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	345534	A. BUILDING _____ B. WING _____	C 10/11/2017

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SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (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-	F 157		11/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/30/2017

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F 157	Continued From page 1 (A) A change in room or roommate assignment 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 record review, physician ' s assistant interview and staff interviews, the facility failed to notify the physician of the resident ' s elevated blood glucose and refusal to take medication which resulted in a delay of treatment and hospitalization for 1 of 3 sampled residents reviewed for nutrition and hydration (Resident #1). Findings included: Resident #1 was admitted to the facility on 11/4/13 with diagnoses which included anemia, hypertension, diabetes mellitus, and dementia. The quarterly Minimum Data Set dated 7/7/17 revealed Resident #1 had severely impaired cognition and no behaviors. The resident required extensive assistance of total dependence for all activities of daily living (ADL) and for nutrition/hydration. The resident was always incontinent of bowel and bladder. Diagnoses were diabetes mellitus, non-Alzheimer ' s dementia, and dysphagia. The resident received insulin 7 days a week. The resident ' s care plan dated 7/7/17 had goals and interventions for diabetes the potential for	F 157	F157 □ Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. Nurse #1 was terminated on October 3, 2017 prior to the survey. Nurse #2 received 1:1 education by the Staff Development Coordinator on October 15, 2017. This education included following a physician□s order, specific to Blood Glucose and physician notification. The education also included notification of a change in condition i.e. a change in the residents physical, mental, or psychosocial status (that is, deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications)and notification of physician for medication refusals and appropriate	

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F 157	Continued From page 2 hypo and hyperglycemia and refusal of care. A physician ' s order dated 9/5/17 specified to administer Novolog 100 units/ml according to blood glucose level before meals and at bedtime with sliding scale as follows: Blood glucose 0-150 = 0 units Blood glucose 151-200 = 2 units Blood glucose 201-250 = 4 units Blood glucose 251 - 300 = 6 units Blood glucose 301 - 350 = 8 units Blood glucose 351 or greater = 10 units and to notify the physician A review of the September 2017 Medication Administration Record (MAR) revealed on 9/19/17 at 6:30 am Resident #1 ' s blood glucose was recorded as 581 and that 10 units of Novolog insulin was administered by Nurse #1. A review of Resident #1 ' s September 2017 nurses ' notes revealed there was no assessment of the resident ' s condition or notification to the physician about the 9/19/17 at 6:30 am elevated blood glucose of 581. A review of the September 2017 MAR revealed documentation by Nurse #3 that Resident #1 refused all his 8:00 pm medications on 9/21/17. There was no documentation that the physician was informed of the resident ' s refusal to take his medications. The Physician ' s Assistant (PA) order dated 9/21/17 revealed Lantus 10 units every evening (increased). The PA ' s order dated 9/22/17 was to administer	F 157	documentation of physician notification. Nurse #3 received 1:1 education by the Staff Development Coordinator on October 15, 2017. This education included notification of physician for medication refusals and appropriate documentation of physician notification. The Medication Administration Records of all residents with sliding scale blood glucose checks were audited by the Director of Nursing, Staff Development Coordinator, and Nurse Unit Coordinators between October 15, 2017 and November 6, 2017 for any instances where the physician was not notified as ordered within the past (30) days. Any instances of non-compliance were reported to the physician no later than November 6, 2017. All licensed nursing staff was in-serviced by the Staff Development Coordinator between the dates of October 15, 2017 and November 6, 2017 regarding notifying the physician with any change of condition. This education included following a physician□s order, specific to Blood Glucose and physician notification. The education also included notification of a change in condition i.e. a change in the residents physical, mental, or psychosocial status (that is, deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) and notification of physician for medication refusals and appropriate documentation of physician notification. Any licensed nurse not in-serviced by November 6, 2017 will not	

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F 157	Continued From page 3 Novolog insulin 100 units/ml inject 10 units now for one dose (given at 3 pm) and to administer Novolog insulin 100 unit/ml by checking blood sugar every 2 hours and give 10 units of Novolog until blood sugar decreased to 300 and then discontinue. The 9/22/17 PA ' s note revealed Resident #1 ' s vital signs were stable and he was afebrile, but ill-appearing. Two additional doses of Novolog 10 units were administered in addition to sliding scale with lunch and dinner. Blood glucose reading continued to register HIGH (too high to register on the blood glucometer). The PA ordered for increased fluids and to re-check blood glucose at bedtime. However, the resident ' s representative requested resident be sent for full evaluation at the hospital. The PA ordered to send the resident to the hospital via emergency medical service for evaluation to exclude infection or diabetic ketoacidosis or hyperosmolar hyperglycemic nonketotic syndrome (severely elevated blood glucose and metabolic dysfunction). A review of the hospital discharge summary dated 10/1/17 revealed Resident #1 was sent to the Emergency Department on 9/22/17 for severe dehydration and altered mental status. The resident was admitted into the intensive care unit with the diagnoses of hypernatremia (high sodium) and central diabetes insipidus (diabetic induced body ' s inability to retain water), acute renal failure (ARF), aspiration pneumonia, and severe dysphagia. After aggressive fluid resuscitation, the resident ' s sodium was normal range. The ARF resolved. The resident was discharged from the hospital on 10/1/17 with an order for weekly sodium lab level and	F 157	work until in-servicing has been completed. In order to provide quality assurance, unit managers or designees will complete an audit to include review of 24-hour reports for compliance with notification of the physician on changes of condition. This audit will be completed daily for two weeks, twice weekly for two additional weeks, and then weekly for two months. Results of these audits will be presented by the Director of Nursing or Staff Development Coordinator in the Quality Assurance Performance Improvement meeting for a minimum of three consecutive meetings and on-going as indicated. The Director of Nursing, Staff Development Coordinator, or Unit Managers will monitor the Medication Administration Record for a minimum of (5) residents receiving sliding scaled insulin to ensure the physician is notified as ordered. These audits will be completed weekly for four weeks and on-going as indicated. Results of these audits will be presented by the Director of Nursing or Staff Development Coordinator in the Quality Assurance Performance Improvement meeting for any needed continuous of monitoring.	

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desmopressin 10 mcg intranasal (aids the body to retain water) every evening.

On 10/11/17 at 12:35 pm an interview was conducted with the facility ' s Physician ' s Assistant (PA). The PA stated that she was first informed of Resident #1 ' s elevated blood glucose on 9/21/17. The PA was not informed by staff that the resident ' s blood glucose was 581 on 9/19/17 at 6:30 am. The PA stated that the Novolog sliding scale order was to inform the physician if the blood glucose was greater than 350. The PA also stated that she would have liked to have been informed that the blood glucose was 581 on 9/19/17 and if the resident refused his medication. The PA stated she would have changed the insulin order and ordered labs before 9/21/17.

On 10/11/17 at 2:45 pm an interview was conducted with Nurse #2. Nurse #2 was assigned to Resident #1 on 9/21/17 night shift and remembered when the resident had a blood glucose of 581. Nurse #2 stated she administered Novolog insulin 10 units. Nurse #2 stated she did not call the physician and did not assess the resident. The resident was alert. Nurse #2 was convinced that the increase in the resident ' s blood glucose was related to the change in tube feeding formula. Nurse #1 stated that she was aware the sliding scale for blood glucose over 350 order required the nurse to call the physician. Nurse #1 stated that in retrospect she should have assessed the resident for the cause of such a high blood glucose and should have informed the physician.

On 10/11/17 at 12:00 pm, 2:50 pm and 4:00 pm an attempt to contact Nurse #3 for an interview

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F 157	Continued From page 5 was unsuccessful. On 10/11/17 at 3:45 pm an interview was conducted with the Director of Nursing (DON). The DON stated that she expected staff to follow the physician ' s orders as written and to notify the physician if the resident refused their medication.	F 157		
F 224 SS=E	PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN CFR(s): 483.12(b)(1)-(3) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, and Physician's Assistant interview, the facility failed to protect residents from staff who willfully neglected to provide medications as ordered to 5 of 5 residents reviewed for	F 224	F224 Nurse #1 was terminated on October 3, 2017 and a complaint to the North Carolina Board of Nursing was filed by the Director of Nursing on October 9, 2017.	11/6/17

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F 224	Continued From page 6 medications (Residents #2, #13, #14, #15, #16) and tube feeding as ordered to 1 of 4 residents reviewed for tube feeding (Resident #17). The findings included: 1. Resident #13 was admitted to the facility on 8/11/17 with multiple diagnoses that included heart disease, Diabetes Mellitus Type 2, chronic pain syndrome, hyperlipidemia, and hypernatremia. The admission Minimum Data Set (MDS) assessment dated 8/18/17 indicated Resident #13 ' s cognition was fully intact. He received scheduled pain medications and as needed pain medications. Resident #13 was administered insulin, antidepressant medication, and diuretic medication on 7 of 7 days during the MDS look back period. He was administered antianxiety medication on 1 of 7 days during the MDS look back period. A grievance form was completed by Resident #13 for an incident that occurred on 10/2/17. The narrative of the grievance read, "I never got my night [medications] or insulin". The grievance investigation and findings indicated Resident #13 was alert and oriented. His electronic Medication Administration Record (eMAR) was reviewed and his medications had been signed out by Nurse #1. Nurse #1 was interviewed by the Director of Nursing (DON) and was terminated. A review of Resident #13's physician's orders in place on 10/2/17 indicated his evening medications were Lantus (insulin), Humalog (insulin), Lovastatin (high cholesterol medication), Gabapentin (nerve pain medication), Tylenol, and Sodium chloride.	F 224	On October 3, 2017, Residents (#13, #2, #14, #15, #16) omitted medications were reported to the physician by the Director of Nursing. The physician determined that none of the omitted medications resulted in harm of Residents (#13, #2, #14, #15, and #16). Between October 30, 2017 and November 3, 2017, all residents with a BIMS score equal to or higher than 11 were interviewed by the Director of Nursing, Staff Development Coordinator, or Social Worker to ensure there were no additional instances of neglect including but not limited to the omission of medication administration. Between October 30, 2017 and November 3, 2017 the Responsible Party of all residents with a BIMS score less than 11 were contacted by the Director of Nursing, Staff Development Coordinator, or Nurse Unit Manager to ensure there were no additional instances of neglect including but not limited to the omission of medication administration. All staff, including: licensed nurses, nurse aides, dietary, housekeeping, and administration were in-serviced by the Staff Development Coordinator between October 15, 2017 and November 6, 2017 regarding abuse and neglect. This in-service included education to identify signs and/or symptoms of abuse and neglect, reporting procedures when signs or symptoms are identified, and	

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F 224	Continued From page 7 A 24-hour initial report was completed by the facility Administrator in Training (AIT) on 10/3/17. The allegation/incident type was listed as resident neglect. The report indicated the incident occurred on 10/2/17 through 10/3/17 between the times of 7:00 PM and 7:00 AM. The allegation description read, "Received complaints from [Resident #13] that [Nurse #1] did not administer nor offer medications during shift". There was no indication of any harm to Resident #13. Nurse #1 was listed on the report as the accused individual. An Employee Counseling Notice dated 10/3/17 indicated Nurse #1 met with the DON. The narrative of this notice indicated Nurse #1 failed to administer residents' medications, signed out medications as given when the medication was still in the medication card, and failed to administer tube feeding as ordered. The 5-working day report was completed by the AIT on 10/6/17. The allegation of resident neglect referred to in the 24-hour initial report completed on 10/3/17 was substantiated. The investigation was completed by the DON on 10/3/17 and Nurse #1 was terminated on 10/3/17. The narrative of the investigation of neglect indicated an initial grievance was received by Resident #13 that alleged Nurse #1 failed to administer or offer medications during her scheduled shift of 10/2/17 from 7:00 PM to 7:00 AM. The investigation read, in part, "Review of eMAR reveals that [Nurse #1] did not administer medications for [Resident #13] during her scheduled shift ...during investigation, multiple other residents ...completed grievances stating that they too had not received any scheduled medications during shift of 10/2/17 [7:00 PM to	F 224	notification of the physician. Any staff not in-serviced by November 6, 2017 will not work until in-servicing is completed. In order to provide quality assurance, the Director of Nursing, Staff Development Coordinator, or Nurse Unit Managers will interview a minimum of two residents with a BIMS score equal to or greater than 11 weekly for four weeks and longer if indicated to ensure no additional instances of neglect, including omission of medication administration have occurred. Findings of these interviews will be presented in the Quality Assurance Performance Improvement Meeting to determine if results indicate a need for continued monitoring. In order to provide quality assurance, the Director of Nursing, Staff Development Coordinator, or Nurse Unit Managers will observe a minimum of two medication administration passes weekly for four weeks and longer if indicated to ensure no additional instances of neglect, including omission of medication administration have occurred, and the Medication Administration Record is complete and accurate. Findings of these medication administration observations will be presented in the Quality Assurance Performance Improvement Meeting to determine if results indicate a need for continued monitoring.	

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7:00 AM]. Review of eMAR reveals that [Nurse #1] did not administer scheduled medications for [3 additional residents]. Further investigation of [Nurse #1 ' s] assignment of residents indicates that [Nurse #1] signed off multiple medications in eMAR that were still in medication card, indicating that nurse falsely documented the administration of these medications".

A phone interview was conducted with Nurse #1 on 10/10/17 at 11:00 AM. Nurse #1 declined to provide any information during the interview.

An initial interview was conducted with the DON on 10/10/17 at 11:30 AM. She reported she has worked at the facility for several months, but had been in her role as the DON for a month and a half. The grievance for Resident #13 related to the incident on 10/2/17 in which he reported he had not received his evening medications was reviewed with the DON. She stated this issue was first identified during the morning meeting on 10/3/17 when it was noted a couple of residents mentioned to staff they had not received their medications the previous night. The nursing assignments were reviewed and it was identified Nurse #1 had worked with the residents who reported their medications had not been received. She stated an investigation was initiated that included writing grievances, interviewing residents, reviewing eMARs, and completing a 24-hour report. The DON reported that on the initial review several medications were identified as administered 5 to 6 hours after their scheduled time. She explained that upon further review, including interviews with alert and oriented residents, it was determined a total of 4 alert and oriented residents all stated they had not received their evening medications from Nurse #1. It was

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also verified that 1 cognitively impaired resident had a controlled medication that was signed off in the eMAR as administered, but it was not signed off on the narcotic control sheet and it remained in the medication cart. The DON was asked if the investigation found any evidence of drug diversion by Nurse #1. She stated she had to review her investigation to provide additional information.

An interview was conducted with Resident #13 on 10/10/17 at 1:45 PM. Resident #13 confirmed the information in the grievance related to the incident on 10/2/17 in which he had not received his evening medications. He identified the nurse who was assigned to him on 10/2/17 as Nurse #1. He indicated he had no negative effects from not receiving the medications. Resident #13 reported no further concerns with receiving his medications.

A second interview was conducted with the DON on 10/10/17 at 4:03 PM. She stated she reviewed her investigation and it was determined there was no evidence of drug diversion by Nurse #1 related to any controlled medications. She reported non-controlled medications were maintained on medication cards in the medication carts. She stated there was no count maintained for any of these non-controlled medications. The DON explained that for these non-controlled medications it was impossible to be certain if the medications were taken from the medication card and/or if they were administered the residents when they were signed out by Nurse #1. She revealed that based on the corroborating statements from Resident #13 and 3 additional alert and oriented residents it was suspected Nurse #1 signed off on the medications for these

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residents and had not administered them.

An interview was conducted with the Physician's Assistant (PA) on 10/10/17 at 4:35 PM. She stated her expectation was for medications to be administered as ordered. She stated she was aware of the medications that were not administered as ordered and she reported no negative effects to the residents.

A follow up interview was conducted with the DON on 10/11/17 at 10:12 AM. She stated that following the investigation, the PA was informed of the information and she had no concerns of any harm to the residents. The DON indicated she interviewed Nurse #1 on 10/3/17. She stated that during the interview Nurse #1 acknowledged she signed out medications in the eMAR and had not administered the medications. She additionally admitted to documenting a tube feeding as administered without administering the tube feeding. The DON revealed Nurse #1 had neglected her residents by signing out medications and/or tube feedings and not administering them.

This interview with the DON continued. She stated that since Nurse #1 was terminated there were no further issues reported. She stated she interviewed a few families to ensure there were no additional concerns. She stated for two to three days following the completion of the investigation she observed two of the second shift (7:00 PM to 7:00 AM) nurses (Nurse #2 and Nurse #3) to ensure medications were administered timely and as documented. She indicated there were no issues observed. The DON reported there was no ongoing monitoring related to this issue. She stated she believed the

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issue was caused by Nurse #1 and since she was terminated the issue had been resolved.

2. Resident #2 was initially admitted to the facility on 6/30/15 and most recently readmitted on 12/27/16 with multiple diagnoses that included chronic obstructive pulmonary disease (COPD), hyperlipidemia, hypertension, and insomnia.

The quarterly Minimum Data Set (MDS) assessment dated 9/7/17 indicated Resident #2 ' s cognition was fully intact. He received scheduled pain medications. Resident #2 was administered antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS look back period.

A grievance form was completed by Resident #2 for an incident that occurred on 10/2/17. The narrative of the grievance read, "I did not get my [medications] last night, that nurse came to my room". The corrective action by facility to resolve the grievance indicated a 24-report was filed, 5-day report was filed, and the nurse was terminated.

A review of Resident #2's physician's orders in place on 10/2/17 indicated his evening medications were Trazodone (antidepressant medication), Atorvastatin (high cholesterol medication), Clonazepam (antianxiety medication), Colace (stool softener/laxative), Gabapentin (nerve pain medication), and Tylenol.

A 24-hour initial report was completed by the facility Administrator in Training (AIT) on 10/3/17. The allegation/incident type was listed as resident

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neglect. The report indicated the incident occurred on 10/2/17 through 10/3/17 between the times of 7:00 PM and 7:00 AM. The allegation description read, "Received complaints from resident that [Nurse #1] did not administer nor offer medications during shift". Nurse #1 was listed on the report as the accused individual.

An Employee Counseling Notice dated 10/3/17 indicated Nurse #1 met with the DON. The narrative of this notice indicated Nurse #1 failed to administer residents' medications, signed out medications as given when the medication was still in the medication card, and failed to administer tube feeding as ordered.

The 5-working day report was completed by the AIT on 10/6/17. The allegation of resident neglect referred to in the 24-hour initial report completed on 10/3/17 was substantiated. The investigation was completed by the DON on 10/3/17 and Nurse #1 was terminated on 10/3/17. The narrative of the investigation of neglect indicated an initial grievance was received by a resident that Nurse #1 failed to administer or offer medications during her scheduled shift of 10/2/17 from 7:00 PM to 7:00 AM. The investigation revealed 4 alert and oriented residents (including Resident #2) completed grievances stating they had not received any of their scheduled medications during the shift of 10/2/17 from 7:00 PM to 7:00 AM. A review of the eMARs revealed Nurse #1 had not administered scheduled medications to 4 alert and oriented residents (including Resident #2). The investigation additionally revealed Nurse #1, "signed off multiple medications in eMAR that were still in medication card, indicating that [Nurse #1] falsely documented the administration of these

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medications".

A phone interview was conducted with Nurse #1 on 10/10/17 at 11:00 AM. Nurse #1 declined to provide any information during the interview.

An initial interview was conducted with the DON on 10/10/17 at 11:30 AM. She reported she has worked at the facility for several months, but had been in her role as the DON for a month and a half. The grievance for Resident #2 related to the incident on 10/2/17 in which he reported he had not received his evening medications was reviewed with the DON. She stated this issue was first identified during the morning meeting on 10/3/17 when it was noted a couple of residents mentioned to staff they had not received their medications the previous night. The nursing assignments were reviewed and it was identified Nurse #1 had worked with the residents who reported their medications had not been received. She stated an investigation was initiated that included writing grievances, interviewing residents, reviewing eMARs, and completing a 24-hour report. The DON reported that on the initial review several medications were identified as administered 5 to 6 hours after their scheduled time. She explained that upon further review, including interviews with alert and oriented residents, it was determined a total of 4 alert and oriented residents all stated they had not received their evening medications from Nurse #1. It was also verified that 1 cognitively impaired resident had a controlled medication that was signed off in the eMAR as administered, but it was not signed off on the narcotic control sheet and it remained in the medication cart. The DON was asked if the investigation found any evidence of drug diversion by Nurse #1. She stated she had to

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review her investigation to provide additional information.

An interview was conducted with Resident #2 on 10/10/17 at 1:55 PM. Resident #2 confirmed the information in the grievance related to the incident on 10/2/17 in which he had not received his evening medications. He identified the nurse as Nurse #1. He indicated he had no negative effects from not receiving the medications. Resident #2 reported no further concerns with receiving his medications.

A second interview was conducted with the DON on 10/10/17 at 4:03 PM. She stated she reviewed her investigation and it was determined there was no evidence of drug diversion by Nurse #1 related to any controlled medications. She reported non-controlled medications were maintained on medication cards in the medication carts. She stated there was no count maintained for any of these non-controlled medications. The DON explained that for these non-controlled medications it was impossible to be certain if the medications were taken from the medication card and/or if they were administered the residents when they were signed out by Nurse #1. She revealed that based on the corroborating statements from Resident #2 and 3 additional alert and oriented residents it was suspected Nurse #1 signed off on the medications for these residents and had not administered them.

An interview was conducted with the Physician's Assistant (PA) on 10/10/17 at 4:35 PM. She stated her expectation was for medications to be administered as ordered. She stated she was aware of the medications that were not administered as ordered and she reported no

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negative effects to the residents.

A follow up interview was conducted with the DON on 10/11/17 at 10:12 AM. She stated that following the investigation, the PA was informed of the information and she had no concerns of any harm to the residents. The DON indicated she interviewed Nurse #1 on 10/3/17. She stated that during the interview Nurse #1 acknowledged she signed out medications in the eMAR and had not administered the medications. She additionally admitted to documenting a tube feeding as administered without administering the tube feeding. The DON revealed Nurse #1 had neglected her residents by signing out medications and/or tube feedings and not administering them.

This interview with the DON continued. She stated that since Nurse #1 was terminated there were no further issues reported. She stated she interviewed a few families to ensure there were no additional concerns. She stated for two to three days following the completion of the investigation she observed two of the second shift (7:00 PM to 7:00 AM) nurses (Nurse #2 and Nurse #3) to ensure medications were administered timely and as documented. She indicated there were no issues observed. The DON reported there was no ongoing monitoring related to this issue. She stated she believed the issue was caused by Nurse #1 and since she was terminated the issue had been resolved.

3. Resident #14 was admitted to the facility on 9/21/17 with multiple diagnoses that included spinal stenosis, chronic pain, hyperlipidemia, neuropathy, and insomnia.

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The admission Minimum Data Set (MDS) assessment dated 9/28/17 indicated Resident #14 ' s cognition was fully intact. He received scheduled pain medications and as needed pain medications. Resident #14 was administered antidepressant medication on 7 of 7 days during the MDS look back period.

A grievance form was completed by Resident #14 for an incident that occurred on 10/3/17. The narrative of the grievance read, "[Resident #14] stating he did not receive his medication one night and did not receive them until 2:30 AM the night before". The corrective action by facility to resolve the grievance indicated a 24-report was filed, 5-day report was filed, and the nurse was terminated.

A review of Resident #14's physician's orders in place on 10/3/17 indicated his evening medications were Gabapentin (nerve pain medication), Bisacodyl (laxative), Melatonin (dietary supplement utilized as sleep aid), Trazodone (antidepressant medication), and Metoprolol (beta-blocker).

A 24-hour initial report was completed by the facility Administrator in Training (AIT) on 10/3/17. The allegation/incident type was listed as resident neglect. The report indicated the incident occurred on 10/2/17 through 10/3/17 between the times of 7:00 PM and 7:00 AM. The allegation description read, "Received complaints from resident that [Nurse #1] did not administer nor offer medications during shift". Nurse #1 was listed on the report as the accused individual.

An Employee Counseling Notice dated 10/3/17

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indicated Nurse #1 met with the DON. The narrative of this notice indicated Nurse #1 failed to administer residents ' medications, signed out medications as given when the medication was still in the medication card, and failed to administer tube feeding as ordered.

The 5-working day report was completed by the AIT on 10/6/17. The allegation of resident neglect referred to in the 24-hour initial report completed on 10/3/17 was substantiated. The investigation was completed by the DON on 10/3/17 and Nurse #1 was terminated on 10/3/17. The narrative of the investigation of neglect indicated an initial grievance was received by a resident that Nurse #1 failed to administer or offer medications during her scheduled shift of 10/2/17 from 7:00 PM to 7:00 AM. The investigation revealed 4 alert and oriented residents (including Resident #14) completed grievances stating they had not received any of their scheduled medications during the shift of 10/2/17 from 7:00 PM to 7:00 AM. A review of the eMARs revealed Nurse #1 had not administered scheduled medications to 4 alert and oriented residents (including Resident #14). The investigation additionally revealed Nurse #1, "signed off multiple medications in eMAR that were still in medication card, indicating that [Nurse #1] falsely documented the administration of these medications".

A phone interview was conducted with Nurse #1 on 10/10/17 at 11:00 AM. Nurse #1 declined to provide any information during the interview.

An initial interview was conducted with the DON on 10/10/17 at 11:30 AM. She reported she has worked at the facility for several months, but had

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been in her role as the DON for a month and a half. The grievance for Resident #14 related to the incident on 10/2/17 in which he reported he had not received his evening medications was reviewed with the DON. She stated this issue was first identified during the morning meeting on 10/3/17 when it was noted a couple of residents mentioned to staff they had not received their medications the previous night. The nursing assignments were reviewed and it was identified Nurse #1 had worked with the residents who reported their medications had not been received. She stated an investigation was initiated that included writing grievances, interviewing residents, reviewing eMARs, and completing a 24-hour report. The DON reported that on the initial review several medications were identified as administered 5 to 6 hours after their scheduled time. She explained that upon further review, including interviews with alert and oriented residents, it was determined a total of 4 alert and oriented residents all stated they had not received their evening medications from Nurse #1. It was also verified that 1 cognitively impaired resident had a controlled medication that was signed off in the eMAR as administered, but it was not signed off on the narcotic control sheet and it remained in the medication cart. The DON was asked if the investigation found any evidence of drug diversion by Nurse #1. She stated she had to review her investigation to provide additional information.

An interview was conducted with Resident #14 on 10/10/17 at 2:10 PM. Resident #14 confirmed the information in the grievance related to the incident on 10/3/17 in which he had not received his evening medications one night and another night he received his medications several hours

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late. He identified the nurse who was assigned to him as Nurse #1. He indicated there were no negative effects related to this issue. Resident #14 reported no further concerns with receiving his medications.

A second interview was conducted with the DON on 10/10/17 at 4:03 PM. She stated she reviewed her investigation and it was determined there was no evidence of drug diversion by Nurse #1 related to any controlled medications. She reported non-controlled medications were maintained on medication cards in the medication carts. She stated there was no count maintained for any of these non-controlled medications. The DON explained that for these non-controlled medications it was impossible to be certain if the medications were taken from the medication card and/or if they were administered the residents when they were signed out by Nurse #1. She revealed that based on the corroborating statements from Resident #14 and 3 additional alert and oriented residents it was suspected Nurse #1 signed off on the medications for these residents and had not administered them.

An interview was conducted with the Physician ' s Assistant (PA) on 10/10/17 at 4:35 PM. She stated her expectation was for medications to be administered as ordered. She stated she was aware of the medications that were not administered as ordered and she reported no negative effects to the residents.

A follow up interview was conducted with the DON on 10/11/17 at 10:12 AM. She stated that following the investigation, the PA was informed of the information and she had no concerns of any harm to the residents. The DON indicated

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she interviewed Nurse #1 on 10/3/17. She stated that during the interview Nurse #1 acknowledged she signed out medications in the eMAR and had not administered the medications. She additionally admitted to documenting a tube feeding as administered without administering the tube feeding. The DON revealed Nurse #1 had neglected her residents by signing out medications and/or tube feedings and not administering them.

This interview with the DON continued. She stated that since Nurse #1 was terminated there were no further issues reported. She stated she interviewed a few families to ensure there were no additional concerns. She stated for two to three days following the completion of the investigation she observed two of the second shift (7:00 PM to 7:00 AM) nurses (Nurse #2 and Nurse #3) to ensure medications were administered timely and as documented. She indicated there were no issues observed. The DON reported there was no ongoing monitoring related to this issue. She stated she believed the issue was caused by Nurse #1 and since she was terminated the issue had been resolved.

4. Resident #15 was admitted to the facility on 1/12/16 and most recently readmitted on 7/13/17 with multiple diagnoses that included hypertension, atrial fibrillation, depression, and hyperlipidemia.

The 30-day Minimum Data Set (MDS) assessment dated 8/14/17 indicated Resident #15 ' s cognition was fully intact. She received scheduled pain medications. Resident #15 was administered antidepressant medication and

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anticoagulant medication on 7 of 7 days during the MDS look back period. She received diuretic medication on 3 of 7 days.

A grievance form was completed by Resident #15 for an incident that occurred on 10/2/17. The narrative of the grievance indicated Resident #15 stated she had not received her medications one night and another night she received them really late. The corrective action by facility to resolve the grievance indicated a 24-report was filed, 5-day report was filed, and the nurse was terminated.

A review of Resident #15's physician's orders in place on 10/2/17 indicated his evening medications were Trazodone (antidepressant medication), Atorvastatin (high cholesterol medication), Mapap (acetaminophen), Metoprolol (beta-blocker), and Eliquis (anticoagulant).

A 24-hour initial report was completed by the facility Administrator in Training (AIT) on 10/3/17. The allegation/incident type was listed as resident neglect. The report indicated the incident occurred on 10/2/17 through 10/3/17 between the times of 7:00 PM and 7:00 AM. The allegation description read, "Received complaints from resident that [Nurse #1] did not administer nor offer medications during shift". Nurse #1 was listed on the report as the accused individual.

An Employee Counseling Notice dated 10/3/17 indicated Nurse #1 met with the DON. The narrative of this notice indicated Nurse #1 failed to administer residents' medications, signed out medications as given when the medication was still in the medication card, and failed to administer tube feeding as ordered.

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The 5-working day report was completed by the AIT on 10/6/17. The allegation of resident neglect referred to in the 24-hour initial report completed on 10/3/17 was substantiated. The investigation was completed by the DON on 10/3/17 and Nurse #1 was terminated on 10/3/17. The narrative of the investigation of neglect indicated an initial grievance was received by a resident that Nurse #1 failed to administer or offer medications during her scheduled shift of 10/2/17 from 7:00 PM to 7:00 AM. The investigation revealed 4 alert and oriented residents (including Resident #15) completed grievances stating they had not received any of their scheduled medications during the shift of 10/2/17 from 7:00 PM to 7:00 AM. A review of the eMARs revealed Nurse #1 had not administered scheduled medications to 4 alert and oriented residents (including Resident #15). The investigation additionally revealed Nurse #1, "signed off multiple medications in eMAR that were still in medication card, indicating that [Nurse #1] falsely documented the administration of these medications".

A phone interview was conducted with Nurse #1 on 10/10/17 at 11:00 AM. Nurse #1 declined to provide any information during the interview.

An initial interview was conducted with the DON on 10/10/17 at 11:30 AM. She reported she has worked at the facility for several months, but had been in her role as the DON for a month and a half. The grievance for Resident #15 related to the incident on 10/2/17 in which he reported he had not received his evening medications was reviewed with the DON. She stated this issue was first identified during the morning meeting on

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10/3/17 when it was noted a couple of residents mentioned to staff they had not received their medications the previous night. The nursing assignments were reviewed and it was identified Nurse #1 had worked with the residents who reported their medications had not been received. She stated an investigation was initiated that included writing grievances, interviewing residents, reviewing eMARs, and completing a 24-hour report. The DON reported that on the initial review several medications were identified as administered 5 to 6 hours after their scheduled time. She explained that upon further review, including interviews with alert and oriented residents, it was determined a total of 4 alert and oriented residents all stated they had not received their evening medications from Nurse #1. It was also verified that 1 cognitively impaired resident had a controlled medication that was signed off in the eMAR as administered, but it was not signed off on the narcotic control sheet and it remained in the medication cart. The DON was asked if the investigation found any evidence of drug diversion by Nurse #1. She stated she had to review her investigation to provide additional information.

A second interview was conducted with the DON on 10/10/17 at 4:03 PM. She stated she reviewed her investigation and it was determined there was no evidence of drug diversion by Nurse #1 related to any controlled medications. She reported non-controlled medications were maintained on medication cards in the medication carts. She stated there was no count maintained for any of these non-controlled medications. The DON explained that for these non-controlled medications it was impossible to be certain if the medications were taken from the medication card

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and/or if they were administered the residents when they were signed out by Nurse #1. She revealed that based on the corroborating statements from Resident #15 and 3 additional alert and oriented residents it was suspected Nurse #1 signed off on the medications for these residents and had not administered them.

An interview was conducted with the Physician's Assistant (PA) on 10/10/17 at 4:35 PM. She stated her expectation was for medications to be administered as ordered. She stated she was aware of the medications that were not administered as ordered and she reported no negative effects to the residents.

An interview was conducted with Resident #15 on 10/11/17 at 8:00 AM. Resident #15 confirmed the information in the grievance related to the incident on 10/2/17 in which she had not received her evening medications one night and another night she received her medications several hours late. She identified the nurse who was assigned to her as Nurse #1. She indicated there were no negative effects related to this issue. Resident #15 reported no further concerns with receiving his medications.

A follow up interview was conducted with the DON on 10/11/17 at 10:12 AM. She stated that following the investigation, the PA was informed of the information and she had no concerns of any harm to the residents. The DON indicated she interviewed Nurse #1 on 10/3/17. She stated that during the interview Nurse #1 acknowledged she signed out medications in the eMAR and had not administered the medications. She additionally admitted to documenting a tube feeding as administered without administering the

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tube feeding. The DON revealed Nurse #1 had neglected her residents by signing out medications and/or tube feedings and not administering them.

This interview with the DON continued. She stated that since Nurse #1 was terminated there were no further issues reported. She stated she interviewed a few families to ensure there were no additional concerns. She stated for two to three days following the completion of the investigation she observed two of the second shift (7:00 PM to 7:00 AM) nurses (Nurse #2 and Nurse #3) to ensure medications were administered timely and as documented. She indicated there were no issues observed. The DON reported there was no ongoing monitoring related to this issue. She stated she believed the issue was caused by Nurse #1 and since she was terminated the issue had been resolved.

5. Resident #16 was admitted to the facility on 10/16/14 with multiple diagnoses that included neuropathy, insomnia, anxiety, and hyperlipidemia.

The annual Minimum Data Set (MDS) assessment dated 9/28/17 indicated Resident #16's cognition was moderately impaired. He received scheduled pain medications. Resident #16 was administered antidepressant medication and antianxiety medication on 7 of 7 days during the MDS look back period.

A review of Resident #16's physician's orders in place on 10/2/17 indicatedhis evening medications were Clonazepam (antianxiety medication), Trazodone (antidepressant

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medication), Atorvastatin (high cholesterol medication), Neurontin (nerve pain medication), and Divalproex Sodium (mood stabilizer).

A 24-hour initial report was completed by the facility Administrator in Training (AIT) on 10/3/17. The allegation/incident type was listed as resident neglect. The report indicated the incident occurred on 10/2/17 through 10/3/17 between the times of 7:00 PM and 7:00 AM. The allegation description read, "Received complaints from resident that [Nurse #1] did not administer nor offer medications during shift". Nurse #1 was listed on the report as the accused individual.

An Employee Counseling Notice dated 10/3/17 indicated Nurse #1 met with the DON. The narrative of this notice indicated Nurse #1 failed to administer residents' medications, signed out medications as given when the medication was still in the medication card, and failed to administer tube feeding as ordered.

The 5-working day report was completed by the AIT on 10/6/17. The allegation of resident neglect referred to in the 24-hour initial report completed on 10/3/17 was substantiated. The investigation was completed by the DON on 10/3/17 and Nurse #1 was terminated on 10/3/17. The narrative of the investigation of neglect indicated an initial grievance was received by a resident that Nurse #1 failed to administer or offer medications during her scheduled shift of 10/2/17 from 7:00 PM to 7:00 AM. The investigation revealed 4 alert and oriented residents completed grievances stating they had not received any of their scheduled medications during the shift of 10/2/17 from 7:00 PM to 7:00 AM. A review of the eMARs revealed Nurse #1 had not

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administered scheduled medications to 4 alert and oriented residents. The investigation additionally revealed Nurse #1, "signed off multiple medications in eMAR that were still in medication card, indicating that [Nurse #1] falsely documented the administration of these medications".

A phone interview was conducted with Nurse #1 on 10/10/17 at 11:00 AM. Nurse #1 declined to provide any information during the interview.

An initial interview was conducted with the DON on 10/10/17 at 11:30 AM. She reported she has worked at the facility for several months, but had been in her role as the DON for a month and a half. The Employee Counseling Notice for Nurse #1 dated 10/3/17 was reviewed with the DON. She stated this issue was first identified during the morning meeting on 10/3/17 when it was noted a couple of residents mentioned to staff they had not received their medications the previous night. The nursing assignments were reviewed and it was identified Nurse #1 had worked with the residents who reported their medications had not been received. She stated an investigation was initiated that included writing grievances, interviewing residents, reviewing eMARs, and completing a 24-hour report. The DON reported that on the initial review several medications were identified as administered 5 to 6 hours after their scheduled time. She explained that upon further review, including interviews with alert and oriented residents, it was determined a total of 4 alert and oriented residents all stated they had not received their evening medications from Nurse #1. It was also verified that 1 cognitively impaired resident (Resident #16) had a controlled medication (Clonazepam) that was

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signed off in the eMAR as administered, but it was not signed off on the narcotic control sheet and it remained in the medication cart. The DON was asked if the investigation found any evidence of drug diversion by Nurse #1. She stated she had to review her investigation to provide additional information.

A second interview was conducted with the DON on 10/10/17 at 4:03 PM. She stated she reviewed her investigation and it was determined there was no evidence of drug diversion by Nurse #1 related to any controlled medications. She reported non-controlled medications were maintained on medication cards in the medication carts. She stated there was no count maintained for any of these non-controlled medications. The DON explained that for these non-controlled medications it was impossible to be certain if the medications were taken from the medication card and/or if they were administered the residents when they were signed out by Nurse #1. She revealed that based on the corroborating statements from 4 alert and oriented residents and the evidence from Resident #16's narcotic control sheet, it was suspected Nurse #1 signed off on the medications for these residents and had not administered them.

An interview was conducted with the Physician's Assistant (PA) on 10/10/17 at 4:35 PM. She stated her expectation was for medications to be administered as ordered. She stated she was aware of the medications that were not administered as ordered and she reported no negative effects to the residents.

A follow up interview was conducted with the DON on 10/11/17 at 10:12 AM. She stated that

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following the investigation, the PA was informed of the information and she had no concerns of any harm to the residents. The DON indicated she interviewed Nurse #1 on 10/3/17. She stated that during the interview Nurse #1 acknowledged she signed out medications in the eMAR and had not administered the medications. She additionally admitted to documenting a tube feeding as administered without administering the tube feeding. The DON revealed Nurse #1 had neglected her residents by signing out medications and/or tube feedings and not administering them.

This interview with the DON continued. She stated that since Nurse #1 was terminated there were no further issues reported. She stated she interviewed a few families to ensure there were no additional concerns. She stated for two to three days following the completion of the investigation she observed two of the second shift (7:00 PM to 7:00 AM) nurses (Nurse #2 and Nurse #3) to ensure medications were administered timely and as documented. She indicated there were no issues observed. The DON reported there was no ongoing monitoring related to this issue. She stated she believed the issue was caused by Nurse #1 and since she was terminated the issue had been resolved.

6. Resident #17 was admitted to the facility on 4/5/16 and most recently readmitted on 9/1/17 with multiple diagnoses that included Parkinson ' s and schizophrenia.

The quarterly Minimum Data Set (MDS) dated 9/13/17 indicated Resident #17 ' s cognition was severely impaired. He received scheduled pain

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medications. Resident #17 was administered antipsychotic medication and antidepressant medication 7 of 7 days during the MDS look back period. He received antibiotic medication on 5 of 7 days and antianxiety medication on 1 of 7 days. Resident #17 received 51% or more of his nutrition from tube feeding.

A physician's order dated 9/13/17 for Resident #17 indicated Isosource 1.5 (nutritional tube feeding formula) at 65 milliliters (ml)/hour (hr) continuous via gastrostomy tube (g-tube) once daily for supplement.

A nutritional progress note dated 9/13/17 indicated Resident #17's diet was NPO (nothing by mouth) and he was ordered continuous tube feeding.

A written statement was completed by the Unit Manager for an incident that occurred with Resident #17 on 10/2/17. The narrative of the statement read, "On 10/2/17 I was called into [Resident #17 ' s room] by floor nurse. Upon entering the room [Resident #17] was not hooked up to any tube feeding. Bag was hanging but tubing was not connected to the [Resident #17]"

An Employee Counseling Notice dated 10/3/17 indicated Nurse #1 met with the DON. The narrative of this notice indicated Nurse #1 failed to administer residents ' medications, signed out medications as given when the medication was still in the medication card, and failed to administer tube feeding as ordered.

A phone interview was conducted with Nurse #1 on 10/10/17 at 11:00 AM. Nurse #1 declined to provide any information during the interview.

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An interview was conducted with the Physician's Assistant (PA) on 10/10/17 at 4:35 PM. She stated her expectation was for tube feedings to be administered as ordered. She stated she was aware of the tube feeding that was not administered as ordered and she reported no negative effects to the resident.

An interview was conducted with the DON on 10/11/17 at 10:12 AM. The Employee Counseling Notice for Nurse #1 dated 10/3/17 was reviewed with the DON. The DON indicated she interviewed Nurse #1 on 10/3/17. She stated that during the interview Nurse #1 admitted to documenting a tube feeding as administered without actually administering the tube feeding. Additionally, she acknowledged she signed out medications in the eMAR and then had not administered the medications. The DON revealed Nurse #1 had neglected her residents by signing out tube feedings and/or medications and not administering them as ordered.

This interview with the DON continued. She stated that since Nurse #1 was terminated there were no further issues reported. She stated she interviewed a few families to ensure there were no additional concerns. She stated for two to three days following the report of the incident she observed two of the second shift (7:00 PM to 7:00 AM) nurses (Nurse #2 and Nurse #3) to ensure tube feedings and medications were administered timely and as documented. She indicated there were no issues observed. The DON reported there was no ongoing monitoring related to this issue. She stated she believed the issue was caused by Nurse #1 and since she was terminated the issue had been resolved.

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F 224	Continued From page 32 An interview was conducted with the Unit Manager on 10/11/17 at 1:50 PM. She confirmed the written statement she completed about Resident #17 not being administered his tube feeding as ordered on 10/2/17. She stated she typically came into work around 8:00 AM so she believed she was notified of this information by the floor nurse shortly after 8:00 AM. She reported the tube feeding bag was hanging, but it was not connected to Resident #17. She indicated Nurse #1 had been assigned to Resident #17 the previous shift. The Unit Manager stated she was unsure how long Resident #17 had not received his tube feeding. She reported she hooked up the tube feeding to Resident #17, she informed the DON, and she informed the physician.	F 224		
F 322 SS=D	NG TREATMENT/SERVICES - RESTORE EATING SKILLS CFR(s): 483.25(g)(4)(5) (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services	F 322		11/6/17

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F 322	Continued From page 33 to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, and Physician ' s Assistant interview, the facility failed to provide tube feeding as ordered to 1 of 4 residents reviewed for tube feeding (Resident #17). The findings included: Resident #17 was admitted to the facility on 4/5/16 and most recently readmitted on 9/1/17 with multiple diagnoses that included Parkinson's and schizophrenia. The plan of care for Resident #17 included the Problem/Need area of Percutaneous Endoscopic Gastrostomy (PEG) tube for adequate nutrition and hydration initiated on 7/18/17. The quarterly Minimum Data Set (MDS) dated 9/13/17 indicated Resident #17's cognition was severely impaired. He received scheduled pain medications. Resident #17 was administered antipsychotic medication and antidepressant medication 7 of 7 days during the MDS look back period. He received antibiotic medication on 5 of 7 days and antianxiety medication on 1 of 7 days. Resident #17 received 51% or more of his nutrition from tube feeding. A physician's order dated 9/13/17 for Resident #17 indicated Isosource 1.5 (nutritional tube feeding formula) at 65 milliliters (ml)/hour (hr) continuous via gastrostomy tube (g-tube) once daily for supplement.	F 322	F322 – Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. Resident #17 was administered the omitted tube feeding immediately following observation by the oncoming nurse on October 3, 2017. The physician was notified on October 3, 2017 and no harm was identified by the physician. A 100% audit of all residents receiving tube feedings was completed by Staff Development Coordinator and Administrator-In-Training on October 12, 2017 to ensure that residents are receiving correct tube feeding formula administered at correct rate and time with no issues noted. All licensed nursing staff was in-serviced by the Staff Development Coordinator between the dates of October 15, 2017 and November 6, 2017 on administration of proper feeding per physician orders, including proper notification of provider for	

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F 322	Continued From page 34 A nutritional progress note dated 9/13/17 indicated Resident #17's diet was NPO (nothing by mouth) and he was ordered continuous tube feeding. A written statement was completed by the Unit Manager for an incident that occurred with Resident #17 on 10/2/17. The narrative of the statement read, "On 10/2/17 I was called into [Resident #17 ' s room] by floor nurse. Upon entering the room [Resident #17] was not hooked up to any tube feeding. Bag was hanging but tubing was not connected to the [Resident #17]" An Employee Counseling Notice dated 10/3/17 indicated Nurse #1 met with the DON. The narrative of this notice indicated Nurse #1 failed to administer tube feeding as ordered to Resident #17 and her employment at the facility was terminated. A phone interview was conducted with Nurse #1 on 10/10/17 at 11:00 AM. Nurse #1 declined to provide any information during the interview. An interview was conducted with the Physician's Assistant (PA) on 10/10/17 at 4:35 PM. She stated her expectation was for tube feedings to be administered as ordered. She stated she was aware of the tube feeding that was not administered as ordered and she reported no negative effects to Resident #17. An interview was conducted with the DON on 10/11/17 at 10:12 AM. The Employee Counseling Notice for Nurse #1 dated 10/3/17 was reviewed with the DON. The DON indicated she interviewed Nurse #1 on 10/3/17. She stated that	F 322	any unexpected lapse in tube feeding delivery of greater than 60 minutes and accurate documentation via nursing notes. Any licensed nurse not in-serviced by November 6, 2017 will not work until in-servicing is completed. In order to provide quality assurance, the Staff Development Coordinator or designee will audit a minimum of two residents receiving tube feedings weekly for four weeks and longer if indicated to ensure administration of proper feeding per physician orders, including proper notification of provider for any unexpected lapse in tube feeding delivery of greater than 60 minutes and accurate documentation via nursing notes. Results of these audits will be presented in the Quality Assurance Performance Improvement meeting to determine if further monitoring is indicated.	

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F 322	Continued From page 35 during the interview Nurse #1 admitted to documenting a tube feeding as administered without actually administering the tube feeding. She stated that since Nurse #1 was terminated there were no further issues reported. She stated she interviewed a few families to ensure there were no additional concerns. She stated for two to three days following the report of the incident she observed two of the second shift (7:00 PM to 7:00 AM) nurses (Nurse #2 and Nurse #3) to ensure tube feedings were administered as ordered. She indicated there were no issues observed. The DON reported there was no ongoing monitoring related to this issue. She stated she believed the issue was caused by Nurse #1 and since she was terminated the issue had been resolved. An interview was conducted with the Unit Manager on 10/11/17 at 1:50 PM. She confirmed the written statement she completed about Resident #17 not being administered his tube feeding as ordered on 10/2/17. She stated she typically came into work around 8:00 AM so she believed she was notified of this information by the floor nurse shortly after 8:00 AM. She reported the tube feeding bag was hanging, but it was not connected to Resident #17. She indicated Nurse #1 had been assigned to Resident #17 the previous shift. The Unit Manager stated she was unsure how long Resident #17 had not received his tube feeding. She reported she hooked up the tube feeding to Resident #17, she informed the DON, and she informed the physician.	F 322		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 441		11/6/17

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(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 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

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F 441	Continued From page 37 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 annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to failed to change gloves and wash hands after providing incontinent care and before providing further care for 1 of 3 residents (Resident #10). Findings included: A review of the facility standard precautions policy statement dated December 2007 revealed that "standard precautions shall apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease."	F 441	F441 Nursing Assistant #2 was in-serviced by the Staff Development Coordinator on October 10, 2017 regarding infection control, proper incontinence care, and importance of changing gloves between contaminations. All staff, including: licensed nurses, nurse aides, dietary, housekeeping, and administration were in-serviced by the Staff Development Coordinator between	

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F 441	Continued From page 38 The policy also indicated that staff "change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body site to another ..." On 10/10/17 at 1:25 pm an observation of incontinence care was done with Nursing Assistant (NA) #1 and NA #2. NA #2 cleaned incontinence of stool and used the same gloves to place a clean undergarment and clothing and to touch clean objects in the room such as the bedside rail and call bell. On 10/10/17 at 1:29 pm an interview was conducted with NA #2. NA #2 stated that she did not change her gloves after incontinence care. NA #2 was not aware she should have changed her gloves after incontinence care before starting other resident care. NA #2 stated that housekeeping cleaned the room every day to clean the surfaces she touched. On 10/11/17 at 3:45 pm an interview was conducted with the Director of Nursing (DON). The DON stated that she expected all staff to follow standard precautions during all resident contact and specifically to change gloves after cleaning stool.	F 441	October 15, 2017 and November 6, 2017 regarding standard precautions; including but not limited to, changing of gloves between clean and dirty surfaces, prevention of cross-contamination from one body site to another or contamination of equipment, blood borne pathogens, and communicable diseases. Any staff not in-serviced by November 6, 2017 will not work until in-servicing is completed. All licensed nurses and nurse aides were educated by the Staff Development Coordinator between October 10, 2017 and November 6, 2017 regarding proper incontinence care, including but not limited to standard precautions, changing of gloves, and hand washing. Any staff not in-serviced by November 6, 2017 will not work until in-servicing is completed. In order to provide quality assurance, the Staff Development Coordinator or designee will monitor incontinence care with routine infection control surveillance to ensure standard precautions are met. These audits will include a minimum of five observations weekly for two weeks and then one observation weekly for two additional weeks. Results of these audits will be presented in the Quality Assurance Performance Improvement meeting to determine if additional monitoring is indicated.	
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5)	F 514		11/6/17

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F 514	Continued From page 39 (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; (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, resident interview, and staff interview, the facility failed to have accurate medication administration records for 6 of 6 residents reviewed. The findings included:	F 514	F514 – The physician was notified of the omitted medications for Residents (#13, #2, #14, #15, #16, and #17) on October 3, 2017.	

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F 514	Continued From page 40 1. Resident #13 was admitted to the facility on 8/11/17 with multiple diagnoses that included heart disease, Diabetes Mellitus Type 2, chronic pain syndrome, hyperlipidemia, and hypernatremia. The admission Minimum Data Set (MDS) assessment dated 8/18/17 indicated Resident #13 ' s cognition was fully intact. He received scheduled pain medications and as needed pain medications. Resident #13 was administered insulin, antidepressant medication, and diuretic medication on 7 of 7 days during the MDS look back period. He was administered antianxiety medication on 1 of 7 days during the MDS look back period. A grievance form was completed by Resident #13 for an incident that occurred on 10/2/17. The narrative of the grievance read, "I never got my night [medications] or insulin". The grievance investigation and findings indicated Resident #13 was alert and oriented. His electronic Medication Administration Record (eMAR) was reviewed and his medications had been signed out by Nurse #1. Nurse #1 was interviewed by the Director of Nursing (DON) and was terminated. A review of Resident #13 ' s physician ' s orders in place on 10/2/17 indicated his evening medications were Lantus (insulin), Humalog (insulin), Lovastatin (high cholesterol medication), Gabapentin (nerve pain medication), Tylenol, and Sodium chloride. A 24-hour initial report was completed by the facility Administrator in Training (AIT) on 10/3/17. The allegation/incident type was listed as resident	F 514	The physician identified that no harm occurred in the omission of medications. Between October 30, 2017 and November 3, 2017, all residents with a BIMS score equal to or higher than 11 were interviewed by the Director of Nursing, Staff Development Coordinator, or Social Worker to ensure there were no additional instances of neglect including but not limited to the omission of medication administration. Between October 30, 2017 and November 3, 2017 the Responsible Party of all residents with a BIMS score less than 11 were contacted by the Director of Nursing, Staff Development Coordinator, or Nurse Unit Manager to ensure there were no additional instances of neglect including but not limited to the omission of medication administration. All nursing staff was in-serviced by the Staff Development Coordinator between the dates of October 15, 2017 and November 6, 2017 regarding accurate and timely documentation of medication administration including but not limited to, following physician's order, medication administration within the time limit ordered, and signing the Medication Administration Record accurately. Any nursing staff not in-serviced by November 6, 2017 will not work until in-servicing is completed. In order to provide quality assurance, the Director of Nursing, Staff Development	

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neglect. The report indicated the incident occurred on 10/2/17 through 10/3/17 between the times of 7:00 PM and 7:00 AM. The allegation description read, "Received complaints from [Resident #13] that [Nurse #1] did not administer nor offer medications during shift". Nurse #1 was listed on the report as the accused individual.

An Employee Counseling Notice dated 10/3/17 indicated Nurse #1 met with the DON. The narrative of this notice indicated Nurse #1 failed to administer residents ' medications, signed out medications as given when the medication was still in the medication card, and failed to administer tube feeding as ordered.

The 5-working day report was completed by the AIT on 10/6/17. The allegation of resident neglect referred to in the 24-hour initial report completed on 10/3/17 was substantiated. The narrative of the investigation indicated a review of eMARs revealed that Nurse #1 signed off multiple medications in eMAR that were still in medication card, indicating that nurse falsely documented the administration of these medications.

A phone interview was conducted with Nurse #1 on 10/10/17 at 11:00 AM. Nurse #1 declined to provide any information during the interview.

An interview was conducted with Resident #13 on 10/10/17 at 1:45 PM. Resident #13 confirmed the information in the grievance related to the incident on 10/2/17 in which he had not received his evening medications. He identified the nurse who was assigned to him on 10/2/17 as Nurse #1. He indicated he had no negative effects from not receiving the medications. Resident #13 reported no further concerns with receiving his

Coordinator, or Nurse Unit Managers will interview a minimum of two residents with a BIMS score equal to or greater than 11 weekly for four weeks and longer if indicated to ensure no additional instances of neglect, including omission of medication administration have occurred. Findings of these interviews will be presented in the Quality Assurance Performance Improvement Meeting to determine if results indicate a need for continued monitoring.

In order to provide quality assurance, the Director of Nursing, Staff Development Coordinator, or Nurse Unit Managers will observe a minimum of two medication administration passes weekly for four weeks and longer if indicated to ensure no additional instances of neglect, including omission of medication administration have occurred, and the Medication Administration Record is complete and accurate. Findings of these medication administration observations will be presented in the Quality Assurance Performance Improvement Meeting to determine if results indicate a need for continued monitoring.

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medications.

An interview was conducted with the DON on 10/10/17 at 4:03 PM. She reviewed the results of the investigation that was conducted for the allegation of neglect referred to in the 24-hour report dated 10/3/17. She indicated the investigation revealed Nurse #1 had signed out medications as given when the medication was still in the medication card. She confirmed Resident #13 was one of the residents whose eMAR was reviewed during the investigation. The DON revealed that based on the corroborating statements from Resident #13 was well as 3 additional alert and oriented residents it was suspected Nurse #1 signed off on the medications for these residents and had not administered them.

A follow up interview was conducted with the DON on 10/11/17 at 10:12 AM. She stated that following the investigation, the PA was informed of the information and she had no concerns of any harm to the residents. The DON indicated she interviewed Nurse #1 on 10/3/17. She stated that during the interview Nurse #1 acknowledged she signed out medications in the eMAR and had not administered the medications. She additionally admitted to documenting a tube feeding as administered without administering the tube feeding.

This follow up interview with the DON continued. She stated that since Nurse #1 was terminated there were no further issues reported. She stated she interviewed a few families to ensure there were no additional concerns. She stated for two to three days following the completion of the investigation she observed two of the second shift

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(7:00 PM to 7:00 AM) nurses (Nurse #2 and Nurse #3) to ensure medications were administered timely and as documented. She indicated there were no issues observed. The DON reported there was no ongoing monitoring related to this issue. She stated she believed the issue was caused by Nurse #1 and since she was terminated the issue had been resolved.

2. Resident #2 was initially admitted to the facility on 6/30/15 and most recently readmitted on 12/27/16 with multiple diagnoses that included chronic obstructive pulmonary disease (COPD), hyperlipidemia, hypertension, and insomnia.

The quarterly Minimum Data Set (MDS) assessment dated 9/7/17 indicated Resident #2 ' s cognition was fully intact. He received scheduled pain medications. Resident #2 was administered antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS look back period.

A grievance form was completed by Resident #2 for an incident that occurred on 10/2/17. The narrative of the grievance read, "I did not get my [medications] last night, that nurse came to my room". The corrective action by facility to resolve the grievance indicated a 24-report was filed, 5-day report was filed, and the nurse was terminated.

A review of Resident #2 ' s physician ' s orders in place on 10/2/17 indicated his evening medications were Trazodone (antidepressant medication), Atorvastatin (high cholesterol medication), Clonazepam (antianxiety medication), Colace (stool softener/laxative),

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Gabapentin (nerve pain medication), and Tylenol.

A 24-hour initial report was completed by the facility Administrator in Training (AIT) on 10/3/17. The allegation/incident type was listed as resident neglect. The report indicated the incident occurred on 10/2/17 through 10/3/17 between the times of 7:00 PM and 7:00 AM. The allegation description read, "Received complaints from resident that [Nurse #1] did not administer nor offer medications during shift". Nurse #1 was listed on the report as the accused individual.

An Employee Counseling Notice dated 10/3/17 indicated Nurse #1 met with the DON. The narrative of this notice indicated Nurse #1 failed to administer residents ' medications, signed out medications as given when the medication was still in the medication card, and failed to administer tube feeding as ordered.

The 5-working day report was completed by the AIT on 10/6/17. The allegation of resident neglect referred to in the 24-hour initial report completed on 10/3/17 was substantiated. The narrative of the investigation indicated a review of eMARs revealed that Nurse #1 signed off multiple medications in eMAR that were still in medication card, indicating that nurse falsely documented the administration of these medications.

A phone interview was conducted with Nurse #1 on 10/10/17 at 11:00 AM. Nurse #1 declined to provide any information during the interview.

An interview was conducted with Resident #2 on 10/10/17 at 1:55 PM. Resident #2 confirmed the information in the grievance related to the incident on 10/2/17 in which he had not received

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his evening medications. He identified the nurse as Nurse #1. He indicated he had no negative effects from not receiving the medications. Resident #2 reported no further concerns with receiving his medications.

An interview was conducted with the DON on 10/10/17 at 4:03 PM. She reviewed the results of the investigation that was conducted for the allegation of neglect referred to in the 24-hour report dated 10/3/17. She indicated the investigation revealed Nurse #1 had signed out medications as given when the medication was still in the medication card. She confirmed Resident #2 was one of the residents whose eMAR was reviewed during the investigation. The DON revealed that based on the corroborating statements from Resident #2 was well as 3 additional alert and oriented residents it was suspected Nurse #1 signed off on the medications for these residents and had not administered them.

A follow up interview was conducted with the DON on 10/11/17 at 10:12 AM. She stated that following the investigation, the PA was informed of the information and she had no concerns of any harm to the residents. The DON indicated she interviewed Nurse #1 on 10/3/17. She stated that during the interview Nurse #1 acknowledged she signed out medications in the eMAR and had not administered the medications. She additionally admitted to documenting a tube feeding as administered without administering the tube feeding.

This follow up interview with the DON continued. She stated that since Nurse #1 was terminated there were no further issues reported. She stated

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she interviewed a few families to ensure there were no additional concerns. She stated for two to three days following the completion of the investigation she observed two of the second shift (7:00 PM to 7:00 AM) nurses (Nurse #2 and Nurse #3) to ensure medications were administered timely and as documented. She indicated there were no issues observed. The DON reported there was no ongoing monitoring related to this issue. She stated she believed the issue was caused by Nurse #1 and since she was terminated the issue had been resolved.

3. Resident #14 was admitted to the facility on 9/21/17 with multiple diagnoses that included spinal stenosis, chronic pain, hyperlipidemia, neuropathy, and insomnia.

The admission Minimum Data Set (MDS) assessment dated 9/28/17 indicated Resident #14 ' s cognition was fully intact. He received scheduled pain medications and as needed pain medications. Resident #14 was administered antidepressant medication on 7 of 7 days during the MDS look back period.

A grievance form was completed by Resident #14 for an incident that occurred on 10/3/17. The narrative of the grievance read, "[Resident #14] stating he did not receive his medication one night and did not receive them until 2:30 AM the night before". The corrective action by facility to resolve the grievance indicated a 24-report was filed, 5-day report was filed, and the nurse was terminated.

A review of Resident #14 ' s physician ' s orders in place on 10/3/17 indicated his evening medications were Gabapentin (nerve pain

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medication), Bisacodyl (laxative), Melatonin (dietary supplement utilized as sleep aid), Trazodone (antidepressant medication), and Metoprolol (beta-blocker).

A 24-hour initial report was completed by the facility Administrator in Training (AIT) on 10/3/17. The allegation/incident type was listed as resident neglect. The report indicated the incident occurred on 10/2/17 through 10/3/17 between the times of 7:00 PM and 7:00 AM. The allegation description read, "Received complaints from resident that [Nurse #1] did not administer nor offer medications during shift". Nurse #1 was listed on the report as the accused individual.

An Employee Counseling Notice dated 10/3/17 indicated Nurse #1 met with the DON. The narrative of this notice indicated Nurse #1 failed to administer residents ' medications, signed out medications as given when the medication was still in the medication card, and failed to administer tube feeding as ordered.

The 5-working day report was completed by the AIT on 10/6/17. The allegation of resident neglect referred to in the 24-hour initial report completed on 10/3/17 was substantiated. The narrative of the investigation indicated a review of eMARs revealed that Nurse #1 signed off multiple medications in eMAR that were still in medication card, indicating that nurse falsely documented the administration of these medications.

A phone interview was conducted with Nurse #1 on 10/10/17 at 11:00 AM. Nurse #1 declined to provide any information during the interview.

An interview was conducted with Resident #14 on

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10/10/17 at 2:10 PM. Resident #14 confirmed the information in the grievance related to the incident on 10/3/17 in which he had not received his evening medications one night and another night he received his medications several hours late. He identified the nurse who was assigned to him as Nurse #1. He indicated there were no negative effects related to this issue. Resident #14 reported no further concerns with receiving his medications.

An interview was conducted with the DON on 10/10/17 at 4:03 PM. She reviewed the results of the investigation that was conducted for the allegation of neglect referred to in the 24-hour report dated 10/3/17. She indicated the investigation revealed Nurse #1 had signed out medications as given when the medication was still in the medication card. She confirmed Resident #14 was one of the residents whose eMAR was reviewed during the investigation. The DON revealed that based on the corroborating statements from Resident #14 was well as 3 additional alert and oriented residents it was suspected Nurse #1 signed off on the medications for these residents and had not administered them.

A follow up interview was conducted with the DON on 10/11/17 at 10:12 AM. She stated that following the investigation, the PA was informed of the information and she had no concerns of any harm to the residents. The DON indicated she interviewed Nurse #1 on 10/3/17. She stated that during the interview Nurse #1 acknowledged she signed out medications in the eMAR and had not administered the medications. She additionally admitted to documenting a tube feeding as administered without administering the

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tube feeding.

This follow up interview with the DON continued. She stated that since Nurse #1 was terminated there were no further issues reported. She stated she interviewed a few families to ensure there were no additional concerns. She stated for two to three days following the completion of the investigation she observed two of the second shift (7:00 PM to 7:00 AM) nurses (Nurse #2 and Nurse #3) to ensure medications were administered timely and as documented. She indicated there were no issues observed. The DON reported there was no ongoing monitoring related to this issue. She stated she believed the issue was caused by Nurse #1 and since she was terminated the issue had been resolved.

4. Resident #15 was admitted to the facility on 1/12/16 and most recently readmitted on 7/13/17 with multiple diagnoses that included hypertension, atrial fibrillation, depression, and hyperlipidemia.

The 30-day Minimum Data Set (MDS) assessment dated 8/14/17 indicated Resident #15 ' s cognition was fully intact. She received scheduled pain medications. Resident #15 was administered antidepressant medication and anticoagulant medication on 7 of 7 days during the MDS look back period. She received diuretic medication on 3 of 7 days.

A grievance form was completed by Resident #15 for an incident that occurred on 10/2/17. The narrative of the grievance indicated Resident #15 stated she had not received her medications one night and another night she received them really

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late. The corrective action by facility to resolve the grievance indicated a 24-report was filed, 5-day report was filed, and the nurse was terminated.

A review of Resident #15 ' s physician ' s orders in place on 10/2/17 indicated his evening medications were Trazodone (antidepressant medication), Atorvastatin (high cholesterol medication), Mapap (acetaminophen), Metoprolol (beta-blocker), and Eliquis (anticoagulant).

A 24-hour initial report was completed by the facility Administrator in Training (AIT) on 10/3/17. The allegation/incident type was listed as resident neglect. The report indicated the incident occurred on 10/2/17 through 10/3/17 between the times of 7:00 PM and 7:00 AM. The allegation description read, "Received complaints from resident that [Nurse #1] did not administer nor offer medications during shift". Nurse #1 was listed on the report as the accused individual.

An Employee Counseling Notice dated 10/3/17 indicated Nurse #1 met with the DON. The narrative of this notice indicated Nurse #1 failed to administer residents ' medications, signed out medications as given when the medication was still in the medication card, and failed to administer tube feeding as ordered.

The 5-working day report was completed by the AIT on 10/6/17. The allegation of resident neglect referred to in the 24-hour initial report completed on 10/3/17 was substantiated. The narrative of the investigation indicated a review of eMARs revealed that Nurse #1 signed off multiple medications in eMAR that were still in medication card, indicating that nurse falsely documented the

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administration of these medications.

A phone interview was conducted with Nurse #1 on 10/10/17 at 11:00 AM. Nurse #1 declined to provide any information during the interview.

An interview was conducted with the DON on 10/10/17 at 4:03 PM. She reviewed the results of the investigation that was conducted for the allegation of neglect referred to in the 24-hour report dated 10/3/17. She indicated the investigation revealed Nurse #1 had signed out medications as given when the medication was still in the medication card. She confirmed Resident #15 was one of the residents whose eMAR was reviewed during the investigation. The DON revealed that based on the corroborating statements from Resident #15 was well as 3 additional alert and oriented residents it was suspected Nurse #1 signed off on the medications for these residents and had not administered them.

An interview was conducted with Resident #15 on 10/11/17 at 8:00 AM. Resident #15 confirmed the information in the grievance related to the incident on 10/2/17 in which she had not received her evening medications one night and another night she received her medications several hours late. She identified the nurse who was assigned to her as Nurse #1. She indicated there were no negative effects related to this issue. Resident #15 reported no further concerns with receiving his medications.

A follow up interview was conducted with the DON on 10/11/17 at 10:12 AM. She stated that following the investigation, the PA was informed of the information and she had no concerns of

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any harm to the residents. The DON indicated she interviewed Nurse #1 on 10/3/17. She stated that during the interview Nurse #1 acknowledged she signed out medications in the eMAR and had not administered the medications. She additionally admitted to documenting a tube feeding as administered without administering the tube feeding.

This follow up interview with the DON continued. She stated that since Nurse #1 was terminated there were no further issues reported. She stated she interviewed a few families to ensure there were no additional concerns. She stated for two to three days following the completion of the investigation she observed two of the second shift (7:00 PM to 7:00 AM) nurses (Nurse #2 and Nurse #3) to ensure medications were administered timely and as documented. She indicated there were no issues observed. The DON reported there was no ongoing monitoring related to this issue. She stated she believed the issue was caused by Nurse #1 and since she was terminated the issue had been resolved.

5. Resident #16 was admitted to the facility on 10/16/14 with multiple diagnoses that included neuropathy, insomnia, anxiety, and hyperlipidemia.

The annual Minimum Data Set (MDS) assessment dated 9/28/17 indicated Resident #16 ' s cognition was moderately impaired. He received scheduled pain medications. Resident #16 was administered antidepressant medication and antianxiety medication on 7 of 7 days during the MDS look back period.

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A review of Resident #16 ' s physician ' s orders in place on 10/2/17 indicated his evening medications were Clonazepam (antianxiety medication), Trazodone (antidepressant medication), Atorvastatin (high cholesterol medication), Neurontin (nerve pain medication), and Divalproex Sodium (mood stabilizer).

A 24-hour initial report was completed by the facility Administrator in Training (AIT) on 10/3/17. The allegation/incident type was listed as resident neglect. The report indicated the incident occurred on 10/2/17 through 10/3/17 between the times of 7:00 PM and 7:00 AM. The allegation description read, "Received complaints from resident that [Nurse #1] did not administer nor offer medications during shift". Nurse #1 was listed on the report as the accused individual.

An Employee Counseling Notice dated 10/3/17 indicated Nurse #1 met with the DON. The narrative of this notice indicated Nurse #1 failed to administer residents ' medications, signed out medications as given when the medication was still in the medication card, and failed to administer tube feeding as ordered.

The 5-working day report was completed by the AIT on 10/6/17. The allegation of resident neglect referred to in the 24-hour initial report completed on 10/3/17 was substantiated. The narrative of the investigation indicated a review of eMARs revealed that Nurse #1 signed off multiple medications in eMAR that were still in medication card, indicating that nurse falsely documented the administration of these medications.

A phone interview was conducted with Nurse #1 on 10/10/17 at 11:00 AM. Nurse #1 declined to

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provide any information during the interview.

An interview was conducted with the DON on 10/10/17 at 4:03 PM. She reviewed the results of the investigation that was conducted for the allegation of neglect referred to in the 24-hour report dated 10/3/17. She indicated the investigation revealed Nurse #1 had signed out medications as given when the medication was still in the medication card. The DON stated it was verified through eMAR review that Resident #16 had a controlled medication (Clonazepam) that was signed off in the eMAR as administered, but it was not signed off on the narcotic control sheet and it remained in the medication cart.

A follow up interview was conducted with the DON on 10/11/17 at 10:12 AM. She stated that following the investigation, the PA was informed of the information and she had no concerns of any harm to the residents. The DON indicated she interviewed Nurse #1 on 10/3/17. She stated that during the interview Nurse #1 acknowledged she signed out medications in the eMAR and had not administered the medications. She additionally admitted to documenting a tube feeding as administered without administering the tube feeding.

This follow up interview with the DON continued. She stated that since Nurse #1 was terminated there were no further issues reported. She stated she interviewed a few families to ensure there were no additional concerns. She stated for two to three days following the completion of the investigation she observed two of the second shift (7:00 PM to 7:00 AM) nurses (Nurse #2 and Nurse #3) to ensure medications were administered timely and as documented. She

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indicated there were no issues observed. The DON reported there was no ongoing monitoring related to this issue. She stated she believed the issue was caused by Nurse #1 and since she was terminated the issue had been resolved.

6. Resident #17 was admitted to the facility on 4/5/16 and most recently readmitted on 9/1/17 with multiple diagnoses that included Parkinson ' s and schizophrenia.

The quarterly Minimum Data Set (MDS) dated 9/13/17 indicated Resident #17 ' s cognition was severely impaired. He received scheduled pain medications. Resident #17 was administered antipsychotic medication and antidepressant medication 7 of 7 days during the MDS look back period. He received antibiotic medication on 5 of 7 days and antianxiety medication on 1 of 7 days. Resident #17 received 51% or more of his nutrition from tube feeding.

A physician ' s order dated 9/13/17 for Resident #17 indicated Isosource 1.5 (nutritional tube feeding formula) at 65 milliliters (ml)/hour (hr) continuous via gastrostomy tube (g-tube) once daily for supplement.

A nutritional progress note dated 9/13/17 indicated Resident #17 ' s diet was NPO (nothing by mouth) and he was ordered continuous tube feeding.

A written statement was completed by the Unit Manager for an incident that occurred with Resident #17 on 10/2/17. The narrative of the statement read, "On 10/2/17 I was called into

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[Resident #17 ' s room] by floor nurse. Upon entering the room [Resident #17] was not hooked up to any tube feeding. Bag was hanging but tubing was not connected to the [Resident #17]"

An Employee Counseling Notice dated 10/3/17 indicated Nurse #1 met with the DON. The narrative of this notice indicated Nurse #1 failed to administer residents ' medications, signed out medications as given when the medication was still in the medication card, and failed to administer tube feeding as ordered.

A phone interview was conducted with Nurse #1 on 10/10/17 at 11:00 AM. Nurse #1 declined to provide any information during the interview.

An interview was conducted with the DON on 10/11/17 at 10:12 AM. The Employee Counseling Notice for Nurse #1 dated 10/3/17 was reviewed with the DON. The DON indicated she interviewed Nurse #1 on 10/3/17. She stated that during the interview Nurse #1 admitted to documenting a tube feeding as administered without actually administering the tube feeding. Additionally, she acknowledged she signed out medications in the eMAR and then had not administered the medications.

This interview with the DON continued. She stated that since Nurse #1 was terminated there were no further issues reported. She stated she interviewed a few families to ensure there were no additional concerns. She stated for two to three days following the report of the incident she observed two of the second shift (7:00 PM to 7:00 AM) nurses (Nurse #2 and Nurse #3) to ensure tube feedings and medications were administered timely and as documented. She indicated there

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were no issues observed. The DON reported there was no ongoing monitoring related to this issue. She stated she believed the issue was caused by Nurse #1 and since she was terminated the issue had been resolved.

An interview was conducted with the Unit Manager on 10/11/17 at 1:50 PM. She confirmed the written statement she completed about Resident #17 not being administered his tube feeding as ordered on 10/2/17. She stated she typically came into work around 8:00 AM so she believed she was notified of this information by the floor nurse shortly after 8:00 AM. She reported the tube feeding bag was hanging, but it was not connected to Resident #17. She indicated Nurse #1 had been assigned to Resident #17 the previous shift. The Unit Manager stated she was unsure how long Resident #17 had not received his tube feeding. She reported she hooked up the tube feeding to Resident #17, she informed the DON, and she informed the physician.