physical therapy to determine safe transfers to and from surfaces. Completed:5/17/17

3. Measures or systemic changes put in place to ensure the corrective actions do not
reoccur:
" The Director of Nursing and/or Assistant Director of Nursing will continue to review incident/accident forms and document any new interventions/referrals etc. These entries will be dated and timed at the time of the initial incident report review. The Fall Team Members will review the reports again weekly during the interdisciplinary fall team meeting.
" The DON and/or the ADON will be notified immediately of a fall the occurring during the use of a mechanical lift.
" Physical Therapy will be notified

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F 323	Continued From page 13 Resident #70 could be re-evaluated by therapy. The physician and responsible party were notified. A review of the Fall Scene Investigation Report dated 3/18/17 indicated Resident #70 lost strength and appeared to get weak. The fall was intercepted during a transfer using the standing left. The report indicated Resident #70 was being put back into her wheelchair. The report documented she was wearing slippers at the time of the fall and there was greater than 15 feet from the beauty shop chair to Resident #70 ' s wheelchair. Immediate interventions put in place by Nurse #3 were to use a sling lift with two person assistance for transfers for the rest of the weekend and to ensure she was wearing gripper socks or shoes for transfers. A review of the Fall Team Members portion of the Fall Scene Investigation Report was not completed until 4/6/17. It read Resident #70 was lowered to the floor while in the standing lift. She could no longer stand. The sling lift was used to assist her back to her wheelchair after being lowered to the floor. The plan was to monitor Resident #70 during standing lift transfers. The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) signatures were on Resident #70 ' s Fall Members form but there was no member from the therapy department documented as involved the Fall Team discussion on 4/6/17 of Resident #70 ' s fall that occurred on 3/18/17. The Fall Team discussion made no documented mention of the foot wear used during the transfer or Nurse #3 ' s recommendation to use gripper socks during transfers. In a late entry nursing note dated Saturday	F 323	immediately of a fall occurring during the use of a mechanical lift. Therapy will assess the resident within 24 hours of the fall to ensure the appropriate mechanical lift is being used. " All falls will be discussed during daily Department Meetings. Those in attendance will be; Administrator, Director of Nursing, Assistant Director of Nursing, Director of Social Services, Admission Director, Transition Care Nurse, MDS Coordinators, Dietary Manager, Director of Physical/Occupational Therapy, Medical Record Manager, Human Resources Manager, Business Office Manager, Staff Coordinator, Environmental Services Manager, Maintenance Manager. " Fall meetings are currently scheduled to occur weekly. The MDS Coordinator has been appointed to conduct/lead the interdisciplinary meeting in the absence of the DON/ADON to assure the falls are reviewed by the interdisciplinary at least weekly. " All Licensed nurses and Nursing Assistants will be in-serviced on the therapy referral process listed above by the DON and/or ADON. Completion Date: 5/17/17 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: " The Administrator will audit all Fall	

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F 323	Continued From page 14 3/18/17 at 3:22 PM specified at 11:35 AM the nurse was called to the beauty shop by the aide. Resident #70 ' s legs slid out from under her while in the standing lift. Resident #70 was assisted to the floor where she was assessed for injuries. After no injuries determined, Resident #70 was assisted to her wheelchair using the mechanical sling lift. The immediate intervention was the continued use of a sling lift until Resident #70 could be re-evaluated by therapy. In an interview on 4/18/17 at 3:57 PM, the Occupational Therapist (OT) stated she completed the transfer screen on Resident #70 on 2/27/17. The OT stated she did not actually observed a transfer using the standing lift nor did she reassess Resident #70 ' s transfer ability using the standing lift after the fall on 3/18/17. The OT stated the Rehabilitation Director attended weekly fall meetings with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). The OT stated Resident #70 had a history of not participating in therapy. In an interview on 4/18/17 at 5:00 PM, the DON stated it was her expectation that therapy evaluate Resident #70 ' s lift status at least quarterly or if there was a concern involving safe transfers. In an interview on 4/18/17 at 6:00 PM, Nurse #3 stated Resident #70 ' s personal beautician came in to do her hair. Two aides went to get Resident #70 from the beauty shop with the standing lift. NA #2 reported to Nurse #3 that Resident #70 ' s legs gave out from under her while she was in the lift from the beauty shop chair to her wheelchair. Nurse #3 stated NA #2 reported she and the beautician lowered Resident #70 to the floor.	F 323	Investigation Reports to assure the initial review conducted by the DON and/or ADON has been completed and documented. The auditing will occur as follows: All reports weekly for 1 month, then at least 5 per month for 3 months. " The DON/ADON will monitor all falls involving a mechanical lift to assure a therapy referral was initiated and an evaluation/screen completed. All falls weekly for 1 month, then at least 5 per month for 3 months. " QA Audit tools were developed to record the results of the monitoring. The DON will take the audits to the QA Committee and results of that monitoring will be reviewed and discussed in the monthly QA Committee meeting. " The QA committee will assess and modify the action plan as needed to ensure continual compliance the results of that monitoring will be reviewed and discussed in the monthly QA Committee meeting. The QA committee will assess and modify the action plan as needed to ensure continual compliance. Completed:5/17/17	

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Nurse #3 assessed Resident #70 for injuries and Nurse #3 stated she instructed the NA #2 to use the sling lift to transfer Resident #70 off the floor back into her wheelchair. Nurse #3 told NA #2 to continue using the sling lift until Monday. Nurse #3 stated Resident #70 was sitting in the beauty shop chair prior to the transfer and she did not recall who the other aide was. Nurse #3 stated she was not interviewed or asked to write a statement about the incident involving Resident #70 ' s fall Saturday 3/18/17. But she completed the incident report and wrote a nursing note.

In an observation on 4/18/17 at 6:52 PM, NA #3 and NA# 4 transferred Resident #70 using the standing lift from her wheelchair to the bathroom and placed Resident #70 on the toilet. Resident #70 was wearing gripper socks. During the positioning from the wheelchair unto the standing lift, Resident #70 appeared cooperative. She lifted her feet to allow to the base of the lift to slide under her feet while she reached out with her hands and grasped the handles on the standing lift. The aides applied the sling around Resident #70 ' s waist under her arms then hooked the sling onto the handles of the lift. NA #3 proceeded to raise the lift. Resident #70 was observed to be unsteady on her feet while NA #4 reminded Resident #70 to lock her knees while standing. Resident #70 was unable to maintain a full upright posture due to her diagnoses of scoliosis.

In an interview with NA #4 on 4/18/17 at 6:52 PM, NA #4 stated she had worked at the facility for five years. She stated she thought Resident #70 was to be lifted with a "sling lift" when she was initially admitted but she was upgraded to the standing lift. NA #4 stated she was not aware of

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any problems with Resident #70 and the use of the standing lift. She stated she followed the recommendation of resident lift status by reviewing a lift recommendation list at the nursing stations that was periodically updated. NA #4 stated one staff member could perform a standing lift and they could use their discretion on how to lift a resident if they felt the way indicated was unsafe. NA #3 and NA #4 stated they were not aware that any change in a lift status should be reported to a nurse.

In an interview on 4/19/17 at 8:55 AM, NA #2 confirmed she was involved in the incident on 3/18/17 and stated she had worked at the facility for twenty-four years. NA #2 recalled assisting Resident #70 out of the beauty shop chair when her legs gave out. NA #2 stated Resident #70 was wearing gripper socks to the best of her memory. NA #2 stated Resident #70 ' s knees buckled under her and she eased Resident #70 to the floor with the assistance of Resident #70 ' s personal beautician. She stated she was the only aide present and she left to get Nurse #3 to come and assess Resident #70 before she was moved. She stated Resident #70 did not complaint of any pain anywhere. After Nurse #3 assessed Resident #70, she got another aide to help her and used the sling lift to transfer Resident #70 from off the floor back into her wheelchair. NA #2 was unable to recall who the other aide was that assisted her but Nurse #3 told the aides to use the sling lift until therapy could assess Resident #70 ' s lift safety. NA #2 stated she was not sure what day it was that following week, but Resident #70 complained about using the sling lift and said it was uncomfortable. NA #2 stated she asked Nurse # 5 on 3/21/17 if it was alright to go back to using the standing lift. She stated Nurse #5 told

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her to go ahead and try it. NA #2 stated she did not have any problems transferring Resident #70 using the standing lift after that. NA #2 stated she was not aware if therapy ever re-evaluated Resident #70 ' s her lift status after the fall on 3/18/17. NA #2 stated she was never interviewed or asked to write a statement about the fall that occurred on Saturday 3/18/17.

In an interview on 4/19/17 at 9:03 AM, Nurse #5 stated she did not recall NA #2 coming to her but they use their own discretion as needed to lift residents. Nurse #5 stated she did not recall therapy re-evaluating Resident #70 ' s lift status after the fall on 3/18/17.

In another interview on 4/19/17 at 9:34 AM, the DON stated she was unable to provide any evidence of the monitoring of the standing lift for transfers as stated in the fall meeting on 4/6/17.

In an interview on 4/19/17 at 10:00 AM, the Rehabilitation Manager (RM) stated she was part of the weekly fall meeting. She stated the fall meetings were scheduled for every Thursday. She confirmed there was no fall meeting on 3/23/16 or on 3/30/17 because the DON and the ADON were not available for the meeting. The RM stated she was at the fall meeting on 4/6/17 and recalled discussing Resident #70. The RM stated she left early every day and on 4/6/17, the fall meeting ran late so she had to leave before she signed the Fall Meeting portion of the Fall Investigation Report. The RM stated she did not become aware of Resident #70 ' s fall until the meeting on 4/6/17. The RM stated if a fall occurred from a mechanical lift, it would be her expectation that some sort of an evaluation be completed to determine safe continued use of the

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lift but it was not her expectation that therapy be the staff necessarily performing the evaluation. The RM stated if there was a concern from the nursing staff about a resident ' s functional status, there were rehabilitation referral forms available at both nursing stations and anyone could complete the rehabilitation referral form.

In an interview on 4/19/17 at 11:30 AM, the MDS nurse stated she care planned the intervention on 3/6/17 that therapy be notified for any falls involving Resident #70. The MDS nurse stated the facility had a computer compliance center that allowed for rapid notification of any incidents, accidents or changes in a resident. The computer notified all the department managers so interventions or notification could be completed timely. The MDS nurse stated when the incident report was generated on 3/18/17, the computer generated a notification to all the department managers including therapy that there had been an incident. She stated she would have expected therapy to have re-evaluated the lift status and had any new interventions been initiated, they would have been care planned during the weekly fall meeting.

In a second interview on 4/19/17 at 12:28 PM, the RM confirmed she did receive a computer prompt from the facility compliance center program regarding the fall that occurred involving Resident #70. She stated she would have seen the prompt on Monday 3/20/17 when she returned to work. The RM also confirmed she had the ability to expand and investigate the nature of the incident from her computer without having to be given a written therapy referral or physician order.

In another interview on 4/19/17 at 12:35 PM, the

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F 323	Continued From page 19 DON confirmed there were no fall meetings on 3/23/17 or 3/30/17 because she and ADON were both out for personal reasons. The DON stated all falls were reviewed immediately to determine if interventions were needed. The DON confirmed it was the practice of the facility that the computer compliance center was primarily used for falls to address immediate interventions needed since they were more serious with possibility of injury. The DON recalled the staff asking about using the standing lift on resident #70 on 3/20/17 because Resident #70 was afraid of the sling lift. The DON stated she was uncertain if therapy ever re-evaluated for a safe transfer using the standing lift. She stated it was her expectation that any fall involving a mechanical device be evaluated for resident safety but it was the facility ' s belief that it was not an actual fall but Resident #70 was just eased to the ground. The DON stated she did not feel Resident #70 was wearing improper footwear and that slippers could be considered a safe for Resident #70.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F 329		5/17/17

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F 329	Continued From page 20 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (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; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and physician interview, the facility failed to follow the physician signed Note to Attending Physician/Prescriber from the pharmacist regarding a follow up Thyroid Stimulating Hormone (TSH) level lab for 1 out of 5 residents (Resident # 23). Findings included: Record review revealed Resident #23 was admitted to the facility on 3/3/04. The resident's most recent Minimum Data Set (MDS)	F 329	F329 Drug Regimen is Free of Unnecessary Drugs 1. Corrective actions taken for those residents found to have been affected by the deficient practice. " On 4/20/17 THS level was obtained on resident # 23. and physician notified of results TSH 5.45 via phone by the Assistant Director on Nursing. Order received to increase Synthroid to 175 mgc	

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F 329	Continued From page 21 assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 3/9/17. The MDS indicated the resident's cognition was severely impaired with short and long term memory loss. The resident was coded with abnormal behaviors and requiring extensive staff assistance to being totally dependent on staff for all activities of daily living. The resident's coded diagnoses included hypothyroidism (underactive thyroid gland). Resident #23's most recent TSH level lab was drawn on 11/9/16. The TSH level on the lab report was 22.07 (The normal range is 0.350 to 4.500. A high TSH level confirms hypothyroidism). A note on the reports indicated the resident's current levothyroxine dose was 125 micrograms (mcg) daily. An additional note written on the lab report and signed by the physician indicated an increase of the levothyroxine medication dose to 150 mcg every morning. The physician recommendation was documented as noted and transcribed on 11/10/16. A review of Resident #23's pharmacist recommendations revealed a Note To the Attending Physician/Prescriber, from the pharmacist dated 12/5/16. The pharmacist noted the resident's levothyroxine dose had been increased to 150 mcg daily on 11/10/16. The pharmacist's note further read the pharmacist did not find a follow up lab had been ordered to check thyroid hormone levels. The pharmacist written inquiry to the physician was when would the physician like a follow-up TSH completed? The pharmacist further expanded the resident had been refusing medications, if the TSH result was abnormal, the pharmacist asked the physician to look into the frequency of refusal of	F 329	daily. " On 4/23/17 The RN who processed the pharmacy note was re-educated by the ADON on proper completion of the Physician Order on the Note to Attending Physician/Prescriber form. 2. Residents having the potential to be affected by the same deficient practice were identified and the following action taken: " All Pharmacy recommendations for the last month were reviewed by the ADON to determine if recommendations had been addressed by the Physician and orders written when applicable (change in medication/treatment). Completed on: 4/28/17 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur: " The ADON will review all Notes to Attending Physician/Prescriber form issued by Pharmacy Consultant and transcribe any orders instructed by the Physician/Practitioner. The ADON will indicate on the Note to Attending Physician Form if orders were written, and the date. " The DON will receive copies of the orders and review them for accuracy. " Pharmacy will review monthly the Note to Attending Physician/Prescriber form for completion of recommendations made and notify the DON and/or ADON in person on the day the pharmacy reviewed	

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F 329	Continued From page 22 the levothyroxine. The physician checked he had agreed with the pharmacist's recommendation and signed the note. The note was stamped "FAXED" indicating the lab had been faxed on the date of 12/18/16 and a Registered Nurse (RN) wrote below the stamp mark "Noted no new orders" and was signed by the RN. A review was completed of the medical record of Resident #23. No TSH lab results were noted in the medical record since 11/19/16. An interview completed with the Director of Nursing (DON) on 4/18/17 at 4:12 PM revealed when a pharmacist had made a recommendation on a Note To Attending Physician/Prescriber and a physician had signed and checked agreed, the order would have been noted by the nurse. The DON reviewed Resident #23's Note to the Attending Physician/Prescriber dated 12/5/16 and acknowledged the nurse had written there were no new orders. The DON reviewed the recommendation from the pharmacist to the physician regarding the TSH level and acknowledged the physician had agreed with the recommendation and signed the document. The DON stated her expectation was the nurse should have written a new order for the TSH lab. A phone interview was conducted with Resident #23's physician on 4/19/17 at 10:58 AM. The physician stated he had signed the Note To Attending Physician/Prescriber and agreed a TSH lab should have been completed. The physician further clarified it was his expectation due to having signed off on the Note To Attending Physician/Prescriber a lab had been recommended such as the TSH lab should have been ordered and completed.	F 329	the record of any incomplete orders. Completed:5/17/17 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: " The DON will monitor 10 Note to Attending Physician/Prescriber forms where the Physician/Practitioner has approved an order change to assure the order was written/transcribed correctly. This will be done every week for 4 weeks, then taper to monthly for 2 months. QA Audit tools were developed to record the results of the monitoring. Completed: 5/17/17 " Pharmacy will perform a monthly review of the previous month□s recommendations for completion of recommendations made and notify the DON and ADON of any incomplete orders " The DON will take the audits to the QA Committee and results of that monitoring will be reviewed and discussed in the monthly QA Committee meeting. The QA committee will assess and modify the action plan as needed to ensure continual compliance Completed:5/17/17	

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F 329	Continued From page 23 An interview was conducted with the Administrator on 4/19/17 at 1:22 PM revealed it was her expectation the nursing staff review the Pharmacy Note To Attending Physician/Prescriber for any recommendations the resident's physician had agreed upon and signed off on. TSH if the T4 is low, a high TSH level would confirm that the thyroid gland (not the pituitary gland) is responsible for the hypothyroidism. If the T4 level is low and TSH is not elevated, the pituitary gland is more likely to be the cause for the hypothyroidism.	F 329		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (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. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 428		5/17/17

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F 428	Continued From page 24 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide documented reasoning for the continuation of medication according to pharmacy recommendations for 2 of 5 residents reviewed for unnecessary drug review (Resident #188) and (Reisdent #23). The findings included: Resident #188 was admitted to the facility on	F 428	F428 Drug Review 1. Corrective actions taken for those residents found to have been affected by the deficient practice. " On 4/20/17 the physician for residents #188 and #23 was re-educated by the Assistant Director of Nursing on CMS	

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F 428	Continued From page 25 10/15/16 with diagnoses that included right hip pain, anemia, Alzheimer's and dementia. The most recent Minimum Data Set (MDS) assessment dated 1/19/17 revealed Resident #188 was severely cognitively impaired as evidenced by a brief interview for mental status (BIMS) score of 1. Review of Resident 188 care plan dated 1/24/17 revealed a problem of, "Psychotropic drug use related to new order for citalopram and Xanax. The goals stated 1) Xanax will be effective for anxiety with no side effects x 90 days 2) Celexa will be effective for depression with no side effects x 90 days. The approaches included; medication review monthly with recommendations sent to medical doctor, monitor mood, behavior and cognitive status. Review of "note to attending physician/prescriber" from the outside pharmacy dated 3/1/17 stated, "would a gradual dose reduction (GDR) be appropriate for either order? If not please give a reason for risk vs benefit. Thanks". The note revealed the following medications: Xanax 0.25 milligrams (mg) 1 every 8 hours as needed (PRN) 10/16/16), Celexa 10mg every night (qhs) (11/16, depression/anxiety), and Sonata 10mg qhs PRN sleep (12/16, sleep). The physician/prescriber response revealed "other". The note contained no reason for the continuation of the medications. The report indicated it was faxed and signed by the physician with no date identified. On 3/19/17 the report identified it was faxed and stated no new orders by a registered nurse. Interview with the Assistant Director of Nursing (ADON) on 4/18/17 at 4:00pm revealed the medical doctor was aware that the pharmacist	F 428	guidelines requiring a reason be given for declining a dose reduction request from a pharmacy review " On 4/26/17 the ADON contacted the physician asking him to give a reason for denial of a GDR requested by the pharmacist on residents #188 and # 23. " On 4/27/17 the Physician responded to the ADON□s request for resident #188 and #23. 2. Residents having the potential to be affected by the same deficient practice were identified and the following action taken: " All Pharmacy recommendations for the last month were reviewed by the ADON to determine if recommendations had been addressed by the Physician and orders written for those found incomplete. Completed on: 4/28/17 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur: " The ADON will review all Notes to Attending Physician/Prescriber form issued by Pharmacy Consultant for the physician□s response to the request for a GDR. The ADON will contact the physician by fax for any pharmacy request that do not state a reason for denial of GDR made by the pharmacists. " The ADON will follow up by phone in 7 days if no response has been received regarding request. " The DON will receive copies of the	

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F 428	Continued From page 26 needed a reason why the GDR (gradual dose reduction) was not wanted. He was made aware in March 2017 following a meeting with the pharmacist in regards to the request not having a reason for "disagree" or "other". The ADON continued with she did find other residents pharmacy request to have "other" and "disagree" checked with no response. She stated that when there was missing reason as to why the physician checked "other" or "disagree" she had to contact the physician and clarify his reasoning for the pharmacist. Interview with the Director of Nursing (DON) on 4/19/17 at 9:47am revealed it was her expectation that the physician included a reason in the instance he disagreed or identified other on the notification form. She stated that in the instance the physician did not include a reason the ADON would contact the physician to clarify the reason why he disagreed. Interview with the Pharmacist on 4/19/17 at 9:07am reveled in the instance she did not have a physician response for the reasoning as to why he chose "disagree" or "other" she would note that she needed a reason the following month. She further revealed that she normally talked with the DON or ADON if she couldn't locate a reason for pharmacy recommended GDR. She revealed in March 2017 she had a discussion with the ADON in regards to lack of physician documentation when pharmacy recommendations were declined. The expectation is that the physician document reason for "disagree" or "other" on the form. Interview with the Physician on 4/19/17 at 10:57am indicated that he did not necessarily put	F 428	request to review them for accuracy. " Pharmacy will review monthly the Note to Attending Physician/Prescriber form for completion of recommendations made and notify the DON and ADON of any incomplete orders. Completed: 5/17/17 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: " The DON will monitor 10 Note to Attending Physician/Prescriber forms where request for GRD have been made by the pharmacy to assure request for GDR□s have been addressed by the physician. This will be done every week for 4 weeks, then taper to monthly for 2 months. QA Audit tools were developed to record the results of the monitoring. " Pharmacy will perform a monthly review of the previous month□s recommendations for completion of recommendations made and notify the DON and ADON of any incomplete orders " The DON will take the audits to the QA Committee and results of that monitoring will be reviewed and discussed in the monthly QA Committee meeting. The QA committee will assess and modify the action plan as needed to ensure continual compliance. " Completed: 5/17/17	

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the reason for the continuation of medication on the pharmacy recommendation report. He stated his reason for not reducing medications was due to the potential of resident's behaviors increasing. He stated the he received a call from the ADON when the pharmacy required clarification when he identified he for the agree, disagree or other was checked.

2. Record review revealed Resident #23 was admitted to the facility on 3/3/04. The resident's most recent Minimum Data Set (MDS) assessment was coded as a quarterly assessment with an Assessment Reference Date (ARD) of 3/9/17. The MDS indicated the resident's cognition was severely impaired with short and long term memory loss. The resident was coded with abnormal behaviors and requiring extensive assistance to being totally dependent on staff for all activities of daily living. The resident's coded diagnoses included: non-alzheimer's dementia and depression. The resident's recorded medications included an antidepressant and a diuretic.

A review of Resident #23's April 2017 Medication Administration Record revealed the resident was ordered citalopram 20 milligrams (mg) on 4/8/15 to be given orally every day and lorazepam 1 mg on 1/31/15 to be given intramuscular (IM) every 4 hours as needed.

A review of Resident #23's pharmacist recommendations revealed a Note To the Attending Physician/Prescriber, from the pharmacist, with a printed date of 9/6/16 and a faxed date of 9/18/16. The pharmacist noted the resident was ordered alprazolam and lorazepam. Due to both medications being antianxiolytics

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(Anti-anxiety medications) it may be viewed as duplicative therapy. The note further stated if the physician intended to continue both medications to please provide a reason for the risk versus the benefit for the continued use of both medications. The physician checked the box indicating he disagreed with the pharmacist, signed the note, but provided no documentation as to the reason for checking the disagree box. The note was stamped "FAXED" indicating the note had been faxed on the date of 9/18/16 and a Registered Nurse (RN) wrote below the stamp mark "Noted no changes" and was signed by the RN.

A Note To the Attending Physician/Prescriber regarding Resident #23, from the pharmacist, dated 1/4/17 was reviewed. The pharmacist inquired to the physician if a Gradual Dose Reduction (GDR) would be appropriate for the resident due to her receiving citalopram 20 milligrams (mg) ordered 4/8/14 to be given orally every day for depression and lorazepam 1 mg intramuscularly every four hours as needed for agitation. The pharmacist further noted, if the physician chose not to pursue a GDR to please provide a reason for risk versus benefit. The physician checked the box indicating he disagreed with the pharmacist, signed the note, but provided no documentation as to the reason for checking the disagree box. The note was stamped "FAXED" indicating the note had been faxed on the date of 2/19/17 and a Registered Nurse (RN) wrote below the stamp mark "Noted no changes" and was signed by the RN.

Another Note To the Attending Physician/Prescriber regarding Resident #23, from the pharmacist, dated 3/2/17 was reviewed. The pharmacist communicated to the physician

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Medicare and Medicaid regulatory agencies require the facility to ask you for and you to provide the reason for declining the dose reduction on 2/19/17. The note further requested the physician comment on the note regarding the reason for declining the dose reduction. Lastly, the pharmacist wrote the following, "PLEASE GIVE A REASON FOR THE 2/19/17 DECLINE OF THE GDR FOR [brand name for CITALOPRAM] OR [brand name for LORAZEPAM]. THANK YOU." The physician checked the box indicating he disagreed with the pharmacist, signed the note, but provided no documentation as to the reason for checking the disagree box. The note was stamped "FAXED" indicating the lab had been faxed on the date of 3/19/17 and a Registered Nurse (RN) wrote below the stamp mark "Noted no changes" and was signed by the RN.

An interview with the Pharmacist on 4/19/17 at 9:07 AM revealed she did not have a physician response for the reasoning as to why the physician chose "disagree" or "other." The pharmacist stated she would document that she needed a response and reason for the following month. She further revealed that she normally talked with the DON (Director of Nursing) or the ADON (Assistant Director of Nursing) if she couldn't locate a reason for pharmacy recommended GDR. She revealed in March 2017 she had a discussion with the ADON in regards to lack of physician documentation when pharmacy recommendations were declined. The expectation was that the physician document reason for "disagree" or "other" on the form.

Interview with the Physician on 4/19/17 at 10:57 AM indicated that he did not necessarily put the

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F 428	Continued From page 30 reason for the continuation of medication on the pharmacy recommendation report. He stated his reason for not reducing medications was due to the potential of resident's inappropriate behaviors increasing. An interview was conducted with the facility Administrator on 04/19/17 at 1:22 PM and the administrator stated it was her expectation there be documentation from the physician in the medical record regarding the Gradual Dose Reduction (GDR) recommendations made by the pharmacist.	F 428		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections	F 441		5/17/17

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before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an

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F 441	Continued From page 32 annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, manufacturer's specifications and facility policy, the facility failed to follow manufacturer's specifications for effective use of germicidal wipes used for the disinfection of the glucometer between residents for four of four residents (Resident #282, #219, #172, #160 and #118). The findings included: The Centers for Disease Control and Prevention (CDC) Summary statement on Infection Prevention during Blood Glucose Monitoring and Insulin Administration reports, in part: "The Centers for Disease Control and Prevention (CDC) has become increasingly concerned about the risks for transmitting hepatitis B virus (HBV) and other infectious diseases during assisted blood glucose monitoring and insulin administration ...Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions." Recommendations for Cleaning and Disinfection of Glucometers North Carolina Statewide Program for Infection control and Epidemiology (SPICE) state, in part, "2. If no visible organic material is present, disinfect after each use the exterior surfaces following the manufacturer's directions using a cloth/wipe with either an EPA registered detergent/germicide with a tuberculocidal or HBV (hepatitis B virus)/ HIV (human immunodeficiency virus) label claim, or a dilute bleach solution of 1:10 (one part bleach to	F 441	F441 1. Corrective actions taken for those residents found to have been affected by the deficient practice. " Nurse # 1, 2 and 4 were educated on the appropriate sanitizing and cleaning of glucometers by the Director of Nursing on 4/18/17. The DON issued an individual glucometer to Residents # 282 #219, #172, #160, #118 on 4/21/17. 2. Residents having the potential to be affected by the same deficient practice were identified and the following action taken: " A list of all residents with orders for finger stick blood sugar testing was made by the DON. These residents were issued an individual glucometer on 4/21/17 by the DON Completed on 4/21/17 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur: " On 4/22/17 all resident□s requiring finger stick blood sugar testing were issued an individual glucometer eliminating the need to share glucometers. " In the event, a glucometer should be shared amongst residents □ all nurses were educated regarding the appropriate sanitizing process of glucometers	

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F 441	Continued From page 33 9 parts water) to 1:100 concentration." A facility policy, undated, stated "Glucometers are to be cleaned and disinfected with a EPA-registered detergent/ germicide with a tuberculocidal or HBV/HIV label claim, or a dilute bleach solution of 1:10 (one part bleach to 9 parts water) to 1:100 concentration, Glucometers are to be cleaned between each patient use." 1. On 4/18/17 at 8:00PM, Nurse #1 was observed obtaining Resident #282's blood sugar. Nurse #1 wiped the glucometer with a germicidal wipe for 10 seconds, obtained Resident #282's blood sugar, cleaned the glucometer with another germicidal wipe for 10 seconds and placed the glucometer in the basket. A review of Manufacturer's instructions for the germicidal wipes stated, in part, to disinfect, use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full 3 minutes. Use additional wipes if needed to assure continuous three minutes wet contact time. On 4/18/17 at 8:20PM, an interview was conducted with Nurse #1. She stated the procedure for cleaning the glucometer was to use a germicidal wipe and wipe the glucometer off for approximately 10 seconds and let dry for 1 minute. She stated she cleaned the glucometer before beginning and after each use on resident. She reviewed the instructions on the germicidal wipe and stated she did not know it should remain wet for 3 minutes. On 4/18/17 at 8:35PM, an interview was conducted with the Director of Nursing who stated	F 441	between use by the Assistant Director of Nursing Completed on 4/28/26 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: " The DON and/or ADON will monitor nurses on all shifts performing finger stick blood sugars to assure an individual assigned glucometer is used for testing. The auditing will occur as follows: All nurse monitored weekly for two weeks, then every other week for one month, then monthly for 3 months. " The DON and/or ADON will observe all Licensed Nurses clean a glucometer. The auditing will occur as follows: All nurse monitored weekly for two weeks, then every other week for one month, then monthly for 3 months. " The DON will take the audits to the QA Committee and results of that monitoring will be reviewed and discussed in the monthly QA Committee meeting. The QA committee will assess and modify the action plan as needed to ensure continual compliance Completed 5/17/17	

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the facility followed the CDC and SPICE guidelines for cleaning the glucometer. She stated she expected staff to follow the manufacturer's instructions and facility policy for cleaning and disinfecting the glucometers.

2. On 4/18/17 at 8:10PM, Nurse #1 was observed obtaining Resident #219's blood sugar. Nurse #1 removed the glucometer from the basket, wiped the glucometer with a germicidal wipe for approximately 10 seconds, obtained the blood sugar, cleaned the glucometer with a germicidal wipe for 13 seconds and put the glucometer in the basket.

A review of Manufacturer's instructions for the germicidal wipes stated, in part, to disinfect, use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full 3 minutes. Use additional wipes if needed to assure continuous three minutes wet contact time.

On 4/18/17 at 8:20PM, an interview was conducted with Nurse #1. She stated the procedure for cleaning the glucometer was to use a germicidal wipe and wipe the glucometer off for approximately 10 seconds and let dry for 1 minute. She stated she cleaned the glucometer before beginning and after each use on resident. She reviewed the instructions on the germicidal wipe and stated she did not know it should remain wet for 3 minutes.

On 4/18/17 at 8:35PM, an interview was conducted with the Director of Nursing who stated the facility followed the CDC and SPICE guidelines for cleaning the glucometer. She

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stated she expected staff to follow the manufacturer's instructions and facility policy for cleaning and disinfecting the glucometers.

3. On 4/18/17 at 8:17PM, Nurse #1 was observed obtaining Resident #172's blood sugar. Nurse #1 wiped the glucometer with a germicidal wipe for 10 seconds, obtained the blood sugar, cleaned the glucometer with a germicidal wipe for 10 seconds and placed the glucometer in the basket.

A review of Manufacturer's instructions for the germicidal wipes stated, in part, to disinfect, use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full 3 minutes. Use additional wipes if needed to assure continuous three minutes wet contact time.

On 4/18/17 at 8:20PM, an interview was conducted with Nurse #1. She stated the procedure for cleaning the glucometer was to use a germicidal wipe and wipe the glucometer off for approximately 10 seconds and let dry for 1 minute. She stated she cleaned the glucometer before beginning and after each use on resident. She reviewed the instructions on the germicidal wipe and stated she did not know it should remain wet for 3 minutes.

On 4/18/17 at 8:35PM, an interview was conducted with the Director of Nursing who stated the facility followed the CDC and SPICE guidelines for cleaning the glucometer. She stated she expected staff to follow the manufacturer's instructions and facility policy for cleaning and disinfecting the glucometers.

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5. On 4/18/17 at 4:52PM, Nurse #2 was observed obtaining Resident #118's blood sugar. Nurse #2 obtained Resident #118's blood sugar, returned to the medication cart, wiped the glucometer with an alcohol wipe and returned the glucometer to the drawer in the cart. Nurse #2 stated she usually cleaned the glucometer with an alcohol wipe.

A review of Manufacturer's instructions for the germicidal wipes stated, in part, to disinfect, use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full 3 minutes. Use additional wipes if needed to assure continuous three minutes wet contact time.

On 4/18/17 at 8:35PM, an interview was conducted with the Director of Nursing who stated the facility followed the CDC and SPICE guidelines for cleaning the glucometer. She stated she expected staff to follow the manufacturer's instructions and facility policy for cleaning and disinfecting the glucometers.

4. Resident #160 was admitted 3/16/17. His admission MDS dated 3/23/17 indicated he was cognitively intact with a diagnosis of diabetes. His April physician orders read his blood glucose levels were to be tested using the glucometer (device for monitoring blood sugar levels) four times daily.

In an observation on 4/18/17 at 7:14 PM, Nurse #4 was observed performing a blood glucose

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F 441	Continued From page 37 check on Resident #160 using a glucometer. Prior to testing she took the glucometer from her rolling cart and proceeded to wipe the device down using a Santi-wipe. She wiped the device for 30 seconds then proceeded to check Resident #160 ' s blood glucose level. After Nurse #4 completed his blood glucose check, she returned to her cart and again took a fresh Santi wipe and proceeded to wipe the glucometer for 45 seconds. She disposed of the wipe and returned the glucometer to the cart. Nurse #4 stated it was her practice to use the Santi-wipe to disinfect the glucometer using the Santi wipe for "about a minute" before using it on a resident and before returning it to the cart. Nurse #4 stated she was not trained specifically on the manufacture instructions for disinfecting the glucometers. She was just advised to wipe the glucometers down with the Santi-wipes in between residents. On 4/18/17 at 8:35PM, an interview was conducted with the Director of Nursing who stated the facility followed the CDC and SPICE guidelines for cleaning the glucometer. She stated she expected staff to follow the manufacturer's instructions and facility policy for cleaning and disinfecting the glucometers.	F 441		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 514		5/17/17

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F 514	Continued From page 38 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (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 interview the facility failed to maintain an accurate allergy list for 1 of 5 residents reviewed for unnecessary drug review (Resident #188). The findings included: Resident #188 was admitted to the facility on 10/15/16 with diagnoses that included right hip pain, anemia, Alzheimer's and dementia. The most recent Minimum Data Set (MDS) assessment dated 1/19/17 revealed Resident	F 514	F514 Resident Records Complete/Accurate 1. Corrective actions taken for those residents found to have been affected by the deficient practice. " On 4/20/17 RN received order to remove Tylenol from resident #188 allergy list. Resident showed no side effects of medication.	

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F 514	Continued From page 39 #188 received scheduled pain medication. The MDS further revealed Resident #188 was cognitively impaired as evidenced by a brief interview for mental status (BIMS) score of 1. Review of Resident #188's red allergy tab in her physical medical record had no allergies identified. view of Resident #188's History and physical Assessment (H&P) dated 10/17/16 indicated Resident #188 was admitted to the facility for physical therapy and occupational therapy following a hospital stay for a fall that resulted in a right hip fracture. The H&P identified the flowing drug allergies: Darvocet, penicillin, Sulfa, and Allegra. Review of Physician order dated 10/17/16 stated, Tylenol 650 milligrams (mg) by mouth (po) 4x a day (QID). Review of Resident #188's Medication Administration Record (MAR) for April 2017, March 2017, Feb 2017, January 2017, December 2016, November 2016, October 2016 included acetaminophen as an allergy. Review of Medication Aide #1 note dated 10/18/16 stated Tylenol 325mg tablet secluded for 10/18/16 8:00am was not administered due to patient allergies list. The note continued with the nurse was made aware. Review of Medication Aide #1 note dated 10/18/16 stated Tylenol 325mg tablet secluded for 10/18/16 at 12:00pm was not administered due to patient allergies list. The note continued with the nurse was made aware.	F 514	2. Residents having the potential to be affected by the same deficient practice were identified and the following action taken: " On 5/3/17 Pharmacy completed reviewed of all residents listed allergies for accuracy. Two records were found to be incorrect. Findings were given to the Assistant Director of Nursing for correction. " On 5/3/17 the ADON notified MD of findings and corrections made at that time. 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur: " The pharmacy will perform monthly reviews of each residents allergy list. Any discrepancies will be reported to the ADON to obtain clarification. " The Director of Nursing and/or ADON will re-educated all Licensed Nurses on the process of reviewing the residents allergy list each time a new medication order is received. All Licensed Nurses will receive education prior to their next scheduled shift to work. Completed: 5/17/17 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented:	

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F 514	Continued From page 40 Interview with Medication Aide #1 on 4/18/17 at 5:31 pm revealed he was made aware of resident's allergies through the resident's electronic medical record. He stated that as a Medication Aid he was not responsible for contacting the physician in regards to notification of an allergy. He indicated that he only communicated the allergy to the nurse on duty. The nurse on duty would be responsible for contacting the physician and notify them of any discrepancy in any medication. Interview with Nurse #7 on 4/19/17 at 8:00am revealed she administered medications to Resident #188. She stated that she identified what medications residents were allergic to through documentation in the resident's electronic medical record, physical medical record and physician orders. She stated that she recalled Resident #188's allergy to acetaminophen but should have been removed from Resident #188's allergy list. She stated she recalled the family of Resident #188 indicating the resident was not allergic to the medication and was unsure as to why it was listed as an allergy. Nurse #7 indicated that she had given Resident #188 her scheduled Tylenol that am and had not notified the physician of the allergy still being listed on the electronic record. Interview with the Assistant Director of Nursing (ADON) on 4/18/17 at 3:27pm revealed that upon admission the facility would use the list of allergies identified on the discharge summary from the hospital. The ADON indicated that she would further discuss allergies with the resident's family or the resident. The ADON stated if the resident's family said the resident could have the medication and there is no allergy, the physician	F 514	" The DON and or ADON will monitor 10 resident records for accurate allergy lists. This will be done every week for 4 weeks, then taper to monthly for 2 months. QA Audit tools were developed to record the results of the monitoring. " Pharmacy will perform a monthly review of the previous month□s recommendations for completion of recommendations made and notify the DON and ADON of any incomplete orders " The DON will take the audits to the QA Committee and results of that monitoring will be reviewed and discussed in the monthly QA Committee meeting. The QA committee will assess and modify the action plan as needed to ensure continual compliance Completed: 5/17/17	

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would be notified and would write a telephone order to assess the resident for the allergy. When a resident had an allergy to a medication there would be an order to monitor the resident for that allergy. She indicated that the note written on 10/18/16 written by Medication Aid #1 should have been followed up by the nurse he communicated the concern to. She further revealed that her exception was that the nurse follow up with the physician with a nursing note clarifying the medication use and allergy. The ADON stated she could not find documentation or nursing note in regards to Med Aide holding resident #188's Tylenol.

Interview with the Director of Nursing (DON) on 4/19/17 at 9:47am revealed allergies were identified by the discharge hospital records. The facility also became aware of allergies in instances the resident was having a reaction such as a rash, interviews with the resident or family upon admission. She stated the physician would be notified. The note written by Medication Aid #1 on 10/18/16 indicated the Med Aid did not give Tylenol to Resident #188 because the medication was listed as an allergy. She revealed it was her expectation that the nurse that was notified by Med Aid #1 contact the physician and notify the physician that there was an allergy noted and the resident had received the medication. The physician would see if the allergy was truly an allergy. The DON stated that there should have been a nursing note written that identified the physician was notified in regards to the allergy. Her expectation was that current allergies be noted in the resident medical record and addressed properly.

Interview with the Administrator on 4/19/17 at

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F 514	Continued From page 42 8:40am revealed the facility had a fax from a previous admission dated 3/4/16 that stated Resident #188 could have the Tylenol per family. She further stated that when they readmitted Resident #188 the allergies would have pulled over and were not removed. The nurse should have clarified the order and taken the allergy to acetaminophen out of the system to prevent the discrepancy from occurring. She revealed it was her expectation that the facility staff follow the standards of care and clarify resident allergies with the physician. Interview with the Physician on 4/19/17 at 10:57 am revealed he was familiar with resident #188. Resident #188 had had previous admission at the facility. He further revealed that Resident #188 had an allergic reaction to a combination medication that had acetaminophen in it. Resident #188 had taken acetaminophen since admission and had no allergic reaction to it. He indicated that he didn't become aware of the allergy listed in Resident #188's medical record until today (4/19/17) by the facility. He indicated that his expectation was to be notified that Resident #188 had an allergy identified in the medical record to acetaminophen so that it could have been removed from the resident's allergy list.	F 514		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:	F 520		5/17/17

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F 520	Continued From page 43 (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into	F 520	F520 QA Committee-Members/Meet Quarterly/Plans 1. Corrective actions taken for those residents found to have been affected by	

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F 520	Continued From page 44 place following the 4/14/16 recertification survey. This was for a recited deficiency in the area of Accidents (F323). This deficiency was cited again on the current recertification survey of 4/19/17. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: F323 - Accidents: Based on observation, staff interviews and record review, the facility failed to evaluate and monitor the safe continued use of a mechanical standing lift for a resident who sustained a fall during the use of the standing lift for a transfer for 1 (Resident #70) of 1 residents reviewed for accidents. During the recertification survey of 4/14/16 the facility was cited F323 for failing to ensure hazard chemicals were stored out of reach of residents as evidenced by leaving disinfectant/deodorant cans on top of hand rails. On the current recertification survey of 4/19/17 the facility was cited for failure to evaluate and monitor the safe continued use of a mechanical standing lift for a resident who sustained a fall during the use of the standing lift. An interview was conducted with the Director of Nursing (DON) on 4/19/17 at 1:11 PM. She stated she was the head of the facility ' s QAA Committee. She indicated the committee consisted of the Administrator, Assistant Director of Nursing (ADON), Minimum Data Set (MDS) Coordinator #1, MDS Coordinator #2, Admissions Director, Dietary Manager, Social Worker,	F 520	the deficient practice. " 4/25/17 Physical Therapy re-evaluated Resident # 70 to confirm the use of Stand Lift as safe means of transfer. The Stand Lift was determined to be an appropriate mechanical lift to be used for the residents transfers to and from surfaces. 2. Residents having the potential to be affected by the same deficient practice were identified and the following action taken: " All falls for the last month were reviewed to determine if a therapy referral/evaluation was necessary. No falls using mechanical lifts were noted. Completed:5/5/17 " Review of all residents requiring the use of a mechanical lift will be completed by physical therapy to determine safe transfers to and from surfaces. Completed:5/17/17 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur: " The Director of Nursing and/or Assistant Director of Nursing will continue to review incident/accident forms and document any new interventions/referrals etc. These entries will be dated and timed at the time of the initial incident report review. The Fall Team Members will review the reports again weekly during the	

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F 520	Continued From page 45 Therapy Manager, Medical Director, Floor Nurse, and Nursing Assistant. She stated the committee met quarterly. The DON indicated she was aware Accidents was a repeat citation from the 4/14/16 recertification survey. She indicated the previous Plan of Correction (POC) included several months of audits that were monitored by the Housekeeping Manager. She stated she believed the current citation was unrelated to their previous POC. She additionally stated she believed this was a repeat deficiency because the area of accidents was so broad that a variety of items fell under this categorization.	F 520	interdisciplinary fall team meeting. " The DON and/or the ADON will be notified immediately of a fall the occurring during the use of a mechanical lift. " Physical Therapy will be notified immediately of a fall occurring during the use of a mechanical lift. Therapy will assess the resident within 24 hours of the fall to ensure the appropriate mechanical lift is being used. " All falls will be discussed during daily Department Meetings. Those in attendance will be; Administrator, Director of Nursing, Assistant Director of Nursing, Director of Social Services, Admission Director, Transition Care Nurse, MDS Coordinators, Dietary Manager, Director of Physical/Occupational Therapy, Medical Record Manager, Human Resources Manager, Business Office Manager, Staff Coordinator, Environmental Services Manager, Maintenance Manager. " Fall meetings are currently scheduled to occur weekly. The MDS Coordinator has been appointed to conduct/lead the interdisciplinary meeting in the absence of the DON/ADON to assure the falls are reviewed by the interdisciplinary at least weekly. " All Licensed nurses and Nursing Assistants will be in-serviced on the therapy referral process listed above by the DON and/or ADON. " Observations using the Environmental Hazard Check List will be conducted weekly by various departments to assess for potential areas that could pose an accident hazard to the residents with any	

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F 520	Continued From page 46	F 520	immediate threats reported to the DON and/or ADONcorrected upon discovery. Completion Date: 5/17/17 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: " The Administrator will audit all Fall Investigation Reports to assure the initial review conducted by the DON and/or ADON has been completed and documented. The auditing will occur as follows: All reports weekly for 1 month, then at least 5 per month for 3 months. " The DON/ADON will monitor all falls involving a mechanical lift to assure a therapy referral was initiated and an evaluation/screen completed. All falls weekly for 1 month, then at least 5 per month for 3 months. " QA Audit tools were developed to record the results of the monitoring. The DON will take the audits to the QA Committee and results of that monitoring will be reviewed and discussed in the monthly QA Committee meeting. " The QA committee will assess and modify the action plan as needed to ensure continual compliance the results of that monitoring will be reviewed and discussed in the monthly QA Committee meeting. The QA committee will assess and modify the action plan as needed to ensure continual compliance.	

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F 520	Continued From page 47	F 520	Completed:5/17/17	
F 526 SS=D	483.70(o)(1)-(4) Hospice (o) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. (2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:	F 526		5/17/17

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F 526	Continued From page 48 (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board	F 526		

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care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.

(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.

(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.

(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.

(K) A delineation of the responsibilities of the hospice and the LTC facility to provide

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bereavement services to LTC facility staff.

(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

The designated interdisciplinary team member is responsible for the following:

(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.

(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.

(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.

(iv) Obtaining the following information from the

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F 526	Continued From page 51 hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. (4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.20. This REQUIREMENT is not met as evidenced by:	F 526		

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F 526	Continued From page 52 Based on family interview, staff interview, and record review, the facility failed to coordinate care with the hospice provider for 1 of 1 residents (Resident #281) reviewed for hospice. The findings included: Resident #281 was admitted to the facility on 4/7/17 with multiple diagnoses that included Alzheimer's. A family interview for Resident #281 was conducted on 4/17/17 at 12:47 PM. The family member indicated Resident #281 had been on hospice services for several months and continued on hospice when she was transferred to this facility on 4/7/17. They reported Resident #281 was bed bound and non-verbal. A review of the medical record revealed an FL2 Form (a form completed prior to admission to a nursing home that contained diagnoses, medications, and care needed) completed on 4/5/17 for Resident #281 that indicated she began hospice services on 10/1/16 with a primary diagnosis of Alzheimer's. This form was received by the facility on 4/5/17 prior to Resident #281's admission. A Hospice Standing Orders and Comfort Pak (medications used when needed to relieve symptoms that commonly arise in terminally ill patients) form was signed by Resident 281's physician and received at the facility on 4/15/17. A further review of Resident #281's medical record (hard copy and electronic copy) revealed none of the following documents: physician's order for hospice, hospice plan of care, hospice election form, or hospice certification of terminal illness.	F 526	F526 Hospice Services 1. Corrective action taken for those residents found to have been affected by deficient practice. " On 4/18/17 DON received physician order for resident #281 continuation of hospice services, documentation of hospice plan of care, hospice election form and hospice certification of terminal illness for resident. The documentation was placed on chart and a label indicating the resident was receiving hospice services. 2. Residents having the potential to be affected by the same deficient practice were identified and the following action taken. " On 5/5/17 the DON reviewed all charts of patients receiving hospice services to ensure that all required info was in medical record. All records were found to have appropriate Hospice chart labeling and documents. " On 5/5/17 Administrator contacted hospice to validate accurate list of hospice patients being followed in facility. 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur. " On 5/5/17 Administrator in serviced admission director and admission nurses on the procedure to follow when admitting a hospice patient. " Admission Director will put a note in our electronic medical record informing all staff that a patient will be receiving	

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F 526	Continued From page 53 An interview was conducted with Nurse #1 on 4/18/17 at 3:30 PM. She stated she was familiar with Resident #281. She indicated when Resident #281 was admitted she was unaware the resident was on hospice services. She revealed it was not until 4/12/17 (7 days after admission to the facility) that she spoke with a hospice nurse who informed her Resident #281 was on hospice services. Nurse #1 indicated the hospice nurse provided her with a Standing Orders and Comfort Pak form that she faxed to Resident #281 ' s physician for signature. This form was signed by the physician and faxed back to the facility on 4/15/17 (10 days after admission to the facility). Resident #281's medical record was reviewed with Nurse #1. She verified there was no physician ' s order for hospice, hospice plan of care, hospice election form, or hospice certification of terminal illness for Resident #281 in the medical record. An interview was conducted with the Admissions Nurse on 4/18/17 at 3:50 PM. She stated she completed the admission for Resident #281. She reported she had not known Resident #281 was on hospice services. The Admissions Nurse stated when a resident was transferred from another facility while they were on hospice services she was informed by the FL2 and/or from the previous facility verbally. She revealed the previous facility had not informed her verbally that Resident #281 was on hospice services and she was unable to recall if the FL2 indicated the resident was on hospice services. She stated that if she had known Resident #281 was on hospice services she would have obtained a physician's order for hospice when she verified Resident #281 ' s orders during the admission	F 526	hospice services. " Admissions Director will communicate to admitting nurse when a patient will be admitted under hospice services. " Admitting nurse will contact physician and obtain an order for hospice services. " Admitting nurse will contact hospice to inform that patient has been admitted to the facility. " Hospice will place on pertinent information on the chart. 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented. " The Administrator will monitor audits on weekly basis for 4 weeks; every 2 weeks for 30 days and the monthly for 3 months to assure accuracy. " The results of that monitoring will be reviewed and discussed in the monthly QA Committee meeting. The QA committee will assess and modify the action plan as needed to ensure continual compliance. Completed: 5/17/17	

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process and she would have reported to the floor nurse that the resident was on hospice when she completed the admission. The information on the FL2 form that indicated Resident #281 was on hospice services was shared with the Admissions Nurse. She revealed she had overlooked the information regarding hospice services for Resident #281.

An interview was conducted with the Admissions Director on 4/18/17 at 3:55 PM. She stated she coordinated the admission for Resident #281. She reported that she believed Resident #281 was on hospice services and she recalled that this was indicated on her FL2 form. She stated the FL2 form was given to the Admissions Nurse. The Admissions Director revealed the hospice information indicated on Resident #281's FL2 form must have just been missed by the Admissions Nurse.

An interview was conducted with the Director of Nursing (DON) on 4/18/17 at 4:10 PM. When asked how staff were informed if a resident was on hospice she stated the primary way staff were informed was by a label that was placed on the outside binding of the hard copy chart for all residents on hospice. The hard copy chart of Resident #281 was reviewed with the DON. There was no label on Resident #281's hard copy chart that indicated she was on hospice. The DON revealed she expected a label to be on the chart. The admissions process was then reviewed with the DON. She verified the information provided by the Admissions Nurse and the Admissions Director. She stated that the Admissions Nurse reviewed the FL2 and other admission paperwork and determined if a resident was on hospice. She indicated the

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Admissions Nurse should have obtained a physician's order for hospice during the admission process after she reviewed the FL2 that indicated Resident #281 received hospice services. She stated the Admissions Nurse should have then reported to the floor nurse that the resident was on hospice when the admission was completed. Resident #281's medical record (electronic and hard copy) was reviewed with the DON. She verified there was no physician's order for hospice for Resident #281. The DON stated she expected a physician's order for hospice to be on the medical record. She additionally verified there was no hospice plan of care, hospice election form, or hospice certification of terminal illness in Resident #281's medical record. She stated normally the hospice provider brought in all of that paperwork to the facility within a couple of days of admission. She indicated she expected this documentation to be in the medical record. The DON revealed the lack of hospice documentation and coordination and was due to an oversight of the Admissions Nurse. The DON reported she was going to contact the hospice provider to obtain the necessary documentation.

The interview with the DON continued on 4/18/17 at 4:15 PM. The hospice Standing Orders and Comfort Pak form signed by Resident #281's physician that was received at the facility on 4/15/17 was reviewed with the DON. She stated that when this form was received at the facility she expected the nurse on the floor to have also obtained a physician's order for hospice. The DON indicated that there was no single person who was responsible for the coordination of care with the hospice provider. She stated that the floor nurses were responsible for coordination

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F 526	Continued From page 56 with the hospice provider. A follow up interview was conducted with the DON on 4/18/17 at 6:03 PM. She provided documentation of a physician's order dated 4/18/17 for Resident #281's continuation of hospice services. She additionally provided documentation she received on 4/18/17 of the hospice plan of care, hospice election form, and the hospice certification of terminal illness for Resident #281. The DON indicated this documentation had been placed in Resident #281's medical record and a label that indicated the resident was on hospice was placed on the outside binding of her hard copy medical record.	F 526		