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AUTUMN CARE OF BISCOE	401 LAMBERT ROAD BISCOE, NC 27209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to obtain physician orders and assess a resident with observed medications at his bedside. The facility also failed to assess the ability of a resident to self-administer his eye drops for 1 (Resident #70) of 1 residents reviewed for self-administration of medications. The findings included: Resident #70 was admitted on 2/13/17 with cumulative diagnoses of Sarcoidosis (abnormal collection of inflammatory cells that affect multiple areas of the body) and Diabetes. Resident #70's quarterly Minimum Data Set (MDS) dated 3/5/18 indicated he was cognitively intact, exhibited verbal behaviors and rejection of care. He was coded for extensive assistance of his activities of daily living and coded with no impairments to his upper extremities. Review of the facility policy dated last revised May 2016 titled "Self Administration of Medications" read there must be physician order for self-administration of specific medications under consideration, a Self-Administration of Medication Assessment must be completed, the Interdisciplinary Team (IDT) would review the assessment and document their findings and a care plan for the approved self-administration	F 554	Preparation and submission of this Plan Of Correction is required by state and federal law. This Plan Of Correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F554 Process that led to the deficiency cited: Nurse did not obtain a physician order or complete a self-administer medication assessment due to lack of knowledge regarding the self-administration policy. Procedure for implementing plan of correction: 100% education for all licensed nurses, to include unit managers, weekend and/or as needed nurses, on completing self-administer medication assessment and obtaining physician order to self-administer medication completed by on 4/30/18 by ADON. In addition on 4/30/18, Interdisciplinary Care Plan Team, as represented by Activity Director, Dietary Manager, Director of Rehab, Social Services, Assessment Nurses, Assistant Director of Nursing, Director of Nursing and	4/30/18

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

Electronically Signed | 04/30/2018

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F 554	Continued From page 1 medications would be developed. If medications were to be left at the bedside, the medications must be kept in a locked drawer. Review of Resident #70's April 2018 physician orders read an order dated 4/6/18 for him to keep his Artificial Tears (drops that lubricate dry eyes) at the bedside. Review of a nursing note dated 4/6/18 at 2:55 PM read Resident #70 was given his eye drops to keep at the bedside. He was aware to use the eye drops up to three times a day. Review of Resident #70's electronic medical record revealed an assessment titled "Resident's Ability to Safely Self-Administer Medications" was completed on 4/10/18. There was no documentation of the IDT review or IDT approval. Review of Resident #70's care plan dated 4/10/18 read Resident #70 was to administer his medications as ordered and nursing would assess his self-administration quarterly and as needed. Interview on 4/10/18 at 3:30 PM, MDS Nurse #2 stated she care planned Resident #70 earlier on 4/10/18 for the self-administration of his eye drops. She stated the self-administration of Resident #70's eye drops should have been approved by the IDT then care planned on 4/6/18. Interview on 4/11/18 at 3:10 PM, Nurse #5 stated she wrote the order dated 4/6/18 to allow Resident #70's eye drops to be left at the bedside but did not do complete the Resident Self-Administration Assessment. She confirmed she completed the Resident Self-Administration	F 554	Administrator were educated on policy/process for self-administration of medication by Regional Director of Clinical Services. Monitoring procedure: The DON and interdisciplinary team, to include unit managers for weekend coverage, will implement steps for self-administering medications for any future residents by review of new physician orders daily to identify any resident for self-administration or may leave at beside. 100% of residents who self-administer medications will be audited to validate Self-Administration Process components, will be conducted daily for 1 week then weekly for 2 weeks then monthly x2 by DON and/or unit manager. Results of the audit will be presented by DON for review by QAPI committee monthly for two months. If discrepancies are noted, further actions will be implemented. Title of person responsible for implementing plan of correction: Director of Nursing Date when Corrective Action will be completed: 4/30/18	

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F 554	Continued From page 2	F 554		

Assessment 4/10/18 after the Director of Nursing (DON) told her to complete it.

Interview and observation on 4/12/18 at 8:35 AM, Resident #70 was sitting up in bed. Observed on his bedside table was a bottle of Artificial Tears and a medication cup containing 8 pills. He stated he was recently allowed to keep his eye drops in his room. Resident #70 stated he was not informed his eye drops should be in a locked drawer. He stated he was waiting on his breakfast tray and his milk to take his medications. Nurse #3 entered Resident #70's room and stated she left Resident #70's medications with him while she went to get him some orange juice. When questioned as to why she did not return with orange juice, Nurse #3 stated she could not find Resident #70's aide. Nurse #3 stated she did not normally leave Resident #70's medications with him at the bedside. Resident #70 declined to comment if it was normal practice for the nurses to leave is medications at the bedside for him to self-administer.

Review of Resident #70's April 2018 Medication Administration Record (MAR) read he received the following 8 medications daily at 8:00 AM:

1. Cholecalciferol (Vitamin D Supplement)
2. Folic Acid (B-complex Vitamin)
3. Januvia (lowers Blood Sugar for Type 2 Diabetics)
4. Omeprazole (treats too much stomach acid)
5. Prednisone (Steroid)
6. Stress Formula with Zinc (Multivitamin)
7. Ascorbic Acid (Vitamin C)
8. Midodrine (treats hypotension-low blood pressure)

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F 554	Continued From page 3 Interview on 4/12/18 at 1:50 PM, the DON stated it was her expectation that residents with orders to self-administer their medications be evaluated prior to allowing the resident to take possession of the medication, the IDT review the Resident Self-Administration Assessment to determine if there were safety concerns. The DON further stated all self-administered medications ordered to be kept at the bedside should be care planned, assessed quarterly and secured in a locked drawer in the resident's room. The DON stated it was her expectation that Nurse #3 would not have left Resident #70's morning medications at the bedside for him to take on his own without supervision.	F 554		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, Responsible Party (RP) interview and record review, the facility failed to complete a significant change Minimum Data Set (MDS) for a resident with three areas of decline for 1 (Resident #10) of	F 637	F637 Process that led to the deficiency cited: Facility failed to appropriately document a significant change on the MDS who had 3 areas of decline.	4/30/18

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F 637	Continued From page 4 2 residents reviewed for pressure ulcers. The findings included: Resident #10 was admitted 2/11/16 with cumulative diagnoses of Postural Kyphosis (excessive outward curve of the upper spine), chronic pain and osteoporosis. Review of Resident #10's quarterly MDS dated 4/30/17 indicated she was supervision for eating and coded for no skin impairments and required no as needed medications for pain. Her weight was 112 pounds. Review of Resident #10's nursing note dated 5/25/17 indicated an abrasion was noted to her upper left back. Review of Resident #10's 5/26/17 care plan indicated Resident #10 developed an open area to her left upper back. Review of a nursing note dated 6/13/17 read Resident #10's open are to her left upper back was noted with eschar and yellow necrotic tissue. Review of Resident #10's quarterly MDS dated 6/23/17 indicated she required limited assistance with eating, was coded for one unstageable pressure ulcer and receiving as needed medications for pain. Her weight was 114 pounds. Review of Resident #10's quarterly MDS dated 9/17/17 indicated she required limited assistance with eating, was coded for one stage 3 pressure ulcer and no medications for pain. Her weight was 126 pounds.	F 637	Procedure for implementing plan of correction: A Significant Change Assessment was completed and submitted for Resident #10 by MDS nurse #2. MDS nurses education, separate from and in addition to IDT, learning session on Significant Change MDS as presented by Regional Director of Reimbursement on 4/27/18. MDS nurses to complete tracking log with reconciliation note with rationale for completion of Significant Change MDS, or not as may be the case, upon computer generated warnings triggered by coding of MDS indicating significant change MDS may be warranted. Monitoring Procedure: Completed assessments will be audited by Administrator weekly for one month then 5 randomly weekly for 2 months with review by Regional Reimbursement as to appropriateness of rationale. Findings will be presented to the QAPI committee monthly for three months, by Administrator. If discrepancies are noted, further actions will be implemented. Title of person responsible for implementing plan of correction: DON and Regional Director of Reimbursement Date when corrective action will be completed:	

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F 637	Continued From page 5	F 637	4/30/18	

Review of Resident #10's quarterly MDS dated 12/7/17 indicated she required limited assistance with eating, was coded for one stage 3 pressure ulcer and no medications for pain. Her weight was 112 pounds.

The quarterly MDS dated 1/7/18 indicated Resident #10 had severe cognitive impairments and was coded for physical behaviors with rejection of care. She was coded for supervision with eating and for a stage 4 pressure ulcer. Her weight was 110 pounds.

Review of Resident #10's meal intake amounts from 2/1/18 to present indicated she ate anywhere from 0% to 75% of her meals.

Observation on 4/9/18 at 12:20 PM in the dining room on 400-hall was conducted. Resident #10 was observed slumped over in her wheelchair and had not eaten. Nurse #2 began attempting to feed Resident #10.

Interview on 4/9/18 at 12:40 PM, Nurse #2 stated Resident #10 required more assistance with eating than she did prior to the development of her pressure ulcer to her upper back. She stated Resident #10 was often observed slumped over in her wheelchair and would grimace when sitting up. She stated Resident #10's responsible party was at the facility earlier on 4/9/18 and spoke to the Nurse Practitioner about something stronger than Tylenol for pain.

In a telephone interview on 4/10/18 at 1:12 PM, Resident #10's RP stated she has declined in her ability to feed herself and no longer self propelling around the facility. She stated Resident #10's decline began May 2017 when she developed a

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pressure ulcer on her back where her kyphosis was. The RP stated she was at the facility 4/9/18 and requested something other than Tylenol for pain since Resident #10 stayed slumped over when she sat up in her wheelchair. She stated she felt Resident #10 stayed slumped over because it was painful to sit upright and have her pressure ulcer up against the back of her wheelchair

Interview on 4/10/18 at 2:40 PM, Nursing Assistant (NA) #6 stated Resident #10 developed a pressure ulcer on her upper back. She stated since Resident #10 developed the pressure ulcer, she has gradually "gone down-hill". NA #6 stated Resident #10 just started on pain medications because she would lay doubled over in her wheelchair to keep from hitting her pressure ulcer. NA #6 stated the facility replaced her wheelchair with a padded back wheelchair a few months after she developed the area. She stated Resident #10 required eating assistance for most meals and before she developed the pressure ulcer, she could feed herself.

Interview on 4/10/18 at 2:50 PM, NA #5 stated Resident #10 has had an overall decline since she developed her pressure ulcer. She stated prior to the pressure ulcer, Resident #10 was known to self-propel about the halls but as her pressure ulcer got worse, she stopped moving about in her wheelchair.

Observation on 4/11/18 at 8:10 AM, NA #5 was feeding Resident #10. She was sitting upright in her wheelchair. NA #5 stated she felt the pain medication was helping with Resident #10 and she was eating better.

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Interview on 4/11/18 at 8:45 AM, MDS Nurse #2 stated when she completed Resident #10's quarterly MDS dated 6/23/17, she did not consider her development of an unstageable pressure ulcer and minor changes in her ADL status and noted weight loss was a significant change in her status. MDS Nurse #2 stated she could not be sure the weight obtained in September 2017 was accurate but stated there was no evidence of a re-weight. The MDS Nurse stated she referred to the ADL documentation completed by the aides for the seven-day look back and reviewed the documentation when completing a MDS.

Review of the medical record on 4/11/18 at 9:20 AM indicated a significant change MDS was initiated on 4/11/18 by MDS Nurse #2.

Observation on 4/11/18 at 8:35 AM, NA #5 was feeding Resident #10. She was sitting upright in her wheelchair.

Interview on 4/12/18 at 9:00 AM, MDS Nurse #2 stated she started a significant change MDS on Resident #10 on 4/11/18 because the areas of decline did not appear to be self-limiting.

In a telephone interview on 4/12/18 at 9:28 AM, the Registered Dietitian (RD) stated there had been no significant weight loss since Resident #10 developed the pressure ulcer and she was getting multiple supplements. She stated she did not feel the September 2017 weight of 126 pounds was accurate but confirmed there was no documented evidence of a reweight. She confirmed Resident #10's intake varied greatly and the supplements were likely only maintaining her weight but there were not enough calories left

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F 637	Continued From page 8 over to aid in healing of her pressure ulcer. She recommended Resident #10 be full staff assistance with all meals. Interview on 4/12/18 at 10:20 AM, the Wound Physician stated he could not say Resident #10's pressure ulcer was avoidable due to the severe kyphosis noted at her upper back. He stated there was internal pressure to her back related to her kyphosis and was aware the facility obtained a wheelchair with a padded back shortly after she developed the area. Interview on 4/12/18 at 1:50 PM, the Director of Nursing stated it was her expectation that all MDS assessments be an accurate reflection of the Resident #10's status. She stated there should have been a reweight completed September 2017 and any time after June 2017, there should have been a significant changed MDS completed for Resident #10 since there was noted physical decline.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medication (Resident #58), active diagnosis (Resident #7) and discharge status (Resident #100) for 3 of 26 sampled residents. The findings included:	F 641	F641 Process that led to the deficiency cited: The MDS nurses failed to accurately code the MDS in areas of medication, active diagnosis and discharge status. Procedure for implementing plan of correction:	5/1/18

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F 641	Continued From page 9 1. Resident #58 was admitted to the facility on 9/6/17 with multiple diagnoses that included atrial fibrillation. A review of Resident #58 ' s February 2018 physician's orders included Eliquis (anticoagulant medication) 2.5 milligrams (mg) twice daily for atrial fibrillation. The quarterly Minimum Data Set (MDS) assessment dated 2/20/18 indicated Resident #58's cognition was moderately impaired and she had an active diagnosis of atrial fibrillation. Section N, Medications, indicated Resident #58 had not received anticoagulant medication during the 7-day MDS review period (2/14/18 through 2/20/18). Section N of Resident #58 ' s 2/20/18 MDS was completed by Nurse Unit Manager (UM) #2. A review of the February 2018 Medication Administration Record (MAR) for Resident #58 indicated she received Eliquis on 7 of 7 days during the 2/20/18 MDS review period (2/14/18 through 2/20/18). An interview was conducted with Nurse Unit UM #2 on 4/12/18 at 8:50 AM. Section N of the MDS dated 2/20/18 for Resident #58 that indicated she had not received anticoagulant medication during the 7-day MDS review period was reviewed with Nurse UM #2. The February 2018 MAR that indicated Resident #58 had received Eliquis on 7 of 7 days during the 2/20/18 MDS review period (2/14/18 through 2/20/18) was reviewed with Nurse UM #2. She reviewed the record and confirmed this 2/20/18 MDS for Resident #58 was coded incorrectly for anticoagulant medication. Nurse UM #2 revealed she had made an error.	F 641	MDS for Resident #58 was corrected and resubmitted 4/13/18. MDS for Resident #7 was corrected and resubmitted 5/1/18. MDS for Resident #100 was corrected and resubmitted 5/1/18. Education for MDS nurses regarding accuracy on the MDS including medication, diagnosis and d/c status completed 4/27/18 by Regional Director of Reimbursement. Education of Interdisciplinary Care Plan Team regarding accuracy on the MDS including medication, diagnosis and discharge status completed 4/27/18 by Regional Director of Reimbursement. Monitoring Procedure: Audit beginning 4/30/18 to include, but not limited to, accuracy of MDS as related to medication, diagnosis and discharge status will be completed by Administrator. Audit of 100% of completed assessments x 1 week then 5 randomly weekly for three weeks and 4 randomly ongoing thereafter. Results of the audit, presented by administrator, will be reviewed monthly for three months by the QAPI committee. If discrepancies are noted, further actions will be implemented. Title of person responsible for implementing plan of correction: DON and Regional Director of Reimbursement	

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F 641	Continued From page 10 An interview was conducted with the Director of Nursing on 4/12/18 at 1:47 PM. She indicated she expected the MDS to be coded accurately. 2. Resident #7 was admitted to the facility 6/28/17. Cumulative diagnoses included other symbolic dysfunction (social impairment), major depressive disorder, delirium due to known physiological condition and psychosis. A mental health consult dated 10/16/17 was reviewed and stated Resident #7 had visual hallucinations and received Risperdal (antipsychotic medication). Diagnoses noted on the consult was dementia with behavioral disturbance, insomnia and visual hallucinations. A pharmacy recommendation dated 1/16/18 indicated Resident #7 received Risperdal twice daily for delirium die to known physiological cause. The pharmacist requested a Gradual Dose Reduction (GDR) for Risperdal for Resident #7. The physician responded on 1/29/18 and declined the GDR due to return of psychosis. A review of physician orders for March 2018 revealed an order for Risperdal (antipsychotic medication) 0.25 milligrams twice a day. A quarterly Minimum Data Set (MDS) dated 4/2/18 indicated Resident #7 was cognitively intact. Further review of Section I of the quarterly MDS revealed there was not an active diagnosis indicated related to the use of an antipsychotic medication. Section N revealed Resident #7 had received an antipsychotic medication for seven days during the assessment period. On 4/11/18 at 9:20 AM, an interview was	F 641	Date when corrective action will be completed: 5/1/18	

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conducted with MDS Nurse #1 and she stated she had completed the quarterly MDS dated 4/2/18. MDS Nurse #1 said there was not a diagnosis linked to the medication Risperdal in the electronic record but she should have had an active diagnosis for the use of the medication in the physician orders and that would have been included in Section I for the use of Risperdal.

On 4/12/18 at 1:50 PM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be accurate and there should have been a diagnosis included on the MDS for the use of Risperdal.

3. Resident #100 was admitted on 2/14/18.

Resident #100's discharge Minimum Data Set (MDS) dated 2/21/18 revealed the resident had moderate difficulty with hearing and clear speech. The resident was understood and understands. The resident had a moderately impaired cognition. The resident required extensive assistance for transfers, bathing and dressing and was independent with all other activities of daily living. The resident's diagnoses were anemia, atrial fibrillation, bronchiectasis, chronic renal failure stage 4, and congestive heart failure.

Resident #100's care plan dated 2/14/18 revealed goals and interventions for personal care deficit, cardiac deficits, hearing and vision deficit, at risk for falls, potential for pain, and skin breakdown.

Facility discharge summary dated 2/22/18 revealed documentation that the resident was discharged to home with family.

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F 641	Continued From page 12 The discharge MDS dated 2/24/18 revealed Section A 2100 discharge status was coded to acute hospital. On 4/12/18 at 1:00 pm an interview was conducted with MDS Nurse #2 who stated that Resident #100 ' s discharge MDS was incorrectly coded as discharged to acute hospital. The resident was discharged to home and the MDS would be corrected. On 4/12/18 at 3:00 pm an interview was conducted with the Director of Nursing (DON). The DON stated that she expected the MDS to be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		4/30/18

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F 656	Continued From page 13 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident and staff interviews, the facility failed to implement the resident's comprehensive care plan for padded side rail to prevent injury for 1 of 4 residents reviewed for choices (Resident #60). Resident #60 was admitted on 9/22/15. Resident #60 ' s quarterly Minimum Data Set (MDS) dated 2/21/18 revealed the resident had moderate difficulty hearing, clear speech and was usually understood and understands. The resident had a moderate cognitive deficit. The resident required extensive assistance of two persons for all transfers and one person for all other activities of daily living except meals were set-up. The resident's diagnoses were	F 656	F656 Process that led to the deficiency cited: Padding to side rail was removed from care plan prior to discussion with the interdisciplinary team. Procedure for implementing plan of correction: Padding to side rail discussed with resident #60, resident declined padding on 4/30/18. Education has been provided to the MDS nurses that care plan revisions shall not be made by the MDS nurse without prior discussion with the interdisciplinary team. MDS nurses education, separate from	

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F 656	Continued From page 14 paraplegia, cancer of the bone, Vitamin D and nutritional deficiency, insomnia, potential for skin breakdown, and chronic pain. Resident #60's care plan dated 2/21/18 revealed the resident had goals and interventions for preferred to remain in bed, right bedside rail to be padded, bilateral arm sleeves, and elbow protectors to prevent skin breakdown. On 4/10/18 at 12:30 pm an interview was attempted with the resident. The resident had occasionally garbled communication with limited ability to make his needs known. The resident was able to nod his head no to the question if he had any care concerns or ability to make his needs known and he indicated no. On 4/10/18 at 12:30 pm an observation was done of Resident #60. He was alert sitting up in his bed before lunch. The resident was wearing his protective arm sleeves and elbow pads. The right bedside rail was not padded and was against the wall. The resident was wearing his heel boot and the nurse checked the skin. The resident was wearing his knee brace and the nurse entered to remove it as ordered. On 4/10/17 at 3:30 pm an interview was conducted with Nurse #2 who stated she was regularly assigned to Resident #60. Nurse #2 stated she was not aware that the resident had a care plan intervention for a right-sided padded side rail to prevent skin tears. Nurse #2 stated that currently the resident did not have a pad on his right-side bed rail. On 4/11/18 at 12:45 pm an interview was conducted with MDS Nurse #2 who stated that	F 656	and in addition to IDT regarding Care Revisions as presented by Regional Director of Reimbursement on 4/27/18. Monitoring Procedure: Care plan revisions are to be discussed at am clinical meetings and/or weekly risk meeting. Revisions to care plans will be audited starting 4/30/18 by the Administrator daily for four weeks then 5 random per week for 2 months. Results of the audit will be reviewed monthly for three months by the QAPI committee, as presented by administrator. If discrepancies are noted, further actions will be implemented. Title of person responsible for implementing plan of correction: Administrator and Regional Reimbursement Date when corrective action will be completed: 4/30/18	

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F 656	Continued From page 15 the resident was care planned for padding on the right-side rail to protect the resident's fragile skin. MDS Nurse #2 stated that she removed the padded side rail from the resident ' s care plan intervention today because the padding was not in place. Nurse #2 stated that she did not assess the resident whether he needed the padding on the side rail and had not asked the assigned nurse if she had assessed the resident or thought the resident could go without the padding on the side rail. MDS Nurse #2 further stated that she would check with the assigned nurse. A review of the nurses' notes for the past 30 days revealed there was no evaluation for use of the right bedside rail pad documented. On 4/11/18 at 12:50 pm an observation was done of Resident #60. The resident was lying on an air mattress bed with the right-side rail up and the right side of the bed was against the wall. The resident's size filled the bed and his right arm reached the rail. The rail was not padded. The resident had protective sleeves on his arms and elbow pads on due to a prior history of skin tears and bruises. The resident ' s right arm could also reach the wall through the opening in the rail. On 4/12/18 at 3:00 pm an interview was conducted with the Director of Nursing (DON). The DON stated she expected the staff to implement the comprehensive care plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		5/1/18

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F 657	Continued From page 16 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to revise the care plan for 1 (Resident #10) 2 residents reviewed for pressure ulcers and positioning device, and 1 (Resident #40) of 3 residents reviewed for range of motion. The facility also failed to revise the care plan for 1 (Resident #7) of 5 residents reviewed for unnecessary medications. The findings included: 1.Resident #10 was admitted to the facility on 2/11/16 with Postural Kyphosis (excessive outward curve of the upper spine), chronic pain,	F 657	F657 Process that led to the deficiency cited: Failure to update resident care plans to reflect current status as related to device application and/or removal. Procedure for implementing plan of correction: Care Plan updated, by MDS nurse, for Resident #10 to include padded back and lateral support in wheelchair on 4/12/18. Care Plan updated, by MDS nurse, for Resident #40 to reflect discontinuance of	

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F 657	Continued From page 17 Osteoporosis and Anemia. The quarterly Minimum Data Set (MDS) dated 1/7/18 indicated Resident #10 had severe cognitive impairments and was coded for physical behaviors with rejection of care. Resident #10 was coded as non-ambulatory and a wheelchair her mobility device. Resident #10's care plan was last revised 3/1/18 to include the resident had an open area to her left upper back. There was no mention of Resident #10's wheelchair with the padded back rest, the wheelchair seat cushion and no mention of a right lateral support device to her wheelchair. Interview on 4/10/18 at 2:40 PM, Nursing Assistant (NA) #6 stated Resident #10 had a cushion to her wheelchair to sit on and therapy added a right side lateral support several months ago to prevent her from leaning to the right. NA #6 stated she followed the electronic Kardex to know what task and interventions were needed for Resident #10. Observation on 4/11/18 at 4:25 PM revealed Resident #10 was sitting in her wheelchair made with a padded back rest, a wheelchair seat cushion and leaning on a padded right lateral support device. Observation on 4/12/18 at 8:35 AM, Resident #10 was sitting up in her wheelchair with the padded back rest and sitting on a wheelchair seat cushion. NA #5 was assisting her with breakfast. Also observed was a padded right lateral support device to her wheelchair. NA #5 stated Resident #10 got the wheelchair with the padded back rest after she developed the pressure ulcer. NA #5	F 657	elbow splints on 4/9/18. Care Plan updated, by MDS nurse, for Resident #7 to reflect discontinuance of anti-rollback 4/11/18 and dycem (non-slip matting) 5/1/18. MDS nurses education, separate from and in addition to IDT regarding Care Revisions as presented by Regional Director of Reimbursement on 4/27/18. Monitoring Procedure: Care plan revisions are to be discussed at am clinical meetings and/or weekly risk meeting. Revisions to care plans will be audited starting 4/30/18 by the Administrator daily for four weeks than 5 random per week for 2 months. Results of the audit, as presented by administrator, will be reviewed monthly for three months by the QAPI committee. If discrepancies are noted, further actions will be implemented. Title of person responsible for implementing plan of correction: Administrator and Regional Director of Reimbursement Date when corrective action will be completed: 5/1/18	

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stated therapy added the right lateral support device sometime last fall. NA #5 stated she followed the electronic Kardex to know how to care for Resident #10.

Review of the undated electronic Kardex for Resident #10 made no mention of the padded back rest wheelchair, the wheelchair seat cushion, or the right lateral support device to her wheelchair.

Interview on 4/12/18 at 9:00 AM, MDS Nurse #2 stated she forgot to care plan Resident #10's for the wheelchair with the padded back rest and the right lateral support device. MDS Nurse #2 stated she did not care plan the wheelchair seat cushion because all residents had wheelchair seat cushion. She stated if an intervention was added to the care plan, it would be populated to the electronic Kardex. MDS Nurse #2 stated therapy added the right lateral support in November 2017 to Resident #10's wheelchair to prevent her from leaning.

Interview on 4/12/18 at 9:50 AM, the Rehabilitation Director stated the wheelchair with the padded back rest was ordered and given to Resident #10 sometime in June 2017 and the padded right lateral support device was added to Resident #10's wheelchair November 2017.

Interview on 4/12/18 at 1:50 PM, the Director of Nursing stated it was her expectation that Resident #10's current care plan would have been revised to include the wheelchair with the padded back rest and the right lateral support device to her wheelchair. She stated it these interventions were care planned, they would have appeared on the electronic Kardex.

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2. Resident #40 was admitted to the facility on 1/8/13 and readmitted 4/5/17 with cumulative diagnoses of contractures and Paraplegia.

Review of Resident #40's medical record indicated there was an occupational evaluation dated 11/13/17 with recommendation for his bilateral elbow splints to be applied for 2 hours in the morning and 2 hours in the afternoon. This order was discontinued on 11/14/17 due to Resident #40's refusal to wear the elbow splints.

Resident #40's annual Minimum Data Set (MDS) dated 1/28/18 indicated he was cognitively intact with verbal behaviors and required total assistance with all of the activities of daily living. He was coded as having impairments to his bilateral upper extremities.

Resident #40's care plan for risk of skin breakdown, last revised on 4/9/18, indicated he was at risk for skin impairment related to his contractures. The care plan included the intervention of elbow splints as ordered.

During an interview on 4/10/18 at 2:40 PM, Nursing Assistant (NA) #6 stated Resident #40 refused to wear his bilateral elbow splints. NA #6 stated she used the electronic Kardex to know what interventions and devices were ordered for Resident #40.

During an interview on 4/10/18 at 2:50 PM, NA #5 stated Resident #40 refused to wear his bilateral elbow splints. She stated she thought the splints were discontinued. NA #5 stated she used the electronic Kardex to know what interventions and

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devices were ordered for Resident #40.

Review of the undated electronic Kardex for Resident #40 read he was to wear bilateral elbow splints as ordered.

During an interview on 4/10/18 at 3:30 PM, MDS Nurse #2 stated Resident #40's refused to wear his elbow splints and they were discontinued. She stated the intervention for the elbow splints should have been removed from the revised care plan and electronic Kardex.

During an interview on 4/11/18 at 10:00 AM, Resident #40 stated he had not been wearing the elbow splints in several months. He stated he did not like them so they were discontinued.

Interview on 4/12/18 at 1:50 PM, the Director of Nursing stated it was her expectation that Resident #40's care plan and electronic Kardex be updated to include that the intervention regarding the elbow splint has been discontinued.

3. Resident #7 was admitted to the facility 6/28/17. Cumulative diagnoses included muscle weakness, unsteadiness on feet, major depressive disorder and dementia without behavioral disturbance.

A quarterly Minimum Data Set (MDS) dated 4/2/18 indicated Resident #7 was cognitively intact. Section J1700 for falls indicated Resident #7 had one fall with no injury since admission or prior assessment.

Medical record review revealed Resident #7 had one fall since the last MDS assessment dated

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1/4/18. The fall occurred on 3/30/18.

A care plan dated 7/12/17 and last reviewed on 4/2/18 stated Resident #7 had an actual fall and was at risk for falls related to decreased mobility, weakness, history of falls and short and long-term memory deficit. Interventions included, in part, anti-rollbacks (devices that will stop any wheelchair from rolling backwards at any time) on wheelchair initiated 8/24/17 and non-slip matting in wheelchair initiated 4/2/18.

On 4/11/18 at 9:00 AM, an observation of Resident #7 was conducted. She was alert and oriented at the time of the interview. Resident #7 was sitting on the edge of her bed with her wheelchair in front of her. No anti-rollback devices were on the wheelchair. There was a cushion in her wheelchair. There was no non-slip matting noted on top of the cushion or under the cushion. Resident #7 stated she only had the cushion for her chair and nothing else.

On 4/11/18 at 9:20 AM, an interview was conducted with MDS Nurse #1. MDS Nurse #1 stated she talked to staff and did visual observations when she was reviewing/ updating the care plan quarterly. The care plan was updated by the MDS nurse at the time the MDS assessments were completed. She said she was new to the position/ facility and had only been at the facility for a few weeks. MDS Nurse #1 stated she had removed the anti-rollbacks for the wheelchair 4/11/18 because she had looked at the wheelchair on the morning of 4/11/18 and saw they were not on the wheelchair. She did not know if the non-slip matting was still being used on the wheelchair.

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F 657	Continued From page 22 On 4/11/18 at 9:20 AM, MDS Nurse #2 checked Resident #7 ' s wheelchair and said the non-slip matting was not being used on the wheelchair. MDS Nurse #1 and MDS Nurse #2 stated the care plan should reflect a current picture of the resident and the anti-rollback tippers and non-slip matting should have been removed from the care plan. Both stated they were responsible for updating the care plans. They did not know when the anti-rollback tippers and non-slip matting was discontinued. On 4/11/18 at 5:10 PM, an interview was conducted with the Director of Nursing who stated they had a weekly falls meeting and, if a fall occurred, it would also be discussed in the morning meeting the next day. Interventions would be reviewed at that time and MDS staff would put the interventions on the care plan. Also, at the weekly meeting, falls were discussed and there was a review to make sure all interventions were in place, interventions were appropriate and on the care plan. She said the MDS staff was included in the falls meetings held weekly. On 4/12/18 at 1:50 PM, a second interview was conducted with the Director of Nursing who stated she expected the care plan to reflect the current status of Resident #7 and the interventions for anti-tippers to the wheelchair and the use of the non-slip matting should have been removed from the care plan. She did not indicate she knew when these were discontinued.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		4/30/18

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F 658	Continued From page 23 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately transcribe a physician order for a resident to self-administer eye drops for 1 (Resident #70) of 1 residents reviewed accuracy of physician orders. The findings included: Resident #70 was admitted on 2/13/17 with cumulative diagnoses of Sarcoidosis (abnormal collection of inflammatory cells that affect multiple areas of the body) and Diabetes. Resident #70's quarterly Minimum Data Set (MDS) dated 3/5/18 indicated he was cognitively intact, exhibited verbal behaviors and rejection of care. He was coded for extensive assistance of his activities of daily living. Review of Resident #70's April 2018 physician orders included an order dated 4/6/18 which read he may keep his Artificial Tears (drops that lubricate dry eyes) at the bedside. Review of a nursing note dated 4/6/18 at 2:55 PM read Resident #70 was given his eye drops to keep at the bedside. He was aware he could use the eye drops up to three times a day. Review of Resident #70's electronic Medication Administration Record (MAR) read orders for Artificial Tears Solution starting on 4/6/18 through 4/9/18. Instill 2 drops in both eyes every 8 hours as needed for dry eyes for 3 days then	F 658	F658 Process that led to the deficiency cited: Nurse failed to accurately transcribe a physician order for resident to self-administer eye drops Procedure for implementing plan of correction: 100% education for all licensed nurses to include unit managers, weekends and as needed nurses, on Transcription of Physician Orders, completed 4/30/18 by ADON. Monitoring Procedure: Review of new physician orders, by DON, ADON and/or unit manager, in morning clinical meeting to audit for discrepancy of physician order transcription with need for clarification by physician. Review findings will be reported by DON or ADON to QAPI monthly x 2, with further action as warranted. Title of person responsible for implementing plan of correction: DON Date when corrective action will be completed: 4/30	

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F 658	Continued From page 24 re-evaluate with the physician. If the eye was matted or draining, notify the physician. Interview on 4/11/18 at 3:10 PM, Nurse #5 stated she wrote the order dated 4/6/18 to allow eye drops at bedside and wrote the nursing note dated 4/6/18 stating she informed Resident #70 not to use the eye drops more than 3 times per day. Nurse #5 stated she entered the facility's standing orders for Artificial Tears in the electronic MAR and confirmed there was a conflict regarding the verbal physician order and what was entered on the MAR. Interview on 4/12/18 at 1:50 PM, the Director of Nursing (DON) stated it was her expectation that Resident #70's verbal orders for Artificial Tears would have been clarified and correspond with the MAR.	F 658		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interviews, the facility failed to implement interventions identified through a fall investigation's root cause analysis for 1 of 3 residents reviewed for accidents. The intervention identified the need to evaluate a	F 689	F689 Process that led to the deficiency cited: Failure to further investigate root cause to identify appropriate intervention to attempt to prevent further accidents	4/30/18

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F 689	Continued From page 25 room change to improve supervision of the resident who was located at the end of the hall and had a roommate who preferred a closed door. Resident #51 sustained a subsequent fall resulting in a C1 cervical fracture (a fracture of the first vertebrae of the neck). The findings included: Resident #51 was admitted to the facility on 6/30/15 and most recently readmitted on 8/26/16 with multiple diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction affecting left non-dominant side, unsteadiness on feet, muscle weakness, difficulty in walking, glaucoma, end stage renal disease, and dementia without behavioral disturbance. Resident #51's plan of care, initiated on 12/7/16, indicated he was at risk for falls related to decreased mobility, weakness, impaired vision, glaucoma, left hemiparesis, muscle weakness, unsteady, debility, short and long-term memory deficiency, and history of falls. The interventions included, in part: - Staff education for toileting prior to meals (initiated on 1/23/17) - Assist with toileting during care rounds and as needed (initiated on 6/30/17) The quarterly Minimum Data Set (MDS) assessment dated 10/1/17 indicated Resident #51's cognition was moderately impaired. He was assessed as requiring the extensive assistance of 1 staff with bed mobility, transfers, locomotion on the unit, dressing, eating, and personal hygiene. He was dependent on 1 staff for locomotion off the unit and bathing. Resident	F 689	Procedure for implementing plan of correction: Education of IDT on initiation of Root Cause Analysis utilizing the 5 Why□s when determining appropriate interventions as presented by Regional Director of Clinical Services in conjunction with Regional Vice President of Operations, completed 4/30/18. Beginning 5/1/18, utilize the "5 Whys" Root Cause Analysis approach with any fall that will be reviewed in morning clinical meeting on weekdays with unit manager review on weekends, to include review by IDT to ensure appropriate interventions are implemented to attempt to prevent further falls. DON, with assistance of IDT to validate interventions are implemented through visual verification, in conjunction with care plan audit. Monitoring Procedure: Audit 100% of falls weekly x 2 months to ensure implementation of appropriate interventions as determined by IDT root cause analysis then 4 monthly ongoing thereafter with results of audit reported to QAPI committee. If discrepancies are noted, further actions will be implemented. Title of person responsible for implementing plan of correction: DON Date when corrective action will be completed: 4/30/18	

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#51 was not steady on his feet and he was only able to stabilize with staff assistance. He had impairment on one side of his upper and lower extremities and utilized a wheelchair. Resident #51 was frequently incontinent of bladder and bowel (defined as 2 or more episodes of incontinence with at least one episode of continent bladder/bowel movement). He was not on a toileting program. Resident #51 was on dialysis.

A nursing note dated 11/12/17 completed by Nurse #1 indicated the Nursing Assistant (NA) went to answer a call light and upon entering Resident #51's rooms he was noted on the floor. Nurse #1 was called to the room by the NA and Resident #51 was noted to be on the floor seated in an upright position between the bed and wheelchair in the room. Resident #51 stated he was going to the bathroom and a smell of bowel movement was noted by Nurse #1. Resident #51 was assessed with no injuries, assisted to bed, and incontinence care was provided.

An incident report dated 11/12/17 completed by Nurse #1 indicated Resident #51 had an unobserved fall on 11/12/17 at 10:30 AM. He sustained no injuries from the fall. The incident report indicated Resident #51 was found on the floor between the bed and wheelchair. Resident #51 reportedly stated he was going to the bathroom. Resident #51 was noted as oriented to self, confused, impaired memory, gait imbalance, and incontinent. A predisposing situational factor indicated the door to Resident #51's room stayed closed at all times per his roommate's preference and request. The physician and Responsible Party (RP) were notified.

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The Fall Scene Investigation Report related to Resident #51's 11/12/17 fall completed by Nurse #1 was reviewed. Resident #51 was noted to be alone and unattended at the time of the fall with his assigned NA in another resident ' s room providing care. Resident #51 was last toileted at 8:00 AM and was noted to be incontinent of bladder at that time. Nurse #1 indicated, "Roommate prefers door be shut to room therefore unable to hear resident when he calls out." This investigation asked for the initial root cause analysis of the fall as identified by the staff member completing the investigation. The root cause stated, "Door closed to room, unable to hear or visually see resident. Needs [evaluation] for room change."

The incident report for Resident #51's 11/12/17 fall was updated on 11/14/17 with a note written by the Director of Nursing (DON) that stated, "Toileting before/after meals, upon awakening, and prior to bedtime."

The plan of care related to the risk for falls was updated on 11/14/17 with the intervention of toileting Resident #51 before and after meals and at bedtime.

The NA Tasks (a care guide of tasks for NAs) related to Resident #51 was updated on 11/14/17 to indicate toileting upon rising, toileting at bedtime, and toileting between meals.

The record indicated Resident #51's room was located at the end of the hall furthest away from his unit ' s nurse ' s station. Resident #51's room was not changed following the 11/12/17 fall.

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The quarterly MDS assessment dated 1/1/18 indicated Resident #51's cognition was severely impaired. He was assessed as requiring the extensive assistance of 1 staff with bed mobility, transfers, dressing, and personal hygiene. He was dependent on 1 staff for locomotion on/off the unit, eating, and bathing. Resident #51 was not steady on his feet and he was only able to stabilize with staff assistance. He had impairment on one side of his upper and lower extremities and utilized a wheelchair. Resident #51 was frequently incontinent of bladder and always incontinent of bowel. He was not on a toileting program. Resident #51 was on dialysis.

A nursing note dated 1/25/18 completed by Nurse #1 indicated she was called to Resident #51's room by an NA. Resident #51 was noted lying on his left side with a large hematoma to his left forehead. Blood was noted on the floor under his head and a laceration was noted in the hematoma. Notification was made to 911 for transfer to the Emergency Room (ER). Resident #51 was assisted to his back by 3 nurses, pillow placed under head, and ice pack applied to hematoma. The bleeding was stopped. Resident #51 was verbal during the assessment and indicated his head hurt. Emergency Medical Services (EMS) transported Resident #51 to the hospital. The physician and RP were notified.

An incident report dated 1/25/18 completed by Nurse #1 indicated Resident #51 had an unobserved fall with major injury on 1/25/18 at 3:15 PM. The incident report indicated Nurse #1 was called to Resident #51's room by NA #1. Resident #51 was noted lying on his left side with a large hematoma to left forehead. Blood was noted on the floor under his head and a laceration

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was noted in the hematoma. Resident #51 was unable to report what had happened. Resident #51 was noted as oriented to self, had impaired memory, and gait imbalance. A predisposing situational factor indicated Resident #51 was ambulating without assistance. The physician and RP were notified.

The Fall Scene Investigation Report related to Resident #51's 1/25/18 fall completed by Nurse #1 was reviewed. Resident #51 was noted to be alone and unattended at the time of the fall with his assigned NA in the shower room providing care to another resident. Resident #51 was believed to be sitting in his wheelchair prior to the fall and got up without assistance. Nurse #1 stated NA #1 was informed by a visitor that a resident was on the floor in a room at the end of the hall. NA #1 immediately found Nurse #1 to assess Resident #51.

The Emergency Department Physician Documentation dated 1/25/18 indicated Resident #51 was brought to the ER after a fall out of his wheelchair. Resident #51 hit his head, but had not lost consciousness. He was noted with a hematoma over the left side of his frontal scalp as well as a small laceration to the left forehead. A head CT (computed tomography) and CT of the C-spine (cervical spine) were obtained. There were no acute findings of the head CT, however the CT of the C-spine revealed a C1 ring fracture. The scalp wound was an abrasion and was closed with a suture. A Neurosurgery consultation conducted while Resident #51 was in the ER indicated non-operative intervention of the C1 ring fracture that included a neck collar and follow up with a Neurosurgeon.

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A nursing note dated 1/25/18 indicated Resident #51 returned from the hospital with a laceration to the forehead and a diagnosis of a C1 fracture. A C-spine collar was put in place. Resident #51 reported no pain or discomfort.

A physician's order dated 1/25/18 indicated a C-spine collar in place for Resident #51.

The plan of care related to the risk for falls was updated on 1/25/18 with the intervention of Resident #51 being moved to a room closer to the nurse ' s station.

The record indicated on 1/26/18 Resident #51's room was changed. He was moved from the room on his hall that was furthest from the nurse ' s station to the room on the same hall that was closest to the nurse's station.

The incident report for Resident #51 ' s 1/25/18 fall was updated on 1/26/18 with a note written by the DON that stated, "Ice pack and dressing applied to stop bleeding. EMS called for transport to ER. Returned with C1 fracture and collar in place...moved to room closer to nurse's station ...had received incontinent care 30 minutes prior to the fall."

A Neurosurgery consultation note dated 1/30/18 indicated this was a follow up for a C1 fracture Resident #51 sustained after a fall on 1/25/18. The treatment plan included wearing a cervical collar 24 hours per day for 12 weeks. Resident #51 was to follow up with the neurosurgeon for an assessment of healing at the conclusion of the 12 weeks.

A physician's order dated 1/30/18 indicated

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Resident #51 was to wear the cervical collar at all times for 12 weeks.

An observation was conducted of Resident #51 on 4/9/18 at 11:56 AM. Resident #51's room was located in close proximity to the nurse ' s station and the door to his room was open. He was in his room seated in his wheelchair wearing a cervical collar.

An interview was conducted with the DON on 4/11/18 at 8:35 AM. The incident report and Fall Scene Investigation Report for Resident #51's 11/12/17 fall were reviewed with the DON. Nurse #1 ' s root cause analysis of this fall that stated, "Door closed to room, unable to hear or visually see resident. Needs [evaluation] for room change" was reviewed with the DON. The DON reported she had reviewed this Fall Scene Investigation Report and Nurse #1 ' s root cause analysis after Resident #51's 11/12/17 fall. She revealed she had not evaluated Resident #51 for a room change after the 11/12/17 fall as recommended by Nurse #1. She stated she instead implemented the intervention of toileting Resident #51 before meals, after meals, upon awakening, and prior to bedtime. The DON was asked how these interventions differed from Resident #51's care plan interventions for toileting that had been in place prior to the 11/12/17 fall (toileting prior to meals, initiated on 1/23/17; toileting during care rounds, initiated on 6/30/17) and she indicated the timing of the toileting was now on a more specific schedule and it was added to the NA Tasks to be checked off after completion. The DON was asked why Resident #51 had not been evaluated for a room change after the 11/12/17 fall as recommended by Nurse #1. She reported she felt the cause of the fall

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was related to toileting as Resident #51 was incontinent when he was assessed by staff after the fall. She additionally reported it was not always simple to change rooms as there was not always another room available and/or if the resident or RP had not wanted the resident to be moved. The DON was asked if Resident #51 or his RP were asked about a room change and she indicated they were not, as she had not felt this was a contributing factor to the fall.

This interview with the DON continued. The incident report and Fall Scene Investigation Report for Resident #51's 1/25/18 fall in which he sustained a cervical fracture were reviewed with the DON. The intervention of Resident #51 being moved to a room closer to the nurse's station was reviewed with DON. The DON was asked why this intervention was implemented for the 1/25/18 fall. She indicated that changing Resident #51's room increased his visibility to staff as the door to his room could remain open as well as there being increased foot traffic going past the new room because it was close to the nurse's station.

An interview was conducted with Nurse #1 on 4/11/18 at 10:09 AM. Nurse #1 stated she had worked at the facility for about a year and she worked with Resident #51 frequently. The incident report and Fall Scene Investigation Report for Resident #51's 11/12/17 fall were reviewed with Nurse #1. Her analysis of the root cause of the fall that stated, "Door closed to room, unable to hear or visually see resident. Needs [evaluation] for room change" was reviewed with Nurse #1. Nurse #1 was asked to explain how she developed her root cause of the 11/12/17 fall for Resident #51. She stated at the time of the 11/12/17 fall, Resident #51 resided in

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a room at the far end of the hall (furthest from the nurse's station) with a roommate who preferred to keep the door to the room closed at all times. She explained that because the door to the room was always closed, visual checks were limited as well as the ability to hear Resident #51 if he called out verbally. Nurse #1 additionally explained that Resident #51 rarely used his call bell and if he needed assistance he would call out. She indicated in the instance of the 11/12/17 fall it was Resident #51's roommate who had pressed his call bell to alert staff that Resident #51 had fallen. She reported if the call bell had not been pressed by Resident #51's roommate it would have been difficult for staff to hear Resident #51 call out for assistance with the door to the room being shut. She also pointed out that because his room was at the end of the hall there was less foot traffic going past that room than the rooms that were closer to the nurse ' s station. Nurse #1 revealed Resident #51 ' s room was not changed following the 11/12/17 fall. She stated after she completed the Fall Scene Investigation Report it was given to the DON. She reported it was the DON who had the final call as to what interventions were implemented. The interventions of toileting Resident #51 before meals, after meals, upon awakening, and prior to bedtime that were implemented after the 11/12/17 fall were reviewed with Nurse #1. Nurse #1 was asked how these interventions differed from Resident #51 ' s care plan interventions that had already been in place for toileting (toileting prior to meals, initiated on 1/23/17; toileting during care rounds, initiated on 6/30/17). She indicated that the NAs had already been checking on Resident #51 ' s toileting needs about every 2 hours during their normal care rounds, but these interventions had been added to the NA Tasks which required

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the NA to document their completion following the 11/12/17 fall.

This interview with Nurse #1 continued. The incident report and Fall Scene Investigation Report for Resident #51's 1/25/18 fall in which he sustained cervical fracture were reviewed with Nurse #1. She stated she had been in a meeting when NA #1 came and informed her Resident #51 had fallen. She indicated it was a visitor who had informed NA #1 that she saw Resident #51 on the floor in his room. She stated the door to the room happened to be open at the time of this 1/25/18 fall. She reported it appeared Resident #51 had attempted to get up from his wheelchair unassisted and fell head first onto the floor.

An interview was conducted with NA #2 on 4/11/18 at 10:52 AM. NA #2 stated she had worked at the facility for about 15 years and was familiar with Resident #51. She stated he required assistance with toileting at the time of 11/12/17 fall through present. She indicated Resident #51 was checked for toileting needs about every 2 hours.

An interview was conducted with Nurse Unit Manager (UM) #1 on 4/11/18 at 2:00 PM. She stated she had worked at the facility for 21 years and had been in her position as UM for about 3 months. Nurse UM #1 was asked who was responsible for completing incident reports and root cause analyses for falls. She stated it was the nurse that was assigned to the resident at the time of the fall as she was normally the staff member who was most familiar with the resident.

An interview was conducted with NA #1 on 4/11/18 at 3:05 PM. She stated she began

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working at the facility in January 2018 and she had been working with Resident #51 since the end of January following his room change on 1/26/18. She reported she was working on 1/25/18 when a facility visitor had informed her she saw Resident #51 on the floor of his room. NA #1 indicated she had not been assigned to Resident #51 at the time of the fall, but she had immediately found Nurse #1 and informed her of Resident #51 being seen on the floor of his room.

An interview was conducted with NA #3 on 4/11/18 at 3:15 PM. She stated she had worked at the facility for over 2 years and she had worked with Resident #51 on several occasions. She indicated when she worked with Resident #51 she checked on him about every 2 hours and offered to toilet him. NA #3 reported she recalled no change in Resident #51's toileting schedule before or after his 11/12/17 fall.

A phone interview was conducted with NA #4 on 4/11/18 at 3:50 PM. She stated she had worked at the facility for 3 years and she was very familiar with Resident #51. She indicated she recalled Resident #51's 11/12/17 fall and his 1/25/18 fall. NA #4 stated there was no change in Resident #51's toileting schedule after the 11/12/17 fall. She indicated he was checked on during care rounds which were about every 2 hours. NA #4 reported at the time of both falls (11/12/17 and 1/25/18), Resident #51 resided in a room at the end of the hall (furthest from the nurse's station) with a roommate who preferred to keep the door shut. She stated because the door was always kept closed she was unable to see Resident #51 just by walking by the room. She additionally stated that because Resident #51's room was at the end of the hall there was less staff walking by

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F 689	Continued From page 36 the room. NA #4 revealed she believed Resident #51's room should have been changed prior to the 1/25/18 fall so he was more visible to staff. An interview was conducted with the SDC on 4/12/18 at 9:00 AM. The SDC was asked to explain the purpose of Fall Scene Investigation Reports and root cause analyses. She indicated the purpose was to evaluate the circumstances surrounding the fall, try to identify specific risks, and to develop new interventions based on the identified risks to prevent future incidences. She stated it was important to speak to the resident's nurse and/or NA to get their opinion on the cause of the fall as they were most familiar with the resident. A follow up interview was conducted with the DON on 4/12/18 at 1:47 PM. The DON was asked to explain the purpose of Fall Scene Investigation Reports and root cause analyses. She stated the purpose was to try to identify the cause of the resident's fall, analyze the risks, develop interventions based on the risks, and implement those interventions with the hope of preventing any future incidences. The DON revealed she expected the root cause analysis to be utilized in the development of new interventions.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		4/30/18

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F 695	Continued From page 37 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident and staff interviews, the facility failed to provide the correct dose of oxygen liters which resulted in the potential for respiratory distress for 3 of 4 residents observed for oxygen administration (Residents #28, #30, and #45). The findings include: 1. Resident #30 was admitted on 9/24/17. Resident #30's quarterly Minimum Data Set dated 3/18/18 revealed the resident had minimal difficulty hearing, clear speech and understands and was understood. The resident had an intact cognition. The resident required extensive assistance of one person for personal care and was independent with meals after set-up. The diagnoses were heart failure, hypertension, anxiety, chronic obstructive pulmonary disease, respiratory failure, and was dependent on oxygen. Resident #30 had a care plan dated 3/30/18 with goals and interventions for cardiac and respiratory disease. Physician order dated 4/3/18 revealed oxygen 2 liters per nasal cannula. On 4/9/18 an observation was done of Resident #30 at 9:30 am 10:25 am and 11:15 pm which revealed Resident #30's oxygen regulator was set at 1.5 liters flow by nasal cannula with humidification.	F 695	F695 Process that led to the deficiency cited: Nurse failed to observe oxygen concentrator at eye level to ensure that oxygen was administered at rate per physician order. Procedure for implementing plan of correction: 100% education for licensed nurses to observe oxygen concentrator at eye level to ensure that oxygen rate is per physician order, completed by ADON 4/30/18. Monitoring Procedure: Audit by unit manager of residents receiving oxygen to validate receiving oxygen per ordered rate on oxygen concentrator by observing at eye level. Audit of 5 daily x one week, then 5 weekly x 8 weeks with results of audit reported by DON or ADON to QAPI committee monthly x 2. If discrepancies are noted, further actions will be implemented. Title of person responsible for implementing plan of correction: DON Date when corrective action will be completed: 4/30	

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F 695	Continued From page 38 On 4/9/18 at 11:25 am an interview was conducted with the Staff Development Coordinator (SDC) and she was asked to examine Resident #30 ' s oxygen concentrator. The SDC thought the concentrator was set at 2 liters from a standing position while looking down at the oxygen concentrator regulator. The SDC was asked to bend and look horizontal, eye level to the oxygen concentrator regulator and stated she could then see that the oxygen flow was only at 1.5 liters. The SDC increased the oxygen flow to 2 liters. On 4/9/18 at 11:28 am Resident #30 was interviewed and had stated she was a little short of breath. Her pulse oximetry was 94%. The resident stated that her oxygen was ordered for 2 liters and she was unaware of any change. On 4/9/17 at 11:55 pm an interview was conducted with Nurse #2 who stated that she was not aware that the oxygen regulator on the concentrator appeared to be at 2 liters when standing over the machine looking down. Nurse #2 stated that when she observed the regulator horizontally at eye level she could see that the flow was not 2 liters. Nurse #2 stated that she would adjust the flow to administer 2 liters. On 4/9/17 at 12:30 pm the Director of Nursing (DON) was informed of the three oxygen concentrator regulators observed that were not dialed to the correct administration. The DON stated that she expected the oxygen to be administered as ordered. 2. Resident #28 was admitted on 10/23/17.	F 695		

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Resident #28 ' s quarterly Minimum Data Set dated 3/25/18 revealed the resident had adequate hearing, clear speech and understands and was understood. The resident had an intact cognition. The resident required extensive assistance of one person for transfer and activities of daily living and was independent with meals after set-up. The resident's diagnoses were hypertension and atrial fibrillation.

Resident #28's care plan dated 3/25/18 revealed goals and interventions at risk for nutrition and hydration deficit, at risk for pain, and cardiac deficit.

Physician order dated 4/9/10 revealed oxygen 2 liters per minute by nasal cannula

On 4/9/18 at 11:30 am Resident #28 was observed at rest in his bed. He was alert and calm and was wearing his nasal cannula. Respirations were even and unlabored and he was without shortness of breath. The oxygen concentrator was set at 1.5 liters per minute when viewed at horizontal, eye level.

On 4/9/18 at 11:30 am an interview was conducted with Resident #28. The resident stated that he was to receive 2 liters of oxygen and was not aware of a change to the order.

On 4/9/17 at 11:55 pm an interview was conducted with Nurse #2 who stated that she was not aware that the oxygen regulator on the concentrator appeared to be at 2 liters when standing over the machine looking down. Nurse #2 stated that when she observed the regulator horizontally at eye level she could see that the flow was not 2 liters. Nurse #2 stated that she

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F 695	Continued From page 40	F 695		

would adjust the flow to administer 2 liters.

On 4/9/17 at 12:30 pm the Director of Nursing (DON) was informed of the three oxygen concentrator regulators observed that were not dialed to the correct administration. The DON stated that she expected the oxygen to be administered as ordered.

3. Resident #45 was admitted on 10/24/16.

Resident #45's quarterly Minimum Data Set dated 2/9/18 revealed the resident had adequate hearing, clear speech and understood and understands. The resident had an intact cognition. The resident required 2-person extensive assistance for transfer, 1-person extensive assistance for activities of daily living, and set up for meals. The resident's diagnoses were heart failure, anemia, hypertension, anxiety, chronic pain, and coronary artery disease.

The resident's care plan dated 2/4/18 revealed goals and interventions for hydration potential deficit, history of pneumonia, and cardiac and respiratory deficits.

The physician order dated 4/9/18 revealed oxygen 2 liters by nasal cannula.

On 4/9/18 at 11:45 am Resident #45 was observed in her room sitting in the wheel chair. She was alert and oriented and was wearing her nasal cannula. Respirations were even and unlabored and she was without shortness of breath. The oxygen concentrator was set at 1.5 liters per minute when viewed at horizontal eye level.

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F 695	Continued From page 41 On 4/9/18 at 11:45 am an interview was conducted with Resident #45. The resident stated that she was to receive 2 liters of oxygen and was not aware of a change to the order. On 4/9/17 at 11:55 pm an interview was conducted with Nurse #2 who stated that she was not aware that the oxygen regulator on the concentrator appeared to be at 2 liters when standing over the machine looking down. Nurse #2 stated that when she observed the regulator horizontally at eye level she could see that the flow was not 2 liters but lower. Nurse #2 stated that she would adjust the flow to administer 2 liters. On 4/9/17 at 12:30 pm the Director of Nursing (DON) was informed of the three oxygen concentrator regulators observed that were not dialed to the correct administration. The DON stated that she expected the oxygen to be administered as ordered.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		4/30/18

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F 755	Continued From page 42 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to stock resident designated insulin when needed for 3 of 6 residents observed for the medication pass (Residents #86, #97, and #95). Findings include: 1. Resident #86 was admitted on 3/12/18. Resident #86's 14-day Minimum Data Set dated 3/26/18 revealed the resident had adequate hearing, clear speech, and was understood and understands. The resident had an intact cognition. The resident required limited assistance of 1 person for all activities of daily living except ambulation was supervision and meals were set up. The diagnosis was diabetes mellitus. Physician order dated 3/12/18 revealed Humalog	F 755	F755 Process that led to the deficiency cited: Nurse failed to re-order insulin. Procedure for implementing plan of correction: 100% education for all licensed nurses regarding ordering and re-ordering of medication, completed by ADON 4/30/18. Monitoring Procedure: Licensed nurse as assigned is responsible for auditing for medication availability by utilizing a visual MAR to Cart check every week for eight weeks. Audits will be reviewed by DON and/or ADON, with results of audit reported to QAPI committee monthly x 2.	

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F 755	Continued From page 43 insulin subcutaneous administered per sliding scale before meals and at bedtime. On 4/10/18 at 4:40 pm an observation was done of medication pass with Nurse #4. Nurse #4 was observed to check the blood glucose of Resident #86 and administered Humalog insulin 10 units sliding scale to the resident from Resident #93 ' s Humalog multi-dose insulin vial that was accessed/used. She indicated that was not her usual process to share multi-dose insulin vials but Resident #86 had no Humalog insulin available, and she went on "we are not supposed to share insulin vials" between residents. Nurse #4 complained that the nurse who used the last of Resident #86 ' s insulin was required to follow the facility process and order more from the pharmacy. On 4/10/18 at 5:10 pm an interview was conducted with Nurse #4 who stated the process for ordering medication. The nurse that used the last dose was required to reorder medication using a carbon order form and fax to the pharmacy (demonstrated). Nurse #4 stated that not having medication made medication pass difficult and this was not the first time. Humalog insulin was not kept in general stock. Nurse #4 indicated that she would inform the Director of Nursing (DON) so the nurse who used the last dose could be reeducated. On 4/11/17 at 8:45 am an interview was conducted with the DON. The DON stated she was informed that Nurse #4 used the multi-dose insulin vial of Resident #93 for Resident #86. The DON stated that she expected staff to order medication at the time it is finished or getting low. The DON further stated that she expected staff	F 755	If discrepancies are noted, further actions will be implemented. Title of person responsible for implementing plan of correction: DON and ADON Date when corrective action will be completed: 4/30/18	

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F 755	Continued From page 44	F 755		

not to share multi-dose vials of insulin dedicated to the resident. The DON planned to keep stock insulin in the future as back up.

4/11/18 at 4 pm an interview was conducted with the pharmacy consultant. The consultant stated that use of an insulin multi-dose vial for a resident other than was prescribed could have caused medication error. The consultant expected the staff to order insulin before it ran out and not to share multi-dose insulin vials between residents.

2. Resident #97 was admitted on 3/26/18.

Resident #97's admission MDS dated 4/2/18 revealed the resident had adequate hearing and wore a hearing aid, usually had clear speech, and was usually understood and understands. The resident had an intact cognition. The resident required extensive assistance of 2 persons for all transfers and bed mobility and one person for personal care and meals. The diagnosis was diabetes.

Physician order dated 3/26/18 revealed Humalog insulin subcutaneous administered per sliding scale before meals and at bedtime.

On 4/10/18 at 4: 55 pm an observation was done of medication pass with Nurse #4. Nurse #4 was observed to check the blood glucose of Resident #97. The resident was due Humalog insulin and there was none available for the resident. Nurse #4 looked in the medication storage and there was no general stock Novolog insulin available. Nurse #4 called the nurse practitioner and obtained a hold order until the pharmacy could send a stat Novolog insulin vial.

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On 4/10/18 at 5:10 pm an interview was conducted with Nurse #4 who stated the process for ordering medication. The nurse that used the last dose was required to reorder medication using a carbon order form and fax to the pharmacy (demonstrated). Nurse #4 stated that not having medication made medication pass difficult and this was not the first time. Humalog insulin was not kept in general stock. Nurse #4 stated that she would inform the Director of Nursing (DON) so the nurse who used the last dose could be reeducated.

On 4/11/17 at 8:45 am an interview was conducted with the DON. The DON stated she was informed that Nurse #4 used the multi-dose insulin vial of Resident #93 for Resident #86. The DON stated that she expected staff to order medication at the time it is finished or getting low. The DON further stated that she expected staff not to share multi-dose vials of insulin dedicated to the resident. The DON planned to keep stock insulin in the future as back up.

4/11/18 at 4 pm an interview was conducted with the pharmacy consultant. The consultant stated that use of an insulin multi-dose vial for a resident other than was prescribed could have caused medication error. The consultant expected the staff to order insulin before it ran out and not to share multi-dose insulin vials between residents.

3. Resident #95 was re-admitted on 3/16/18.

Resident #95's re-admission Minimum Data Set dated 3/16/18 revealed the resident had adequate hearing, clear speech, and was understood and understands. The resident had an intact cognition and required extensive assistance of

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one person for transfer and limited assistant for the remaining activities of daily living with set up for meals. The diagnoses were diabetes mellitus and the resident received insulin for 7 days.

Physician order dated 3/16/18 revealed Lispro insulin subcutaneous administered per sliding scale before meals and at bedtime.

On 4/10/18 at 5:00 pm an observation was done of medication pass with Nurse #4 who attempted to administer Lispro insulin sliding scale to Resident #95 but there was none available. Nurse #4 returned to the phone and obtained an order from the nurse practitioner for medication hold and to obtain Lispro insulin stat from the pharmacy.

On 4/10/18 at 5:10 pm an interview was conducted with Nurse #4 who stated the process for ordering medication. The nurse that used the last dose was required to reorder medication using a carbon order form and fax to the pharmacy (demonstrated). Nurse #4 indicated that not having medication made medication pass difficult and this was not the first time. Lispro insulin was not kept in general stock. Nurse #4 would inform the DON so the nurse who used the last dose could be reeducated.

On 4/11/17 at 8:45 am an interview was conducted with the DON. The DON stated she was informed that Nurse #4 used the multi-dose insulin vial of Resident #93 for Resident #86. The DON stated that she expected staff to order medication at the time it is finished or getting low. The DON further stated that she expected staff not to share multi-dose vials of insulin dedicated to the resident. The DON planned to keep stock

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F 755	Continued From page 47 insulin in the future as back up. 4/11/18 at 4 pm an interview was conducted with the pharmacy consultant. The consultant stated that use of an insulin multi-dose vial for a resident other than was prescribed could have caused medication error. The consultant expected the staff to order insulin before it ran out and not to share multi-dose insulin vials between residents.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to	F 756		4/30/18

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AUTUMN CARE OF BISCOE	401 LAMBERT ROAD BISCOE, NC 27209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 48 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Pharmacy Consultant interview, the Pharmacy Consultant failed to identify and address the use of an antibiotic prescribed on an indefinite basis and without an adequate clinical indication for use for 1 of 1 residents reviewed for antibiotic usage (Resident #72). The findings included: Resident #72 was admitted to the facility on 3/6/18 with multiple diagnoses that included Alzheimer' s disease. The admission Minimum Data Set (MDS) assessment dated 3/13/18 indicated Resident #72 was rarely/never understood and rarely/never understands. She was assessed with short term memory problems, long term memory problems, and severely impaired decision making. A review of Resident #72 ' s history and physical submitted to the facility for her 3/6/18 admission included a Nurse Practitioner note dated 2/28/18. The note indicated a diagnosis of cellulitis of the right ankle for Resident #72. The NP ' s plan for treatment included Doxycycline (antibiotic	F 756	F756 Process that led to the deficiency cited: Nurse failed to complete an admission audit to ensure all medications have appropriate diagnosis and timeframe for medication administration. Procedure for implementing plan of correction: Facility Pharmacy Consultant was provided education by Pharmacy Clinical Manager, 4/30/18. 100% education for Unit Managers on completion of audits for admits/re-admits completed 4/30/18. 100% education with licensed nurses regarding Antibiotic Stewardship completed 4/30/18. Monitoring Procedure: Unit Manager and/or ADON is responsible for completing audits on new and re-admissions to the facility to determine stop date and clinical indication for use appropriate as to the Antibiotic Stewardship Program.	

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F 756	Continued From page 49 medication) 100 milligrams (mg) twice daily for 10 days to treat Resident #72 ' s cellulitis. A physician ' s order for Resident #72 dated 3/6/18 indicated Doxycycline Hyclate (antibiotic medication) 100 mg twice daily for wound. The duration of this antibiotic order was indicated as indefinite. Resident #72 ' s plan of care included the focus area of antibiotic therapy related to wounds. This area was initiated on 3/7/18. A Wound Care Physician ' s initial evaluation, dated 3/8/18, indicated Resident #72 was admitted to the facility with 4 unstageable pressure ulcers. Resident #72 was noted to be taking an oral antibiotic related to the unstageable pressure ulcer of the right, lateral ankle. There was no documentation of an active infection for Resident #72. The admission Minimum Data Set (MDS) assessment dated 3/13/18 indicated Resident #72 was admitted to the facility with 4 unstageable pressure ulcers. She was assessed with no infections (including no wound infections). Resident #72 was administered an antibiotic on 7 of 7 days during the MDS review period. Resident #72 ' s plan of care was updated on 3/20/18 to include the focus areas of the risk for infections related to wounds. The monthly drug regimen review, completed by the Pharmacy Consultant on 3/20/18, included no documentation related to Resident #72 ' s antibiotic prescribed on an indefinite basis and without an adequate clinical indication for use.	F 756	New physician orders audited in morning clinical meeting to ensure new antibiotics follow Antibiotic Stewardship with regards to stop date and clinical indication for use, by DON and/or ADON, with results of audit reported to QAPI committee monthly x 3. If discrepancies are noted, further actions will be implemented. Title of person responsible for implementing plan of correction: DON Date when corrective action will be completed: 4/30/18	

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F 756	Continued From page 50	F 756		

A review of the March 2018 ' s Medication Administration Record (MAR) indicated Resident #72 was administered Doxycycline Hyclate 100 mg twice daily from admission (3/6/18) through 3/31/18.

A review of the April 2018 MAR from 4/1/18 through 4/9/18 indicated Resident #72 was administered Doxycycline Hyclate 100mg twice daily. This April 2018 MAR and the April physician ' s orders for Resident #72 indicated this Doxycycline Hyclate order continued to be active as of 4/10/18 and had no stop date.

An interview was conducted with Nurse #2 on 4/10/18 at 11:53 AM. She indicated she was familiar with Resident #72. She stated she believed Resident #72 ' s Doxycycline Hyclate order was prescribed as a prophylactic (preventative) related to her wounds. Nurse #2 reviewed Resident #72 ' s record and confirmed this antibiotic was prescribed prophylactically for wound healing and had no stop date. She stated Resident #72 had no active infections since admission (3/6/18).

An interview was conducted with the Director of Nursing (DON) on 4/10/18 at 11:55 AM. She stated she was responsible for monitoring antibiotic usage at the facility. She reported it was not normal practice to utilize prophylactic antibiotics nor was it normal practice to prescribe an antibiotic with an indefinite duration. The pre-admission NP note dated 2/28/18, the physician ' s order dated 3/6/18 for Doxycycline Hyclate, the Wound Care Physician ' s note dated 3/8/18, and the March and April 2018 MARs for Resident #72 were reviewed with the DON. The DON reviewed the record and indicated Resident

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#72 was on this antibiotic prior to admission. She explained that on 2/28/18, prior to her admission to the facility, Resident #72 was ordered Doxycycline for 10 days related to cellulitis. She further explained that when Resident #72 was admitted to the facility she remained on the antibiotic, but the order was put in place indefinitely. The DON stated she was unsure why the order for the antibiotic was changed to an indefinite order. She reported she needed to look into this further.

A second interview was conducted with the DON on 4/10/18 at 5:11 PM. She stated she had again reviewed Resident #72 ' s records through present (4/10/18). She revealed Resident #72 ' s antibiotic order dated 2/28/18 (prescribed prior to her facility admission) that indicated a duration of 10 days should have been followed (stop date 3/10/18). She stated Resident #72 ' s antibiotic should not have been changed to an indefinite duration as there was no clinical indication for use beyond the 10 days noted on the 2/28/18 order.

An interview was conducted with the Pharmacy Consultant by phone on 4/11/18 at 4:05 PM. The physician ' s order dated 3/6/18 for Doxycycline Hyclate prescribed on an indefinite basis and the March and April 2018 MARs for Resident #72 were reviewed with the Pharmacy Consultant. The monthly drug regimen review completed on 3/20/18 that included no documentation of Resident #72 ' s antibiotic prescribed on an indefinite basis and without an adequate clinical indication for use was reviewed with the Pharmacy Consultant. The Pharmacy Consultant was asked if he had identified that this antibiotic for Resident #72 was prescribed on an indefinite basis and without an adequate clinical indication

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for use. He stated he needed to review his records and he scheduled a follow up interview for 4/12/18.

A follow up interview with the Pharmacy Consultant was conducted in person on 4/12/18 at 9:15 AM. The Pharmacy Consultant stated he had reviewed his records and revealed he had not identified that Resident #72 ' s antibiotic was prescribed on an indefinite basis during his monthly drug regimen review on 3/20/18. He also stated he had not identified that the antibiotic was prescribed without an adequate clinical indication for use. The Pharmacy Consultant reported the facility utilized electronic medical records. He stated that consultations, including Wound Care Physician notes, were scanned into the record. He indicated that sometimes there was delay in the scanning process. He explained that at the time of his 3/20/18 review he had noticed that Resident #72 had an order for an antibiotic, that she had wounds, and that she was being seen by the Wound Care Physician. He further explained that based on this information he assumed there was an adequate clinical indication for use of the antibiotic. He confirmed he had not noticed that there was no stop date for Resident #72 ' s antibiotic order. The Pharmacy Consultant revealed that in hindsight, he should have requested a clinical indication for use of the antibiotic as well as a stop date.

A follow up interview was conducted with the DON on 4/12/18 at 1:47 PM. She stated she expected the Pharmacy Consultant to identify and address the use of an antibiotic prescribed with no stop date and without an adequate indication for use during his monthly Drug Regimen Review.

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F 758	Continued From page 53	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		4/30/18

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F 758	Continued From page 54 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, Psychiatric Nurse Practitioner interview, and Pharmacy Consultant interview, the facility failed to ensure physician ' s orders for as needed (PRN) psychotropic medications were time limited in duration for 1 of 5 residents (Resident #51) reviewed for unnecessary medications. The findings included: Resident #51 was admitted to the facility on 6/30/15 and most recently readmitted on 8/26/16 with multiple diagnoses that included depression and dementia without behavioral disturbance. A significant change Minimum Data Set (MDS) assessment dated 2/14/18 indicated Resident #51 ' s cognition was moderately impaired. He was noted with delusions during the 7-day MDS review period. Resident #51 was assessed with verbal behaviors on 1 to 3 days during the MDS review period. He was administered antipsychotic medication, antianxiety medication, and antidepressant medication during the MDS review period. A Psychiatric Nurse Practitioner (NP) note dated	F 758	F758 Process that led to the deficiency cited: Licensed staff failed to ensure that an as needed psychotropic medication did not include a time limited duration upon ordering by physician. Procedure for implementing plan of correction: Resident #51 PRN Trazodone was discontinued by Physician Order on 4/11/18. 100% education for licensed nurses regarding as needed psychotropic medications are to be time limited in duration completed by ADON 4/30/18. Monitoring Procedure: Orders will be audited by DON or ADON during morning cliniclal meeting to ensure as needed psychotropic medications are of a time limited duration with results of audit reported to QAPI committee monthly x 2. If discrepancies are noted, further actions will be implemented.	

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F 758	Continued From page 55 3/12/18 indicated the addition of a low dose of PRN (as needed) Trazodone (antidepressant medication) for Resident #51 for sleep support. A physician ' s order for Resident #51 dated 3/12/18 indicated PRN Trazodone 25 milligrams (mg) for sleep. There was no stop date for this PRN Trazodone order for Resident #51. This order had been entered into Resident #51 ' s medical record by Nurse #1. The Pharmacy Consultant ' s monthly drug regimen review for Resident #51 dated 3/20/18 included a notation to follow up on PRN Trazodone. There were recommendations made by the Pharmacy Consultant related to Resident #51 ' s PRN Trazodone. A review of the March 2018 Medication Administration Record (MAR) from 3/12/18 through 3/31/18 indicated Resident #51 received PRN Trazodone once on 3/12/18. There were no other administrations of PRN Trazodone for Resident #51 in March 2018. On 4/11/18 Resident #51 ' s April 2018 MAR from 4/1/18 through 4/11/18 was reviewed. This MAR indicated Resident #51 continued to have an active order for PRN Trazodone. There were no administrations of PRN Trazodone for Resident #51 from 4/1/18 through 4/11/18. A phone interview was conducted with the Pharmacy Consultant on 4/11/18 at 4:05 PM. He indicated he was aware of the regulation that required PRN orders for psychotropic medications to have a time limited duration. The physician ' s order for Resident #51 ' s PRN Trazodone dated 3/12/18 that had no stop date	F 758	Title of person responsible for implementing plan of correction: DON Date when corrective action will be completed: 4/30/18	

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F 758	Continued From page 56	F 758		

was reviewed with the Pharmacy Consultant. The March 2018 and April 2018 MAR from 3/12/18 through 4/11/18 that indicated PRN Trazodone remained an active order for Resident #51 was reviewed with the Pharmacy Consultant. The monthly drug regimen review dated 3/20/18 for Resident #51 that indicated a notation to follow up on PRN Trazodone was reviewed with the Pharmacy Consultant. He stated at the time of his review on 3/20/18, the PRN Trazodone (ordered 3/12/18) had not yet been in place for 14 days so he had not made any recommendations related to the order. He explained his notation about following up on PRN Trazodone was intended to remind himself on the next monthly drug regimen review to address Resident #51 ' s PRN Trazodone if it was still an active order. The Pharmacy Consultant was asked if he had identified that the PRN Trazodone order had no stop date and he stated he had not noted that information.

An interview was conducted with Nurse #1 on 4/11/18 at 4:30 PM. She confirmed she had entered the order dated 3/20/18 for PRN Trazodone for Resident #51. She additionally confirmed this PRN order had no stop date. She stated the order was obtained from the Psychiatric NP because one of the night nurses reported Resident #51 was having some trouble sleeping. Nurse #1 reported she was aware of the regulation that required PRN orders for psychotropic medications to have a time limited duration. She revealed she had forgotten that Trazodone was considered a psychotropic medication when she entered the PRN order and she failed to include a stop date. Nurse #1 indicated the Psychiatric NP was very good about limiting PRN psychotropic medication orders to a

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F 758	Continued From page 57 14-day duration as per the regulations. She reported she and the Psychiatric NP both made an error. A nursing note dated 4/11/18 at 4:55 PM written by Nurse #1 indicated Resident #51 ' s PRN Trazodone order was discontinued. A physician's order dated 4/11/18 indicated Resident #51 ' s PRN Trazodone was discontinued. A phone interview was conducted with the Psychiatric NP on 4/12/18 at 10:00 AM. She confirmed she had prescribed PRN Trazodone for Resident #51 on 3/12/18 and provided no stop date for the order. She stated she was well aware of the regulation regarding PRN psychotropic medications and revealed this was a mistake on her part. She confirmed the PRN Trazodone order for Resident #51 was discontinued as of 4/11/18. An interview was conducted with the Director of Nursing (DON) on 4/12/18 at 1:47 PM. She stated her expectation was for all PRN orders for psychotropic medications to be time limited in duration as per the regulations.	F 758		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;	F 865		4/30/18

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F 865	Continued From page 58 §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility ' s Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and to monitor the interventions that the committee put into place in March 2017. This was for one recited deficiencies (Minimum Data Set (MDS) accuracy) which was originally cited on 3/26/17 during the recertification/ complaint investigation survey. The continued failure of the facility during the two federal surveys of record show a pattern of the facility ' s inability to sustain an effective QAPI program. The findings included: This tag is cross referred to: F641 Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medication (Resident #58), active diagnosis (Resident #7) and discharge status (Resident #100) for 3 of 26 sampled residents. During the recertification survey of 3/26/17, the facility was cited F278 for failure to code the MDS accurately in the areas of life expectancy and	F 865	F865 Process that led to the deficiency cited: The MDS nurses failed to accurately code the MDS in areas of medication, active diagnosis and discharge status. Procedure for implementing plan of correction: MDS for Resident #58 was corrected and resubmitted 4/13/18. MDS for Resident #7 was corrected and resubmitted 5/1/18. MDS for Resident #100 was corrected and resubmitted 5/1/18. 100% education for MDS nurses regarding accuracy on the MDS including medication, diagnosis and d/c status by Regional Director of Reimbursement on 4/27/18. MDS nurses education, separate from and in addition to IDT regarding accuracy of MDS as presented by Regional Director of Reimbursement on 4/27/18.	

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F 865	Continued From page 59 medications. On 4/12/18 at 2:13 PM, an interview was conducted with the Administrator and the Director of Nursing. The Director of Nursing stated there was a Licensed Practical Nurse (LPN) aiding the MDS Coordinator. They felt there needed to be another Registered Nurse (RN) in the MDS position to help the current MDS Coordinator. The facility had placed advertisements for that position as far back as last fall. The Director of Nursing said they had finally found another RN with experience in MDS. She had begun employment on 3/28/18 so a changeover in the department was a definite factor for the recited deficiency.	F 865	Change in department, previously one LPN and one RN, currently with two RNs in MDS department. Monitoring Procedure: Audit beginning 4/30/18 to include, but not limited to, accuracy of MDS as related to medication, diagnosis and discharge status will be completed by Administrator for 100% of completed assessments x 1 week then 5 randomly weekly for three weeks with 4 randomly ongoing thereafter. Results of the audit presented by Administrator will be reviewed monthly by the QAPI committee. If discrepancies are noted, further actions will be implemented. Title of person responsible for implementing plan of correction: DON and Regional Director of Reimbursement Date when corrective action will be completed: 5/1/18	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.	F 881		4/30/18

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F 881	Continued From page 60 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Wound Care Physician' s interview, and Pharmacy Consultant interview, the facility failed to follow its Antibiotic Stewardship Program as evidenced by the administration of an antibiotic prescribed on an indefinite basis without an adequate clinical indication for use for one of one sampled residents (Resident #72). The findings included: A review of the facility ' s Antibiotic Stewardship Program ' s policy (last revised 2/12/18) read, in part, " ...minimize antibiotic usage and utilizing only as clinically indicated. This ensures [a] decrease in the unnecessary or inappropriate antibiotic use and residents who need them are prescribed the right drug at the right dose for the right duration." The policy additionally indicated the facility would monitor/review for antibiotic usage when a resident was new to the facility. The facility ' s antibiotic use protocol addressed antibiotic prescribing practices that included documentation of the indication, dose, and duration of the antibiotic. Resident #72 was admitted to the facility on 3/6/18 with multiple diagnoses that included Alzheimer ' s disease. A review of Resident #72 ' s history and physical submitted to the facility for her 3/6/18 admission included a Nurse Practitioner note dated 2/28/18. The note indicated a diagnosis of cellulitis of the right ankle for Resident #72. The NP ' s plan for treatment included Doxycycline (antibiotic medication) 100 milligrams (mg) twice daily for 10	F 881	F881 Process that led to the deficiency cited: Nurse failed to complete an admission audit to ensure all medications have appropriate diagnosis and time limited duration as per the Antibiotic Stewardship Program. Procedure for implementing plan of correction: A Physician order on 4/10/18 provided for doxycycline stop date of 4/17/18. 100% education for Unit Managers on completion of antibiotic audits for admits/re-admits by DON completed 4/30/18. 100% education with licensed nurses regarding facility Antibiotic Stewardship Program by ADON completed 4/30/18. Monitoring Procedure: Unit Manager or ADON responsible for completing an audit on new admissions and re-admissions to the facility to determine stop date and clinical indication for use appropriate as to Antibiotic Stewardship. New physician orders audited in morning clinical meeting to ensure new antibiotics follow Antibiotic Stewardship Program with regards to stop date and clinical indication for use, by DON and/or ADON, with results of audit reported to QAPI committee monthly X 3. If discrepancies	

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F 881	Continued From page 61 days to treat Resident #72 ' s cellulitis. A physician ' s order for Resident #72 dated 3/6/18 indicated Doxycycline Hyclate (antibiotic medication) 100 mg twice daily for wound. The duration of this antibiotic order was indicated as indefinite. Resident #72 ' s plan of care included the focus area of antibiotic therapy related to wounds. This area was initiated on 3/7/18. A Wound Care Physician ' s initial evaluation, dated 3/8/18, indicated Resident #72 was admitted to the facility with 4 unstageable pressure ulcers. Resident #72 was noted to be taking an oral antibiotic related to the unstageable pressure ulcer of the right, lateral ankle. There was no documentation of an active infection for Resident #72. The admission Minimum Data Set (MDS) assessment dated 3/13/18 indicated Resident #72 was rarely/never understood and rarely/never understands. She was assessed with short term memory problems, long term memory problems, and severely impaired decision making. Resident #72 was admitted to the facility with 4 unstageable pressure ulcers. She was assessed with no infections (including no wound infections). Resident #72 was administered an antibiotic on 7 of 7 days during the MDS review period. Resident #72 ' s plan of care was updated on 3/20/18 to include the focus areas of the risk for infections related to wounds. The monthly drug regimen review, completed by the Pharmacy Consultant on 3/20/18, included no	F 881	are noted, further actions will be implemented. Title of person responsible for implementing plan of correction: DON Date when corrective action will be completed: 4/30/18	

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documentation related to Resident #72 ' s antibiotic prescribed on an indefinite basis and without an adequate clinical indication for use.

A review of the March 2018 ' s Medication Administration Record (MAR) indicated Resident #72 was administered Doxycycline Hyclate 100 mg twice daily from admission (3/6/18) through 3/31/18.

A review of the April 2018 MAR from 4/1/18 through 4/9/18 indicated Resident #72 was administered Doxycycline Hyclate 100mg twice daily. This April 2018 MAR and the April physician ' s orders for Resident #72 indicated this Doxycycline Hyclate order continued to be active as of 4/10/18 and had no stop date.

An interview was conducted with Nurse #2 on 4/10/18 at 11:53 AM. She indicated she was familiar with Resident #72. She stated she believed Resident #72 ' s Doxycycline Hyclate order was prescribed as a prophylactic (preventative) related to her wounds. Nurse #2 reviewed Resident #72 ' s record and confirmed this antibiotic was prescribed prophylactically for wound healing and had no stop date. She stated Resident #72 had no active infections since admission (3/6/18).

An interview was conducted with the Director of Nursing (DON) on 4/10/18 at 11:55 AM. She stated she was responsible for monitoring the Antibiotic Stewardship Program at the facility. She reported it was not normal practice to utilize prophylactic antibiotics nor was it normal practice to prescribe an antibiotic with an indefinite duration. The pre-admission NP note dated 2/28/18, the physician ' s order dated 3/6/18 for

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Doxycycline Hyclate, the Wound Care Physician ' s note dated 3/8/18, and the March and April 2018 MARs for Resident #72 were reviewed with the DON. The DON reviewed the record and indicated Resident #72 was on this antibiotic prior to admission. She explained that on 2/28/18, prior to her admission to the facility, Resident #72 was ordered Doxycycline for 10 days related to cellulitis. She further explained that when Resident #72 was admitted to the facility she remained on the antibiotic, but the order was put in place indefinitely. The DON stated she was unsure why the order for the antibiotic was changed to an indefinite order. She reported she needed to follow up the Wound Care Physician to determine if it was his recommendation to the change the antibiotic order to an indefinite duration.

An interview was conducted with the Wound Care Nurse on 4/10/18 at 2:05 PM. She stated the DON had asked her to contact the Wound Care Physician to determine why Resident #72 was prescribed an antibiotic with an indefinite duration. She reported she had spoken with the Wound Care Physician by phone on this date (4/10/18) and he had recommended continuing Resident #72 ' s antibiotic for one more week. The Wound Care Nurse was asked what the clinical indication was for the use of Resident #72 ' s antibiotic. She stated Resident #72 was on the antibiotic when she was admitted and she was kept on it related to her wounds. She reported Resident #72 had no active infections since her admission on 3/6/18.

A physician ' s order dated 4/10/18 at 2:51 PM updated Resident #72 ' s Doxycycline Hyclate 100 mg twice daily order with a stop date of

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4/17/18.

A second interview was conducted with the DON on 4/10/18 at 5:11 PM. She stated she had again reviewed Resident #72 ' s records through present (4/10/18). She revealed Resident #72 ' s antibiotic order dated 2/28/18 (prescribed prior to her facility admission) that indicated a duration of 10 days should have been followed (stop date 3/10/18). She stated Resident #72 ' s antibiotic should not have been changed to an indefinite duration as there was no clinical indication for use beyond the 10 days noted on the 2/28/18 order. The DON verified the administration of a prophylactic antibiotic ordered on an indefinite basis was not in accordance with the facility ' s Antibiotic Stewardship Program ' s policy.

An interview was conducted with the Pharmacy Consultant by phone on 4/11/18 at 4:05 PM. The physician ' s order dated 3/6/18 for Doxycycline Hyclate prescribed on an indefinite basis and the March and April 2018 MARs for Resident #72 were reviewed with the Pharmacy Consultant. The monthly drug regimen review completed on 3/20/18 that included no documentation of Resident #72 ' s antibiotic prescribed on an indefinite basis and without an adequate clinical indication for use was reviewed with the Pharmacy Consultant. The Pharmacy Consultant was asked if he had identified that this antibiotic for Resident #72 was prescribed on an indefinite basis and without an adequate clinical indication for use. He stated he needed to review his records and he scheduled a follow up interview for 4/12/18.

A follow up interview with the Pharmacy Consultant was conducted in person on 4/12/18

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at 9:15 AM. The Pharmacy Consultant stated he had reviewed his records and revealed he had not identified that Resident #72 ' s antibiotic was prescribed on an indefinite basis during his monthly drug regimen review on 3/20/18. He also stated he had not identified that the antibiotic was prescribed without an adequate clinical indication for use. The Pharmacy Consultant reported the facility utilized electronic medical records. He stated that consultations, including Wound Care Physician notes, were scanned into the record. He indicated that sometimes there was delay in the scanning process. He explained that at the time of his 3/20/18 review he had noticed that Resident #72 had an order for an antibiotic, that she had wounds, and that she was being seen by the Wound Care Physician. He further explained that based on this information he assumed there was an adequate clinical indication for use of the antibiotic. He confirmed he had not noticed that there was no stop date for Resident #72 ' s antibiotic order. The Pharmacy Consultant revealed that in hindsight he should have requested a clinical indication for use of the antibiotic as well as a stop date. He additionally revealed administration of a prophylactic antibiotic ordered on an indefinite basis was not in accordance with the facility ' s Antibiotic Stewardship Program ' s policy.

An interview was conducted with the Wound Care Physician on 4/12/18 at 12:06 PM. He stated he was familiar with Resident #72 and he treated her for her wounds. He indicated he believed Resident #72 was admitted to the facility on an antibiotic that was ordered for cellulitis prior to her admission. When asked if Resident #72 had cellulitis when she was admitted to the facility he indicated he was unable to say for certain. He

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F 881	Continued From page 66 confirmed Resident #72 had no cellulitis at this time (4/12/18). The Wound Care Physician revealed it was not normal practice to prescribe an antibiotic on an indefinite basis. He stated the Wound Care Nurse contacted him this week (4/10/18) regarding the antibiotic order and he instructed her to continue the antibiotic until he was able to assess Resident #72 in person. A follow up interview was conducted with the DON on 4/12/18 at 1:47 PM. She stated she expected the facility ' s Antibiotic Stewardship Program ' s policy to be followed.	F 881		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 883		4/30/18

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F 883	Continued From page 67 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to provide documented evidence that the pneumonia vaccine was administered for 2 (Resident #10 and Resident #35) of 5 residents reviewed for immunizations. The findings included:	F 883	F883 Process that led to the deficiency cited: Nurse failed to administer pneumonia vaccine once consent obtained. Procedure for implementing plan of correction:	

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F 883	Continued From page 68 Review of the facility policy titled "Infection Control-Pneumococcal Vaccine" dated 9/14/17 indicated a pneumonia vaccine would be administered if consented, if age 65 or older and if more than 5 years since last vaccine. The policy also indicated a booster (extra administration of the vaccine) would be administered for residents with chronic kidney disease. 1. Resident #10 was admitted 2/11/16 with chronic pain, osteoporosis and anemia. The quarterly Minimum Data Set dated 1/7/18 indicated Resident #10 had severe cognitive impairments and coded for supervision to extensive assistance with her activities of daily living. Record review indicated Resident #10's Responsible Party (RP) signed a consent on 12/21/17 to receive the pneumonia vaccine. Review of Resident #10's medical record included no documented evidence that the pneumonia vaccine was administered. Interview on 4/5/18 at 11:12 AM, the Staff Development Coordinator (SDC) stated it appeared that Resident #10 did not receive her pneumonia vaccine when consented on 12/21/17. Interview on 4/12/18 at 1:50 PM, the Director of Nursing stated she was the facility Infection Control Nurse but delegated the immunizations to the SDC. She stated it was an oversight and the pneumonia vaccine should have been administered and documented in the medical record at the time consent was obtained. The DON stated it was her expectation that the	F 883	Resident #10 received pneumonia vaccine on 4/20/18. Resident #35 declined pneumonia vaccine with signed declination on 4/19/18. One on one education for licensed nurse responsible for obtaining consent regarding failure to administer, completed 4/16/18 by ADON. 100% education for licensed nurses regarding Pneumonia vaccinations completed by ADON 4/30/18. Monitoring Procedure: Unit Manager will audit weekly x 8 weeks to validate for pneumonia vaccination administration upon signed consent. Audit findings will be reported by DON or ADON to QAPI committee monthly x 2, if discrepancies are noted further action will be taken. Title of person responsible for implementing plan of correction: DON Date when corrective action will be completed: 4/30/18	

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pneumonia vaccine be administered as stated in their policy if consent was obtained.

2. Resident #35 was admitted 7/23/13 with a diagnosis of End Stage Renal Disease.

The quarterly Minimum Data Set dated 2/4/18 indicated Resident #35 was cognitively intact and coded as independent to total assistance with her activities of daily living.

Record review indicated Resident #35 received a pneumonia vaccine on 1/31/12 while at dialysis.

Review of Resident #35's medical record included no documented evidence that the pneumonia booster vaccine was administered since she last received the vaccine on 1/31/12.

Interview on 4/5/18 at 11:12 AM, the Staff Development Coordinator (SDC) stated she contacted the dialysis clinic on 4/5/18 and Resident #35 had no documented evidence that she received a pneumonia booster vaccine while at dialysis. The SDC stated there was no documented evidence that Resident #35 received her booster pneumonia vaccine.

Interview on 4/12/18 at 1:50 PM, the Director of Nursing stated she was the facility Infection Control Nurse but delegated the immunizations to the SDC. She stated it was an oversight and the booster pneumonia vaccine should have been administered or the dialysis center should have been contacted to ensure Resident #35 had not received a booster while at dialysis. The DON stated it was her expectation that the pneumonia vaccine be administered as stated in their policy if

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F 883	Continued From page 70 consent was obtained.	F 883		