STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345293	A. BUILDING _____ B. WING _____	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

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E 000	Initial Comments An unannounced recertification/complaint investigation was conducted 04/22/18 through 04/26/18.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to establish and maintain a comprehensive emergency preparedness. (EP) plan which described the facility's comprehensive approach to meeting health, safety and security	E 001	Richmond Pines Healthcare and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is	5/24/18

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

Electronically Signed | 05/18/2018

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E 001	Continued From page 1 needs for their staff and resident population during an emergency or disaster situation. The facility's EP plan failed to address to following: Resident population Process for EP collaboration Subsistence need for staff and residents Procedure for tracking of staff and residents Policies and Procedures for medical records Policies and procedures for volunteers Arrangement with other facilities Development of a communication plan Names and contact information Emergency Officials contact information Primary/alternate means for communication Methods for sharing information Sharing information on occupancy/needs EP training Emergency power Review of the facility EP plan manual provided by the facility with policies and procedures was conducted. The manual did not contain a written established comprehensive EP program that met the federal requirements. Interview on 04/26/18 at 7:28 PM AM, the Administrator stated it was her expectation the facility has a complete EP Plan to meet the federal requirements.	E 001	factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Richmond Pines Healthcare and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Richmond Pines Healthcare and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. E001 Emergency Program	

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E 001	Continued From page 2	E 001	The plan of correcting the specific deficiency The position of Richmond Pines Nursing and Rehabilitation center regarding the process that led to this deficiency was the staff failure to establish and maintain a comprehensive emergency preparedness (EP) plan. On 5/18/18, the regional vice president in-serviced the administrator related to development of a comprehensive EP plan which described the facility□s comprehensive approach to meeting health, safety and security needs for their staff and resident population during an emergency or disaster situation. On 5/18/18, the administrator began development of a comprehensive EP plan which described the facility□s comprehensive approach to meeting health, safety and security needs for their staff and resident population during an emergency or disaster situation. The facility□s EP plan includes addressing resident population, process for EP collaboration, subsistence need for staff and residents, procedure for tracking of staff and residents, policies and procedures for medical records, policies and procedures for volunteers, arrangement with other facilities, development of a communication plan, names and contact information, emergency officials contact information, primary/alternate means for	

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E 001	Continued From page 3	E 001	communication, methods for sharing information, sharing information on occupancy/needs, EP training and emergency power. The procedure for implementing the acceptable plan of correction for the specific deficiency cited By 5/24/18 the regional vice president will review the facility EP plan to ensure the facility plan included a comprehensive approach to meeting health, safety and security needs for their staff and resident population during an emergency or disaster situation. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The monthly quality improvement (QI) committee will review the EP plan monthly and make recommendations for changes for continued compliance. The administrator and/or director of nursing will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for	

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E 001	Continued From page 4	E 001	implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		5/24/18

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F 550	Continued From page 5 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to promote dignity by feeding resident while wet and soiled for 1 of 2 sampled residents reviewed for dignity (Resident #69). Findings included: 1. Resident #69 was admitted to the facility on 1/20/11 with multiple diagnoses including anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 4/2/18 indicated that Resident #69 had memory and decision making problems and she required total staff assistance with personal hygiene. The assessment further indicated that the resident was incontinent of bowel and bladder. Resident #69's care plan dated 4/2/18 was reviewed. One of the care plan problems was that the resident required assistance with toileting. The goal was for the resident to remain dry of urine. The approaches included to check resident frequently for incontinent episodes. On 4/26/18 at 12:06 PM, 12:33 PM, 1:01 PM and 1:15 PM, Resident #69 was observed up in the	F 550	F 550 The plan of correcting the specific deficiency The position of Richmond Pines Healthcare and Rehabilitation Center regarding the process that led to the deficiency of failure to promote resident right of dignity by assisting a resident with eating while the resident required incontinent care was incorrect understanding of staff, including floor staff and administrative staff regarding incontinent care during mealtimes. On 4/26/18 at 1:22 PM, nurse assistant (NA) #4 and #5 provided incontinent care to Resident #69 and assisted the resident with incontinent care, including a new disposable brief and clean pants. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/14/18, the staff facilitator (SF), DON, quality improvement (QI) nurse, Minimum	

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F 550	Continued From page 6 chair in her room with seat belt on. She was wearing a pair of pants and her pants were observed to be wet on the crotch and thigh areas. On 4/26/18 at 1:15 PM, Nurse Aide (NA) #5 was observed to enter the room of Resident #69 with the lunch tray. She was observed to set up the tray in front of the resident and was about to feed her. On 4/26/18 at 1:16 PM, NA #5 was interviewed before she started feeding Resident #69. She stated that she checked the resident at 11:30 AM by looking at the color on the disposable brief and the resident was dry. She added that she didn't get the chance to check her again because "it was kind of hectic today" she said. NA #5 looked at the resident's pants and said "she was wet". NA #5 and NA #6 were observed to put Resident #69 in bed using a mechanical lift. When in bed, Resident #69's pants were observed soaking wet on the buttock area. Her disposable brief was soaking wet and was soiled with feces. Her thighs were observed to have dried feces. On 4/26/18 at 1:22 PM, NA #4 and #5 were observed to provide incontinent care to Resident #69 and to put on a new disposable brief and clean pair of pants. On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that she expected the staff to check resident frequently and before meals for incontinent episodes.	F 550	Data Set (MDS) nurses, and treatment (Tx) nurse initiated a 100% re-education of registered nurses (RNs), licensed practical nurses (LPNs), NAs, and geriatric care assistants (GCAs) titled Resident Rights - Dignity and Respect, including part time, as needed (PRN), and agency. The re-education instructs staff on the importance of maintaining dignity and respect of residents to include activities of daily living (incontinent care) during meal times, clean clothing, and noted odors. The in-service is to be completed by 5/24/18. Any staff not in-serviced by 5/24/18 will not be allowed to work until the in-service completed. During the new employee orientation process, the SF, QI nurse, DON or administrator will provide resident rights □ dignity and respect training, to staff including part time, prn, and agency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements Beginning 5/14/18, the QI nurse, MDS nurse, SF, activities director, and social worker (SW), administrator, manager on duty, or corporate consultant began resident care observations during mealtime at random meals, to cover breakfast, lunch, and supper and seven days per week, to ensure residents have been treated with dignity and respect and observed for cleanliness, and noted for	

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F 550	Continued From page 7	F 550	odors. This information is being documented on a Dignity Audit Tool. The dignity audits will be completed with 10 residents weekly times 4 weeks, then once weekly for 8 weeks, then once monthly for one month. The QI nurse will review with the monthly QI committee the results of the audits for four months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring to maintain compliance. The QI nurse will present the dignity audit tool findings and QI committee recommendations to the quarterly quality assessment and assurance (QAA) Committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The director of nursing is responsible for implementing the acceptable plan of correction.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F 561		5/24/18

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F 561	Continued From page 8 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to honor a resident ' s choice to receive showers per preference for showers over bed baths for two of eight sampled residents (Resident #11 and #68). The findings included: 1. Resident #11 was admitted to the facility 2/10/17. Cumulative diagnoses included: diabetes, rheumatoid arthritis, and hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side. A care plan dated 2/22/17 and last revised on 1/26/18 indicated Resident #11 required assistance for bathing related, in part, to	F 561	F561 The plan of correcting the specific deficiency The position of Richmond Pines Nursing and Rehabilitation center regarding the process that led to the deficiency of failing to allow resident choice of shower preferences over bed bath was knowledge deficit. On 5/11/18, Resident #11 received a shower per resident preference. On 5/8/18, Resident #68 received a	

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F 561	Continued From page 9	F 561		

hemiplegia and decreased mobility. Interventions stated total dependence for bathing. Prefers showers Tuesday and Friday.

The quarterly Minimum Data Set (MDS) dated 4/10/18 indicated Resident #11 was moderately impaired in cognition. Resident #11 required extensive assistance with dressing, toilet use and personal hygiene. He was totally dependent on staff for bathing.

During Resident council meeting held on 4/24/18 at 2:40 PM, Resident #11 stated he was not always receiving his showers.

A review of the shower schedule revealed resident #11 was scheduled for showers every Monday and Thursday during the 7:00 AM-3:00 PM shift.

A review of shower schedule for the past three months revealed Resident #11 received the following: February 2018--3 showers and 13 full bed baths; March 2018-- 5 showers and 20 full bed baths; April 2018--No documentation from 3/31/18 until 4/6/18 when a partial bed bath was given. Resident #11 received three showers and 7 full bed baths during the month of April.

On 4/24/18 at 3:00 PM, an interview was conducted with Nurse #3 who stated Resident #11 was usually cooperative and did not refuse medication or care most of the time.

On 4/25/18 at 10:30 AM, an interview was conducted with Resident #11 who stated he preferred showers instead of bed baths. He stated he had not told anyone he was not getting showers. Resident #11 stated staff come in and shower per resident preference.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited

On 5/1/18 through 5/10/18, the social worker (SW), quality improvement (QI) nurse, and admissions director reviewed residents in the facility for showers given in the last 7 days for showers provided per resident preference using the nursing assistant documentation in the medical record and resident shower preference sheet. The Shower Preference sheet is completed through resident interviews, and/or family/resident representative interviews by the SW, QI nurse, admissions, minimum data set nurse (MDS), director of nursing (DON), staff facilitator, (SF), payroll, accounts payable, activity director, and/or charge nurse. Shower preference sheets are completed on admission, readmission, and as requested by resident, their responsible party, or as needed.

All registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs), including part time, as needed (PRN), and agency, will be in-serviced by 5/24/18 by the DON or SF on resident choice including bathing preference which includes showers. After 5/24/18, no licensed nurse or CNA can work including part time, prn, and agency until in-service is complete. This in-service will be added to the orientation

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F 561	Continued From page 10 he did not tell them he wanted a shower instead of a bed bath and lets then do what they want but he would prefer a shower. On 4/26/18 at 1:40 PM, a second interview was conducted with Nurse #3 who stated residents were getting their showers and looked forward to their showers when there was a shower team but they stopped the shower team a few months ago and put the shower team staff working on the floor. Since that time, residents had not been getting their showers consistently. More bed baths were being done because it was quicker for the staff to do that than take them to the shower. Nurse #3 said Resident #11 would refuse a shower on occasion. If he refused a shower, the aide would tell the nurse, the nurse would talk to the resident and document in the nursing notes if they continued to refuse. A review of the nursing notes for the past three months revealed Resident #11 had refused a shower on one occasion. On 4/26/18 at 1:43 PM, a second interview was conducted with Resident #11. He said he did not receive his shower this morning because he had the Resident council meeting. His Nursing Assistant was present at the time of the conversation and told him she would give him his shower when he was ready to take it. Resident #11 stated he received showers consistently when they had the shower team but he thought the shower team dissolved around the same time the locked unit was closed and those residents went to 200 hall. Since that time, showers have not been consistent and he rarely received a shower.	F 561	process for new licensed nurses and CNAs, including part time, prn, and agency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, staff facilitator, facility consultant, and/or MDS nurse will audit 20 residents weekly for 12 weeks to ensure showers were given per resident choice, audit includes resident interviews, observations, family interviews (as needed), and staff interviews, also review of nursing staff documentation of showers provided. This audit will be documented on the Resident Care Audit Tool. The monthly QI committee will review the results of the resident care audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction.	

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F 561	Continued From page 11 On 4/26/18 at 7:21 PM, an interview was conducted with the Administrator who stated she expected a resident's choice of bath or shower be honored., 2. Resident #68 was admitted 8/10/16 with a diagnosis of major depression and psychosis. Review of a grievance completed by Resident #68 dated 3/23/18 read he had not received a shower since 3/19/18. Resident #68 requested a shower on 3/23/18 and for his shower days to be changed. The grievance summary read his concerns were validated after interviews with staff. He showers days were changed to Tuesday and Friday on first shift. Review of a grievance completed by Resident #68 dated 4/10/18 read the aide gave him a wash cloth and told him to bath himself after he requested a shower. A care plan meeting was held with Resident #68 and read Resident #68 requested a shower on 4/9/18 and requested staff assistance. The grievance read Resident #68 would receive staff assistance while encouraging independence with his activities of daily living (ADLs). His quarterly Minimum Data Set dated 4/2/18 indicated Resident #68 was cognitively intact with no behaviors. He was coded for total assistance with bathing. Resident #68's last revised care plan dated 4/5/18 included staff assistance with bathing. Interview with Resident #68 was conducted on	F 561	The DON is responsible for implementing the acceptable plan of correction.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 12 4/25/18 at 10:19 AM. He stated he received a shower on Wednesday 4/23/18 but thought his shower days were changed to Tuesday and Friday. He stated he completed a grievance recently requesting his shower days be changed and stated he was not receiving his showers as scheduled. Review of Resident #68's ADL documentation indicated he received a shower on 3/4/18, 3/27/18 and 3/30/18 for a total of 3 showers during the month of March 2018. He received a shower on 4/6/18, 4/9/18, 4/12/18, 4/16/18, 4/19/18 and 4/23/18 for a total of 6 showers from April 1 through April 25, 2108. There were no documented refusals. Interview on 4/26/18 at 8:10 AM, Nursing Assistant (NA) #11 stated she gave Resident #68 a shower on 4/25/18. She stated he did not refuse showers. Interview on 4/26/18 at 4:40 PM, NA #12 stated Resident #68 received his showers on second shift up until recently when he requested his shower days be changed. She stated Resident #68 did not have a history of refusing showers. Interview on 4/26/18 at 7:28 PM, the Administrator stated it was her expectation that Resident #68 request for showers be honored and completed as scheduled.	F 561		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		5/24/18

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F 600	Continued From page 13 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with staff, police, and the Nurse Practitioner (NP), the facility neglected to provide adequate supervision for a cognitively impaired male resident (Resident #45) with frequent wandering behaviors and a history of sexually inappropriate behaviors. Resident #45 entered the room of a cognitively impaired female resident, shut the door, and exposed his genital region to Resident #13. This was for 1 of 1 residents reviewed for neglect. The findings included: Resident #45 was admitted to the facility on 12/1/16 and most recently readmitted to the facility on 11/22/17 with multiple diagnoses that included dementia with behavioral disturbance. The quarterly Minimum Data Set assessment dated 3/3/18 indicated Resident #45 was rarely/never understood and rarely/never	F 600	F600 The plan of correcting the specific deficiency The position of Richmond Pines Nursing and Rehabilitation center regarding the process that led to this deficiency – the facility neglected to provide adequate supervision to prevent a resident-to-resident event- was knowledge deficit. On 4/26/18, Resident # 45 was placed on 1-to-1 staff supervision which continued until 5/8/18 at which time the resident was determined by the facility to be exhibiting no sexual behaviors, as evidenced by no documented behaviors. On 4/26/18, Resident #13 was observed by the staff LPN immediately post	

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understands. He had short-term and long-term memory problems and severely impaired decision making. Resident #45 was assessed with continuous inattention and disorganized thinking. He had no behaviors, no rejection and no wandering during the MDS review period. Resident #34 was independent with set up help only for walking in/out of room and corridor. He was noted to be unsteady on his feet, but he was able to stabilize without staff assistance.

Resident #45 ' s plan of care included, in part, the focus areas of:

-Problematic manner in which resident acts characterized by ineffective coping: wandering and/or at risk for unsupervised exits from the facility related to: attempts to leave unit/building if not prevented. Resident wandering in and out of other residents ' rooms/exit seeking behavior at times. This focus area was initiated on 5/8/17 and last revised on 6/26/17. The interventions included: allow resident to wander on the unit (initiated on 5/8/17 and last on revised 3/6/18).
-Problematic manner in which resident acts characterized by inappropriate behavior and resistance to treatment/care related to cognitive impairment. This focus area was initiated on 8/21/17 and last revised on 4/23/18.

A record review indicated Resident #45 had previously resided on the facility ' s locked memory care unit. This unit was temporarily closed in January 2018 for maintenance and had not yet been reopened. All of the residents who had resided on the locked memory care unit, including Resident #45, presently resided in unlocked units of the facility.

incident. The LPN noted in the progress note at 0206 “no visible injury, no sign of pain, no grimacing, no tearfulness.”

On 4/26/18, Resident #13 was assessed at the hospital emergency department. The physician performed an “external examination of the vaginal area and rectal area; there is no evidence of injury…No obvious bruising or injury were visualized.” The facility was informed by the police that the results of the rape kit will not be available for 2 to 3 months.

On 4/26/18, to protect the resident as it related to the allegation of abuse, the facility provided ongoing monitoring of Resident #13 and 1-to-1 supervision of Resident #45. Resident #13 returned to the facility with no new orders from the emergency department physician. Resident #13 was returned to her assigned room, bed alarm in place to alert staff if resident exited the bed. Resident #45 remained on 1-to-1 supervision. On 4/26/18, the quality improvement (QI) nurse noted in the progress note “resident sleeping peacefully until afternoon. Up in scoot chair, eating ice cream and moving about facility. Smiled when spoken to.”

The procedure for implementing the acceptable plan of correction for the specific deficiency cited

On 5/18/18, the QI nurse began an in-service with all staff including licensed, unlicensed, part time, as needed (PRN),

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F 600	Continued From page 15 Resident #45 was observed ambulating independently with a shuffled and slow gait on his unit of the facility on 4/23/18 at 12:00 PM. Resident #45 had minimal speech that was garbled and indistinguishable. Resident #45 was observed ambulating with a shuffled and slow gait on a different unit at the facility on 4/23/18 at 4:00 PM. Resident #45 was observed standing in a common area of the facility on 4/24/18 at 2:30 PM. An incident report dated 4/26/18 and completed by Nurse #5 indicated Resident #45 was found in a female resident ' s room (Resident #13) on the night of 4/25/18 (no time indicated). Resident #45 was wearing only a shirt and socks. His brief and pants were observed laying at the head of Resident #13 ' s bed. There was no physical contact observed by staff between Resident #45 and Resident #13. Resident #45 was able to be directed to sit down on Resident #13 ' s bed as Resident #13 was assisted out of the room. Resident #45 and Resident #13 were not interviewable. (Resident #13 ' s 1/15/18 quarterly MDS indicated she was rarely/never understood and rarely/never understands). A physical assessment was completed of both residents and no injuries were noted. Resident #45 was assisted with getting dressed and was then placed on 1 on 1 supervision. The Quality Assurance (QA) Nurse, Administrator, on call physician ' s assistant, and the Responsible Party (RP) of each resident were notified. A 24-hour initial report was completed on 4/26/18 at 12:15 AM for the incident that occurred on the	F 600	and agency, on behavior management including wandering, and sexual behaviors. This in-service will be completed by 5/24/18. After 5/24/18, no staff will be allowed to work without the in-service. This in-service will be added to the orientation for newly hired staff, including licensed, unlicensed, part time, PRN, and agency staff. On 5/18/18, the QI nurse began an in-service with all staff including licensed, unlicensed, part time, PRN, and agency, on neglect. This in-service will be completed by 5/24/18. After 5/24/18, no staff will be allowed to work without the in-service. This in-service will be added to the orientation for newly hired staff, including licensed, unlicensed, part time, PRN, and agency staff. By 5/22/18, the staff facilitator, QI nurse, director of nursing (DON) and/or corporate consultant had reviewed all residents with wandering behaviors (based on last minimum data set assessment and wandering risk assessment) to ensure interventions are in place to protect the resident and other residents that may be affected by the behavior. The audit revealed all residents with wandering behaviors have interventions in place to protect the resident and other residents that may be affected by the behavior. By 5/22/18, the staff facilitator, QI nurse, DON and/or corporate consultant had reviewed all residents with sexual	

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F 600	Continued From page 16 night of 4/25/18 with Resident #45 and Resident #13. The allegation included reasonable suspicious of a crime and resident abuse. The allegation description indicated Resident #13 ' s bed alarm had sounded in her room. A Nursing Assistant (NA) went to the room and found Resident #13 clothed in a nightgown and brief sitting on the floor of her room with Resident #45 standing beside her. Resident #45 was noted to be wearing only a shirt and socks. An investigation was initiated and the police were notified. The facility ' s investigation of the 4/25/18 incident related to Resident #45 and Resident #13 was reviewed. Resident #13 ' s bed alarm was heard sounding by an NA (NA #9) on 4/25/18 around 11:15 PM. NA #9 went to Resident #13 ' s room, attempted to enter through the door to the room, but found the door was blocked by something and she was unable to enter. NA #9 was able to access Resident #13 ' s room by entering through an adjoining bathroom of the room next to Resident #13. Resident #13 was found sitting on the floor in front of the door to her room. She was clothed in a nightgown and brief. Resident #45 was standing over her clothed in only a short-sleeved shirt and socks. Resident #45 had removed his pants and his brief. His pants were found on Resident #13 ' s bed and his brief was on the floor in her room. Staff assisted Resident #13 off the floor, into her wheelchair, and out of her room. Resident #45 refused to exit the room and he had also refused to be assisted with putting a brief and pants back on. Resident #13 and Resident #45 were assessed for injuries with no signs of physical contact or injury. Resident #45 was placed on 1 on 1 supervision. The police were notified and Resident #13 remained	F 600	behaviors (based on care plan) to ensure interventions are in place to protect the resident and other residents that may be affected by the behavior. All residents with sexual behaviors have a care plan in place with appropriate interventions in place to protect residents and other residents that may be affected by the behavior. On 4/26/18, current staff including licensed, unlicensed, full time, part time, PRN, and agency were interviewed related to sexual behaviors/sexual abuse by the DON, administrator, QI nurse, social worker, and or staff facilitator. Through interviews with staff, no other residents were identified with sexual behaviors. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, staff facilitator, QI nurse, and/or weekend manager on duty will review progress notes from the previous 24 hours 5 times weekly x 12 weeks to ensure all documented wandering and/or sexual behaviors have appropriate interventions to protect the resident and other residents that may be affected. This audit will be documented in the progress note audit tool. The DON, staff facilitator, QI nurse, and/or corporate facility consultant will	

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F 600	Continued From page 17 with staff in a common area of the facility until police arrived. Following the arrival of the police, Resident #13 was transferred to the hospital with police accompaniment for an evaluation and the completion of a sexual assault sample. Hospital staff evaluated Resident #13, found no identifiable concerns to her physical status related to the incident, and she was returned to the facility. The sexual assault sample had been forwarded to the local police department. The hospital Emergency Department note dated 4/26/18 for Resident #13 was reviewed. Resident #13 was brought in with police accompaniment for evaluation of possible sexual assault. The officer present at the hospital with Resident #13 reported there was no evidence of any kind of a struggle. A sexual assault sample was performed and Resident #13 was examined. There was no obvious evidence of injury. Resident #13 was discharged back to the facility following the evaluation. On 4/26/18 at 8:15 AM an interview was conducted at the local police department with a Police Captain and the incident/investigation report related to Resident #45 and Resident #13 was reviewed. The incident/investigation report indicated the crime in question was rape, the suspect was identified as Resident #45, and the victim was identified as Resident #13. The police were noted to be dispatched to the facility at approximately 1:00 AM on 4/26/18. The QA Nurse provided the incident details to the officer when he arrived at the facility. The report indicated NA #9 discovered Resident #45 inside Resident #13 ' s room after a bed alarm was activated. Resident #45 had no pants or brief on, he was blocking the door to Resident #13 ' s	F 600	review visually and through documentation 5 residents designated as high risk for wandering and/or with sexual behaviors. The review will occur weekly on varying days and shifts (to cover seven days and all shifts) x 12 weeks. This audit will be documented on the resident behavior audit tool. The monthly QI committee will review the results of the progress note review audit tool and resident behavior audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction	

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room, and Resident #13 was sitting on her floor fully clothed. NA #9 had to access Resident #13 ' s room through the bathroom door that connected to the room next door as Resident #45 refused to move away from door. NA #9 removed Res #13 from her room as Resident #45 refused to leave. NA #9 was interviewed and she stated Resident #45 removed his clothing a lot. Resident #45 ' s brief and clothing were near Resident #13 ' s bed. Nurse #5 was interviewed and she stated she had observed Resident #45 with an erection. No physical injuries were observed on either resident. Resident #13 was taken to the hospital for a sexual assault sample. The Police Captain reported that the results of the sexual assault sample could take anywhere from a week to a month to receive back. He had confirmed that based on the information there were no physical injuries observed on either resident.

A phone interview was conducted with NA #7 on 4/26/18 at 8:36 AM. She stated she worked on the unit where Resident #13 and Resident #45 resided on 4/25/18 during the 3:00 PM to 11:00 PM shift, but she was not assigned to either resident. She reported NA #10 was assigned to both Resident #13 and Resident #45 on 4/25/18 during the 3:00 PM to 11:00 PM shift. NA #7 indicated prior to leaving the facility at the close of her shift on 4/25/18, she last saw Resident #45 at the nurse ' s station around 9:00 PM and she last saw Resident #13 being assisted back to her room by NA #10 around 9:30 PM. NA #7 stated that Resident #45 ' s normal routine included wandering through the halls of the facility. She reported he frequently wandered into other resident ' s rooms. She indicated Resident #45 could be combative and difficult to redirect, but she had not witnessed him with any sexually

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inappropriate behavior.

An interview was conducted with the QA Nurse on 4/26/18 at 9:10 AM. She stated Resident #45 wandered throughout the facility during most of the day. She reported he wandered into other residents ' rooms and was difficult to redirect at times. She indicated she believed he was unable to determine which room was his. The QA Nurse was asked if Resident #45 had any specific interventions related to the frequency of monitoring his whereabouts due to his frequent wandering and entering other residents ' rooms. She reported that prior to the incident last night (4/25/18) there were no specific timeframes in place for monitoring his whereabouts. She indicated Resident #45 was now on 1 on 1 supervision at all times.

A phone interview was conducted with Nurse #6 on 4/26/18 at 11:10 AM. She stated she worked on the unit where Resident #13 and Resident #45 resided on 4/25/18 during the 3:00 PM to 11:00 PM shift. She reported the last time she had observed Resident #13 and Resident #45 prior to the incident that night (4/25/18) was at approximately 10:30 PM. She stated at that time, Resident #45 was seated on a chair that was positioned in the hallway outside of his room and Resident #13 was in bed in her room. She reported after that observation she went to the nurse ' s station to complete paperwork. She indicated that there was no visual line of sight from the nurse ' s station to Resident #13 ' s and Resident #45 ' s rooms as both rooms were located around a corner. Nurse #6 stated she was getting ready to exit the facility around 11:26 PM on 4/25/18 when Nurse #5 (the nurse working the 11:00 PM to 7:00 AM shift for that unit) called

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her to Resident #13 ' s room. She reported when she arrived at the room several other staff members were present. Nurse #6 stated Resident #45 had no pants or brief on and he was seated on the foot of Resident #13 ' s bed. She reported Resident #13 was seated on the floor with her knees bent and her feet on the ground.

This phone interview with Nurse #6 continued. She indicated Resident #45 frequently wandered throughout the facility, up and down the hallways, and sometimes into other residents ' rooms. She stated she was unaware of Resident #45 exhibiting any sexually inappropriate behaviors recently, but she had known of an incident that occurred sometime in 2017 in which Resident #45 was observed holding another female resident ' s hand and going into her room. Nurse #6 reported Resident #45 occasionally had behaviors that included combativeness, verbal behaviors, and being difficult to redirect. She indicated staff tried to keep an eye on him and monitor his whereabouts. She reported there were no specific interventions related to how often Resident #45 ' s whereabouts were monitored.

A second interview was conducted with the QA Nurse on 4/26/18 at 11:20 AM. She was asked if Resident #45 had any history of sexually inappropriate behavior. She reported there was no recent history of this type of behavior for Resident #45, but there was an incident that occurred about a year ago. She indicated during that incident, Resident #45 had been seated next to another female resident and it had appeared he was attempting to remove her pants. She stated the female ' s pants were only slightly

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pulled down from her waist. She reported the two residents were separated and Resident #45 was placed on 1 on 1 supervision for a period of time (she was unable to recall how long this 1 on 1 supervision was in place). The QA Nurse stated there had been no other instances of any type of sexually inappropriate behavior for Resident #45 since that occurrence.

A phone interview was conducted with NA #10 on 4/26/18 at 12:35 PM. She stated she worked on the unit where Resident #13 and Resident #45 resided on 4/25/18 during the 3:00 PM to 11:00 PM shift and she was assigned to both residents. She reported the last time she had observed Resident #13 and Resident #45 prior to the incident that night (4/25/18) was at approximately 10:30 PM. She indicated she had tried to perform incontinence care on Resident #45, but he had refused. She stated she left the facility around 11:05 PM. She indicated she had recently started working at the facility so she was not too familiar with Resident #45, but in the three times she had worked with him she had seen him wander frequently. NA #10 reported she had heard from other staff members that Resident #45 wandered into other residents ' rooms at times. She stated she tried to lay eyes on Resident #45 about every 25 minutes when she worked with him to check on his whereabouts. She indicated she had observed no inappropriate sexual behaviors for Resident #45.

A phone interview was conducted with NA #8 on 4/26/18 at 12:35 PM. She stated she worked on the unit where Resident #13 and Resident #45 resided on 4/25/18 during the 11:00 PM to 7:00 AM shift, but she was not assigned to either resident. She indicated NA #9 was assigned to

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Resident #13 and Resident #45. NA #8 reported she and NA #9 were at the nurse ' s station receiving their report from the prior shift until about 11:20 PM on 4/25/18. She stated at that time (around 11:20 PM), she and NA #9 left the nurse ' s station and proceeded down the hallway of the unit that Resident #13 and Resident #45 resided on. She reported that when they got to the end of the hallway Resident #13 ' s bed alarm was heard sounding. She stated NA #9 went to Resident #13 ' s room to attend to the bed alarm and she proceeded to assist another resident. NA #8 reported that when NA #9 approached Resident #13 ' s door it was shut and she was unable to open it. She stated NA #9 had then called for her assistance. She reported she completed her care with the resident she was with and she then went to assist NA #9 within a couple of minutes. NA #8 stated NA #9 had to enter Resident #13 ' s room by going through the bathroom door that adjoined the bedrooms. She reported she also had to enter Resident #13 ' s room through the adjoining room ' s bathroom door and she had observed Resident #13 seated on the floor in front of the door to the room with her legs bent and feet on the ground. She stated Resident #45 was standing directly in front of Resident #13 with his genitals exposed. NA #8 explained that Resident #45 was wearing only a short-sleeved shirt and socks.

This interview with NA #8 continued. She stated she had not regularly worked with Resident #45, but she was aware he wandered all of the time and entered other residents ' rooms if the doors were open. She indicated she had observed no inappropriate sexual behaviors for Resident #45.

An interview was conducted with the Nurse

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RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

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Practitioner (NP) on 4/26/18 at 1:22 PM. She stated she was familiar with Resident #45. She indicated he had no recent sexually inappropriate behaviors. She explained that when he had resided on the locked memory care unit there was a female resident whom he spent a lot of time around. She further explained that she believed that female resident was the aggressor in that situation.

A phone interview was conducted with NA #9 on 4/26/18 at 1:25 PM. She stated she was assigned to Resident #13 and Resident #45 on 4/25/18 during the 11:00 PM to 7:00 AM shift. She reported that when she came on shift she was at the nurse ' s station receiving a report from the previous shift until around 11:25 PM (4/25/18). She indicated that there was no visual line of sight from the nurse ' s station to Resident #13 ' s and Resident #45 ' s rooms as both rooms were located around a corner. NA #9 reported that at around 11:25 PM she and NA #8 left the nurse ' s station and proceeded down the hallway of the unit that Resident #13 and Resident #45 resided on. She stated that was when she had heard Resident #13 ' s bed alarm sounding. She reported she went to Resident #13 ' s door and found that it was closed. She stated she attempted to open the door to the room, but she was only able to open it partially. She explained that she saw Resident #45 inside of Resident #13 ' s room through the partially opened door and she observed him push on the door to close it. NA #9 indicated that she was then unable to reopen the door so she proceeded to enter the room by going through the door of the adjoining room ' s bathroom. She reported that when she entered the room she observed Resident #13 seated on the floor in front of the door with her

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legs bent up and her feet on the ground. She stated Resident #45 was standing directly in front of Resident #13 with his genitals exposed. She explained that he was wearing only a short-sleeved shirt and socks. She indicated that Resident #45 ' s pants and brief were on Resident #13 ' s bed and his brief was soaked with urine. NA #9 stated this was when she called for assistance from NA #8 and Nurse #5. NA #9 indicated she believed Resident #13 had slid off of her bed independently and crawled over to the area near the door. She explained that Resident #13 had completed this type of action in the past. She confirmed that this was the first time she had seen Resident #45 and Resident #13 since coming on shift that night (4/25/18).

This phone interview with NA #9 continued. She stated that Resident #45 had previously removed his own brief while clothed in a nightgown when he was incontinent, but she had not seen him remove his pants. She reported that Resident #45 wandered all of the time through the halls, the common areas, and into other residents ' rooms. She stated he had moments when he was difficult to redirect and became agitated. She indicated she had observed no inappropriate sexual behaviors for Resident #45, but she was aware of an incident that occurred last year when he was placed on 1 on 1 supervision for, "holding another [female] resident ' s hand or something like that". NA #9 indicated she believed the female was the aggressor in that situation as she had dementia and thought Resident #45 was her husband.

An interview was conducted with Nurse #5 on 4/26/18 at 3:15 PM. She indicated she was assigned to Resident #13 and Resident #45 on

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4/25/18 during the 11:00 PM to 7:00 AM shift. She stated she was at the nurse ' s station until around 11:15 PM on 4/25/18 receiving report from the previous shift. She indicated that there was no visual line of sight from the nurse ' s station to Resident #13 ' s and Resident #45 ' s rooms as both rooms were located around a corner.
Nurse #5 stated the NAs began completing their rounds after the previous shift finished providing their report. She indicated shortly after the NA ' s began their rounds, NA #9 came down the hall toward the nurse ' s station and called for assistance to Resident #13 ' s room. Nurse #5 stated she went to Resident #13 ' s door and she was unable to open the door. She indicated she entered the room by going through the door of the adjoining room ' s bathroom. She reported Resident #13 was seated on the floor in front of the door with her legs bent up and her feet on the ground. She stated Resident #45 was standing directly over Resident #13, he was wearing only a short-sleeved shirt and socks, his genitals were exposed, and he had an erection. She indicated that Resident #45 ' s pants and brief were on Resident #13 ' s bed and his brief was soaked with urine. Nurse #5 stated staff attempted to direct Resident #45 out of the room when he became agitated. She indicated the staff were able to get Resident #45 to sit down on Resident #13 ' s bed while Resident #13 was assisted into her wheelchair and out of the room. She reported it took several attempts for Resident #45 to be redirected out of Resident #13 ' s room.

This interview with Nurse #5 continued. She stated she had been working at the facility for about two weeks, but indicated she had previously worked here in the past. She reported Resident #45 wandered throughout the facility up

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F 600	Continued From page 26 and down all of the hallways. She indicated she had observed no inappropriate sexual behaviors for Resident #45. The DON was unavailable for interview. An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. The information received during the staff interviews was reviewed with the Administrator. The interviews indicated the last observations of Resident #13 and Resident #45 prior to the 4/25/18 incident was around 10:30 PM by Nurse #6 and NA #10. The interviews additionally indicated the next observation of Resident #13 and Resident #45 was between the times of 11:15 PM and 11:25 PM when Resident #13 ' s bed alarm sounded alerting staff that Resident #13 was no longer in bed. Staff then found Resident #45 in Resident #13 ' s room, he had shut the door, and his genitals were exposed to Resident #13. The Administrator stated she expected staff to adequately monitor the residents. She stated Resident #45 was immediately placed on 1 on 1 supervision following the 4/25/18 incident. She indicated the facility ' s plan was to continue 1 on 1 supervision for Resident #45 until the locked memory care unit reopened.	F 600		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a	F 623		5/24/18

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language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;

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(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure

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F 623	Continued From page 29 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to notify the Regional Ombudsman of discharge home or the hospital for 7 (Resident #280, Resident # 281, Resident #50, Resident #13, Resident #34, Resident #38 and Resident #42) of 7 residents reviewed for discharge. The findings included: 1. Resident #280 was admitted 2/19/18 and discharged home on 4/4/18. Interview on 4/26/18 at 9:27 AM, the Social Worker (SW) stated she did not notify the Regional Ombudsman of Resident #280's discharge home on 4/4/18. She stated she thought it was the responsibility of the Admissions Coordinator. Interview on 4/26/18 at 9:30 AM, the Administrator stated she was not aware that the facility had to notify the Regional Ombudsman if resident was discharged home or to the hospital. She stated she was new to the facility was not aware of who was responsible for notifying the Regional Ombudsman. Interview on 4/26/18 at 9:40 AM, the Admission Coordinator stated that she didn't notify the	F 623	F623 The plan of correcting the specific deficiency The position of Richmond Pines Nursing and Rehabilitation regarding the process that led to this deficiency-failed to notify the regional ombudsman of residents discharged home or to the hospital- was knowledge deficit. By 5/24/18, the social worker (SW) will notify by fax and/or e-mail the regional ombudsman of Resident #280, #281, #50, #13, #34, #38 and #42’s discharges. The procedure for implementing the acceptable plan of correction for the specific deficiency cited By 5/24/18, the director of nursing (DON), quality improvement nurse, staff facilitator, admissions director, and/or the administrator will audit all discharges for the past 90 days for notification to the regional ombudsman. No verification	

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F 623	Continued From page 30 Regional Ombudsman for any residents discharged to home or to the hospital. Interview on 4/26/18 at 7:28 PM, the Administrator stated it was her expectation the Regional Ombudsman be notified for any resident discharged home or to the hospital. 2. Resident #281 was admitted 11/3/17 and transferred to hospital 11/8/17. Interview on 4/26/18 at 9:27 AM, the Social Worker (SW) stated she did not notify the Regional Ombudsman of Resident #281's discharge to the hospital on 11/8/17. She stated she thought it was the responsibility of the Admissions Coordinator. Interview on 4/26/18 at 9:30 AM, the Administrator stated she was not aware that the facility had to notify the Regional Ombudsman if resident was discharged home or to the hospital. She stated she was new to the facility was not aware of who was responsible for notifying the Regional Ombudsman. Interview on 4/26/18 at 9:40 AM, the Admission Coordinator stated that she didn't notify the Regional Ombudsman for any residents discharged to home or to the hospital. Interview on 4/26/18 at 7:28 PM, the Administrator stated it was her expectation the Regional Ombudsman be notified for any resident discharged home or to the hospital. 3. Resident #50 was transferred to the hospital on 11/4/17 and again on 1/12/18. He was currently residing at the facility at the time of the survey.	F 623	could be located of regional ombudsman notification for audited discharges. The regional ombudsman was notified by e-mail of all discharges with locations for the past 90 days by social worker on 5/21/18. By 5/22/18, the director of nursing, social worker, and admission coordinator was in-serviced by the administrator on notification of the regional ombudsman of resident discharge including discharge home or to the hospital. Beginning 5/21/18, weekly x 12 weeks then monthly the social worker will be emailing the regional ombudsman of all discharges including reason. This email will be kept as verification in a folder in the social workers office, in case of audit. Per conversation between social worker and regional ombudsman on 5/3/18, email is the preferred method for this communication. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator and/or DON will review all discharges weekly x 12 weeks to ensure notification, including reason for transfer, of the regional ombudsman occurred. This audit will be documented on the Ombudsman Notiication Audit tool. The results of the Ombudsman	

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F 623	Continued From page 31 Interview on 4/26/18 at 9:27 AM, the Social Worker (SW) stated she did not notify the Regional Ombudsman of Resident #50's discharge to the hospital on 11/4/17 or 1/12/18. She stated she thought it was the responsibility of the Admissions Coordinator. Interview on 4/26/18 at 9:30 AM, the Administrator stated she was not aware that the facility had to notify the Regional Ombudsman if resident was discharged home or to the hospital. She stated she was new to the facility was not aware of who was responsible for notifying the Regional Ombudsman. Interview on 4/26/18 at 9:40 AM, the Admission Coordinator stated that she didn't notify the Regional Ombudsman for any residents discharged to home or to the hospital. Interview on 4/26/18 at 7:28 PM, the Administrator stated it was her expectation the Regional Ombudsman be notified for any resident discharged home or to the hospital. 4. Resident #34 was admitted to the facility on 5/4/17 and readmitted on 1/30/18 with diagnoses that included dementia without behavioral disturbance. The quarterly Minimum Data Set (MDS) dated 4/11/18 indicated Resident #34 was rarely/never understood and rarely/never understands. He had short-term and long-term memory problems and severely impaired decision making. A review of the Resident #34's medical records revealed that he had been transferred to the	F 623	Notification Audit tool will be compiled by the administrator and/or DON and presented to the monthly quality improvement (QI) committee monthly x 3months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring. The administrator will present the findings and recommendations of the monthly QI committee meeting to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction. F623 The plan of correcting the specific deficiency The position of Richmond Pines Nursing	

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F 623	Continued From page 32 hospital and discharged from the facility on 1/28/18. He was readmitted to the facility on 1/30/18. A review of the social service progress notes revealed no documentation that the Ombudsman was notified in writing the date and the reason of transfer to the hospital. On 4/26/18 at 9:27 AM, the Social Worker (SW) was interviewed. She stated that she was new to the facility as a social worker and she had not notified the Ombudsman of any residents who had been transferred or discharged from the facility. She indicated that the Admission Coordinator might be responsible for notifying the Ombudsman. On 4/26/18 at 9:40 AM, the Admission Coordinator was interviewed. She stated that she had not notified the Ombudsman of any residents who had been discharged or transferred from the facility. On 4/26/18 at 7:20 PM, the Administrator was interviewed. The Administrator indicated that she didn't know that the facility had to notify the Ombudsman in writing of residents who had been discharged or transferred from the facility. A review of the social service progress notes revealed no documentation that the Ombudsman was notified in writing the date and the reason of transfer to the hospital. On 4/26/18 at 9:27 AM, the Social Worker (SW) was interviewed. She stated that she was new to the facility as a social worker and she had not notified the Ombudsman of any residents who	F 623	and Rehabilitation regarding the process that led to this deficiency-failed to notify the regional ombudsman of residents discharged home or to the hospital- was knowledge deficit. By 5/24/18, the social worker (SW) will notify by fax and/or e-mail the regional ombudsman of Resident #280, #281, #50, #13, #34, #38 and #42□s discharges. The procedure for implementing the acceptable plan of correction for the specific deficiency cited By 5/24/18 the director of nursing (DON), quality improvement nurse, staff facilitator, admissions director, and/or the administrator will audit all discharges for the past 90 days for notification of the regional ombudsman. The regional ombudsman will be notified by fax and/or e-mail of all discharges with locations for the past 90 days. By 5/22/18, the director of nursing, social worker, and admission coordinator will in-serviced by the administrator on notification of the regional ombudsman of resident discharge including discharge home or to the hospital. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator and/or DON will review all discharges weekly x 12 weeks to	

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F 623	Continued From page 33 had been transferred or discharged from the facility. She indicated that the Admission Coordinator might be responsible for notifying the Ombudsman. On 4/26/18 at 9:40 AM, the Admission Coordinator was interviewed. She stated that she had not notified the Ombudsman of any residents who had been discharged or transferred from the facility. On 4/26/18 at 7:20 PM, the Administrator was interviewed. The Administrator indicated that she didn't know that the facility had to notify the Ombudsman in writing of residents who had been discharged or transferred from the facility. 5. Resident #13 was admitted to the facility on 4/28/17 and most recently readmitted on 4/9/18 with multiple diagnoses that included Alzheimer ' s and dementia without behavioral disturbance. The quarterly Minimum Data Set (MDS) assessment dated 1/15/18 indicated Resident #13 was rarely/never understood and rarely never understands. Her short-term and long-term memory were impaired and she had severely impaired decision making. A review of the Resident #13's medical records revealed she had been transferred to the hospital on 4/1/18 in the morning and returned to the facility the same day. Resident #13 was again transferred to the hospital on 4/1/18 in the evening and was admitted to the hospital. A review of the social service progress notes revealed no documentation that the Ombudsman was notified in writing the date and the reason of	F 623	ensure notification of the regional ombudsman occurred. This audit will be documented on the ombudsman audit tool. The results of the Ombudsman Notification Audit tool will be compiled by the administrator and/or DON and presented to the Quality Improvement Committee monthly x 3months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	

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transfer to the hospital.

On 4/26/18 at 9:27 AM, the Social Worker (SW) was interviewed. She stated that she was new to the facility as a social worker and she had not notified the Ombudsman of any residents who had been transferred or discharged from the facility. She indicated that the Admission Coordinator might be responsible for notifying the Ombudsman.

On 4/26/18 at 9:40 AM, the Admission Coordinator was interviewed. She stated that she had not notified the Ombudsman of any residents who had been discharged or transferred from the facility.

On 4/26/18 at 7:20 PM, the Administrator was interviewed. The Administrator indicated that she didn't know that the facility had to notify the Ombudsman in writing of residents who had been discharged or transferred from the facility.
6. Resident #38 was admitted to the facility on 1/26/11 and last readmitted 4/9/18 with diagnoses that included sepsis (serious infection), pneumonia, chronic obstructive pulmonary disease and dementia.

The quarterly Minimum Data Set (MDS) dated 2/23/18 indicated Resident #38 was usually understood and usually understands communication. He was severely impaired in cognition.

A review of the Resident #38's medical records revealed that he had been transferred to the hospital and discharged from the facility on the following dates--11/20/17, 12/25/17 and 4/5/18. He was readmitted to the facility on11/25/17,

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12/29/17 and 4/9/18.

A review of the social service progress notes revealed no documentation that the Ombudsman was notified in writing the date and the reason of transfer to the hospital.

On 4/26/18 at 9:27 AM, the Social Worker (SW) was interviewed. She stated that she was new to the facility as a social worker and she had not notified the Ombudsman of any residents who had been transferred or discharged from the facility. She indicated that the Admission Coordinator might be responsible for notifying the Ombudsman.

On 4/26/18 at 9:40 AM, the Admission Coordinator was interviewed. She stated that she had not notified the Ombudsman of any residents who had been discharged or transferred from the facility.

On 4/26/18 at 7:20 PM, the Administrator was interviewed. The Administrator indicated that she didn't know that the facility had to notify the Ombudsman in writing of residents who had been discharged or transferred from the facility.

7. Resident # 42 was originally admitted to the facility on 11/19/15 with multiple diagnoses including neurogenic bladder and paraplegia. The quarterly Minimum Data Set (MDS) assessment dated 2/21/18 indicated that Resident #42 ' s cognition was intact.

Review of the Resident #42's medical records revealed that he had been transferred to the hospital on 12/8/17, 1/19/18, 2/11/18 and 3/17/18.

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F 623	Continued From page 36 Review of the social service progress notes revealed no documentation that the Ombudsman was notified in writing the date and the reason of transfer to the hospital. On 4/26/18 at 9:27 PM, the Social Worker (SW) was interviewed. She stated that she was new to the facility as social worker and she had not notified the Ombudsman of any residents who had been transferred or discharged from the facility. She indicated that the Admission Coordinator might be responsible for notifying the Ombudsman. On 4/26/18 at 9:40 AM, the Admission Coordinator was interviewed. She stated that she had not notified the Ombudsman of any residents who had been discharged or transferred from the facility. On 4/26/18 at 7:20 PM, the Administrator was interviewed. The Administrator indicated that she didn't know that the facility had to notify the Ombudsman in writing of residents who had been discharged or transferred from the facility.	F 623		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to	F 625		5/24/18

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F 625	Continued From page 37 return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to provide information about the Bed Hold Policy upon transfer to the hospital for 6 (Resident #281, Resident #50, Resident 13, Resident #34, Resident #38 and Resident #42) of 6 residents reviewed for discharge. The findings included: 1. Resident #281 was admitted 11/3/17 and transferred to hospital 11/8/17. Interview on 4/26/18 at 9:27 AM, the Social Worker (SW) stated she did not notify the resident or Responsible Party (RP) of the Bed Hold Policy when Resident #281 was transferred to the hospital on 11/8/17. She stated she thought it was the responsibility of the Admissions Coordinator. Interview on 4/26/18 at 9:30 AM, the	F 625	F625 The plan of correcting the specific deficiency The position of Richmond Pines Nursing and Rehabilitation regarding the process that led to this deficiency-failed to provide information about the bed hold policy upon transfer to the hospital- was knowledge deficit. Residents # 281, #50, #13, #34, #38, #42 were readmitted to the facility. The procedure for implementing the acceptable plan of correction for the specific deficiency cited	

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F 625	Continued From page 38 Administrator stated she was new to the facility was not aware of who was responsible for notifying the resident or RP of the facility Bed Hold Policy when transferred to the hospital. Interview on 4/26/18 at 9:40 AM, the Admission Coordinator stated that she didn't inform the resident or the RP of the facility Bed Hold Policy at the time of a hospital transfer. Interview on 4/26/18 at 7:28 PM, the Administrator stated it was her expectation the facility informs any resident or RP of the Bed Hold Policy when a resident was transferred to the hospital. 2. Resident #50 was transferred to the hospital on 11/4/17 and again on 1/12/18. He was currently residing at the facility at the time of the survey. Interview on 4/26/18 at 9:27 AM, the Social Worker (SW) stated she did not notify the resident or Responsible Party (RP) of the Bed Hold Policy when Resident #50 was transferred to the hospital on 11/4/17 or 1/12/18. She stated she thought it was the responsibility of the Admissions Coordinator. Interview on 4/26/18 at 9:30 AM, the Administrator stated she was new to the facility was not aware of who was responsible for notifying the resident or RP of the facility Bed Hold Policy when transferred to the hospital. Interview on 4/26/18 at 9:40 AM, the Admission Coordinator stated that she didn't inform the resident or the RP of the facility Bed Hold Policy at the time of a hospital transfer. Interview on 4/26/18 at 7:28 PM, the	F 625	On 5/18/18, the quality improvement (QI) and staff facilitator (SF) nurses began an in-service with all licensed nursing staff, including part time, as needed (PRN), and agency, on providing the bed hold policy upon transfer and documentation of this provision. This in-service will be completed by 5/24/18, any staff not in-serviced by 5/24/18 will not be allowed to work until in-service completed. Newly hired licensed nurses, including part time, prn, and agency, will be in-serviced during orientation. By 5/22/18, the social worker and admissions director will audit all hospital discharges for the past 90 days for evidence bed hold policy being provided. Nine residents were not provided bed hold policy at time of transfer. Bed hold policy was provided by social work from 5/15/18 through 5/21/18 and documented in the medical record. Beginning 5/24/18, based on the above in-service, the licensed nurses will document the provision of the bed hold policy in a progress note in the resident record at time of transfer. Follow-up documentation of provision of the bed hold policy will occur by the social worker on an as needed basis in the resident record. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements	

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F 625	Continued From page 39 Administrator stated it was her expectation the facility informs any resident or RP of the Bed Hold Policy when a resident was transferred to the hospital. 3. Resident #34 was admitted to the facility on 5/4/17 and most recently readmitted on 1/30/18 with diagnoses that included dementia without behavioral disturbance. The quarterly Minimum Data Set (MDS) dated 4/11/18 indicated Resident #34 was rarely/never understood and rarely/never understands. He had short-term and long-term memory problems and severely impaired decision making. A review of the Resident #34's medical records revealed that he had been transferred to the hospital and discharged from the facility on 1/28/18. He was readmitted to the facility on 1/30/18. A review of the social service progress notes revealed no documentation that the bed hold policy was provided to the resident upon transfer to the hospital. On 4/26/18 at 9:27 AM, the Social Worker (SW) was interviewed. She stated that she was new to the facility as a social worker and she didn't provide the bed hold policy to the resident upon discharge to the hospital. She indicated that the Admission Coordinator might be responsible for providing the bed hold policy to the resident or the resident's legal representative (RP). On 4/26/18 at 9:30 AM, the Administrator stated	F 625	The administrator and/or director of nursing will review all transfers weekly x 12 weeks to ensure the bed hold policy was provided and documentation is present. This audit will be documented on the transfer audit tool. The results of the transfer audit tool will be compiled by the administrator and/or director of nursing and presented to the quality improvement (QI) committee monthly for three months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring. The administrator and/or director of nursing will present transfer audit tool findings and QI committee recommendations to the quarterly quality assurance (QA) committee for further recommendations and oversight.	

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she was new to the facility was not aware of who was responsible for notifying the resident or RP of the facility Bed Hold Policy when transferred to the hospital.

On 4/26/18 at 9:40 AM, the Admission Coordinator was interviewed. She stated that she didn't provide the resident or the RP the bed hold policy when discharged to the hospital because the resident was coming back anyway and this was their home.

On 4/26/18 at 7:20 PM, a follow up interview was conducted with the Administrator. The Administrator indicated that she expected the staff to provide a copy of the facility's bed hold policy when a resident was discharged to the hospital.

4. Resident #13 was admitted to the facility on 4/28/17 and most recently readmitted on 4/9/18 with multiple diagnoses that included Alzheimer ' s and dementia without behavioral disturbance.

The quarterly Minimum Data Set (MDS) assessment dated 1/15/18 indicated Resident #13 was rarely/never understood and rarely never understands. Her short-term and long-term memory were impaired and she had severely impaired decision making.

A review of the Resident #13's medical records revealed she had been transferred to the hospital on 4/1/18 in the morning and returned to the facility the same day. Resident #13 was again transferred to the hospital on 4/1/18 in the evening and was admitted to the hospital. Resident #13 was readmitted to the facility on

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4/9/18.

A review of the social service progress notes revealed no documentation that the bed hold policy was provided to the resident upon transfer to the hospital.

On 4/26/18 at 9:27 AM, the Social Worker (SW) was interviewed. She stated that she was new to the facility as a social worker and she didn't provide the bed hold policy to the resident upon discharge to the hospital. She indicated that the Admission Coordinator might be responsible for providing the bed hold policy to the resident or the resident's legal representative (RP).

On 4/26/18 at 9:30 AM, the Administrator stated she was new to the facility was not aware of who was responsible for notifying the resident or RP of the facility Bed Hold Policy when transferred to the hospital.

On 4/26/18 at 9:40 AM, the Admission Coordinator was interviewed. She stated that she didn't provide the resident or the RP the bed hold policy when discharged to the hospital because the resident was coming back anyway and this was their home.

On 4/26/18 at 7:20 PM, a follow up interview was conducted with the Administrator. The Administrator indicated that she expected the staff to provide a copy of the facility's bed hold policy when a resident was discharged to the hospital.

5. Resident #38 was admitted to the facility on

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1/26/11 and last readmitted 4/9/18 with diagnoses that included sepsis (serious infection), pneumonia, chronic obstructive pulmonary disease and dementia.

The quarterly Minimum Data Set (MDS) dated 2/23/18 indicated Resident #38 was usually understood and usually understands communication. He was severely impaired in cognition.

A review of the Resident #38's medical records revealed that he had been transferred to the hospital and discharged from the facility on the following dates--11/20/17, 12/25/17 and 4/5/18. He was readmitted to the facility on11/25/17, 12/29/17 and 4/9/18.

A review of the social service progress notes revealed no documentation that the bed hold policy was provided to the resident upon transfer to the hospital.

On 4/26/18 at 9:27 AM, the Social Worker (SW) was interviewed. She stated that she was new to the facility as a social worker and she didn't provide the bed hold policy to the resident upon discharge to the hospital. She indicated that the Admission Coordinator might be responsible for providing the bed hold policy to the resident or the resident's legal representative (RP).

On 4/26/18 at 9:30 AM, the Administrator stated she was new to the facility was not aware of who was responsible for notifying the resident or RP of the facility Bed Hold Policy when transferred to the hospital.

On 4/26/18 at 9:40 AM, the Admission

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Coordinator was interviewed. She stated that she didn't provide the resident or the RP the bed hold policy when discharged to the hospital because the resident was coming back anyway and this was their home.

On 4/26/18 at 7:20 PM, a follow up interview was conducted with the Administrator. The Administrator indicated that she expected the staff to provide a copy of the facility's bed hold policy when a resident was discharged to the hospital.

6. Resident # 42 was originally admitted to the facility on 11/19/15 with multiple diagnoses including neurogenic bladder and paraplegia. The quarterly Minimum Data Set (MDS) assessment dated 2/21/18 indicated that Resident #42 ' s cognition was intact.

Review of the Resident #42's medical records revealed that he had been transferred to the hospital on 12/8/17, 1/19/18, 2/11/18 and 3/17/18.

Review of the social service progress notes revealed no documentation that the bed hold policy was provided to the resident upon transfer to the hospital.

On 4/26/18 at 9:27 PM, the Social Worker (SW) was interviewed. She stated that she was new to the facility as social worker and she didn't provide the bed hold policy to the resident upon discharge to the hospital. She indicated that the Admission Coordinator might be responsible for providing the bed hold policy to the resident or the resident's legal representative (RP).

On 4/26/18 at 9:40 AM, the Admission

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F 625	Continued From page 44 Coordinator was interviewed. She stated that she didn't provide the resident or the RP the bed hold policy when discharged to the hospital because the resident was coming back anyway and this was their home. On 4/26/18 at 7:20 PM, the Administrator was interviewed. The Administrator indicated that she expected the staff to provide a copy of the facility's bed hold policy when a resident was discharged to the hospital.	F 625		
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 review, observation and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of medications (Residents #37 & #52), physical restraints (Resident #69) and Activities of daily living (ADL) (Resident #58) for 4 of 25 sampled residents reviewed. Findings included: 1. Resident #37 was admitted to the facility on 12/21/15 with multiple diagnoses including anxiety disorder. The annual MDS assessment dated 2/9/18 indicated that Resident #37 had not received an antianxiety medication during the assessment period. Resident #37 had a doctor's order dated 1/8/18 for Xanax (antianxiety drug) 0.25 milligrams (mgs) by mouth 3 times a day.	F 641	F641 The plan of correcting the specific deficiency The position of Richmond Pines Healthcare and Rehabilitation regarding the process that led to this deficiency-failure to accurately code the minimum data set (MDS) assessments accurately- was staff failure to follow established policy and procedure. Resident #37's MDS assessment dated 2/9/18 was modified to accurately reflect the resident's use of an antianxiety medication on 5/3/18 by the MDS nurse and transmitted to the national repository on 5/3/18.	5/24/18

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F 641	Continued From page 45 The February 2018 Medication Administration Records (MARs) for Resident #37 revealed that she had received Xanax from February 1-28, 2018. On 4/24/18 at 4:30 PM, the MDS Coordinator and the MDS Nurse were interviewed. They both verified that Resident #37 had received Xanax during the assessment period. The MDS Nurse stated that the antianxiety medication should have been coded 7 on the annual MDS assessment dated 2/9/18 but it was not, it was coded incorrectly. On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that she expected the MDS assessments to be coded correctly. 2. Resident #52 was admitted to the facility on 6/10/15 with multiple diagnoses including dementia with behaviors. The quarterly Minimum Data Set (MDS) assessment dated 4/15/18 indicated that Resident #52 had memory and decision making problems and she had not receive an antianxiety medication during the assessment period. Resident #52 had a doctor's order dated 12/12/17 for Buspar (antianxiety drug) 5 milligrams (mgs) by mouth 2 times a day. The April 2018 Medication Administration Records (MARs) revealed that Resident #52 had received Buspar from April 1-24, 2018. On 4/25/18 at 5:26 PM, the MDS Nurse was interviewed. The MDS Nurse verified that	F 641	Resident #52's MDS assessment dated 4/15/18 was modified to accurately reflect the resident's use of an antianxiety medication on 5/3/18 by the MDS nurse and transmitted to the national repository on 5/3/18. Resident #69's MDS assessment dated 4/2/18 was modified to accurately reflect the resident's use of a physical restraint on 5/3/18 by the MDS nurse and transmitted to the national repository on 5/3/18. Resident #58's MDS assessment dated 4/12/18 was modified to accurately reflect the resident's activities of daily living (ADL) function on 5/3/18 by the MDS nurse and transmitted to the national repository on 5/3/18. The procedure for implementing the acceptable plan of correction for the specific deficiency cited By 5/22/18, the director of nursing (DON) will in-service the MDS coordinator and MDS nurse on accuracy of MDS assessments including antianxiety medications, physical restraints, and ADL function based on the resident assessment instrument (RAI) manual. Any newly hired MDS coordinator will be in-serviced prior to working independently with MDS assessments. By 5/24/18, the MDS nurse will audit all residents to ensure comprehensive	

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F 641	Continued From page 46 Resident #52 had received Buspar during the assessment period. She stated that the antianxiety medication should have been coded 7 on the quarterly MDS assessment dated 4/15/18 but it was not, it was coded incorrectly. On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that she expected the MDS assessments to be coded correctly. 3. Resident # 69 was admitted to the facility on 1/20/11 with multiple diagnoses including anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 4/2/18 indicated that Resident #69 was not using a physical restraint. Resident #69 had a doctor's order dated 7/15/17 for self-release seat belt while out of bed due to decreased safety awareness and unsafe movements. On 4/24/18 at 9:32 AM and on 4/25/18 at 8:02 AM, Resident #69 was observed out of bed in a chair with a self-release seat belt on. On 4/26/18 at 11:33 AM, Nurse #3 was interviewed. She stated that she was assigned to Resident #69. Nurse #3 indicated that Resident #69 was cognitively impaired and she not able to release the seat belt on command. On 4/26/18 at 12:38 PM, the MDS Coordinator was interviewed. She stated that she completed the quarterly MDS assessment dated 4/2/18 for Resident #69. The MDS Coordinator confirmed that Resident #69 was wearing a self-release seat belt when she was out of bed and she was not able to remove it on command. She indicated	F 641	assessments are accurate for antianxiety medications, physical restraint, and ADL function that were completed and/or scheduled for the past 30 days. No other comprehensive assessments were found to be coded incorrectly for antianxiety medications, physical restraints, or ADLs. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, administrator, and/or corporate consultant will audit all MDS assessments completed and submitted to the national repository weekly. The audits will be completed weekly on 100% of MDS assessments completed for 4 weeks, then weekly 50% of MDS assessments completed for 8 weeks to ensure assessments were coded correctly for medications, physical restraints, and ADL function. This audit will be documented on the MDS audit tool. The monthly quality improvement (QI) committee will review the results of the MDS audits monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly	

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F 641	Continued From page 47 that physical restraint should have been coded but it was not, it was coded incorrectly. On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that she expected the MDS assessments to be coded correctly. 4. Resident #58 was admitted to the facility on 2/22/18 and readmitted on 3/9/18 with diagnoses that included feeding difficulties, dysphagia, vascular dementia with behavioral disturbance, and Parkinson' s. The significant change Minimum Data Set (MDS) assessment dated 4/12/18 indicated Resident #58 was rarely/never understood and rarely/never understands. He had short-term and long-term memory problems and severely impaired decision making. Resident #58 was coded as requiring the supervision of 1 staff member for eating. He had impairment on one side of his upper and lower extremities. The plan of care for Resident #58, last revised on 4/19/18, included the focus area of assistance for eating related to dementia, Parkinson ' s, and cerebrovascular accident (CVA). The interventions indicated Resident #58 was dependent on the total assistance of staff with eating. An observation was conducted of Resident #58 in his room during the lunch meal on 4/23/18 at 1:00 PM. Resident #58 was observed to be dependent on 1 staff for eating assistance. A family interview was conducted for Resident	F 641	executive quality assurance QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	

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F 641	Continued From page 48 #58 on 4/24/18 10:05 AM. She reported Resident #58 required the assistance of staff for eating. An observation was conducted of Resident #58 in his room during the lunch meal on 4/24/18 at 1:10 PM. Resident #58 was observed to be dependent on 1 staff for eating assistance. An interview was conducted with the MDS Coordinator on 4/26/18 at 3:48 PM. The 4/12/18 significant change MDS that indicated Resident #58 required the supervision of 1 staff for eating was reviewed with the MDS Coordinator. The care plan that indicated Resident #58 was dependent on the total assistance of staff with eating was reviewed with the MDS Coordinator. She revealed the MDS should have indicated Resident #58 was dependent on 1 staff assistance for eating. She stated she was going to revise the 4/12/18 MDS for Resident #58. The DON was unavailable for interview. An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. She stated she expected the MDS to be coded accurately.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations	F 644		5/24/18

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F 644	Continued From page 49 from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to make a referral for re-evaluation after a significant change in condition, for 1 of 1 sampled residents (Resident #58) reviewed for Preadmission Screening Resident Review Level II status. The findings included: Resident #58 was admitted to the facility on 2/22/18 and readmitted on 3/9/18 with multiple diagnoses that included mood disorder, delirium due to known physiological condition, and depression. A review of the medical record revealed Resident #58 was determined to have a Level II Preadmission Screening Resident Review (PASRR) with no expiration date. A significant change Minimum Data Set (MDS) assessment dated 4/12/18 for Resident #58 indicated he was rarely/never understood and rarely/never understands. He had short-term and long-term memory problems and severely impaired decision making. This assessment indicated Resident #58 had a Level II PASRR related to serious mental illness and he was	F 644	F644 The plan of correcting the specific deficiency The position of Richmond Pines Healthcare and Rehabilitation Center regarding the process that led to this deficiency- failure to make a referral for re-evaluation of pre-admission screening and annual resident review (PASARR) status after a significant change in condition- was the social worker's knowledge deficit. Resident #58 was referred to the PASARR authority on 5/7/18 by the social worker (SW) for re-evaluation of level 2 status. On 5/15/18, the social worker (SW) was in-serviced by the licensed nursing home administrator on referring residents to the PASARR authority when a significant change in condition occurs. The procedure for implementing the	

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F 644	Continued From page 50 receiving hospice services. The plan of care for Resident #58, initiated on 3/5/18 and last reviewed on 4/19/18, included the focus area of a level II PASRR. The plan of care also included the focus area of hospice care initiated on 4/2/18 and last reviewed on 4/19/18. An interview was conducted with the MDS Coordinator on 4/26/18 at 3:48 PM. She indicated the Social Worker (SW) was responsible for all actions related to Level II PASRRs. An interview was conducted with the SW on 4/26/18 at 3:50 PM. She stated was responsible for the actions related to Level II PASRRs. She confirmed Resident #58 had a Level II PASRR with no expiration date. The SW revealed she was unaware of the requirement for a referral for re-evaluation to the PASRR Authority for a resident with a Level II status following a significant change in condition. She explained that this was her first job as a SW in a long-term care setting and she was still in the process of learning all of the requirements. The SW confirmed the PASRR Authority was not notified of Resident #58' s significant change in condition related to his 4/12/18 MDS. The DON was unavailable for interview. An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. She stated it was her expectation that the regulations related to PASRR were followed.	F 644	acceptable plan of correction for the specific deficiency cited On 5/15/18, the social worker (SW) was in-serviced by the licensed nursing home administrator on referring residents to the PASARR authority when a significant change in condition occurs. On 5/16/18, the SW audited all residents with a level 2 PASARR to ensure no significant change in condition assessments had been completed in last 90 days. The findings revealed no additional failures to make a referral for re-evaluation of PASARR status after a significant change in condition. Beginning 5/16/18, the minimum data set (MDS) nurse is notifying the SW and administrator if there is a significant change in a resident's condition. This notification occurs verbally during the morning meeting. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The administrator or director of nursing (DON) will audit 100% of MDS significant change assessments completed and submitted to the national repository weekly x 4 weeks then 50% weekly x 8 weeks to ensure the PASARR authority has been notified if resident is a level 2 PASARR for re-evolution of status. This	

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F 644	Continued From page 51	F 644	audit will be documented on the MDS audit tool. The monthly quality improvement (QI) committee will review the results of the MDS audits monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction.	
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	F 656		5/24/18

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F 656	Continued From page 52 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to implement the plan of care interventions to document meal intake percentages for 3 of 7 residents (Residents #13, #34, and #58) reviewed for nutrition. The findings included:	F 656	F656 The plan of correcting the specific deficiency The position of Richmond Pines Nursing and Rehabilitation center regarding the	

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F 656	Continued From page 53 1. Resident #13 was admitted to the facility on 4/28/17 and most recently readmitted on 4/9/18 with multiple diagnoses that included Alzheimer ' s and dementia without behavioral disturbance. The significant change Minimum Data Set (MDS) assessment dated 4/12/18 indicated Resident #13 was rarely/never understood and rarely never understands. Her short-term and long-term memory were impaired and she had severely impaired decision making. Resident #13 required the extensive assistance of 1 staff for eating. The plan of care for Resident #13, initiated on 5/1/17 and most recently reviewed on 4/19/18, included the focus area of assistance for eating. The interventions included, in part, documentation of Resident #13 ' s meal intake for each meal (initiated on 5/1/17). A review of the Nursing Assistant (NA) documentation of meal intake for Resident #13 from 2/21/18 through 3/31/18 and 4/9/18 through 4/24/18 (Resident #13 was discharged to the hospital on 4/1/18 and returned on 4/9/18). There were 37 meals during this timeframe with no intake percentage documented for Resident #13. An interview was conducted with the Quality Assurance (QA) Nurse on 4/25/18 at 3:45 PM. She stated that NAs were responsible for documenting the meal intake percentage for all residents they were assigned to for all meals that occurred during their shift. An interview was conducted with NA #7 on 4/25/18 at 5:15 pm. She stated NAs were responsible for documenting the meal intake	F 656	process that led to this deficiency was the staff failure to follow established procedure in implementing care plan intervention to document meal intake percentages. On 5/21/18, the quality improvement (QI) nurse, staff facilitator (SF) nurse, director of nursing (DON), and charge nurse observed a meal for Resident #13, #34, and #58. The auditors ensured the meal intake for the observed meal for Resident # 13, #34, and #58 was accurately documented, meal intake was correctly documented. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/18/18 the QI and SF nurses initiated an in-service for all nursing staff including licensed and unlicensed staff, part time, as needed (PRN), and agency, on following care plan interventions, including meal intake documentation. This in-service will be completed by 5/24/18. After 5/24/18 no nursing staff will be allowed to work until this in-service is complete. This in-service will be part of the orientation process for new nursing staff including licensed, unlicensed, part time, prn, and agency. On 5/21/18, the QI nurse, SF nurse, DON, and charge nurse completed an audit of all residents' meal intake documentation for the previous 7 days. The result of the audit: greater than 25% of residents had missing or inaccurate meal intake	

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F 656	Continued From page 54	F 656		

percentage for all residents they were assigned to for all meals that occurred during their shift.

The DON was unavailable for interview.

An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. She stated she expected the care plan interventions to be followed.

2. Resident #34 was admitted to the facility on 1/4/16 and most recently readmitted on 1/30/18 with diagnoses that included dementia without behavioral disturbance.

The quarterly Minimum Data Set (MDS) assessment dated 4/11/18 indicated Resident #34 was rarely/never understood and rarely/never understands. He had short-term and long-term memory problems and severely impaired decision making. Resident #34 required the extensive assistance of 1 with eating.

The plan of care for Resident #34, last reviewed on 4/18/18, included the focus area of assistance for eating. The interventions included, in part, documentation of Resident #34 ' s meal intake for each meal (initiated on 12/22/16).

A review was conducted of the NA ' s meal intake percentage documentation for Resident #34 from 2/21/18 through 4/24/18. There were 31 meals during this timeframe with no intake percentage documented for Resident #34.

An interview was conducted with the Quality Assurance (QA) Nurse on 4/25/18 at 3:45 PM. She stated that NAs were responsible for documentation.

On 5/21/18, the SF nurse continued in-servicing licensed nurses and nursing assistants on correct meal intake documentation.

On 5/23/18, the corporate facility consultant validated nursing assistants had adequate access to the electronic health record for meal intake documentation. The audit result: all nursing assistants and licensed nurses have access to document meal intake.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements
The administrator, DON, and/or QI nurse will audit 20 residents weekly x 12 weeks to ensure meal intake is documented per care plan, including visual confirmation of accuracy of percentage by looking at the meal tray after the resident is finished eating and reviewing the documentation of meal intake. This audit will be documented on the resident care audit tool.

The monthly QI committee will review the results of the resident care audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance.

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F 656	Continued From page 55 documenting the meal intake percentage for all residents they were assigned to for all meals that occurred during their shift. An interview was conducted with NA #7 on 4/25/18 at 5:15 pm. She stated NAs were responsible for documenting the meal intake percentage for all residents they were assigned to for all meals that occurred during their shift. The DON was unavailable for interview. An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. She stated she expected the care plan interventions to be followed. 3. Resident #58 was admitted to the facility on 2/22/18 and readmitted on 3/9/18 with diagnoses that included feeding difficulties, dysphagia, vascular dementia with behavioral disturbance, and Parkinson ' s. The significant change Minimum Data Set (MDS) assessment dated 4/12/18 indicated Resident #58 was rarely/never understood and rarely/never understands. He had short-term and long-term memory problems and severely impaired decision making. Resident #58 was coded as supervision of 1 with eating. The plan of care for Resident #58, last reviewed on 4/19/18, included the focus area of weight loss, inadequate intake, and decreased appetite related to cognitive impairment and refusals to eat meals at times. The interventions included, in part, documentation of Resident #58 ' s meal intake for each meal.	F 656	The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. T he director of nursing is responsible for implementing the acceptable plan of correction.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 56 A review was conducted of the NA ' s meal intake percentage documentation for Resident #58 from 3/10/18 through 4/24/18. There were 28 meals during this timeframe with no intake percentage documented for Resident #58. An interview was conducted with the Quality Assurance (QA) Nurse on 4/25/18 at 3:45 PM. She stated that NAs were responsible for documenting the meal intake percentage for all residents they were assigned to for all meals that occurred during their shift. An interview was conducted with NA #7 on 4/25/18 at 5:15 pm. She stated NAs were responsible for documenting the meal intake percentage for all residents they were assigned to for all meals that occurred during their shift. The DON was unavailable for interview. An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. She stated she expected the care plan interventions to be followed.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		5/24/18

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F 657	Continued From page 57 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 record review and staff interview, the facility failed to review and revise plans of care to reflect the current status of the resident for 2 of 25 residents (Residents #13 and #58) reviewed. The findings included: 1. Resident #58 was admitted to the facility on 2/22/18 and readmitted on 3/9/18 with diagnoses that included feeding difficulties, dysphagia, vascular dementia with behavioral disturbance, and Parkinson ' s. The significant change Minimum Data Set (MDS) dated 4/12/18 indicated Resident #58 was rarely/never understood and rarely/never understands. He had short-term and long-term memory problems and severely impaired decision making. Resident #58 was coded as independent with transfers.	F 657	F 657 The plan of correcting the specific deficiency The position of Richmond Pines Healthcare and Rehabilitation Center regarding the process that led to the deficiency of failure to revise care plan was staff failure to follow established policy and procedure. On 4/26/18, the minimum data set (MDS) coordinator revised Resident #58’s care plan to accurately reflect the current status of Resident #58’s transfer needs. On 4/26/18, the MDS coordinator revised Resident #13’s care plan to accurately	

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F 657	Continued From page 58 The plan of care for Resident #58, last reviewed on 4/19/18, included the focus area of assistance with transferring from one position to another related to dementia, Parkinson ' s, and cerebrovascular accident (CVA). The interventions indicated Resident #58 required 2 persons for constant supervision/physical assistance with transfer belt. An interview was conducted with the MDS Coordinator on 4/26/18 at 3:48 PM. The 4/12/18 significant change MDS that indicated Resident #58 was independent with transfers was reviewed with the MDS Coordinator. The care plan that indicated Resident #58 required the 2 persons for constant supervision/physical assistance with transfer belt was reviewed with the MDS Coordinator. She reviewed the Nursing Assistant (NA) documentation related to transfers for the 4/12/18 MDS review period and indicated the MDS was coded accurately. She stated Resident #58 ' s transfer ability fluctuated and the care plan should have been revised to reflect this fluctuation rather than indicating he required the assistance of 2 staff. The MDS Coordinator indicated she was going to revise the care plan related to transfers so it accurately reflected the status of Resident #58. The DON was unavailable for interview. An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. She stated she expected plans of care to be revised to reflect the resident ' s current status. 2. Resident #13 was admitted to the facility on 4/28/17 and most recently readmitted on 4/9/18	F 657	reflect the current status of Resident #13's meal assistance needs. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/26/18, the MDS coordinator audited current resident care plans for transfers and meal assistance for accuracy and to ensure appropriate assistance is provided to residents to transfer and during mealtimes. There were no further discrepancies identified. On 4/26/18, the director of nursing (DON) in-serviced the MDS coordinator and the MDS nurse on care plan revisions. Any newly hired MDS coordinator will be in-serviced by the DON on care plan revisions. The in-services will aide in ensuring the problem with MDS nurses making timely and accurate care plan revisions does not recur. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, quality improvement (QI) nurse, staff facilitator (SF) nurse, or administrator will monitor through direct observation staff assisting residents with transferring and eating at mealtimes. The	

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F 657	Continued From page 59 with multiple diagnoses that included Alzheimer ' s and dementia without behavioral disturbance. The significant change Minimum Data Set (MDS) assessment dated 4/12/18 indicated Resident #13 was rarely/never understood and rarely never understands. Her short-term and long-term memory were impaired and she had severely impaired decision making. Resident #13 required the extensive assistance of 1 staff for eating. The plan of care for Resident #13, initiated on 5/1/17 and most recently reviewed on 4/19/18, included the focus area of assistance for eating. The interventions included, in part, "Provide supervision with tray set up. Resident is able to feed self." An interview was conducted with the MDS Coordinator on 4/25/18 at 12:35 PM. The 4/12/18 significant change MDS that indicated Resident #13 required the extensive assistance of 1 staff for eating was reviewed with the MDS Coordinator. The care plan that indicated Resident #13 required supervision with set up only for eating was reviewed with the MDS Coordinator. She stated she needed to review the Nursing Assistant (NA) documentation related to eating for the 4/12/18 MDS review period to determine why there was a discrepancy between Resident #13 ' s MDS and her care plan. An interview was conducted with the MDS Nurse on 4/25/18 at 12:43 PM. She stated she reviewed the NA documentation related to eating and Resident #13 varied from supervision to extensive assistance with eating. She reported the MDS was coded accurately based on the NA documentation. She revealed the plan of care	F 657	audits will include 10 residents weekly x 4 weeks and then 5 residents weekly x 8 weeks to ensure transfer and mealtime assistance listed as the MDS care plan intervention is appropriate and accurate. This audit will be documented on the Care Plan Audit tool. Through observation and supervision of direct care staff, the problem with care plans/following care plans/identifying the need to update a care plan should not recur. The monthly QI committee will review the results of the Care Plan Audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The MDS coordinator, DON, and/or QI nurse will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	

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F 657	Continued From page 60 related to eating should have been updated to accurately reflect Resident #13 ' s status. The MDS Nurse stated she was going to revise Resident #13 ' s care plan related to eating. An interview was conducted with NA #4 on 4/25/18 at 12:55 PM. She stated since Resident #13 was readmitted on 4/9/18 she had required assistance to eat for almost all meals. The DON was unavailable for interview. An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. She stated she expected plans of care to be revised to reflect the resident ' s current status.	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 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 observation, record review and staff interviews, the facility failed to have a physician ' s order for oxygen therapy for one of two residents who received continuous oxygen therapy (Resident #38) and failed to have a physician ' s order for a wander guard bracelet for two of two residents who had wander guard bracelets (Resident #38 and #16). The findings included: 1. a. Resident #38 was readmitted to the facility 4/9/18. Cumulative diagnoses included chronic	F 658	F658 The plan of correcting the specific deficiency The position of Richmond Pines Healthcare and Rehabilitation center regarding the process that led to the deficiency of failure to have a physician□s order for continuous oxygen therapy and use of a wander guard was staff failure to follow established policy and procedure.	5/24/18

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F 658	Continued From page 61 obstructive pulmonary disease (COPD), pneumonia (4/9/18), shortness of breath, heart failure and dependence on supplemental oxygen. The quarterly Minimum Data Set (MDS) dated 2/23/18 indicated Resident #38 was severely impaired in cognition. Oxygen was documented as being used during the assessment period. A care plan last revised on 2/27/18 stated resident #38 had potential for or actual ineffective breathing pattern as related to oxygen dependence. Interventions included, in part, oxygen therapy at three liters via nasal cannula continuous as ordered. A review of the medical record revealed there was no order for oxygen. Observations were conducted daily throughout the survey (4/23, 4/24, 4/25, 4/26). Resident #38 was observed to wear oxygen at three liters via nasal cannula each day. On 4/26/18 at 9:38 AM, an interview was conducted with the Nurse Practitioner who stated a physician order should be written for the use of oxygen. She stated Resident #38 was on continuous oxygen and he did have an order but it might have not gotten transferred when he went to the hospital and came back. She stated there was also a standing order related to oxygen use. A review of standing orders revealed the following regarding the use of oxygen: may start oxygen at two liters/ minute via nasal cannula as needed for shortness of breath (x 24 hours). On 4/26/18 at 10:11 AM, an interview was	F 658	On 5/18/18, the staff nurse obtained an order for Resident #38 to have continuous oxygen at a rate of three (3) liters per minute. The order was placed on Resident #38'□s medication administration record (MAR). On 5/18/18, the staff nurse obtained an order for Resident #16 and # 38 to have wander guard placement. The wander guard monitoring sheet was placed in the wander guard monitoring binder. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/18/18, the quality improvement (QI) nurse and staff facilitator (SF) nurse began in-servicing all licensed nurses and medication aides, including part time (PT), as needed (PRN), and agency, in an effort to protect residents in similar situations from using oxygen without a correct oxygen order and/or wander guard order from the physician. The in-service covered oxygen use per physician order and wander guard per physician order and/or care plan intervention. The in-service will be completed by 5/24/18. No licensed nurse or medication aide, including PT, PRN, and agency will be allowed to work until the in-service is completed. This in-service will be included in the orientation of all new licensed nurses and medication aides, including PT, PRN, and agency staff.	

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F 658	Continued From page 62 conducted with the Quality Assurance Nurse. She said her expectation was for an order to be written if a resident used oxygen. On 4/26/18 at 7:21 PM, an interview was conducted with the Administrator. She stated a physician ' s order should be obtained if a resident required and/or used oxygen. b. Resident #38 was readmitted to the facility 4/9/18. Cumulative diagnoses included major depressive disorder, dementia and agitation. The quarterly Minimum Data Set (MDS) dated 2/23/18 indicated Resident #38 was severely impaired in cognition. There were no episodes of psychosis or behaviors noted during the assessment period. A care plan dated 1/15/18 indicated Resident #38 was at risk for wandering and/or at risk for unsupervised exits from facility related to cognitive impairment. Resident #38 had a history of cutting off his wander guard bracelet with nail clippers. Interventions included, in part, ensure resident picture and name was on the wandering resident board. An interview with the Nurse Practitioner was conducted on 4/26/18 at 9:30 AM. She stated there should be a physician ' s order for a wander guard. On 4/26/18 at 9:48 AM, an interview was conducted with the Administrator. She stated the facility was changing their practice for wander guard bracelets. The Administrator said any time a wander guard bracelet was placed on a resident at risk for wandering, the must be a	F 658	On 5/18/18, the director of nursing (DON), QI nurse, SF nurse, and charge nurse initiated an audit to ensure all residents using oxygen on a regular basis have a physician□s order, including the rate per minute. The audit results: 2 residents were without correct flow rates on the physician orders. On 5/23/18, the QI nurse clarified oxygen orders with the physician/provider and updated the medication administration record (MAR) with the new oxygen orders. On 5/23/18, the SF nurse completed an audit to ensure all residents using a wander guard have a physician□'s order. The audit results: 14 orders were not available in the resident health record. The SF nurse and QI nurse obtained from the physician/provider 14 orders to validate the use of a wander guard for a resident. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, QI nurse, SF nurse, or administrator will audit 20 residents weekly x 12 weeks to ensure oxygen and/or wander guard is in place according to the physician order. This audit will be documented on the physician order audit tool.	

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F 658	Continued From page 63 physician ' s order. She stated that was her expectation. On 4/26/18 at 11:15AM, Resident #38 was observed sitting in his room. He stated he had a white band on his leg. Resident #38 was observed to have a white wander guard bracelet on his right ankle. A review of the medical record for Resident #38 revealed there was not an order for a wander guard bracelet. On 4/26/18 at 7:21 PM, an interview was conducted with the Administrator who stated her expectation was for a resident that had a wander guard bracelet, a physician ' s order must be in place. 2. Resident #16 was admitted 4/8/16 with cumulative diagnoses of Cerebral Vascular Accident (CVA) Hemiplegia and Diabetes. Review of Resident #16's nursing notes indicated he voiced threats of leaving the facility on 7/9/17 and a wander guard was placed on him. Resident #16's annual Minimum Data Set dated 1/22/18 indicated moderate cognitive impairment with no wandering behaviors. Review of a Wandering Risk Assessment dated 1/22/18 indicated Resident #16 was at risk for wandering. Review of Resident #16's care plan revised on 2/22/18 indicated he was at risk for wandering and at risk for unsupervised exits from the facility. He was care planned for the use of a wander guard.	F 658	The monthly QI committee will review the results of the physician order audit tool monthly for 3 months for identification of trends, actions taken, and to determine if the added monitoring ensures that the problem does not recur. The QI nurse and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for review of the facility's progress and make sure the solutions are sustained. The QA committee may make further recommendations and require additional oversight by the administrator. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	

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F 658	Continued From page 64 Interview on 4/25/18 at 4:40 PM, the Administrator stated there was no physician order for Resident #16's wander guard implemented 7/9/17. Interview with the Nurse Practitioner (NP) was conducted on 4/26/18 at 9:30 AM. She stated there should be a physician's order for a wander guard. Interview on 4/26/18 at 9:48 AM, the Administrator stated the facility was changing their practice for wander guards. She stated any time a wander guard was placed on a resident at risk for wandering, there must be a physician order. She stated this was her expectation.	F 658		
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and record review, the facility failed to provide psychological services as ordered for 1 (Resident #68) of 6 residents reviewed for unnecessary	F 675	F675 The plan of correcting the specific deficiency	5/24/18

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F 675	Continued From page 65 medications. The findings included: Resident #68 was admitted 8/10/16 with a diagnosis of major depression and psychosis. Review of a psychiatric evaluation dated 4/21/17 read Resident #68 was experiencing mild anxiety and depressed mood. He stated he was sleeping better but not adequately and reported his appetite varied. The note indicated psychiatric follow up as needed. Review of an undated Consultation Report read Resident #68 was being seen due to mood and psychosis. His antidepressant was increased and hospice should be considered for additional support. Review of a nursing note dated 5/3/17 read Resident #68 was seen on 5/2/17 and his antidepressant was increased. Social services were to contact his family regarding hospice services. Resident #68's prescribed an antidepressant was increased on 5/3/17. There were no additional documented adjustments in his antidepressant since 5/3/17. Resident #68 was care planned for sadness, anxiety, tiredness, decreased appetite and insomnia on 6/26/17. Interventions included psychological services.	F 675	The position of Richmond Pines Nursing and Rehabilitation center regarding the process that led to this deficiency- failed to provide psychological services as ordered- was failure to follow procedure for following physician's orders. On 4/26/18, nurse practitioner (NP) wrote an order for "schedule resident for psych follow-up every 6 months for medication review - history of depression, psychosis". On 5/1/18, Resident # 68 was seen by psychiatric services. There were no new orders given on 5/1/18. On 5/15/18, the provider gave a new order to "Initiate Remeron 7.5mg by mouth every night for depression." The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/23/18, the medical records clerk performed an audit to protect residents in similar situations. The medical records clerk audited all residents to ensure any residents with orders for psychiatric services are receiving services as ordered. The medical records clerk also switched all the resident who are receiving psychological services from the previous psychological service provider to the new psychological service provider. The audit results: several resident records required adjustment from the previous provider to	

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F 675	Continued From page 66 Review of Resident #68's nursing notes indicated increased profanity toward his room-mate on 1/18/18, refusal of aide assistance on 1/21/18 and 2/4/18 and pouring urine in the sink on 2/28/18. Review of Resident #68's behavior monitoring indicated he had experienced three episodes of anxiousness since 3/20/18. His quarterly Minimum Data Set dated 4/2/18 indicated Resident #68 was cognitively intact and coded for no behaviors. His mood was coded as the following: Little interest or pleasure in doing things Feeling down, depressed or hopeless Trouble falling and staying asleep Feeling tired or little energy Feelings of being a failure Trouble concentrating Moving and speaking slow Resident #68's last revised care plan dated 4/5/18 included feelings of sadness and insomnia. There was no mention of psychological services as needed. Review of Resident #68's April 2018 physician orders read he was receiving Lexapro (antidepressant) 20 milligrams (mg) daily. Interview with Resident #68 was conducted on	F 675	the new psychological service provider. The medical records clerk made the adjustments and notified the director of nursing. On 5/18/18, the staff facilitator and quality improvement nurse initiated an in-service for all licensed nurses, including part time, as needed, and agency, on the referral process for psychiatric services to the new provider so to protect and ensure other resident receive psychological services for improved quality of life. This in-service will be complete by 5/24/18. This in-service will be part of the orientation process for new nursing staff including part time, as needed, and agency. On 5/18/18, the staff facilitator and quality improvement nurse initiated an in-service with the medical records, and social services regarding the referral process, and process for tracking psychiatric services for residents. This in-service was completed by 5/24/18. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The administrator or director of nursing (DON) will audit 20 residents weekly for 12 weeks to ensure any residents with orders for psychiatric services are provided psychiatric services to promote quality of life. This audit will be	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 675	Continued From page 67 4/25/18 at 10:19 AM. He stated he was slightly depressed and felt like he made bad life choices he regretted. He denied suicidal thoughts. Resident #68 stated he had trouble sleeping and little interest in life. He stated nobody from psychiatric services had visited him in a long time. He stated he could not recall the last time he was seen by psychiatric services. Interview with the facility Nurse Consultant was conducted on 4/25/18 at 2:24 PM and stated she was new to the facility. She stated she reviewed Resident #68"s medical record and found no evidence that he was being followed by psychiatric services. She stated she could determine that sometime last spring, there was and change in psychiatric providers and that was why last April and May, he was seen by two different providers. She stated he was removed from the psychiatric list for unknown reason and had not been seen since May 2017. Interview with the Nurse Practitioner was conducted on 4/26 at 9:30 AM. She stated it was her expectation that Resident #68 was being seen by psychiatric services given his medical, psychiatric and medication history. She stated it appeared somehow, "he fell through the cracks." In a second interview with the Nurse Practitioner on 4/26/18 at 9:50 AM, she stated she wrote orders for Resident #68 to be evaluated now and seen every 6 months. She stated there were gaps in his psychiatric services and he must have gotten lost when there was a brief change in psychiatric services provider. She stated he	F 675	documented on the Resident Care Audit Tool. The monthly quality improvement (QI) committee will review the results of the Resident Care Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight related to residents' quality of life - psychological/psychiatric services. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	

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F 675	Continued From page 68 required psychiatric services for medication management. Telephone interview was conducted with the Psychiatric Nurse Practitioner on 4/26 at 9:55 AM. She stated it appeared the last time her agency saw Resident #68 was 4/21/17. She also stated there was documentation in her computer that he was discharged from her agencies services on 9/15/17 but there was no rationale documented. She stated she would see Resident #68 on 5/1/18. Interview on 4/26/18 at 7:28 PM, the Administrator stated it was her expectation that Resident #68 be seen by psychiatric services as needed and as ordered.	F 675		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide incontinent care (Resident #69) and nail care (Resident #9) for 2 of 8 sampled residents reviewed for activities of daily living (ADL). Findings included: 1. Resident #69 was admitted to the facility on 1/20/11 with multiple diagnoses including anxiety disorder.	F 677	F677 The plan of correcting the specific deficiency The position of Richmond Pines Nursing and Rehabilitation center regarding the process that lead to this deficiency- failed to provide incontinent care and nail care- was failure to follow established	5/24/18

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F 677	Continued From page 69 The quarterly Minimum Data Set (MDS) assessment dated 4/2/18 indicated that Resident #69 had memory and decision making problems and she required total staff assistance with personal hygiene. The assessment further indicated that the resident was incontinent of bowel and bladder. Resident #69's care plan dated 4/2/18 was reviewed. One of the care plan problems was that she required assistance with toileting. The goal was for the resident to remain dry of urine. The approaches included to check resident frequently for incontinent episodes. On 4/26/18 at 12:06 PM, 12:33 PM, 1:01 PM and 1:15 PM, Resident #69 was observed up in the chair in her room with seat belt on. She was wearing a pair of pants and her pants were observed to be wet on the crotch and thigh areas. On 4/26/18 at 1:15 PM, Nurse Aide (NA) #5 was observed to enter the room of Resident #69 with the lunch tray. She was observed to set up the tray in front of the resident and was about to feed her. On 4/26/18 at 1:16 PM, NA #5 was interviewed before she started feeding Resident #69. She stated that she checked the resident at 11:30 AM by looking at the color on the diaper and she was dry. She added that she didn't get the chance to check her again because "it was kind of hectic today" she said. NA #5 looked at the resident's pants and said "she was wet". NA #5 and NA #6 were observed to put Resident #69 in bed using a mechanical lift. When in bed, Resident #69's pants were observed soaking wet on the buttock area. Her diaper was soaking wet and was soiled	F 677	procedure. On 4/25/18, the nursing assistant (NA)#4 assisted Resident #9 with nail care, including trimming and filing of nails on bilateral hands. On 4/26/18, NA #4 and NA #5 assisted Resident #69 with incontinent care, including a new brief and clean pants. The procedure for implementing the acceptable plan of correction for the specific deficiency cited By 5/24/18, the director of nursing (DON), quality improvement (QI) nurse, staff facilitator (SF) nurse, admissions director (nurse), social worker (SW), administrator, manager on duty (MOD), and/or staff nurses will observe incontinent residents during meal times in the dining room and resident rooms to ensure residents are not soiled or wet immediately prior to or during meals. Incontinent care audit results: 0 residents were wet or soiled immediately prior to or wet during meal observations. By 5/24/18, the activity department director and activity assistant will complete a 100% audit of resident nails. The audit results will be submitted to the DON. Finger nail audit results: 10 residents were noted with long nails during audit. The long nails for the 10 residents were trimmed and filed on	

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F 677	Continued From page 70 with feces. Her thighs were observed to have dried feces. On 4/26/18 at 1:22 PM, NA #4 and #5 were observed to provide incontinent care to Resident #69 and to put on a new diaper and clean pair of pants. On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that she expected the staff to check resident frequently and before meals for incontinent episodes. 2. Resident #9 was admitted 9/10/16 with a diagnosis of contractures and feeding difficulties. His annual Minimum Data Set (MDS) dated 4/10/18 indicated severe cognitive impairment with no behaviors. Resident #9 was coded for extensive assistance with his personal hygiene. Resident #9's care plan last revised on 4/16/18 indicated he required assistance with his personal hygiene due to his bilateral and contractures. Staff were to provide total assistance of his personal hygiene. Observation on 4/23/18 at 1:00 PM, Resident #9's finger nails were noted to be long on his bilateral, contracted hands. The finger nails on his left hand were observed leaving an indentation in the palm of his hand due to his contractures. Observation on 4/24/18 at 9:12 AM, Resident #9's finger nails were noted to be long on his bilateral, contracted hands. The finger nails on his left	F 677	5/23/18 by nursing assistant staff assigned by the DON. By 5/24/18, the SF nurse or DON will re-educate staff to help ensure the problem does not recur. All licensed nurses and NAs, including part time, as needed (PRN), and agency, will be in-serviced on 1) incontinent care, including residents must be clean and dry prior to meals to promote dignity and 2) nail care is to be provided as part of routine resident care. No licensed nurse or NA, including part time, prn, and agency, will be allowed to work after 5/24/18 until the in-service completed. This in-service will be added to the new staff orientation process for licensed nurses and NAs, including part time, prn, and agency. To protect residents in similar situations, as added measures: 1) the administrator will instruct department heads to include, during angel rounds, looking for dignity issues, 2) the department heads, while making “angel rounds”, will observe residents for dignity issues including ensuring resident have clean, dry clothing and clean, trimmed finger nails, and 3) any observation of dignity issues will be immediately reported and corrected to the assigned nurse then noted on the administrative rounds sheet for follow up by the DON, SF nurse, and/or QI nurse. The monitoring procedure to ensure that the plan of correction is effective and that	

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F 677	Continued From page 71 hand were observed leaving an indentation in the palm of his hand due to his contractures. Observation on 4/25/18 at 8:30 AM, Resident #9's finger nails were noted to be long on his bilateral, contracted hands. The finger nails on his left hand were observed leaving an indentation in the palm of his hand due to his contractures. Resident #9 was moved off the 400 Hall and onto the 200 Hall on 4/25/18. Nursing Assistant (NA) #4 stated Resident #9 was moved to the 200 Hall around 11:30 AM and she noticed his fingernails were long so she trimmed them. She stated he was cooperative with nail care. Resident #9's fingernails were observed trimmed and filed. There was no observed indentation to the palm of his left hand. Interview on 4/25/18 at 1:10 PM, NA #11 stated Resident #9 was moved off 400 Hall earlier today. She stated she noticed Resident #9's fingernails were long on 4/23/18. She stated she went to look for nail clippers but could not find one. She stated she forgot to look again or let anyone know that she could not find the nail clippers. She stated Resident #9 did not have a history of refusing nail care. Interview on 4/26/18 at 10:35 AM, the Central Supply Clerk stated there was nail care supplies readily available at the nurse station or in the central supply room. Interview on 4/26/18 at 11:20 AM, Quality	F 677	specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, SF nurse, QI nurse, minimum data set (MDS) nurse, and/or corporate consultant will audit 20 residents weekly for 12 weeks prior to or during a meal to ensure residents are clean and dry to promote dignity and nails are not long. The purpose of the audit is to demonstrate more visual supervision, “inspecting what is expected”, and validating the re-education and audit results are effective and accurate so the problem does not recur. This audit will be documented on the Resident Care Audit Tool The monthly QI committee will review the results of the resident care audits monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction.	

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F 677	Continued From page 72 Assurance Nurse stated it was her expectation that Resident #9's be trimmed as needed. Interview on 4/26/18 at 4:40 PM, NA #12 stated she did not notice Resident #9's fingernail being long on 4/23/18 while working second shift. She stated Resident #9 did not refuse nail care. She stated the facility had a nail kit that was keep and the nurses station or there were likely clippers in the central supply room. Interview on 4/26/18 at 7:28 PM, the Administrator stated it was her expectation that nail care be done as needed and if supplies could not be located, staff were to let management know or inquire with the Central Supply Clerk.	F 677	The DON is responsible for implementing the acceptable plan of correction.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and	F 686	F686	5/24/18

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F 686	Continued From page 73 interview, the facility failed to provide treatment to pressure ulcer as ordered and failed to follow treatment as recommended by the wound care specialist for 1 of 2 sampled residents reviewed for pressure ulcer (Resident # 39). Findings included: Resident #39 was admitted to the facility on 12/7/17 with multiple diagnoses including anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 2/28/18 indicated that Resident #39 had moderate cognitive impairment and he required extensive assistance with bed mobility. The assessment further indicated that Resident #39 had a stage 4 pressure ulcer that was present on admission and an unstageable pressure ulcer that was not present on admission. Resident #39's care plan dated 2/28/18 was reviewed. One of the care plan problems was pressure ulcer to bilateral lower extremities. The goal was for the current pressure ulcer not to worsen through the next review. The approaches included to provide treatment as ordered by the physician. The wound care specialist evaluation notes for Resident #39 were reviewed. The wound care specialist notes dated 2/2/18 revealed that the pressure ulcer on the right heel had deteriorated. The ulcer measured 4.5 x (by) 4.5 x 0.2 centimeter (cm), 90% necrotic and with odor. The recommended treatment was Gentamycin ointment (an antibiotic) daily, silver alginate daily and Flagyl (an antibiotic) 500 mgs crushed daily for 5 days. The notes dated 2/16/18 revealed that the pressure ulcer had	F 686	The plan of correcting the specific deficiency The position of Richmond Pines Nursing and Rehabilitation Center regarding the process that led to the deficiency of the facility failing to provide treatment to a pressure ulcer as ordered and failing to follow treatment plan as recommended by wound care specialist was knowledge deficit. On 4/25/18, the treatment nurse contacted the wound care specialist for Resident #39. On 4/25/18, the treatment nurse received a clarification treatment order from the wound care specialist for Resident #39. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/21/18, the quality improvement (QI) nurse, director of nursing (DON), and corporate consultant audited all wound care specialist notes for the past 30 days to ensure orders have been transcribed and treatments are being provided as ordered, to protect residents in similar situations. The audit result: no other residents seen by the wound care specialist had missing or inaccurately transcribed orders. All orders were correct on the treatment administration record (TAR), according to the wound care	

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F 686	Continued From page 74 improved and to continue the treatment of Gentamycin ointment and silver alginate daily. The notes dated 3/16/18 revealed that the pressure ulcer had improved and to change the treatment to negative pressure once weekly for 30 days. The notes dated 3/23/18 revealed that the pressure ulcer had deteriorated and the recommended treatment was silver alginate daily. The notes dated 3/30/18 and 4/13/18 revealed that Resident #39 was seen by the wound care specialists and recommended to continue the treatment of silver alginate once daily. The Treatment Administration Records (TARs) for March 2018 revealed that the right heel pressure ulcer was treated with Gentamycin ointment daily from March 1-31, 2018. The recommendations from the wound care specialist for silver alginate was not followed through. The physician's orders for Resident #39 were reviewed. On 3/9/18, there was an order for Gentamycin ointment to right heel once a day. The TARs for April 2018 revealed that the right heel pressure ulcer was treated with Gentamycin ointment and silver alginate daily from April 1-24, 2018. On 4/25/18 at 9:30 AM, Resident #39 was observed during the dressing change. Nurse #7 (Treatment Nurse) was observed to clean the pressure ulcer on the right heel with anasept wound cleanser, silver alginate was applied and was covered with foam dressing. On 4/25/18 at 10:05 AM, Nurse #7 was interviewed. She stated that she followed the wound doctor weekly during wound rounds and	F 686	specialist and/or physician's last recommendations. By 5/24/18, the staff facilitator (SF) nurse will in-service staff to ensure the problem does not recur due to many new staff. The in-service for all licensed nurses, including part time, as needed (PRN), and agency staff, will cover providing wound care/treatments as ordered per physician or wound care specialist, and transcribing orders correctly including wound care. Any licensed nurse not in-serviced by 5/24/18 will not be allowed to work until the in-service is completed. This in-service will be part of the orientation process for newly hired licensed nurses, including part time, PRN, and agency. The monitoring procedure to ensure that the plan of correction is effective and that specific the deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing (DON), QI nurse, SF nurse, charge nurse, and/or corporate consultant will audit all wound care specialist recommendations by visual review weekly including recommendations received all shifts seven days a week, including weekends, x12 weeks to ensure orders are transcribed so treatments are provided as ordered. This visual audit will be documented on the Wound Audit tool as a verification of interventions and solutions being sustained.	

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F 686	Continued From page 75 she read her weekly notes/recommendations. She was responsible for writing treatment order as recommended by the wound care specialist. Nurse #7 indicated that she forgot to write an order to discontinue the Gentamycin ointment and she failed to write a new order for the silver alginate. On 4/26/18 at 7:20 AM, the Administrator was interviewed. She stated that she expected the Treatment Nurse to write treatment orders as recommended by the wound care specialist and to provide treatment to pressure ulcers as ordered.	F 686	The monthly QI committee will review the results of the Wound Audit tool, monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The treatment nurse, QI nurse and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		5/24/18

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F 688	Continued From page 76 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to utilize bilateral hand splints as ordered for 1 (Resident #19) reviewed for contractures. The findings included: Resident #9 was admitted 9/10/16 with a diagnosis of contractures and feeding difficulties. Review of a Rehabilitation Communication to Nursing form dated 5/19/17 indicated Resident #9 was to receive restorative nursing for splinting to his right-hand. He was to wear his right-hand splint daily for four hours. There was no mention of a splint for the left hand. Review of the restorative nursing documentation indicated Resident #9 was receiving services for right hand splinting 9/1/18 through 10/5/17 when he was admitted to rehabilitation services. Review of a Rehabilitation Communication to Nursing form dated 10/19/17 indicated Resident #9 was to receive restorative nursing for splinting to his left-hand. He was to wear a left-hand splint daily for three to four hours. Review of the restorative nursing documentation indicated Resident #9 was receiving services for	F 688	F688 The plan of correcting the specific deficiency The position of Richmond Pines Health and Rehabilitation center regarding the process that led to the deficiency of failing to utilize bilateral hand splints as ordered for contractures was failure to follow procedure. On 4/26/18, the restorative aide applied bilateral splints to Resident #9's hands. On 4/26/18, the restorative aide/nursing assistant documented the application, removal, and skin observation regarding bilateral hand splinting for Resident #9's hands. On 4/26/18, the minimum data set (MDS) nurse updated Resident #9's care guide to reflect Resident #9's schedule of bilateral hand splinting. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/15/18, the administrator directed an audit of all residents with splints (based on	

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F 688	Continued From page 77 right and left-hand splinting 10/20/17 through 1/17/18 when he was admitted to rehabilitation services. Review of a Rehabilitation Discharge Summary dated 2/8/18 8 indicated Resident #9 was seen due a decline in his feeding abilities related to decreased right shoulder ROM. Goals were met with Resident #9 able to manage his cup and eating utensil. There was no evidence of a referral to restorative nursing. His annual Minimum Data Set (MDS) dated 4/10/18 indicated severe cognitive impairment with no behaviors. Resident #9 was coded for extensive assistance with his activities of daily living and coded with functional limitations with his bilateral upper extremities. Review of a Rehabilitation Communication to Nursing form dated 4/11/18 indicated Resident #9 was to receive restorative nursing for ambulation and exercise to his lower extremities. There was no mention of splinting to Resident #9's left and right hands. Review of the restorative nursing documentation indicated Resident #9 was receiving services for ambulation and ROM to his lower extremities starting 4/18/18 to 4/25/18.There was no documentation of splinting to Resident #9's left and right hand. Resident #9's care plan last revised on 4/18/18	F 688	care plan, therapy, and/or restorative) to ensure documentation was present to support splints used as ordered. The audit revealed the list of residents with an order for splints, care plans, care guides, and splint wear schedule did not match. The 23 residents with splint orders had care plans, care guides, and wear schedule updated by the minimum data set nurse (MDS) and/or MDS coordinator on 5/23/18, which corrected the negative audit findings. On 5/21/18 through 5/22/18, the director of nursing (DON), quality improvement (QI) nurse, charge nurse, and staff facilitator (SF) nurse audited all residents with splints care plan and care guide to ensure the splint wear schedule is correct. The 23 residents with splint orders had care plans, care guides, and wear schedule updated by the minimum data set nurse (MDS) and/or MDS coordinator on 5/23/18, which corrected the negative audit findings On 5/21/18, the DON will in-service the MDS and MDS coordinator on care planning including (care guide) splint use. This in-service will be given to any new MDS nurse during orientation. By 5/24/18, the SF/QI nurse will in-service all nursing staff, including nursing assistants (NAs), part time, as needed (PRN), and agency staff on utilizing splints as ordered, including documentation of use. Any staff not in-serviced by 5/24/18 will not be allowed to work in the facility	

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F 688	Continued From page 78 indicated he was receiving active range of motion (AROM) to his lower extremities and ambulation with contact guard assistance. He was active in the restorative nursing program. There was no mention of any AROM or splinting to his bilateral hand contractures. Review of Resident #9's undated Care Guide indicated he was receiving restorative nursing for ambulation and ROM to his lower extremities. There was no mention of his left and right-hand splints. Observation on 4/23/18 at 1:00 PM, Resident #9's bilateral hands were severely contracted. There were no observed splints in place or observed lying in his room. Observation on 4/24/18 at 9:12 AM, Resident #9's bilateral hands were severely contracted. There were no observed splints in place or observed lying in his room. Observation on 4/25/18 at 8:30 AM, Resident #9's bilateral hands were severely contracted There were no observed splints in place or observed lying in his room. Interview with the Rehabilitation Manager was conducted on 4/25/18 at 12:45 PM. She stated she evaluated Resident #9 for his bilateral hand contractures earlier on 4/25/18 because the Restorative Aide (RA) asked her about the splints for his hands. She stated Resident #9 was	F 688	until the in-service is completed. This in-service will be part of the orientation process for newly hired nursing staff, including NAs, part time, PRN, and agency staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The SF nurse, QI nurse, DON, and/or corporate consultant will audit 20 residents weekly on varying shifts seven days per week to ensure all shifts and days are covered x 12 weeks to ensure splints are applied, removed and documented on according to the plan of care/care guide this audit includes visual checks. The audit will be documented on the Resident Care Audit tool. The monthly QI committee will review the results of the Resident Care Audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The SF nurse, QI nurse and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight.	

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F 688	Continued From page 79 supposed to be wearing his bilateral hand splints three-four hours daily since he was discharged to restorative nursing 10/19/17. She stated somehow, his splinting was dropped off the task for restorative nursing task to perform. She stated both of his hand splints were found in his room 4/25/18. Interview with the Restorative Aide was conducted on 4/25/18 at 12:50 PM. She stated Resident #9 was currently receiving restorative services for ambulation and ROM to his legs. RA stated she was uncertain if he was to wear bilateral hand splints but recalled he did wear them in the past. Interview with the MDS Coordinator on 4/25/18 at 1:00 PM, she stated she was over the restorative program and she was unsure why Resident #9's bilateral hand splints were not being applied. She stated it was likely that when Resident #9 was admitted to rehabilitation services 1/17/18 and discharged from restorative services, he was overlooked for his splinting. She stated he was actively on the restorative nursing program as of 4/18/18 but not for splinting. Interview with the Nurse Practitioner on 4/26/18 at 9:30 AM, stated it was her expectation that Resident #9 wear his bilateral hand splints three to four hours daily to prevent worsening of his hand contractures. Interview on 4/26/18 at 11:20 AM, the Quality Assurance Nurse stated it was her expectation	F 688	The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	

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F 688	Continued From page 80 that Resident #9 receiving restorative nursing and wear his bilateral hand splints as ordered. Interview on 4/25/18 at 1:10 PM, NA #11 stated Resident #9 wore bilateral hand splints in the past but not recently. She stated at one time, the RA was applying his hand splints daily. Interview on 4/26/18 at 4:40 PM, NA #12 stated she was not aware that Resident #9 was to wear bilateral hand splints. Interview on 4/26/18 at 7:28 PM, the Administrator stated it was her expectation that Resident #9 receive therapy services, restorative nursing and wear his bilateral hand splints as ordered.	F 688		
F 689 SS=E	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 observations, record reviews, and interviews with family, staff, police, and the Nurse Practitioner (NP), the facility failed to implement fall risk interventions for Resident #13 for two falls, one of which she sustained a nasal fracture.	F 689	F689 The plan of correcting the specific deficiency	5/24/18

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F 689	Continued From page 81 The facility also failed to provide adequate supervision for a cognitively impaired male resident (Resident #45) to prevent him from exposing his genital region to a cognitively impaired female resident (Resident #13). The facility additionally failed to monitor Resident #16 ' s wanderguard (a device used to monitor exit seeking behaviors for cognitively impaired residents) and failed to thoroughly analyze falls to determine causative factors and implement appropriate interventions to prevent further falls (Residents #22, #50, and #69). This was for 6 of 7 residents reviewed for accidents. The findings included: 1. Resident #13 was admitted to the facility on 4/28/17 with multiple diagnoses that included Alzheimer ' s, dementia without behavioral disturbance, chronic kidney disease, Diabetes Mellitus, and muscle weakness. A review of Resident #13 ' s plan of care, initiated on 5/8/17, indicated she was at risk for falls due to the risk factors of impaired cognition and a history of falls. The interventions included, in part, a fall mat on floor when Resident #13 was in bed (initiated on 6/15/17). The quarterly Minimum Data Set (MDS) assessment dated 1/15/18 indicated Resident #13 was rarely/never understood and rarely never understands. Her short-term and long-term memory were impaired and she had severely impaired decision making. Resident #13 was assessed with inattention, disorganized thinking, and an altered level of consciousness continuously present. She had other behavioral symptoms on 1 to 3 days during the MDS review	F 689	The position of Richmond Pines Nursing and Rehabilitation center regarding the process that led to this deficiency-failure to implement fail risk interventions, provide adequate supervision to prevent a resident-to-resident event, failure to monitor a wander guard, and failure to thoroughly analyze falls to determine causative factors and implement appropriate interventions to prevent falls-was a system-wide failure to follow established policy and procedures. Resident #13 was noted by the staff nurse to have a functioning alarm and fall mat by the bed, according to the care plan on 5/23/18 by the director of nursing (DON). The care plan was reviewed by the minimum data set (MDS) nurse on 5/3/18 with no new interventions added. Resident #45 was assessed, removed from the room, and directly supervised on 4/26/18 by the licensed facility nurse. The care plan was reviewed by the MDS nurse on 5/3/18 with no new interventions added. Resident #16's wander guard was checked by the supply clerk on 4/25/18 and the wander guard was functioning appropriately. Resident #50's care plan was reviewed by the interdisciplinary team (IDT). The interdisciplinary team consists of the MDS coordinator, MDS nurse, DON, quality improvement (QI) nurse, staff facilitator (SF) nurse, social worker (SW), dietary,	

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F 689	Continued From page 82 period. Resident #13 required the extensive assistance of 2 or more staff with bed mobility and the extensive assistance of 1 staff with transfers and locomotion on the unit. She was dependent on 2 or more staff for toileting and personal hygiene and dependent on 1 staff for dressing and bathing. Resident #13 was not steady on her feet and she was only able to stabilize with staff assistance. She was assessed with no functional impairment with range of motion and she utilized a wheelchair. Resident #13 was always incontinent of bladder and bowel. On 1/22/18 Resident #13 ' s plan of care related to the risk for falls was updated with an intervention of a bed alarm. An incident report dated 4/1/18 and completed by Nurse #1 indicated Resident #13 had an unobserved fall on 4/1/18 at 6:25 AM. Nurse #1 reported she was alerted by a Nursing Assistant (NA) that Resident #13 was found on the floor of her room crawling away from her bed. She was actively bleeding from an open wound on the bridge of her nose and droplets of blood were noted on the floor. The wound was cleaned and pressure was applied. Emergency Medical Services (EMS) were contacted as the wound needed to be assessed to determine if sutures were needed. Resident #13 was noted to be alert, but was unable to provide information on the fall. The NP and Responsible Party (RP) were notified. A nursing note dated 4/1/18 and completed by Nurse #1 indicated Resident #13 was toileted and changed on 4/1/18 at 6:15 AM. She was left in bed and appeared comfortable. At 6:25 AM Resident #13 was found crawling on the floor of	F 689	bookkeeper, activities, and/or administrator. The IDT reviewed Resident #50's falls to analyze the resident's falls, to determine causative factors, and ensure appropriate interventions are in place to prevent falls/injuries. No new interventions were added. Resident # 22's care plan was reviewed by the IDT regarding falls to analyze the resident's falls, to determine causative factors, and ensure appropriate interventions are in place to prevent falls/injuries. No new interventions were added. Resident #34's care plan was reviewed by the IDT for falls to analyze the resident's falls, to determine causative factors, and ensure appropriate interventions are in place to prevent falls/injuries. No new interventions were added. Resident #69's care plan was reviewed by the IDT for falls, to analyze resident falls, to determine causative factors, and ensure appropriate interventions in place to prevent falls/injuries. No new interventions were added. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/18/18, the DON initiated an in-service for the QI nurse, SF nurse, MDS nurse coordinator and MDS nurse on thoroughly analyzing falls to determine	

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F 689	Continued From page 83	F 689		

her room with blood droplets noted on the floor. There was a laceration on her nose that was actively bleeding. The laceration was cleaned with a pressure dressing applied. EMS was contacted and Resident #13 was transported the Emergency Room (ER) at 6:45 AM.

An ER note dated 4/1/18 indicated Resident #13 presented at the hospital following a fall at the facility in which she sustained an injury to her nose. There was evidence of bleeding with no active bleeding noted. Resident #13 was assessed with a closed fracture of the nasal bone and a superficial nasal laceration that required no suturing. She was discharged back to the facility.

A nursing note dated 4/1/18 indicated Resident #13 returned from the hospital with facial lacerations and nasal fracture.

An incident report dated 4/1/18 and completed by Nurse #2 indicated Resident #13 had an unobserved fall on 4/1/18 around 9:00 PM. Resident #13 was found on the floor of her room near the foot of her bed. She was face down with her left arm beneath her. Resident #13 was assessed for injuries. She was noted as able to move all extremities. She had an approximate quarter size bruise to the left elbow and 2 superficial 1-inch abrasions to the elbow. Resident #13 was alert with confusion and she was unable to provide information on the fall. The NP and RP were notified.

A nursing note dated 4/1/18 and completed by Nurse #2 indicated Resident #13 was found on the floor of her room. She was assessed for injuries and an approximate quarter sized bruise was noted to her left elbow as well as 2

causative factors and implement appropriate interventions to prevent repeat falls/prevent injury. During the in-service, the DON discussed using the "5 Whys" root cause analysis process and the DON's expectation that the team "digs" deeper to investigate and determine the root cause of the incident/accident. This in-service was completed by 5/24/18. This in-service will be included during the orientation of any new nursing management positions (QI nurse, SF nurse, MDS nurse coordinator and/or MDS nurse).

By 5/18/18, the SF nurse and QI nurse began an in-service with all staff including part time, as needed (PRN), and agency staff, on behavior management including wandering, and sexual behaviors. This in-service will be completed by 5/24/18. Any staff who have not completed this in-service by 5/24/18 will not be allowed to work in the facility until the in-service is completed. This in-service will be added to the orientation for newly hired staff, including part time, PRN, and agency staff.

By 5/21/18, the SF nurse, QI nurse, DON, and/or corporate consultant initiated an in-service for all licensed nurses, including part time, as needed (PRN), and agency staff, on implementing an intervention after each fall to prevent a repeat fall/prevent injury; wander guard check schedule including documentation. This in-service will be completed by 5/24/18, any staff not in-serviced by 5/24/18 will not

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F 689	Continued From page 84 superficial 1-inch abrasions. The medical record indicated Resident #13 was sent to the ER for evaluation on 4/1/18 and she was admitted to the hospital. The hospital record indicated Resident #13 presented to the ER on the evening of 4/1/18 with the chief complaint of a fall. She was assessed with no fever or cough, but laboratory results and evaluation revealed diagnoses that included Urinary Tract Infection (UTI), sepsis secondary to UTI, hypernatremia (high concentrations of sodium), leukocytosis (white cells above the normal range), and chronic kidney disease. A Facility Concern/Grievance Form dated 4/2/18 indicated a grievance was completed for Resident #13 by her RP. The grievance included concerns related to Resident #13 ' s recent falls. The form indicated a meeting was held on 4/2/18 at 10:30 AM with Resident #13 ' s family, the Quality Assurance (QA) Nurse, the MDS Coordinator, and the Social Worker (SW). The meeting included, in part, Resident #13 ' s family reporting concerns related to her fall and nasal fracture. The MDS Coordinator stated during the meeting that Resident #13 ' s NA Care Guide interventions included a fall mat and a bed alarm. The medical record indicated Resident #13 was readmitted to the facility on 4/9/18. A Facility Concern/Grievance Form dated 4/9/18 indicated a grievance was completed for Resident #13 by a family member. The grievance included concerns related to Resident #13 ' s fall mat not being in place and the bed alarm not functioning at the time of either fall on 4/1/18 (6:25 AM and	F 689	be allowed to work in the facility until the in-service is completed. This in-service will be included during the orientation for all newly hired licensed nurses, including part time, PRN, and agency staff. By 5/21/18, the SF nurse, QI nurse, DON, and/or corporate consultant initiated an in-service for all nursing staff, including nursing assistants (NAs), part time, as needed (PRN), and agency staff, on following fall interventions based on the resident care plan. This in-service will be completed by 5/24/18. Any staff not in-serviced by 5/24/18 will not be allowed to work in the facility until the in-service is completed. This in-service will be included during orientation for all newly hired nursing staff, including NAs, part time, PRN, and agency staff. By 5/22/18, the SF nurse, QI nurse, DON and/or corporate consultant will review all falls for the past 30 days to ensure fall interventions on the care plan were in place at the time of the fall. Also, the SF nurse, QI nurse, DON and/or corporate consultant will review documentation of the analysis to determine causative factors and look for implementation of appropriate interventions to prevent repeat falls/injuries. The audit was completed on 5/23/18. The audit result: 1) care plan interventions were in place at the time of the fall, 2) causative factors were examined, and 3) as appropriate, new interventions were in place to prevent future falls.	

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F 689	Continued From page 85 9:00 PM) or at the time of her readmission on 4/9/18. The Grievance Summary Response form confirmed there was no fall mat in place and the bed alarm was not intact during either of Resident #13 ' s falls on 4/1/18 or at the time of readmission on 4/9/18. An interview was conducted with Resident #13 ' s RP on 4/23/18 at 12:15 PM. The RP reported Resident #13 had a fall on the morning of 4/1/18. She indicated Resident #13 was sent to the ER for evaluation and was assessed with a nasal fracture. Resident #13 returned to the facility later that same morning. Resident #13 ' s RP stated that on the same evening (4/1/18), another family member was visiting Resident #13 and observed her being assisted to bed and noted that no fall mat or bed alarm was in place. The family member informed staff, unable to recall the name of the staff member, that the fall mat and bed alarm were not in place. Resident #13 ' s RP reported that later that evening after the family had left the facility, Resident #13 had another fall. The RP indicated Resident #13 was sent to the ER that night (4/1/18) for evaluation and she was admitted to the hospital. Resident #13 remained in the hospital until 4/9/18 when she was readmitted to the facility. Resident #13 ' s RP reported the fall mat and bed alarm were still not in place when she was readmitted on 4/9/18. The staff were again informed of this information and the interventions were implemented by the time of the next family visit on 4/10/18. An observation was conducted on 4/23/18 at 12:55 PM of Resident #13 ' s room. A fall mat a bed alarm were in place. An interview was conducted with the QA Nurse on	F 689	By 5/22/18, the SF nurse, QI nurse, DON, and/or corporate consultant reviewed all residents with wandering behaviors (based on last MDS assessment) to ensure interventions are in place to protect resident and other residents that may be affected by the behavior. The audit result: all residents with wandering behaviors had interventions in place to protect the resident and other residents that may be affected by the behavior. By 5/22/18, the SF nurse, QI nurse, DON, and/or corporate consultant reviewed all residents with sexual behaviors (based on care plan) to ensure interventions are in place to protect the resident and other residents that may be affected by the behavior. The audit result: all residents with sexual behaviors have a care plan in place with appropriate interventions in place to protect the resident and other residents that may be affected by the behavior. On 5/22/18, the SF nurse, QI nurse, DON, and/or corporate consultant reviewed all residents with wander guards to ensure the wander guards were intact and functioning properly. Audit result: all residents assigned wander guards had their wander guard intact and functioning properly. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory	

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F 689	Continued From page 86 4/25/18 at 8:30 AM. The incident reports dated 4/1/18 for Resident #13 ' s morning fall and evening fall were reviewed with QA Nurse. The Grievance Summary Response for the grievance filed on 4/9/18 that indicated Resident #13 ' s fall mat was not in place and the bed alarm was not intact for either fall on 4/1/18 or at the time of her readmission was reviewed with the QA Nurse. She stated that both of these falls for Resident #13 had occurred on a weekend (Sunday) and there was no administrative staff in the building. She explained that because there was no administrative staff in the building on the weekend, the fall had not been reviewed until 4/2/18. When asked why these interventions (fall mat and bed alarm) were not in place when Resident #13 was readmitted from the hospital on 4/9/18 she stated Resident #13 had been moved to a different bed and she thought that may have been why the interventions were not in place. An interview was conducted with the MDS Coordinator on 4/25/18 at 8:35 AM. She reported that she was not in the facility at the time of either of Resident #13 ' s falls on 4/1/18. She revealed when she went to Resident #13 ' s room on 4/2/18 there was no fall mat in her room. She was unsure if there was a bed alarm. She indicated the fall mat and bed alarm should have been in place as they were interventions on Resident #13 ' s care plan. The MDS Coordinator reported Resident #13 was in the hospital at the time of this observation on 4/2/18. A phone interview was conducted with Nurse #1 on 4/25/18 at 9:54 AM. She stated she was the nurse assigned to Resident #13 on the morning of 4/1/18 when she fell and fractured her nose. She confirmed the information in the incident	F 689	requirements The DON, QI nurse, SF nurse, and/or charge nurse will audit 100% of falls weekly x 12 weeks to ensure fall interventions listed on the resident care plan were in place at the time of the fall, and the fall was thoroughly analyzed to determine causative factors and implement appropriate interventions to prevent repeat falls. The “5 Whys” process will be used to help identify causative factors. These audits will be documented on the fall audit tool. The DON, SF nurse, QI nurse, and/or weekend manager on duty (MOD) will review all progress notes 5 times weekly for 12 weeks to ensure all wandering and/or sexual behaviors have appropriate interventions to protect the resident and other residents that may be affected. This audit will be documented in the progress note audit tool. Licensed nurses, restorative NAs, MOD, DON, administrator, SF nurse, QI nurse, MDS nurse, and/or corporate facility consultant will visually observe all residents with wander guards at least daily (including all shifts) seven days per week, to ensure the wander guard is present and functioning. These is documented on the wander guard flow sheet, located in the wander guard book. The monthly QI committee will review the results of fall audits, progress note audit tools, and wander guard flow sheets monthly for 3 months for identification of	

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report and nursing note related to this fall. She revealed there was no fall mat in place at the time if this fall on the morning of 4/1/18. She was unsure if a bed alarm was in place, but she had not recalled a bed alarm sounding. Nurse #1 stated she completed her shift shortly after the fall and she had implemented no new interventions for Resident #13 as she was out of the facility at the ER.

An interview was conducted with Nurse #2 on 4/25/18 at 10:20 AM. She stated she was the nurse assigned to Resident #13 on the evening of 4/1/18 when Resident #13 fell around 9:00 PM. She confirmed the information in the incident report and nursing note related to this fall. She revealed there was no fall mat in place at the time of the fall. She was unsure if a bed alarm was in place, but she had not heard a bed alarm sounding. Nurse #2 indicated she was made aware of the fall Resident #13 had that morning (4/1/18) when she came on shift at 3:00 PM. She reported that prior to Resident #13 ' s fall that evening (4/1/18), she observed there was no fall mat in place in her room. She additionally reported that Resident #13 ' s family member informed her on 4/1/18 prior to the evening fall that there was no fall mat in her room. Nurse #2 revealed she had looked on her unit for an extra fall mat, but she could not find one. She stated she had not looked on the other units to see if there were any extra fall mats.

A phone interview was conducted with NA #1 on 4/25/18 at 11:06 AM. She indicated she and NA #2 were assigned to Resident #13 ' s unit at the time of the morning fall on 4/1/18 in which she fractured her nose. NA #1 stated she had not worked with Resident #13 frequently, she was

trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance in the areas of providing an environment as free of accident hazards as is possible and providing adequate supervision and assistance devices to prevent accidents.

The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight.

The title of the person responsible for implementing the acceptable plan of correction.

The DON is responsible for implementing the acceptable plan of correction.

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unsure if Resident #13 was supposed to have a fall mat, and she could not recall if there was a fall mat in place at the time of this morning fall on 4/1/18. NA #1 also stated was unsure if a bed alarm was in place, but she had not heard a bed alarm sounding. NA #1 was asked how she was made aware of fall risk interventions for residents and she indicated the care plan had the interventions listed. She was asked if she had reviewed the care plan prior to working with Resident #13 on 4/1/18 and she stated she had not.

NA #2 was unavailable for interview.

A phone interview was conducted with NA #3 on 4/25/18 at 12:00 PM. She stated she was assigned to Resident #13 on the evening of 4/1/18 when she had her second fall that day. She stated she had not known if Resident #13 was supposed to have a fall mat or a bed alarm at the time the evening fall on 4/1/18 as that was the first time she had worked with her. NA #3 confirmed there was no fall mat in place and no bed alarm sounded. NA #3 was asked how she was made aware of fall risk interventions for residents and she indicated the care plan and the care guide had the interventions listed. She was asked if she had reviewed the care plan or care guide prior to working with Resident #13 on 4/1/18 and she stated she had not.

The Director of Nursing (DON) was unavailable for interview.

An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. She stated she expected fall risk interventions be implemented at all times.

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2. 2. Resident #45 was admitted to the facility on 12/1/16 and most recently readmitted to the facility on 11/22/17 with multiple diagnoses that included dementia with behavioral disturbance.

The quarterly Minimum Data Set assessment dated 3/3/18 indicated Resident #45 was rarely/never understood and rarely/never understands. He had short-term and long-term memory problems and severely impaired decision making. Resident #45 was assessed with continuous inattention and disorganized thinking. He had no behaviors, no rejection and no wandering during the MDS review period. Resident #34 was independent with set up help only for walking in/out of room and corridor. He was noted to be unsteady on his feet, but he was able to stabilize without staff assistance.

Resident #45 ' s plan of care included, in part, the focus areas of:

- Problematic manner in which resident acts characterized by ineffective coping: wandering and/or at risk for unsupervised exits from the facility related to: attempts to leave unit/building if not prevented. Resident wandering in and out of other residents ' rooms/exit seeking behavior at times. This focus area was initiated on 5/8/17 and last revised on 6/26/17. The interventions included: allow resident to wander on the unit (initiated on 5/8/17 and last on revised 3/6/18).
- Problematic manner in which resident acts characterized by inappropriate behavior and resistance to treatment/care related to cognitive impairment. This focus area was initiated on 8/21/17 and last revised on 4/23/18.

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A record review indicated Resident #45 had previously resided on the facility ' s locked memory care unit. This unit was temporarily closed in January 2018 for maintenance and had not yet been reopened. All of the residents who had resided on the locked memory care unit, including Resident #45, presently resided in unlocked units of the facility.

Resident #45 was observed ambulating independently with a shuffled and slow gait on his unit of the facility on 4/23/18 at 12:00 PM. Resident #45 had minimal speech that was garbled and indistinguishable.

Resident #45 was observed ambulating with a shuffled and slow gait on a different unit at the facility on 4/23/18 at 4:00 PM.

Resident #45 was observed standing in a common area of the facility on 4/24/18 at 2:30 PM.

An incident report dated 4/26/18 and completed by Nurse #5 indicated Resident #45 was found in a female resident ' s room (Resident #13) on the night of 4/25/18 (no time indicated). Resident #45 was wearing only a shirt and socks. His brief and pants were observed laying at the head of Resident #13 ' s bed. There was no physical contact observed by staff between Resident #45 and Resident #13. Resident #45 was able to be directed to sit down on Resident #13 ' s bed as Resident #13 was assisted out of the room. Resident #45 and Resident #13 were not interviewable. (Resident #13 ' s 1/15/18 quarterly MDS indicated she was rarely/never understood and rarely/never understands). A physical assessment was completed of both residents and

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no injuries were noted. Resident #45 was assisted with getting dressed and was then placed on 1 on 1 supervision. The Quality Assurance (QA) Nurse, Administrator, on call physician ' s assistant, and the Responsible Party (RP) of each resident were notified.

A 24-hour initial report was completed on 4/26/18 at 12:15 AM for the incident that occurred on the night of 4/25/18 with Resident #45 and Resident #13. The allegation included reasonable suspicious of a crime and resident abuse. The allegation description indicated Resident #13 ' s bed alarm had sounded in her room. A Nursing Assistant (NA) went to the room and found Resident #13 clothed in a nightgown and brief sitting on the floor of her room with Resident #45 standing beside her. Resident #45 was noted to be wearing only a shirt and socks. An investigation was initiated and the police were notified.

The facility ' s investigation of the 4/25/18 incident related to Resident #45 and Resident #13 was reviewed. Resident #13 ' s bed alarm was heard sounding by an NA (NA #9) on 4/25/18 around 11:15 PM. NA #9 went to Resident #13 ' s room, attempted to enter through the door to the room, but found the door was blocked by something and she was unable to enter. NA #9 was able to access Resident #13 ' s room by entering through an adjoining bathroom of the room next to Resident #13. Resident #13 was found sitting on the floor in front of the door to her room. She was clothed in a nightgown and brief. Resident #45 was standing over her clothed in only a short-sleeved shirt and socks. Resident #45 had removed his pants and his brief. His pants were found on Resident #13 ' s bed and his brief was

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on the floor in her room. Staff assisted Resident #13 off the floor, into her wheelchair, and out of her room. Resident #45 refused to exit the room and he had also refused to be assisted with putting a brief and pants back on. Resident #13 and Resident #45 were assessed for injuries with no signs of physical contact or injury. Resident #45 was placed on 1 on 1 supervision. The police were notified and Resident #13 remained with staff in a common area of the facility until police arrived. Following the arrival of the police, Resident #13 was transferred to the hospital with police accompaniment for an evaluation and the completion of a sexual assault sample. Hospital staff evaluated Resident #13, found no identifiable concerns to her physical status related to the incident, and she was returned to the facility. The sexual assault sample had been forwarded to the local police department.

The hospital Emergency Department note dated 4/26/18 for Resident #13 was reviewed. Resident #13 was brought in with police accompaniment for evaluation of possible sexual assault. The officer present at the hospital with Resident #13 reported there was no evidence of any kind of a struggle. A sexual assault sample was performed and Resident #13 was examined. There was no obvious evidence of injury. Resident #13 was discharged back to the facility following the evaluation.

On 4/26/18 at 8:15 AM an interview was conducted at the local police department with a Police Captain and the incident/investigation report related to Resident #45 and Resident #13 was reviewed. The incident/investigation report indicated the crime in question was rape, the suspect was identified as Resident #45, and the

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victim was identified as Resident #13. The police were noted to be dispatched to the facility at approximately 1:00 AM on 4/26/18. The QA Nurse provided the incident details to the officer when he arrived at the facility. The report indicated NA #9 discovered Resident #45 inside Resident #13 ' s room after a bed alarm was activated. Resident #45 had no pants or brief on, he was blocking the door to Resident #13 ' s room, and Resident #13 was sitting on her floor fully clothed. NA #9 had to access Resident #13 ' s room through the bathroom door that connected to the room next door as Resident #45 refused to move away from door. NA #9 removed Res #13 from her room as Resident #45 refused to leave. NA #9 was interviewed and she stated Resident #45 removed his clothing a lot. Resident #45 ' s brief and clothing were near Resident #13 ' s bed. Nurse #5 was interviewed and she stated she had observed Resident #45 with an erection. No physical injuries were observed on either resident. Resident #13 was taken to the hospital for a sexual assault sample. The Police Captain reported that the results of the sexual assault sample could take anywhere from a week to a month to receive back. He had confirmed that based on the information there were no physical injuries observed on either resident.

A phone interview was conducted with NA #7 on 4/26/18 at 8:36 AM. She stated she worked on the unit where Resident #13 and Resident #45 resided on 4/25/18 during the 3:00 PM to 11:00 PM shift, but she was not assigned to either resident. She reported NA #10 was assigned to both Resident #13 and Resident #45 on 4/25/18 during the 3:00 PM to 11:00 PM shift. NA #7 indicated prior to leaving the facility at the close of her shift on 4/25/18, she last saw Resident #45 at

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the nurse ' s station around 9:00 PM and she last saw Resident #13 being assisted back to her room by NA #10 around 9:30 PM. NA #7 stated that Resident #45 ' s normal routine included wandering through the halls of the facility. She reported he frequently wandered into other resident ' s rooms. She indicated Resident #45 could be combative and difficult to redirect, but she had not witnessed him with any sexually inappropriate behavior.

An interview was conducted with the QA Nurse on 4/26/18 at 9:10 AM. She stated Resident #45 wandered throughout the facility during most of the day. She reported he wandered into other residents ' rooms and was difficult to redirect at times. She indicated she believed he was unable to determine which room was his. The QA Nurse was asked if Resident #45 had any specific interventions related to the frequency of monitoring his whereabouts due to his frequent wandering and entering other residents ' rooms. She reported that prior to the incident last night (4/25/18) there were no specific timeframes in place for monitoring his whereabouts. She indicated Resident #45 was now on 1 on 1 supervision at all times.

A phone interview was conducted with Nurse #6 on 4/26/18 at 11:10 AM. She stated she worked on the unit where Resident #13 and Resident #45 resided on 4/25/18 during the 3:00 PM to 11:00 PM shift. She reported the last time she had observed Resident #13 and Resident #45 prior to the incident that night (4/25/18) was at approximately 10:30 PM. She stated at that time, Resident #45 was seated on a chair that was positioned in the hallway outside of his room and Resident #13 was in bed in her room. She

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reported after that observation she went to the nurse ' s station to complete paperwork. She indicated that there was no visual line of sight from the nurse ' s station to Resident #13 ' s and Resident #45 ' s rooms as both rooms were located around a corner. Nurse #6 stated she was getting ready to exit the facility around 11:26 PM on 4/25/18 when Nurse #5 (the nurse working the 11:00 PM to 7:00 AM shift for that unit) called her to Resident #13 ' s room. She reported when she arrived at the room several other staff members were present. Nurse #6 stated Resident #45 had no pants or brief on and he was seated on the foot of Resident #13 ' s bed. She reported Resident #13 was seated on the floor with her knees bent and her feet on the ground.

This phone interview with Nurse #6 continued. She indicated Resident #45 frequently wandered throughout the facility, up and down the hallways, and sometimes into other residents ' rooms. She stated she was unaware of Resident #45 exhibiting any sexually inappropriate behaviors recently, but she had known of an incident that occurred sometime in 2017 in which Resident #45 was observed holding another female resident ' s hand and going into her room. Nurse #6 reported Resident #45 occasionally had behaviors that included combativeness, verbal behaviors, and being difficult to redirect. She indicated staff tried to keep an eye on him and monitor his whereabouts. She reported there were no specific interventions related to how often Resident #45 ' s whereabouts were monitored.

A second interview was conducted with the QA Nurse on 4/26/18 at 11:20 AM. She was asked if

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Resident #45 had any history of sexually inappropriate behavior. She reported there was no recent history of this type of behavior for Resident #45, but there was an incident that occurred about a year ago. She indicated during that incident, Resident #45 had been seated next to another female resident and it had appeared he was attempting to remove her pants. She stated the female ' s pants were only slightly pulled down from her waist. She reported the two residents were separated and Resident #45 was placed on 1 on 1 supervision for a period of time (she was unable to recall how long this 1 on 1 supervision was in place). The QA Nurse stated there had been no other instances of any type of sexually inappropriate behavior for Resident #45 since that occurrence.

A phone interview was conducted with NA #10 on 4/26/18 at 12:35 PM. She stated she worked on the unit where Resident #13 and Resident #45 resided on 4/25/18 during the 3:00 PM to 11:00 PM shift and she was assigned to both residents. She reported the last time she had observed Resident #13 and Resident #45 prior to the incident that night (4/25/18) was at approximately 10:30 PM. She indicated she had tried to perform incontinence care on Resident #45, but he had refused. She stated she left the facility around 11:05 PM. She indicated she had recently started working at the facility so she was not too familiar with Resident #45, but in the three times she had worked with him she had seen him wander frequently. NA #10 reported she had heard from other staff members that Resident #45 wandered into other residents ' rooms at times. She stated she tried to lay eyes on Resident #45 about every 25 minutes when she worked with him to check on his whereabouts. She indicated she had

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observed no inappropriate sexual behaviors for Resident #45.

A phone interview was conducted with NA #8 on 4/26/18 at 12:35 PM. She stated she worked on the unit where Resident #13 and Resident #45 resided on 4/25/18 during the 11:00 PM to 7:00 AM shift, but she was not assigned to either resident. She indicated NA #9 was assigned to Resident #13 and Resident #45. NA #8 reported she and NA #9 were at the nurse ' s station receiving their report from the prior shift until about 11:20 PM on 4/25/18. She stated at that time (around 11:20 PM), she and NA #9 left the nurse ' s station and proceeded down the hallway of the unit that Resident #13 and Resident #45 resided on. She reported that when they got to the end of the hallway Resident #13 ' s bed alarm was heard sounding. She stated NA #9 went to Resident #13 ' s room to attend to the bed alarm and she proceeded to assist another resident. NA #8 reported that when NA #9 approached Resident #13 ' s door it was shut and she was unable to open it. She stated NA #9 had then called for her assistance. She reported she completed her care with the resident she was with and she then went to assist NA #9 within a couple of minutes. NA #8 stated NA #9 had to enter Resident #13 ' s room by going through the bathroom door that adjoined the bedrooms. She reported she also had to enter Resident #13 ' s room through the adjoining room ' s bathroom door and she had observed Resident #13 seated on the floor in front of the door to the room with her legs bent and feet on the ground. She stated Resident #45 was standing directly in front of Resident #13 with his genitals exposed. NA #8 explained that Resident #45 was wearing only a short-sleeved shirt and socks.

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This interview with NA #8 continued. She stated she had not regularly worked with Resident #45, but she was aware he wandered all of the time and entered other residents ' rooms if the doors were open. She indicated she had observed no inappropriate sexual behaviors for Resident #45.

An interview was conducted with the Nurse Practitioner (NP) on 4/26/18 at 1:22 PM. She stated she was familiar with Resident #45. She indicated he had no recent sexually inappropriate behaviors. She explained that when he had resided on the locked memory care unit there was a female resident whom he spent a lot of time around. She further explained that she believed that female resident was the aggressor in that situation.

A phone interview was conducted with NA #9 on 4/26/18 at 1:25 PM. She stated she was assigned to Resident #13 and Resident #45 on 4/25/18 during the 11:00 PM to 7:00 AM shift. She reported that when she came on shift she was at the nurse ' s station receiving a report from the previous shift until around 11:25 PM (4/25/18). She indicated that there was no visual line of sight from the nurse ' s station to Resident #13 ' s and Resident #45 ' s rooms as both rooms were located around a corner. NA #9 reported that at around 11:25 PM she and NA #8 left the nurse ' s station and proceeded down the hallway of the unit that Resident #13 and Resident #45 resided on. She stated that was when she had heard Resident #13 ' s bed alarm sounding. She reported she went to Resident #13 ' s door and found that it was closed. She stated she attempted to open the door to the room, but she was only able to open it partially. She explained

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that she saw Resident #45 inside of Resident #13 ' s room through the partially opened door and she observed him push on the door to close it. NA #9 indicated that she was then unable to reopen the door so she proceeded to enter the room by going through the door of the adjoining room ' s bathroom. She reported that when she entered the room she observed Resident #13 seated on the floor in front of the door with her legs bent up and her feet on the ground. She stated Resident #45 was standing directly in front of Resident #13 with his genitals exposed. She explained that he was wearing only a short-sleeved shirt and socks. She indicated that Resident #45 ' s pants and brief were on Resident #13 ' s bed and his brief was soaked with urine. NA #9 stated this was when she called for assistance from NA #8 and Nurse #5. NA #9 indicated she believed Resident #13 had slid off of her bed independently and crawled over to the area near the door. She explained that Resident #13 had completed this type of action in the past. She confirmed that this was the first time she had seen Resident #45 and Resident #13 since coming on shift that night (4/25/18).

This phone interview with NA #9 continued. She stated that Resident #45 had previously removed his own brief while clothed in a nightgown when he was incontinent, but she had not seen him remove his pants. She reported that Resident #45 wandered all of the time through the halls, the common areas, and into other residents ' rooms. She stated he had moments when he was difficult to redirect and became agitated. She indicated she had observed no inappropriate sexual behaviors for Resident #45, but she was aware of an incident that occurred last year when he was placed on 1 on 1 supervision for, "holding

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another [female] resident ' s hand or something like that". NA #9 indicated she believed the female was the aggressor in that situation as she had dementia and thought Resident #45 was her husband.

An interview was conducted with Nurse #5 on 4/26/18 at 3:15 PM. She indicated she was assigned to Resident #13 and Resident #45 on 4/25/18 during the 11:00 PM to 7:00 AM shift. She stated she was at the nurse ' s station until around 11:15 PM on 4/25/18 receiving report from the previous shift. She indicated that there was no visual line of sight from the nurse ' s station to Resident #13 ' s and Resident #45 ' s rooms as both rooms were located around a corner. Nurse #5 stated the NAs began completing their rounds after the previous shift finished providing their report. She indicated shortly after the NA ' s began their rounds, NA #9 came down the hall toward the nurse ' s station and called for assistance to Resident #13 ' s room. Nurse #5 stated she went to Resident #13 ' s door and she was unable to open the door. She indicated she entered the room by going through the door of the adjoining room ' s bathroom. She reported Resident #13 was seated on the floor in front of the door with her legs bent up and her feet on the ground. She stated Resident #45 was standing directly over Resident #13, he was wearing only a short-sleeved shirt and socks, his genitals were exposed, and he had an erection. She indicated that Resident #45 ' s pants and brief were on Resident #13 ' s bed and his brief was soaked with urine. Nurse #5 stated staff attempted to direct Resident #45 out of the room when he became agitated. She indicated the staff were able to get Resident #45 to sit down on Resident #13 ' s bed while Resident #13 was assisted into

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her wheelchair and out of the room. She reported it took several attempts for Resident #45 to be redirected out of Resident #13 ' s room.

This interview with Nurse #5 continued. She stated she had been working at the facility for about two weeks, but indicated she had previously worked here in the past. She reported Resident #45 wandered throughout the facility up and down all of the hallways. She indicated she had observed no inappropriate sexual behaviors for Resident #45.

The DON was unavailable for interview.

An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. The information received during the staff interviews was reviewed with the Administrator. The interviews indicated the last observations of Resident #13 and Resident #45 prior to the 4/25/18 incident was around 10:30 PM by Nurse #6 and NA #10. The interviews additionally indicated the next observation of Resident #13 and Resident #45 was between the times of 11:15 PM and 11:25 PM when Resident #13 ' s bed alarm sounded alerting staff that Resident #13 was no longer in bed. Staff then found Resident #45 in Resident #13 ' s room, he had shut the door, and his genitals were exposed to Resident #13. The Administrator stated she expected staff to adequately supervise the residents. She stated Resident #45 was immediately placed on 1 on 1 supervision following the 4/25/18 incident. She indicated the facility ' s plan was to continue 1 on 1 supervision for Resident #45 until the locked memory care unit reopened.

3. Resident #16 was admitted 4/8/16 with

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F 689	Continued From page 102 cumulative diagnoses of Cerebral Vascular Accident (CVA), Hemiplegia and Diabetes. Review of Resident #16's nursing notes indicated he voiced threats of leaving the facility on 7/9/17 and a wander guard (preventive device designed to prevent a person at risk for leaving a facility unsupervised) was placed on him. Review of a Wandering Risk Assessment dated 7/10/17 indicated Resident #16 was at risk for wandering. Review of a Wandering Risk Assessment dated 8/25/17 indicated Resident #16 was at risk for wandering. Review of a Wandering Risk Assessment dated 9/22/17 indicated Resident #16 was at risk for wandering. Review of a Wandering Risk Assessment dated 10/26/17 indicated Resident #16 was at risk for wandering. Resident #16's annual Minimum Data Set dated 1/22/18 indicated moderate cognitive impairment with no wandering behaviors. Review of a Wandering Risk Assessment dated 1/22/18 indicated Resident #16 was at risk for wandering. Review of Resident #16's January 2018 Medication Administration Record (MAR) and his Treatment Administration Record (TAR) included no staff observation or assessment for his wander guard placement or function.	F 689		

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Review of the wander guard Transmitter Testing Log for January 2018 indicated there was no testing documented on the following dates:

Monday 1/1/18
Saturday 1/13/18
Sunday 1/14/18
Monday 1/15/18
Tuesday 1/16/18
Friday 1/26/18

Review of Resident #16's care plan revised on 2/22/18 indicated he was at risk for wandering and at risk for unsupervised exits from the facility. He was care planned for a history of removing his wander guard. Care planned interventions included a daily check of the wander guard for proper function and visualization that the wander guard was in place every shift.

Review of an incident report dated 2/22/18 at 3:40 PM, Resident #16 was discovered sitting outside the facility on the front porch. When questioned about his wander guard, he stated "someone removed it last night".

Review of Resident #16's February 2018 MAR and his TAR included no staff observation or assessment for his wander guard placement or function until 2/23/18 when it added to his MAR. The nursing staff were to verify the wander guard placement on every shift.

Review of the wander guard Transmitter Testing Log for February 2018 indicated there was no testing documented on the following dates:

Saturday 2/3/18

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F 689	Continued From page 104 Saturday 2/10/18 Friday 2/16/18 Thursday 2/22/18 (Wander guard was reapplied) Review of Resident #16's March 2018 MAR and his TAR included no staff on observation or assessment for his wander guard placement or function. Review of the wander guard Transmitter Testing Log for March 2018 indicated there was no testing documented on the following dates: Sunday 3/4/18 Friday 3/9/18 Saturday 3/10/18 Thursday 3/29/18 Friday 3/30/18 Review of a Wandering Risk Assessment dated 4/16/18 indicated Resident #16 was at risk for wandering. Review of Resident #16's April 2018 MAR and his TAR included no staff on observation or assessment for his wander guard placement or function. Review of the wander guard Transmitter Testing Log for April 2018 indicated there was no testing documented on the following dates: Wednesday 4/4/18 Monday 4/9/18 Resident #16 quarterly Minimum Data Set dated 4/16/18 indicated moderate cognitive impairment	F 689		

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and he was coded for wandering behaviors.

Review of the undated Care Guide for Resident #16 read Resident #16 had an alarm bracelet (wander guard). There was no listed task for the aides to observe or assess the wander guard placement or function.

Interview on 4/22/18 at 3:30 PM, the Director of Nursing (DON) stated the facility did away with the door monitor and implemented wander guards on all residents assessed as risk for wandering.

Observation on 4/23/18 11:36 AM, Resident #16 was observed in bed. There was an observed wander guard on his right ankle.

Interview on 4/24/18 at 5:00 PM, the Quality Assurance (QA) Nurse stated on 2/22/18, the previous Administrator notified the DON that Resident #16 was observed sitting unsupervised on the front porch. He was cooperative and stated he cut off his wander guard the night before. The QA Nurse stated she found the removed wander guard in his nightstand. A new wander guard was placed on Resident #16.

Interview on 4/25/18 at 8:25 AM, Nurse #4 stated Resident #16 had not displayed any attempts to exit the facility and stated he likes to sit outside on nice days. She stated he was not to be unsupervised outside. Nurse #4 stated she checked his wander guard for placement on her

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shift but unsure if the other nurses check it on their assigned shifts.

Interview on 4/25/18 at 8:40 AM, Nursing Assistant (NA) #5 stated Resident #16 wore a wander guard on his right ankle. She stated she was not aware of any attempts by Resident #16 to remove his wander guard. She stated thought the Central Supply Clerk checked Resident #16's wander guard each day.

Interview on 4/25/18 at 4:40 PM, the Administrator stated the facility had a separate notebook where the wander guards were tested daily by the Central Supply Clerk and tested on weekends by the manager on duty.

Interview on 4/26/18 at 9:48 AM, the Administrator stated she reviewed the Transmitter Testing Log for Resident #16's wander guard and was unaware that the managers were not consistently checking the placement and function of the wander guards on weekends. The Administrator stated the facility was changing their practice for wander guards to include wander guard monitoring for placement and function on every shift and not just daily. She also stated the task of checking placement and function of the wander guard would be added to the MAR and a task for the nurses to complete on each shift.

Interview on 4/26/18 at 10:35 AM, the Central Supply Clerk stated check checked Resident #16's wander guard for placement and function

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daily Monday through Friday but she was not at the facility on weekends. It was her understanding the manager on duty was to check all wander guards on the weekends.

Interview on 4/26/18 at 4:40 PM, NA #12 stated she had heard rumors of Resident #16 asking staff to remove his wander guard but he had not asked her. She stated she did not assess his wander guard on second shift because the Central Supply Clerk did it daily.

Interview on 4/26/18 at 7:28 PM, the Administrator stated it was her expectation that all residents with wander guards be assessed on every shift for wander guard placement and function.

4. Resident #50 was admitted to the facility on 9/21/17 with cumulative diagnoses of Cirrhosis and fracture of left femur.

Resident #50's admission care plan dated 9/22/17 indicated he was at risk for falls related a history of falls. Interventions included to analyze any falls to determine whether a pattern or trend could be addressed.

Review of an incident report dated 12/27/17 at 8:29 AM read Resident #50 was lying on the floor in front of his bathroom. He stated he was going to the bathroom. There was no evidence of a fall investigation and no evidence that his care plan was revised.

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Review of an incident report dated 1/5/18 at 8:05 AM read Resident #50 was sitting on the floor at the bathroom door. There was no evidence of a fall investigation and no evidence that his care plan was revised.

He was readmitted on 1/14/18 with diagnoses of a necrotic left hip and repeated falls.

Review of an incident report dated 1/24/18 at 8:23 AM read Resident #50 was found on his hands and knees between his bed and wheelchair. He stated he was trying to go to the bathroom. There was no evidence of a fall investigation. The care plan was revised on 1/25/18 with intervention to ensure call bell was pinned to gown when in bed.

Review of an incident report dated 1/28/18 at 7:00 PM read Resident #50 was sitting on the floor in his room stating he wanted to go to the bathroom. There was no evidence of a fall investigation and his care plan was revised 1/29/18 to ensure his environment was free of clutter.

A significant change Minimum Data Set (MDS) dated1/31/18 indicated Resident #50 was admitted to hospice services. He was coded with severe cognitive impairment and no behaviors. Resident #50 was coded for extensive assistant with transfers and toileting. He was also coded for 2 or more falls since his last reentry.

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Review of an incident report dated 3/5/18 at 1:04 PM read Resident #50 was on the floor in the doorway of his bathroom. There was no evidence of a fall investigation and no documented evidence that his care plan was revised.

Review of an incident report dated 3/6/18 at 11:27 AM read Resident #50 was on his knees beside his bed. His wheelchair was behind him with the brakes unlocked. There was no evidence of a fall investigation and his care plan was revised 3/6/18 to provide rest periods as needed.

Review of an incident report dated 3/11/18 at 2:22 PM read Resident #50 was on his knees beside his bed on his floor mat with feces noted in the bed, floor and wheelchair. There was no evidence of a fall investigation and his care plan was revised n 3/12/18 to transfer and change positions slowly.

Review of Resident #50's most recent Fall Risk Assessment dated 4/14/18 indicated a high risk for falls.

Interview on 4/23/18 at 10:56 AM Resident #50 stated he often tried to get up to got to the bathroom but his left hip would give out. He stated he forgets to use his call bell at times. Observed at Resident #50's bedside was a floor fall mat.

Interview on 4/25/18 at 8:25 AM, the Quality

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Assurance (QA) Nurse stated she did not investigate each fall for the root cause analysis but each fall was reviewed in the morning stand up meetings.

Interview on 4/26/18 at 12:30 PM, Nursing Assistant (NA) #11 stated Resident #50 does not consistently use his call bell. She stated he was always incontinent of bowel and bladder.

In a second interview on 4/26/18 at 12:00 PM, the QA Nurse stated she started a new fall investigation process today to include root cause analysis with proper interventions.

Interview on 4/26/18 at 4:40 PM, NA #12 stated Resident #50 was inconsistent with using his call bell. She stated his cognition had improved and he was continent if taken to the bathroom.

Interview on 4/26/18 at 7:28 PM, the Administrator stated it was her expectation that every fall be investigated to determine the root cause and identify trends or patterns.

5. Resident #22 was admitted to the facility 5/12/16. Cumulative diagnoses included: unspecified psychosis not due to a substance or known physiological condition, chronic pain, lack of coordination, difficulty in walking and unsteadiness on his feet.

The quarterly Minimum Data Set (MDS) dated 1/30/28 indicated resident #22 was moderately impaired in cognition. He required supervision with transfers, ambulation in the room and hall and locomotion on and off the unit. Resident #22

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had sustained two or more falls without injury since the last assessment.

The last Fall Risk assessment dated 3/22/18 indicated Resident #22 was a fall risk with a score of 14. A score of 10 or more indicates a high risk for falls.

A care plan for falls dated 5/23/16 and last reviewed 4/25/18 stated Resident #22 was at risk for falls characterized by multiple risk factors related to generalized weakness, decreased mobility and history of falls. Recent interventions included in care plan: monitor and intervene for factors causing falls such as bowel/ bladder needs, mobility, transfers, etc.

A review of the incidents and accidents for Resident #22 from December 31,2017 through present revealed the following:

12/31/17 at 3:03 PM-Resident #22 was sitting on the left side of his bed, reached for bed controls and fell off bed onto his trash can. There was a red mark from above left hip noted extending around to residents left flank area. There was no investigation done; no root-cause-analysis done.

1/17/18 at 2:02 PM stated at 9:00 PM on Tuesday January 16, Resident #22 stated that he had fell while trying to go to the bathroom. He could not remember when the incident occurred. There was no investigation done; no root-cause-analysis done.

2/9/18 at 8:31 PM, Resident #22 was sitting on the floor beside of low bed. He said he slid out of bed. Resident #22was assessed while on the floor and without injuries. There was no

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investigation done; no root-cause-analysis done.

4/1/18 at 6:38 PM, staff was summoned to Resident #22 ' s room. He was lying on floor next to the bathroom door partially sitting up. The wheelchair was in the middle of the room. Resident #22 stated he did not know what happened. A head to toe assessment was done and no injuries were noted. There was no investigation done; no root-cause-analysis done.

4/1/18 at 6:50 PM, Resident #22 was noted to be lying on the floor in hallway. His wheelchair was directly behind him. Resident #22 said he didn ' t know who did it but something knocked him out of his chair. A head to toe assessment was done. No injuries were noted. There was no investigation done; no root-cause-analysis done.

On 4/26/18 at 12:10 PM, an interview was conducted with the Quality Assurance (QA) Nurse and the Administrator. The QA Nurse stated they did not complete any investigations with the falls incidents. She stated all department heads meet every morning and discuss falls and what they are going to put in place for the fall. The QA Nurse stated, starting 4/26/18, she would start her investigation and put all her investigation in the green folder and this would be put in the plan of correction. The Administrator stated she expected a root-cause-analysis (investigation) be done with each fall.
6. Resident # 69 was admitted to the facility on 1/20/11 with multiple diagnoses including anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 4/2/18 indicated that Resident #69 had memory and decision making problems and she had falls with no injury since prior assessments.

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Resident #69's care plan dated 4/18/18 was reviewed. One of the care plan problems was Resident #69 was at risk for fall. The goal was Resident #69 would not sustain serious injury through the next review date. The approaches included scoot chair and self-release seat belt (SRSB) when out of bed (initiated on 7/20/11), fall mat on floor when in bed (initiated on 10/16/11) and low bed with high profile winged mattress (initiated on 11/1/17).

Review of the nurse's notes and incident reports revealed that Resident #69 had falls on 12/30/17, 1/19/18 and 4/17/18.

On 12/30/17, Resident #69 had a fall from the scoot chair with the SRSB. There was no thorough investigation as to the cause of the fall.

On 1/19/18 and 4/17/18, Resident #69 had a fall from the bed. There was no thorough investigation as to the cause of the fall.

On 4/24/18 at 9:32 AM and on 4/25/18 at 8:02 AM, Resident #69 was observed out of bed in a chair with SRSB on.

On 4/25/18 at 2:35 PM, Resident #69 was observed in bed. She had a winged mattress on each side of the bed.

On 4/26/18 at 12:05 PM, The Quality Assurance (QA)/Infection Control (IC) Nurse was interviewed. She stated that she was responsible for investigating the falls. She indicated that all department heads had a morning meeting every day to discuss falls. She indicated that she had investigated the cause of the falls but she didn't

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F 689	Continued From page 114 document her investigation. She added that starting today (4/26/18) she would document her investigation and put them in a green folder. On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that she expected the QA/IC Nurse to investigate every falls to find the root cause and to implement appropriate intervention to prevent further falls.	F 689		
F 695 SS=D	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 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 observation, record review, resident and staff interviews, the facility failed to maintain clean air filters for the oxygen concentrator machine for two of two sampled residents who were on continuous oxygen therapy (Resident #38 and #37). The findings included: 1. Resident #38 was admitted to the facility 1/26/11 and last readmitted on 4/9/18. Cumulative diagnoses included chronic obstructive pulmonary disease (COPD), pneumonia 4/9/18, heart failure, shortness of breath, asthma and dependence on supplemental oxygen.	F 695	F695 Respiratory The plan of correcting the specific deficiency The position of Richmond Pines Nursing and Rehabilitation center regarding the process that led to this deficiency was the staff lack of knowledge and failure to follow the practice related to maintaining clean air filters for the oxygen concentrator machines. On 4/25/18, the central supply clerk cleaned the oxygen concentrator filter of	5/24/18

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F 695	Continued From page 115 The quarterly Minimum Data Set (MDS) dated 2/23/18 indicated Resident #38 was severely impaired in cognition. Oxygen was documented as being used during the assessment period. A care plan last revised on 2/27/18 stated resident #38 had potential for or actual ineffective breathing pattern as related to oxygen dependence. Interventions included, in part, oxygen therapy at three liters via nasal cannula continuous as ordered. On 4/24/18 at 11:07 AM, an observation of the oxygen concentrator for Resident #38 was done. The oxygen concentrator filter was dirty with white dust covering the entire filter. On 4/25/18 at 11:38 AM, an observation of the oxygen concentrator filter on Resident #38 ' s oxygen concentrator machine revealed the concentrator filter was still dirty with white dust covering the entire filter. On 4/25/18 at 6:15 PM, an observation of Resident #38 ' s oxygen concentrator filter was conducted with the Quality Assurance (QA) Nurse. The oxygen filter had white dust like material covering the entire filter on the machine. The QA Nurse stated the supply person was the one who was supposed to maintain the concentrators and change oxygen tubing and clean the filters. She stated they had just had someone take that position within the last week or so. She observed the filter on the concentrator and stated it should have been cleaned. On 4/25/18 at 6:20 PM, an interview was conducted with the Central Supply Clerk. She stated she took over the position last Monday.	F 695	the concentrator used by Resident #38. Resident #38 reported being able to tell an improvement after the concentrator filter was cleaned. The procedure for implementing the acceptable plan of correction for the specific deficiency cited The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements On 4/25/18, the quality improvement (QI) nurse informed the new central supply clerk that it is the responsibility of the central supply clerk to check/change oxygen tubing and clean the filters on the oxygen concentrators. On 5/14/18, the pharmacy nurse representative completed an audit on all oxygen concentrators. The audit result: all concentrator internal filters required cleaning or replacement. The pharmacy representative placed an order for new internal filters for all oxygen concentrators. By 5/16/18, the supply clerk was in-serviced by the administrator and/or staff facilitator related to the cleaning schedule and procedure for oxygen concentrator filters and oxygen tubing to	

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F 695	Continued From page 116 She said she changed the nebulizer equipment and put the nebulizer equipment in a bag. She was not aware she was also responsible for checking/ changing oxygen tubing, cleaning the filters or anything that had to do with the oxygen concentrator. On 4/25/18 at 6:20 PM, the Central Supply Clerk cleaned the oxygen concentrator filter and Resident #38 said he could tell a difference and the air smelled fresher On 4/26/18 at 9:00AM, a second interview was conducted with the QA Nurse who stated they could not find any policy regarding cleaning of the oxygen filters. She stated she could not find where it was the duty of the supply clerk to change oxygen tubing, clean filters and they did not keep a record of when this was done. On 4/26/18 at 7:21 PM, an interview was conducted with the Administrator who stated she expected all oxygen equipment to be cleaned weekly. 2. Resident #37 was admitted to the facility on 12/21/15 with multiple diagnoses including chronic obstructive pulmonary disease (COPD). The annual Minimum Data Set (MDS) assessment dated 2/9/18 indicated that Resident # 37's cognition was intact and she was receiving oxygen therapy while a resident at the facility. On 4/23/18 at 11:53 AM and on 4/25/18 at 8:20 AM, Resident #37 was observed in bed with oxygen on. The filter on the oxygen concentrator was observed to be dirty/dusty. On 4/25/18 at 6:20 PM, the Supply Clerk was interviewed. She stated that she took the position as Supply Clerk on 4//15/18 and she was not	F 695	be changed every 7 days. On 5/16/18, the central supply clerk identified and made a list of residents using an oxygen concentrator. The audit result: 12 residents were identified as previously using an oxygen concentrator; 1 resident was in the hospital; 9 residents had a current order. The central supply clerk worked with the QI nurse and the minimum data set (MDS) nurses to make sure the list of residents using an oxygen concentrator was updated and correct. On 5/16/18, the central supply clerk performed an audit in effort to protect other residents using oxygen concentrators. The central supply clerk audited the filters on the oxygen concentrators to ensure the air filters were clean. The audit result: all oxygen concentrator filters had been cleaned. On 5/18/18, the supply clerk and/or maintenance assistant completed cleaning/replacing oxygen concentrator internal filters for all concentrators, including oxygen concentrators used by Resident #37 and Resident #38. By 5/18/18, the administrator completed in-servicing all department heads related to maintaining clean oxygen concentrator filters. The administrator performed a demonstration and made it clear during the in-service that all department heads are required to immediately clean/rinse out the outside filter of an oxygen concentrator if it is visible dirty/dusty. It is	

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F 695	Continued From page 117 aware that she was responsible for cleaning the oxygen filters. On 4/26/18 at 2:15 PM, the Quality Assurance (QA)/Infection Control(IC) Nurse was interviewed. She stated that the Supply Clerk was responsible for cleaning the oxygen filters. She stated that she had observed the oxygen filter for Resident #37 and it looked too dirty, it looked like it was not cleaned for a while. On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that she expected the oxygen filters to be cleaned at least once a week.	F 695	the responsibility of the central supply clerk, and backed-up by the maintenance director, to ensure the internal filters of oxygen concentrators are replaced at least annually or according to manufacturer guidelines. Beginning 5/24/18, the department heads began auditing oxygen concentrator filters to ensure they are clean while completing their daily rounds. Documentation will be completed on the rounds tool 5 days a week. The auditing for cleanliness of oxygen concentrators will be ongoing long-term as part of department head daily “angel” rounds to ensure all residents are protected when using oxygen concentrators. The monthly QI committee will review the results of the audits monthly for 3 months for identification of trends and to determine if the department head daily monitoring during “angel” rounds is sufficient to sustain the solution of maintaining clean filters on oxygen concentrators. The QI committee will also review the maintenance annual preventative maintenance log for oxygen concentrators to ensure oxygen concentrator internal filters are replaced yearly or according to manufacturer guidelines. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations	

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F 695	Continued From page 118	F 695	and oversight. The title of the person responsible for implementing the acceptable plan of correction. The director is responsible for implementing the acceptable plan of correction.	
F 756 SS=E	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,	F 756		5/24/18

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F 756	Continued From page 119 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §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 and Pharmacy Consultant and staff interview, the Pharmacy Consultant failed to identify and to report drug irregularities to the physician for 1 of 6 sampled residents reviewed for unnecessary medications (Residents #39). Findings included: 1. Resident #39 was admitted to the facility on 12/7/17 with multiple diagnoses including psychosis. The quarterly Minimum Data Set (MDS) assessment dated 2/28/18 revealed that Resident #39 had moderate cognitive impairment and he had received an antipsychotic medication during the assessment period. Review of the Physician's orders revealed that Resident #39 was receiving 2 antipsychotic medications. He was receiving Risperdal 2 milligrams (mgs) by mouth daily (started on 12/8/17), Risperdal 25 mgs intramuscular (IM) every 2 weeks (started 2/13/18) and Seroquel 25 mgs by mouth daily (started 1/11/18). The psychiatric evaluation notes for Resident #39	F 756	F756 The plan of correcting the specific deficiency The position of Richmond Pines Nursing and Rehabilitation Center regarding the process that led to the deficiency of a pharmacy consultant failing to identify and to report drug irregularities to the physician resulting in the nursing staff administering an antipsychotic medication to a resident without a physician order was the staff failure to follow policy regarding following physician orders and reconciling medication orders with the medication administration record. On 4/25/18, the minimum data set (MDS) nurse contacted the nurse practitioner (NP) and clarified the physician order for Resident #39's Seroquel. On 4/25/18, the NP discontinued Resident #39's order for Seroquel. The MDS nurse	

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F 756	Continued From page 120 were reviewed. The notes did not indicate that the resident was on Seroquel. The Medication Administration Records (MARs) for Resident #39 were reviewed. The January 2018 MAR revealed that Seroquel was not listed as one of the resident's medications. The February and March 2018 MARs revealed that Resident #39 had received Seroquel the whole month of February and March. The April 2018 MAR revealed that Resident #39 had received Seroquel from April 1- 25, 2018. The monthly drug regimen review notes were reviewed and there was no mention of Seroquel. On 4/25/18 at 12:45 PM, Nurse #8 was interviewed. She stated that she was assigned to Resident #39. Nurse #8 stated that Resident #39 was on Seroquel 25 mgs daily. Nurse #8 verified that she could not find an order for Seroquel in the resident's medical records. On 4/25/18 at 1:50 PM, the Medical Record clerk was interviewed. She verified that she could not find an order for Seroquel on Resident #39's thin records. On 4/25/18 at 3:48 PM, the Nurse Consultant was interviewed. She stated that she had called the pharmacy and the pharmacy indicated that there was no order for the Seroquel, it was an error on their part and that Seroquel was transcribed incorrectly.	F 756	transcribed the discontinued Seroquel order to the medication administration record (MAR). There was no change at that time for Resident #39's Risperdal orders. On 4/25/18, the nurse facility consultant contacted the pharmacy provider and the pharmacy verified the pharmacy had no order for Resident #39 to have Seroquel. On 4/26/18, the new pharmacy consultant was made aware that the previous pharmacy consultant failed to identify and to report a drug irregularity to the physician for Resident #39. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/21/18 through 5/23/18, the director of nursing (DON), quality improvement (QI) nurse, staff facilitator (SF) nurse, charge nurse, and staff nurses compared April MARs to May MARs to ensure no drug irregularities were noted to protect residents in similar situations. The audit result: no additional drug irregularities were identified, including administration of two antipsychotic medications concurrently without a physician's order. By 5/24/18, the SF nurse and QI nurse will re-educate all licensed nurses, including part-time (PT), as needed (PRN) nurses, and agency nurses on: 1) the process to notify pharmacy of new orders including faxing to pharmacy, 2) medications must	

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F 756	Continued From page 121 On 4/26/18 at 4:31 PM, the Pharmacy Consultant was interviewed. She stated that she was new to the facility as Pharmacy Consultant. Her first visit was in March 2018 and she came 1 day in April 2018. She indicated that the facility had already called her about the Seroquel for Resident #39 and she had reviewed the drug regimen review notes and there was no mention of Seroquel. She revealed that the previous Pharmacist had overlooked the Seroquel. On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that her expectation was for the Pharmacy Consultant to address drug irregularities with the attending physician.	F 756	be verified that they are correct upon delivery by the nurse receiving the medication, 3) the process of obtaining medications not available. Any staff not in-serviced by 5/24/18 will not be allowed to work until the re-education is completed. This re-education will be part of the orientation for newly hired licensed nurses, including PT, PRN, and agency nurses. Beginning 5/24/18, the SF nurse, QI nurse, DON, charge nurse, and staff nurses will ensure residents are free of significant medication errors, including administration of an antipsychotic mediation to a resident without a physician/provider's order. To protect residents in similar situations, the SF nurse, QI nurse, DON, charge nurse, and/or staff nurses will compare monthly the upcoming month's medication administration records (MARs) and treatment administration records (TARs) to the current MARs/TARs and also the paper copy of the physician orders from the physical/hard chart. The system requirement to review the paper copy of the physician orders from the physical/hard chart will help ensure medications/treatments are not added to the new MARs/TARs without a physician's/provider's written order so that the problem will not recur. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 122	F 756	requirements The DON, SF, QI nurse, and/or minimum data set (MDS) nurse will audit all new medication orders, including antipsychotic medication weekly x 12 weeks to ensure the order was transcribed correctly onto the medication administration record (MAR) after verifying there is a physician's/provider's order in the health record. This audit will be documented on the MAR Audit Tool as verification the intervention of physician order review during MAR/TAR reconciliation is effective and solutions are sustained. The monthly QI committee will review the results of the MAR Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring of the facility's performance to make sure the solutions are sustained. In addition, the QI committee will review the status of pharmacy consultant visit date to ensure there is continuity of pharmacy consultant coverage and identified/unidentified irregularities are reported to the physician. If the QI committee identifies any concerns, the DON will notify the pharmacy provider and the resident's physician. The DON and/or QI nurse will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight.	

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	345293	A. BUILDING _____ B. WING _____	C 04/26/2018

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F 756	Continued From page 123	F 756	The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to monitor a resident's blood glucose level as	F 757	F 757 The plan of correcting the specific	5/24/18

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F 757	Continued From page 124 ordered for 1 (Resident #16) of 6 residents reviewed for unnecessary medications. The findings included: Resident #16 was admitted 4/8/16 with a diagnosis of Diabetes. Review of Resident #16's admission orders dated 4/9/16 physician orders indicated he was to have a blood glucose check via fingerstick every Monday morning. He was prescribed Lantus (long-acting insulin) 14 units every morning. He was prescribed a regular diet with no concentrated sweets. This was his current orders as of April 2018. Review of Resident #16's lab work dated 1/23/18 indicated his Hemoglobin A1C (test that demonstrates average blood glucose levels over the past 2-3 months) was high at 7.9 with normal ranges between 5.0-6.1. Review of Resident #16's January 2018 Medication Administration Record (MAR) and electronic medical record indicated there was no documented evidence that his blood glucose test was completed Monday 1/29/18. Review of Resident #16's February 2018 MAR and electronic medical record indicated there was no documented evidence that his blood glucose test was completed Monday 2/5/18, 2/18/18 or 2/26/18.	F 757	deficiency The position of Richmond Pines Nursing and Rehabilitation center regarding the process that led to the deficiency of failing to monitor a resident's blood glucose level as ordered was failure to follow policy for following physician's orders. On 4/26/18, the nurse practitioner (NP) reviewed Resident #16's lab work dated 4/24/18 and wrote orders to increase the amount of the resident's daily insulin and ordered Resident #16's blood glucose checked daily. On 4/26/18, the quality improvement (QI) nurse ensured the new orders were transcribed onto the medication administration record (MAR). On 4/26/18, the administrator made her expectation known to the quality improvement (QI) nurse that Resident #16's blood glucose level be checked and documented as ordered by the physician. On 4/27/18 at approximately 6:00 AM, the third shift staff nurse verified Resident #16's blood glucose level via finger stick and documented the result of "318" on the MAR. Insulin was given as ordered by the physician and documented on the MAR. The staff nurse continued to document on the MAR Resident #16's blood glucose level, as ordered, on 4/28/18, 4/29/18, and 4/30/18. The procedure for implementing the acceptable plan of correction for the	

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F 757	Continued From page 125 Review of Resident #16's care plan revised on 2/23/18 indicated he was care plan for his diagnosis of Diabetes and his blood glucose checks were to be completed as ordered by the physician. Review of Resident #16's March 2018 MAR and electronic medical record indicated there was no documented evidence that his blood glucose test was completed Monday 3/5/18 or 3/19/18. Resident #16 quarterly Minimum Data Set dated 4/16/18 indicated he had moderate cognitive impairment and was coded for insulin for 7 of 7 days. Review of Resident #16's April 2018 MAR and electronic medical record indicated there was no documented evidence that his blood glucose test was completed Monday 4/2/18 or 4/23/18. Interview with Resident #16 was conducted on 4/23/18 at 11:36 AM. He stated he was a Diabetic and received insulin daily. He could not recall if his blood glucose was checked prior to his insulin on 4/23/18. There was no observed food or snacks at his bedside. Review of Resident #16's lab work dated 4/24/18 indicated his Hemoglobin A1C was high at 11.3 with normal ranges between 5.0-6.1. Interview with Nurse #4 was conducted on	F 757	specific deficiency cited On 5/23/18, director of nursing (DON), QI nurse, staff facilitator (SF) nurse, charge nurse, and staff nurses audited all residents with physician ordered blood glucose monitoring per finger stick to ensure last 7 days of results are documented in the MAR. The purpose of the audit was to identify and protect other residents in the same situation of not having documented blood glucose results. The audit result: 12 resident records had missing documentation of blood glucose results on the MAR. The audit identified Resident #16's MAR had no blood glucose results documented on 5/1/18, 5/7/18, 5/10/18, and 5/15/18. By 5/24/18, all licensed nurses including part time, as needed (PRN), and agency, will be re-educated regarding the deficiency of failing to monitor a resident's blood glucose level as ordered, failure to follow policy for following physician's orders, and the importance of following physician's orders so that Resident #16 and other residents are protected. The re-education was given by the SF nurse and QI nurse and included completing blood glucose monitoring per finger stick as ordered per physician including documenting results on the MAR. No nurse will be allowed to work after 5/24/18 until the in-service is completed. This in-service will be part of the orientation process for all newly hired licensed nurses including part time, PRN, and agency.	

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F 757	Continued From page 126 4/25/18 at 8:25 AM. She stated she was assigned Resident #16 on Monday 4/23/18. Nurse #4 stated she thought she obtained Resident #16's blood glucose level on 4/23/18 but was not sure. Nurse #4 stated when a blood glucose level was completed, it was charted on Resident #16's MAR. She stated Resident #16 did not refuse to have his blood glucose level checked. Interview with the Nurse Practitioner (NP) was conducted on 4/26/18 at 9:30 AM. She stated she reviewed Resident #16's lab work dated 4/24/18 and wrote orders to increase his Lantus to 20 units every morning and ordered his blood glucose checked daily. She also ordered a consistent carbohydrate diet (same amount of carbohydrates at each meal). NP stated she would expect Resident #16's blood glucose level to be obtained and documented as ordered. Interview on 4/26/18 at 7:23 PM, the Administrator stated it was her expectation that Resident #16's blood glucose level be checked and documented as ordered by the physician.	F 757	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, SF nurse, QI nurse, minimum data set (MDS) nurse, nurse supervisor, and/or charge nurse will monitor the nurses' performance with documenting residents' blood glucose levels as ordered by the physician for 6 months to make sure solutions are sustained. The DON, SF nurse, QI nurse, MDS nurse, nurse supervisor, and/or charge nurse will audit all residents with physician orders for blood glucose monitoring via finger stick 3 times weekly x 4 weeks, once weekly x 8 weeks, and once monthly x 3 months to ensure blood glucose monitoring was completed as evidenced by documentation on the MAR. This audit will be documented on the MAR audit tool. The monthly QI committee will review the results of the MAR audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The QI nurse and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight.	

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F 757	Continued From page 127	F 757	The title of the person responsible for implementing the acceptable plan of correction. The director of nursing is responsible for implementing the acceptable plan of correction.	
F 758 SS=E	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;	F 758		5/24/18

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F 758	Continued From page 128 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and Pharmacists, Nurse Practitioner and staff interviews, the facility administered an antipsychotic medication to a resident without a physician's order (Resident #39) and failed to ensure that as needed (PRN) psychotropic medications are time limited in duration for 6 of 6 sampled residents reviewed for unnecessary medications (Residents #13, #58, #38, #22, #39 and #52). Findings included: 1a. Resident #39 was admitted to the facility on 12/7/17 with multiple diagnoses including psychosis. The quarterly Minimum Data Set (MDS) assessment dated 2/28/18 revealed that Resident #39 had moderate cognitive impairment and he had received an antipsychotic medication	F 758	F 758 The plan of correcting the specific deficiency The position of Richmond Pines Nursing and Rehabilitation center regarding the process that led to this deficiency – administered an antipsychotic medication without a physician's order and failed to ensure that as needed (PRN) psychotropic medications are time limited – was licensed nurse knowledge deficit. On 4/25/18, the order for Seroquel was clarified (discontinued) with nurse practitioner (NP) for Resident #39 by the	

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F 758	Continued From page 129 during the assessment period. Review of the current printed Physician's orders revealed that Resident #39 had received 2 antipsychotic medications. He had received Risperdal 2 milligrams (mgs) by mouth daily (started on 12/8/17), Risperdal 25 mgs intramuscular (IM) every 2 weeks (started 2/13/18) and Seroquel 25 mgs by mouth daily (started 1/11/18). There was no telephone order for the Seroquel found in the resident's medical records. The psychiatric evaluation notes from January through April 2018 for Resident #39 were reviewed. The notes did not indicate that the resident was on Seroquel. The initial psychiatric evaluation was dated 1/11/18. The notes indicated that the resident's current psychiatric medications were Risperdal 2 mgs by mouth (po) daily, and Ativan 0.5 mgs every 12 hours PRN. The recommendation was to initiate Zoloft (an antidepressant drug) 25 mgs by mouth daily for depression. The psychiatric notes dated 2/13/18 revealed the resident's current medications were Risperdal 2 mgs po daily, Ativan 0.5 mgs BID PRN and Zoloft 25 mgs po daily. The recommendation was to initiate Risperdal Consta 25 mgs IM every 2 weeks for mood lability. The psychiatric notes dated 2/20/18 and 4/17/18 had recommendations to continue Risperdal 2 mgs po daily and Risperdal 25 mgs IM every 2 weeks, Ativan 0.5 mgs BID PRN and Zoloft 25 mgs po daily.	F 758	director of nursing (DON). On 4/25/18, Seroquel was discontinued for Resident #39 by the NP. Order was transcribed to medication administration record (MAR) by the DON. On 4/25/18, the DON obtained an order for Resident #39's as needed (PRN) Ativan (the medication was discontinued). On 4/25/18, the DON obtained an order for Resident # 52's PRN Ativan (the medication was discontinued). On 4/25/18, the DON obtained an order for Resident # 58's PRN Ativan (the mediation was discontinued). On 4/25/18, the DON obtained an order for Resident # 13's PRN Ativan (the medication was discontinued). On 4/25/18, the DON obtained an order for Resident # 38's PRN Haldol (the medication was discontinued). On 4/25/18, the DON obtained an order for Resident # 22's PRN Ativan (the medication was discontinued). The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/21/18 through 5/23/18, the DON, quality improvement (QI) nurse, staff facilitator (SF) nurse, charge nurse, and	

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F 758	Continued From page 130 The Medication Administration Records (MARs) for Resident #39 were reviewed. The January 2018 MAR revealed that Seroquel was not listed as one of the resident's medications. The February and March 2018 MARs revealed that Resident #39 had received Seroquel the whole month of February and March. The April 2018 MAR revealed that Resident #39 had received Seroquel from April 1- 25, 2018. On 4/25/18 at 12:45 PM, Nurse #8 was interviewed. She stated that she was assigned to Resident #39. Nurse #8 stated that Resident #39 was on Seroquel 25 mgs daily. Nurse #8 verified that she could not find an order for Seroquel in the resident's medical records. On 4/25/18 at 1:50 PM, the Medical Record clerk was interviewed. She verified that she could not find an order for Seroquel on Resident #39's thin records. On 4/25/18 at 3:48 PM, the Nurse Consultant was interviewed. She stated that she had called the pharmacy and the pharmacy indicated that there was no order for the Seroquel, it was an error on their part and that Seroquel was transcribed incorrectly onto the summarized monthly order sheet for February 2018. On 4/26/18 at 9:55 AM, interview with the Psychiatric Nurse Practitioner (NP) was conducted. She indicated that she was following up Resident #39 for medication and behavior management. She stated that she did not	F 758	staff nurses compared the April MARs to May MARs to ensure no drug irregularities were noted to protect residents in similar situations. The audit result: no additional irregularities were identified, including administration of an antipsychotic medication without an order and PRN psychotropic medications were time limited. By 5/24/18, the SF nurse and QI nurse will re-educate all licensed nurses, including part-time (PT), as needed (PRN) nurses, and agency nurses on: 1) the process to notify pharmacy of new orders including faxing to pharmacy, 2) medications must be verified that they are correct upon delivery by the nurse receiving the medication, 3) the process of obtaining medications not available. Any staff not in-serviced by 5/24/18 will not be allowed to work until the re-education is completed. This re-education will be part of the orientation for newly hired licensed nurses, including PT, PRN, and agency nurses. Beginning 5/24/18, the SF nurse, QI nurse, DON, charge nurse, and staff nurses will ensure residents are free from unnecessary psychotropic medications, including administration of a PRN psychotropic mediation and time limitations. To protect residents in similar situations, the SF nurse, QI nurse, DON, charge nurse, and/or staff nurses will compare monthly the upcoming month's medication administration records (MARs) to the current MARs and also the new	

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F 758	Continued From page 131 recommend the Seroquel for the resident. The NP indicated that it was not her practice to order double antipsychotic medications and if needed, she would increase the dose of the current antipsychotic medication. She added that she was not aware that Resident #39 was receiving 2 antipsychotic medications. On 4/26/18 at 4:31 PM, the Pharmacy Consultant was interviewed. She stated that she was new to the facility as Pharmacy Consultant. Her first visit was in March 2018 and she came 1 day in April 2018. She indicated that the facility had already called her about the Seroquel for Resident #39 and she had reviewed the drug regimen review notes and there was no mention of Seroquel. She revealed that the previous Pharmacist had overlooked the Seroquel. On 4/26/18 at 4:56 PM, the Pharmacy Pharmacist was interviewed. He stated that the Seroquel was entered incorrectly into the system without a doctor's order and then it appeared on the summarized monthly orders and Medication Administration Records (MARs) for February 2018. He stated that the incident was under investigation on their part. On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that her expectation was for the staff to ensure that medications administered had doctor's orders. 1b. Resident #39 was admitted to the facility on 12/7/17 with multiple diagnoses including psychosis. The quarterly Minimum Data Set (MDS) assessment dated 2/28/18 revealed that Resident #39 had moderate cognitive impairment	F 758	physician orders for completeness to include time limits. The system requirement to review MARs and new physician orders at the end of the month will help ensure the problem of unnecessary psychotropic medications/PRN use will not recur. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, SF, QI nurse, and/or minimum data set (MDS) nurse will audit all new medication orders, including psychotropic medication weekly x 12 weeks to ensure there is a complete and not duplicated physician's/provider's order for psychotropic medication in the health record. This audit will be documented on the MAR Audit Tool as verification the intervention of physician order review during MAR reconciliation is effective and solutions are sustained. The monthly QI committee will review the results of the MAR Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring of the facility's performance to make sure the solutions are sustained. The QI nurse or DON will present the findings and recommendations of the monthly QI committee to the quarterly	

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F 758	Continued From page 132 and he had not received an antianxiety medication during the assessment period. Review of the current physician's orders revealed that Resident #39 had orders dated 2/11/18 for Ativan (antianxiety medication) 1 mgs IM twice a day PRN and Ativan 1 mgs by mouth twice a day PRN. Review of the Medication Administration Records (MARs) for March and April 2018 revealed that PRN Ativan injectable and tablet had not been used. On 4/25/18 at 5:26 PM, the Quality Assurance/Infection Control Nurse was interviewed. She stated that all PRN psychotropic medications should only be ordered for 14 days including hospice residents. On 4/26/18 at 9:27 AM, the Nurse Practitioner was interviewed. She stated that she was aware of the rule for PRN psychotropic medications which was 14 days but she was not following that rule for all residents depending on their medical condition/behaviors. Review of the physician's progress notes revealed no documented rationale for the use of the PRN Ativan beyond 14 days. On 4/26/18 at 4:31 PM, the Pharmacy Consultant was interviewed. She stated that she was new to the facility as Pharmacy Consultant. Her first visit was in March 2018 and she came 1 day in April 2018. She indicated that she had already identified some issues with psychotropic medications including the PRN orders and she had started to address some with the physician.	F 758	executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	

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F 758	Continued From page 133 On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that she expected all PRN psychotropic medications to have a stop date of 14 days. 2. Resident #52 was admitted to the facility on 6/10/15 with multiple diagnoses including dementia with behaviors. The quarterly Minimum Data Set (MDS) assessment dated 4/15/18 indicated that Resident #52 had moderate cognitive impairment. Resident #52 had a doctor's order dated 11/30/17 for Ativan (antianxiety medication) 0.5 milligrams (mgs) by mouth every 8 hours as needed (PRN) for anxiety and hallucinations. On 4/25/18 at 5:26 PM, the Quality Assurance/Infection Control Nurse was interviewed. She stated that all PRN psychotropic medications should only be ordered for 14 days including hospice residents. On 4/26/18 at 9:27 AM, the Nurse Practitioner was interviewed. She stated that she was aware of the rule for PRN psychotropic medications which was 14 days but she was not following that rule for all residents depending on their medical condition/behaviors. Review of the physician s progress notes revealed no documented rationale for the use of the PRN Ativan beyond 14 days.	F 758		

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On 4/26/18 at 4:31 PM, the Pharmacy Consultant was interviewed. She stated that she was new to the facility as Pharmacy Consultant. Her first visit was in March 2018 and she came 1 day in April 2018. She indicated that she had already identified some issues with psychotropic medications including the PRN orders and she had started to address some of the issues with the physician.

On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that she expected all PRN psychotropic medications to have a stop date of 14 days.

3. Resident #58 was admitted to the facility on 2/22/18 and readmitted on 3/9/18 with diagnoses that included vascular dementia with behavioral disturbance and Parkinson ' s.

A physician ' s order dated 3/29/18 indicated Ativan (antianxiety medication) 1 milligrams (mg) intramuscular (IM) every 12 hours as needed (PRN) for Resident #58. There was no stop date for this PRN order.

A physician ' s order dated 3/29/18 indicated Ativan gel equal to 2 mg twice daily PRN for agitation for Resident #58. There was no stop date for this PRN order.

The significant change Minimum Data Set (MDS) dated 4/12/18 indicated Resident #58 was rarely/never understood and rarely/never understands. He had short-term and long-term memory problems and severely impaired decision making. Resident #58 received antianxiety medication once during the MDS assessment period.

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A review of Resident #58 ' s April 2018 MAR from 4/1/18 through 4/24/18 indicated the PRN orders were Ativan 1mg and Ativan gel (equal to 2 mg) continued to be active orders.

An interview was conducted with the Quality Assurance (QA) Nurse on 4/25/18 at 5:26 PM. She stated that all PRN psychotropic medications should only be ordered for 14 days including hospice residents.

An interview was conducted with the Nurse Practitioner on 4/26/18 at 9:27 AM. She stated she was aware of the rule for PRN psychotropic medications which was a time limited duration of 14 days, but she was not following that rule for all residents depending on their medical condition/behaviors.

An interview was conducted with the Pharmacy Consultant on 4/26/18 at 4:31 PM. She stated she was new to the facility as Pharmacy Consultant. Her first visit was in March 2018 and she came 1 day in April 2018. She indicated she had already identified some issues with psychotropic medications, including the PRN orders with no stop date, and she had started to address some of these issues with the physician.

An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. She stated she expected all PRN psychotropic medications to have a stop date of 14 days.

4. Resident #13 was admitted to the facility on 4/28/17 and most recently readmitted on 4/9/18 with multiple diagnoses that included Alzheimer ' s and dementia without behavioral disturbance.

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The quarterly Minimum Data Set (MDS) assessment dated 1/15/18 indicated Resident #13 was rarely/never understood and rarely never understands. Her short-term and long-term memory were impaired and she had severely impaired decision making. Resident #13 was administered no antianxiety medication during the MDS assessment period.

A physician ' s order dated 4/9/18 indicated Ativan (antianxiety medication) 1 milligram (mg) every 4 hours as needed (PRN) for Resident #13. There was no stop date for this PRN order.

A review of Resident #13 ' s April 2018 MAR from 4/9/18 through 4/24/18 indicated the PRN order for Ativan 1mg continued to be an active order. There were no administrations of this PRN Ativan for Resident #13.

An interview was conducted with the Quality Assurance (QA) Nurse on 4/25/18 at 5:26 PM. She stated that all PRN psychotropic medications should only be ordered for 14 days including hospice residents.

An interview was conducted with the Nurse Practitioner on 4/26/18 at 9:27 AM. She stated she was aware of the rule for PRN psychotropic medications which was a time limited duration of 14 days, but she was not following that rule for all residents depending on their medical condition/behaviors.

An interview was conducted with the Pharmacy Consultant on 4/26/18 at 4:31 PM. She stated she was new to the facility as Pharmacy Consultant. Her first visit was in March 2018 and she came 1 day in April 2018. She indicated she

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had already identified some issues with psychotropic medications, including the PRN orders with no stop date, and she had started to address some of these issues with the physician.

An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. She stated that she expected all PRN psychotropic medications to have a stop date of 14 days.

5. Resident #38 was admitted to the facility on 1/26/11 and readmitted on 4/9/18 with diagnoses that included major depressive disorder, psychosis and agitation.

A physician ' s order dated 1/5/18 indicated Haldol (antipsychotic medication) 5 milligrams by mouth three times daily PRN (as needed) agitation for Resident #38. There was no stop date for this PRN order.

The quarterly Minimum Data Set (MDS) dated 2/23/18 indicated Resident #38 was usually understood and usually understands communication. He was severely impaired in cognition. Resident #38 received seven days of anti-psychotic medication during the assessment period. The antipsychotic medication was received as a routine medication.

A review of Resident #38 ' s Medication Administration Records for February 2018, March 2018 and April 2018 indicated the PRN order for Haldol 5 milligrams continued to be active orders.

An interview was conducted with the Quality Assurance (QA) Nurse on 4/25/18 at 5:26 PM.

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She stated that all PRN psychotropic medications should only be ordered for 14 days.

An interview was conducted with the Nurse Practitioner on 4/26/18 at 9:27 AM. She stated she was aware of the rule for PRN psychotropic medications which was a time limited duration of 14 days, but she was not following that rule for all residents depending on their medical condition/behaviors.

An interview was conducted with the Pharmacy Consultant on 4/26/18 at 4:31 PM. She stated she was new to the facility as Pharmacy Consultant. Her first visit was in March 2018 and she came 1 day in April 2018. She indicated she had already identified some issues with psychotropic medications, including the PRN orders with no stop date, and she had started to address some of these issues with the physician.

An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. She stated she expected all PRN psychotropic medications to have a stop date of 14 days.

6. Resident #22 was admitted to the facility 5/12/16 with diagnoses that included unspecified psychosis not due to a substance of known physiological condition, anxiety, major depressive disorder and unspecified mood affective disorder.

The quarterly Minimum Data Set (MDS) dated 1/30/18 indicated Resident #22 was moderately impaired in cognition. Resident #38 received antipsychotic, antianxiety and antidepressant medication during the assessment period.

A physician ' s order dated 3/20/18 indicated

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F 758	Continued From page 139 Ativan 0.25 milligrams daily and q12 hours as needed (PRN). There was no stop date for the PRN order. An interview was conducted with the Quality Assurance (QA) Nurse on 4/25/18 at 5:26 PM. She stated that all PRN psychotropic medications should only be ordered for 14 days. An interview was conducted with the Nurse Practitioner on 4/26/18 at 9:27 AM. She stated she was aware of the rule for PRN psychotropic medications which was a time limited duration of 14 days, but she was not following that rule for all residents depending on their medical condition/behaviors. An interview was conducted with the Pharmacy Consultant on 4/26/18 at 4:31 PM. She stated she was new to the facility as Pharmacy Consultant. Her first visit was in March 2018 and she came 1 day in April 2018. She indicated she had already identified some issues with psychotropic medications, including the PRN orders with no stop date, and she had started to address some of these issues with the physician. An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. She stated she expected all PRN psychotropic medications to have a stop date of 14 days.	F 758		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 760		5/24/18

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F 760	Continued From page 140 by: Based on record review and Pharmacy Consultant, Nurse Practitioner and staff interviews, the facility administered an antipsychotic medication to a resident for almost 3 months without a physician's order for 1 of 6 sampled residents reviewed for unnecessary medications (Resident #39). Findings included: 1. Resident #39 was admitted to the facility on 12/7/17 with multiple diagnoses including psychosis. The quarterly Minimum Data Set (MDS) assessment dated 2/28/18 revealed that Resident #39 had moderate cognitive impairment and he had received an antipsychotic medication during the assessment period. Review of the Physician's orders revealed that Resident #39 was receiving 2 antipsychotic medications. He was receiving Risperdal 2 milligrams (mgs) by mouth daily (started on 12/8/17), Risperdal 25 mgs intramuscular (IM) every 2 weeks (started 2/13/18) and Seroquel 25 mgs by mouth daily (started 1/11/18). The psychiatric evaluation notes for Resident #39 were reviewed. The notes did not indicate that the resident was on Seroquel. The Medication Administration Records (MARs) for Resident #39 were reviewed. The January 2018 MAR revealed that Seroquel was not listed as one of the resident's medications. The February and March 2018 MARs revealed that Resident #39 had received Seroquel the	F 760	F760 The plan of correcting the specific deficiency The position of Richmond Pines Nursing and Rehabilitation Center regarding the process that led to the deficiency of administering an antipsychotic medication to a resident without a physician order was the staff failure to follow policy and procedure. On 4/25/18, the minimum data set (MDS) nurse contacted the nurse practitioner (NP) and clarified the physician order for Resident #39's Seroquel. On 4/25/18, the NP discontinued Resident #39's order for Seroquel. The MDS nurse transcribed the discontinued Seroquel order to the medication administration record (MAR). The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/21/18 through 5/23/18, the director of nursing (DON), quality improvement (QI) nurse, staff facilitator (SF) nurse, charge nurse, and staff nurses will compare April MARs to May MARs to ensure no drug irregularities were noted to protect residents in similar situations. The audit result: no additional drug irregularities were identified, including	

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F 760	Continued From page 141 whole month of February and March. The April 2018 MAR revealed that Resident #39 had received Seroquel from April 1- 25, 2018. On 4/25/18 at 12:45 PM, Nurse #8 was interviewed. She stated that she was assigned to Resident #39. Nurse #8 stated that Resident #39 was on Seroquel 25 mgs daily. Nurse #8 verified that she could not find an order for Seroquel in the resident's medical records. On 4/25/18 at 1:50 PM, the Medical Record clerk was interviewed. She verified that she could not find an order for Seroquel on Resident #39's thin records. On 4/25/18 at 3:48 PM, the Nurse Consultant was interviewed. She stated that she had called the pharmacy and the pharmacy indicated that there was no order for the Seroquel, it was an error on their part and that Seroquel was transcribed incorrectly. On 4/26/18 at 9:55 AM, interview with the Psychiatric Nurse Practitioner (NP) was conducted. She indicated that she was following up Resident #39 for medication and behavior management. She stated that she did not recommend the Seroquel for the resident. The NP indicated that it was not her practice to order double antipsychotic and if needed, she would increase the dose of the current antipsychotic medication. She added that she was not aware that Resident #39 was receiving 2 antipsychotic medications. On 4/26/18 at 4:31 PM, the Pharmacy Consultant was interviewed. She stated that she was new to	F 760	administration of an antipsychotic medication without a physician's order. By 5/24/18, the SF nurse and QI nurse will re-educate all licensed nurses, including part-time (PT), as needed (PRN) nurses, and agency nurses on: 1) the process to notify pharmacy of new orders including faxing to pharmacy, 2) medications must be verified that they are correct upon delivery by the nurse receiving the medication, 3) the process of obtaining medications not available. Any staff not in-serviced by 5/24/18 will not be allowed to work until the re-education is completed. This re-education will be part of the orientation for newly hired licensed nurses, including PT, PRN, and agency nurses. Beginning 5/24/18, the SF nurse, QI nurse, DON, charge nurse, and staff nurses will ensure residents are free of significant medication errors, including administration of an antipsychotic mediation to a resident without a physician/provider's order. To protect residents in similar situations, the SF nurse, QI nurse, DON, charge nurse, and/or staff nurses will compare monthly the upcoming month's medication administration records (MARs) and treatment administration records (TARs) to the current MARs/TARs and also the paper copy of the physician orders from the physical/hard chart. The system requirement to review the paper copy of the physician orders from the physical/hard chart will help ensure	

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F 760	Continued From page 142 the facility as Pharmacy Consultant. Her first visit was in March 2018 and she came 1 day in April 2018. She indicated that the facility had already called her about the Seroquel for Resident #39 and she had reviewed the drug regimen review notes and there was no mention of Seroquel. She revealed that the previous Pharmacist had overlooked the Seroquel. She stated that there were some residents who needed 2 antipsychotic medications but the physician had to specify the rationale for the duplicate use. On 4/26/18 at 4:56 PM, the Pharmacy Pharmacist was interviewed. He stated that the Seroquel was entered incorrectly into the system without doctor's order. He stated that the incident was under investigation on their part. On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that her expectation was for the staff to ensure that medications administered had doctor's orders.	F 760	medications/treatments are not added to the new MARs/TARs without a physician's/provider's written order so that the problem will not recur. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, SF, QI nurse, and/or minimum data set (MDS) nurse will audit all new medication orders, including antipsychotic medication weekly x 12 weeks to ensure the order was transcribed correctly onto the medication administration record (MAR) after verifying there is a physician's/provider's order in the health record. This audit will be documented on the MAR Audit Tool as verification the intervention of physician order review during MAR/TAR reconciliation is effective and solutions are sustained. The monthly QI committee will review the results of the MAR Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring of the facility's performance to make sure the solutions are sustained. The SF and/or QI nurse will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations	

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F 760	Continued From page 143	F 760	and oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition	F 801		5/24/18

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professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
(ii) In States that have established standards for food service managers or dietary managers,

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F 801	Continued From page 145 meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to employ a Certified Dietary Manager with the competencies and skills required to carry out food and nutrition services from March 8, 2018 and continuing at the time of the survey review April 23-April 26, 2018. The findings included: An initial tour of the kitchen was conducted on 4/23/18 at 9:30 AM. The Assistant Dietary Manager stated she was also acting as the Interim Dietary Manager at present. She stated she went on vacation for two weeks and, when she returned, the prior Assistant Dietary Manager had left. On 4/25/18 at 10:45 AM, an interview was conducted with the Assistant Dietary Manager and the Corporate Dietary Consultant. They stated the previous Dietary Manager left March 8, 2018. There had not been a Certified Dietary Manager in that position since that time. The Corporate Dietary Consultant stated they advertised the position but did not have any applicants. The Assistant Dietary Manager stated she had been the first shift cook until 4/13/18. She said she had been on vacation for 2 weeks and came back on 4/13/18 because the facility had called her and stated the Assistant Dietary Manager had left. She stated she was not serve safe certified and would not be able to take the class for certification until September. She also	F 801	F801 The plan of correcting the specific deficiency The position of Richmond Pines Healthcare and Rehabilitation center regarding the process that led to the deficiency of failing to employ a certified dietary manager with the competencies and skills to carry out food and nutrition services was an unfilled vacancy in the certified dietary manager position. On 4/23/18, the administrator verified the facility failed to employ a certified dietary manager (CDM) from March 8, 2018 after the CDM resigned without notice and the assistant dietary manager began assisting with CDM tasks with support from the corporate dietary consultant. On 4/23/18, the administrator also verified the facility was advertising for the position of a certified dietary manager. The administrator contacted the corporate office for assistance with filling the certified dietary manager position. Beginning on 4/23/18, the assistant dietary manager and dietary department received on-site support from the	

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F 801	Continued From page 146 indicated she had not taken any nutrition courses but had worked for several years as cook. On 4/25/18 at 10:45 AM, an interview was conducted with the Administrator. She stated she had been at the facility 2 weeks. At that time the Assistant Dietary Manager had already left--just never showed up for work. The Administrator said she was aware that the current Assistant Dietary Manager was not certified as Dietary Manager. The Administrator stated the only supervision the current Assistant Dietary Manager was via by phone or email if the Corporate Dietary Consultant was not in the facility. She also indicated the facility had placed advertisements for a Dietary Manager but did not have any applicants now. A review of the time card for the Corporate Dietary Consultant revealed she was in the facility on 3/7/18, 3/22/18, 4/3/18, 4/23/18, 4/24/18 and 4/25/18. On 4/26/18 at 7:21 PM, a second interview was conducted with the Administrator who stated the facility would have to find someone qualified to be in that position until a full time Dietary Manager was hired.	F 801	corporate dietary consultant and/or a sister-facility CDM. As of 5/24/18, the facility will continue to receive on-site support from a CDM until the full-time CDM is employed at the facility. On 5/11/18, the administrator hired a qualified CDM for the dietary manager position in effort to correct the deficiency of failing to employ a CDM with the competencies and skills required to carry out food and nutrition services. Pending the results of the pre-employment background checks, the CDM will begin in the dietary manager role and be working at the facility during the week of 5/28/18. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/11/18, the administrator hired a certified dietary manager. The new, qualified CDM will be working at the facility in the role of dietary manager during the week of 5/28/18, pending results of the pre-employment background checks. To prevent the deficiency from recurring, any future vacancies in the CDM/dietary manager role will be promptly (within 24 hours) reported by the payroll clerk and administrator to the regional vice president of operations, the corporate dietary consultant and/or corporate clinical	

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F 801	Continued From page 147	F 801	consultant, and the corporate human resources department vacancy of the certified dietary manager position. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The payroll clerk and/or administrator will validate every two weeks for 3 months the employment of a certified dietary manager (CDM) in the kitchen. The validation will be accomplished through review of payroll submission and supporting CDM credentials. The monthly QI committee will review the status of the CDM position monthly for 3 months for the need of continued monitoring and make recommendations. The administrator will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		5/24/18

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F 812	Continued From page 148 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to have proper dish sanitation, failed to label and date opened food items and failed to discard expired food items. The findings included: 1. On 4/25/18 at 9:35 AM, an observation of the dishwashing machine was conducted. The Corporate Dietary Consultant stated the dishwashing machine was a high temperature machine and the wash cycle should be at a temperature of 150 degrees Fahrenheit and the rinse cycle should be at 180 degrees Fahrenheit. Observations were conducted at 9:35 AM, 9:40 AM and 9:45 AM. The wash cycle was at 142 degrees Fahrenheit and the rinse cycle was at 162 degrees Fahrenheit for the three	F 812	F812 The plan of correcting the specific deficiency The position of Richmond Pines Healthcare and Rehabilitation Center regarding the process that led to the deficiency of failing to have proper dish sanitation, failing to label and date open food items and failing to discard expired food items was lack of education and knowledge of the dietary staff. On 4/23/18, the assistant dietary manager and corporate dietary consultant discarded unlabeled items including 10	

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F 812	Continued From page 149 observations. On 4/25/18 at 9:45 AM, the Corporate Dietary Consultant stopped the dishwasher. She stated, although the dishwasher was a high temperature machine, there had been a problem with obtaining the 180 degrees Fahrenheit needed for the rinse cycle so they had put a second sanitizing liquid that was used in the rinse cycle to make sure everything was sanitized. On 4/25/18 around 9:47 AM, a telephone conversation was conducted with the lead Nutrition Consultant. She stated there had been a problem with maintaining the rinse temperature and that was why there was a second rinse with chlorine solution during the rinse cycle to make sure the dishes were sanitized. When asked regarding the wash temperature at 142 degrees Fahrenheit, she stated that was not acceptable and they should shut down the dishwashing machine. On 4/25/18 at 10:15 AM, an observation of the dishwasher temperatures was conducted with the Maintenance director. He checked the temperature of the wash cycle with a thermometer probe and it read 147 degrees Fahrenheit and the rinse cycle was at 162 degrees Fahrenheit. He stated the entire system ran off one set of water lines so he could not turn the water temperature up to attain the 180 degrees Fahrenheit as that would be the temperature of hot water for the entire building. He stated he would get someone to come and check the machine. On 4/25/18 at 12:15PM, an observation of the dishwashing machine was conducted with the	F 812	cartons of thawed chocolate mighty shakes and 8 cartons of thawed sugar free vanilla mighty shakes from the walk in cooler. On 4/23/18, the assistant dietary manager and corporate dietary consultant discarded undated and unlabeled items including an opened package of raisin cookie dough, 1 bag of chicken breasts, and 1/5 bag of chicken tenders from the freezer. On 4/23/28, the assistant dietary manager and corporate dietary consultant discarded expired items from the walk in cooler including 1 box of eggs (97) and 5 flats of eggs (150). The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/23/18 and 4/24/18, the assistant dietary manager and corporate dietary consultant audited all nourishment rooms, the freezer and the walk in cooler to ensure there were no expired, undated and/or unlabeled items. The audit resulted in several items noted as expired or damaged and were immediately discarded. On 5/23/18, the maintenance assistant had received confirmation a new dishwashing machine was ordered, awaiting arrival and installation. Until the dishwashing machine is installed and properly working, the facility will utilize	

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F 812	Continued From page 150 Food Service personnel who had arrived to check the dishwashing machine. He stated he had turned the thermostats up for wash and rinse. The wash was now at 158 degrees Fahrenheit and the rinse cycle was at 170 degrees Fahrenheit. He stated he was unable to get the rinse cycle any higher that 170 degrees Fahrenheit. On 4/25/18 at 5:20 PM, an observation of the rinse cycle was done with the Corporate Dietary consultant and a representative from the company that maintained the chlorine used in the rinse cycle. He stated the chlorine was not working prior to him servicing the dish machine that day. A test strip was used to check the chlorine levels used in the rinse cycle and tested between 50-100 parts per million (ppm). The Corporate Dietary Consultant stated they had now ordered three new heaters and three new fuses for the current dish machine. 2. a. On 4/23/18 at 9:30 AM, an initial tour of the kitchen was conducted with the Assistant Dietary Manager. An observation of the walk-in cooler revealed there were 10 cartons of chocolate mighty shake supplements and eight sugar free vanilla mighty shakes. All the mighty shakes were thawed and did not have a date on any of the cartons stating when the mighty shakes had been thawed. Instructions on the carton stated once thawed, the item should be used within fourteen days. The Assistant Dietary Manager stated they went by the stock expiration date and did not know there was a 14-day discard date after thawed. b. On 4/23/18 at 9:30 AM, a tour of the freezer	F 812	disposable meal serving products (plastic tableware, Styrofoam plates/bowls). Starting the date of use of the new dishwashing machine, wash and rinse temperatures will be audited by the assistant dietary manager, interim dietary manager, CDM dietary manager, maintenance assistant, and/or corporate dietary consultant. The wash and the rinse temperatures will be documented on the dishwasher water temperature sheets. Starting the date of use of the new dishwasher, the CDM dietary manager, assistant dietary manager, dietary staff, maintenance assistant, and/or corporate consultant will audit the wash and rinse temperatures twice a day to ensure the wash temperature is at 150 degrees Fahrenheit and the rinse temperature is at 180 degrees Fahrenheit. By 5/24/18, the assistant dietary manager in-serviced all dietary staff related to the labeling and dating of food items including dating mighty shakes according to manufacturing guidelines. After 5/24/18, no dietary staff member will be allowed work until receiving this in-service. This in-service will be part of the orientation process for all newly hired dietary employees and maintenance staff. By 5/24/18, the interim CDM, assistant dietary manager, and/or corporate dietary consultant will complete the in-service with all dietary staff on the correct temperatures for the dish machine wash and final rinse. The in-service will also	

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F 812	Continued From page 151 was conducted with the Assistant Dietary Manager. Observation revealed the following: an opened package of what appeared to be raisin cookie dough. The package was not labeled or dated when opened; 1 bag of chicken breasts opened and not labeled or dated when opened; 1/5 bag of chicken tenders unlabeled and undated. The Assistant Dietary Manager stated she was trying to get things done in the kitchen but it was a challenge with having to cook also and do her job. She stated she had just given an in-service last week on labeling and dating things. She stated nothing was done while she was on vacations--such as labeling and dating. Her expectation was for all opened food items to be labeled and dated when opened 3. On 4/23/18 at 9:30 AM, a tour of the walk-in cooler was conducted with the Assistant Dietary Manager. Observation revealed one box of eggs (97) that stated best before; sell by 2/9/18 and 5 flats (150 eggs) with date on best by/ sell by 3/5/18. The Assistant Dietary Manager said the facility did not use fresh eggs anymore. She was unaware of the dates on the boxes of eggs.	F 812	include actions to take when temperature is not within acceptable range. After 5/24/18, no dietary staff member can work until receiving this in-service. This in-service will be part of the orientation process for all newly hired dietary employees and maintenance staff. To ensure the deficiency of Food Procurement, Store/Prepare/Serve-Sanitary does not recur, the administrator has hired a CDM to manage and direct the dietary department. On 5/11/18, the CDM was hired and, pending the results of the pre-employment background checks, the CDM will be working in the facility the week of 5/28/18. The job duties of the CDM include monitoring inventory, expiration dates, proper food storage, and ensuring proper functioning equipment. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The assistant dietary manager, certified dietary manager, corporate consultant, and/or administrator will audit the walk in cooler and freezer weekly (on varying days and shifts to include 7 days a week) for 12 weeks to ensure there are no expired, undated and/or unlabeled food items. The audit will include noting if thawed mighty shakes are dated and stored according to manufactures	

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F 812	Continued From page 152	F 812	guidelines. These audits will be documented on the Dietary Audit tool. The CDM, administrator, maintenance assistant, and/or corporate consultant will audit the wash and rinse temperatures twice daily (on varying days, five days weekly, including weekends) for 12 weeks. This will be documented on the Dishwasher Temperature log. The monthly QI committee will review the results of the Dietary Audit tool and Dishwasher Temperature log monthly for 3 months for identification of trends, actions taken, and to determine if corrective actions are effective and solutions sustained. The CDM and/or administrator will present the findings and recommendations of the monthly quality improvement (QI) committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The dietary manager is responsible for implementing the acceptable plan of correction.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services.	F 849		5/24/18

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F 849	Continued From page 153 §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.	F 849		

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F 849	Continued From page 154 (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies	F 849		

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F 849	Continued From page 155 where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.	F 849		

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F 849	Continued From page 156 (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and	F 849	F 849	

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F 849	Continued From page 157 staff interview, the facility failed to coordinate care with the hospice provider for 1 of 1 residents (Resident #13) reviewed for hospice care. The findings included: Resident #13 was admitted to the facility on 4/28/17 and most recently readmitted on 4/9/18 with multiple diagnoses that included Alzheimer ' s, dementia without behavioral disturbance, chronic kidney disease, Diabetes Mellitus, and muscle weakness. A review of Resident #13 ' s payor source indicated she was under the care of hospice since her readmission to the facility on 4/9/18. The significant change Minimum Data Set (MDS) assessment dated 4/12/18 indicated Resident #13 was rarely/never understood and rarely never understands. Her short-term and long-term memory were impaired and she had severely impaired decision making. Resident #13 received hospice care prior to her readmission to the facility and during this MDS review period while at the facility. Resident #13 ' s plan of care included the focus area of hospice care. This area was initiated on 4/19/18. The medical record was reviewed and revealed the hospice current plan of care and the hospice progress notes were not in Resident #13 ' s medical record. An interview was conducted with Resident #13 ' s RP on 4/23/18 at 12:15 PM. She confirmed Resident #13 had been receiving hospice care since her readmission to the facility on 4/9/18.	F 849	The plan of correcting the specific deficiency The position of Richmond Pines Nursing and Rehabilitation center regarding the process that led to this deficiency was the staff failure to coordinate care with hospice and obtain hospice documentation. On 4/25/18, the facility received progress notes and the hospice current plan of care for Resident #13 via fax. By 5/22/18, the documents were uploaded in Resident #13's electronic medical record. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. On 5/18/18, the minimum data set (MDS) nurse and MDS coordinator began an audit to protect other residents from the deficiency of not having documented coordinated care between the facility and the hospice provider. The audit covered each hospice resident's hard chart and electronic medical record to ensure hospice documentation, including progress notes and current plan of care, were present. The 100% audit of hospice residents' charts for hospice documentation, progress notes, and current plan of care was completed on 5/23/18. The audit result: documentation and updates were needed for multiple residents.	

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F 849	Continued From page 158 On 4/25/18 at 11:00 AM the hospice documentation for Resident #13 providing evidence of the coordination of care was requested from the Administrator. On 4/25/18 at 2:00 PM the MDS Coordinator provided hospice progress notes and the hospice current plan of care for Resident #13. These documents were indicated to have been faxed to the facility on 4/25/18 at 1:17 PM. The MDS Coordinator was asked what staff member was responsible for coordinating care with the hospice provider. She stated she was not sure, but that it was not her. The Director of Nursing (DON) was unavailable for interview. An interview was conducted with the Quality Assurance (QA) Nurse on 4/25/18 at 3:24 PM. The QA Nurse was asked what staff member was responsible for coordinating care with the hospice provider. She indicated it was DON who was responsible for coordination of care with the hospice provider. The QA Nurse stated she expected the hospice documentation to be available at the facility as required per the regulations. An interview was conducted with the Administrator on 4/26/18 at 7:20 PM. She stated she expected care to be coordinated with the hospice provider. She indicated she expected the hospice documentation to be available at the facility as required per the regulations.	F 849	On 5/18/18, the quality improvement (QI) nurse in-serviced the administrative nurses and social worker related to coordinating care with hospice including obtaining resident's current plan of care and progress notes. On 5/18/18, the QI nurse in-serviced medical records related to placing hospice documentation in the resident's medical record. As of 5/24/18, the social worker will notify the hospice service provider of care plan meeting dates and times. On 5/23/18, the director of nursing met with a hospice representative. The facility has set the expectation with the hospice service provider that a hospice representative (nurse, social worker, and/or nursing assistant) will attend care plan meetings of residents receiving hospice services as of 5/24/18. This new process adjustment will serve to protect Resident #13 and other hospice residents at the facility, ensuring continuity and coordination of care. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements On 5/18/18, the MDS nurse and MDS coordinator began auditing hospice residents to ensure the facility is coordinating the resident plan of care with hospice using the Hospice Audit Tool. This audit will be completed for all hospice	

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F 849	Continued From page 159	F 849	residents weekly x 4 weeks then every-other week x 8 weeks by an administrative nurse. The MDS nurse or director of nursing (DON) will present the findings from the Hospice Audit Tool at the monthly QI committee. The monthly QI committee will review the results of the Hospice Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The MDS coordinator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight related to coordination of care with hospice services. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	
F 865 SS=E	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.	F 865		5/24/18

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F 865	Continued From page 160 §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §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, observation, Pharmacists, Nurse Practitioner and staff and resident interviews, the facility ' s Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedure and to monitor these interventions that the committee put into place following the 10/12/17 complaint investigation survey and 6/9/17 recertification survey. This was for the thirteen (13) recited deficiencies (Coordination of Preadmission Screening and Resident Review (PASRR), Abuse/Neglect, Dignity, Choices, Minimum Data Set (MDS) accuracy, Comprehensive care plan, Review/revise care plan, Quality of Life, Activity of daily living (ADL) care, Accident, Unnecessary Drug, Immunizations, and Drug regimen review) which were cited on 10/12/17 complaint investigation survey and 6/9/17 recertification survey and on the current recertification survey of 4/26/18. The continued failure of the facility during the three federal surveys of record show a pattern of the facility ' s inability to sustain an	F 865	F 865 QAPI/QAA Program/Plan The plan of correcting the specific deficiency The position of Richmond Pines Nursing and Rehabilitation Center regarding the process that led to this deficiency was failure to follow established facility policy related to QAPI. The procedure for implementing the acceptable plan of correction for the specific deficiency cited By 5/24/18, the corporate facility consultant will in-service the facility administrator, director of nursing, MDS nurse, admissions, activities director, maintenance director, dietary manager, medical records, therapy director, and	

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F 865	Continued From page 161 effective QAA program. Findings included: This tag is cross referred to: 1.F 600 - Neglect - Based on observation, record review, and interviews with staff, police, and the Nurse Practitioner (NP), the facility neglected to provide adequate supervision for a cognitively impaired male resident (Resident #45) with frequent wandering behaviors and a history of sexually inappropriate behaviors. Resident #45 entered the room of a cognitively impaired female resident, shut the door, and exposed his genital region to Resident #13. This was for 1 of 1 residents reviewed for neglect. During the complaint investigation survey of 10/12/17, the facility was cited F 600 for failure to protect a resident from harm. 2. F 550 - Dignity - Based on record review, observation and staff interview, the facility failed to promote dignity by feeding resident while wet and soiled for 1 of 2 sampled residents reviewed for dignity (Resident #69). During the recertification survey of 6/8/17, the facility was cited F550 for not providing showers to residents. 3. F 561 - Choices - Based on record review, resident interview and staff interviews, the facility failed to honor a resident's choice to receive showers per preference for showers over bed baths for two of eight sampled residents (Resident #11 and #68).	F 865	housekeeping supervisor related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related F600, F550, F561, F641, F644, F656, F657, F675, F677, F689, F757/758, F883, and By 5/24/18 the administrator will facilitate a quarterly quality assurance and performance improvement (QAPI)/QAA Executive Committee meeting to review the purpose and function of the QAA committee and review on-going compliance issues. The Medical Director, Administrator, DON, MDS nurse, Dietary Manager, maintenance director, medical records, and housekeeping supervisor will attend QAPI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. The facility QAPI committee will meet a minimum of monthly and Executive QAPI committee meeting a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. The Executive QAPI committee, including the medical director, will review quarterly compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QAPI committee will validate the facility□s progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or	

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F 865	Continued From page 162 During the recertification survey of 6/9/17, the facility was cited F 561 for not honoring the family request for a cooler in the resident ' s room. 4. F 641 - MDS accuracy - Based on record review, observation and staff interview, the facility failed to promote dignity by feeding resident while wet and soiled for 1 of 2 sampled residents reviewed for dignity (Resident #69). During the recertification survey of 6/9/17, the facility was cited F 641 for not coding the MDS assessments accurately in the areas of dental and diagnoses. 5. F644 - Coordination of PASRR - Based on record review and staff interview, the facility failed to make a referral for re-evaluation after a significant change in condition, for 1 of 1 sampled residents (Resident #58) reviewed for Preadmission Screening Resident Review Level II status. During the complaint investigation survey of 10/12/17, the facility was cited F644 for failure to coordinate with the PASTT program for reevaluation of a resident with PASRR level 11. 6. F 656 - Develop and Implement Care Plan - Based on record review and staff interview, the facility failed to implement the plan of care interventions to document meal intake percentages for 3 of 7 residents (Residents #13, #34, and #58) reviewed for nutrition. During the recertification survey of 6/9/17, the facility was cited F656 for failure to complete a comprehensive and individualized care plan.	F 865	other interventions. As of 5/24/18, after the facility consultant in-service, the facility QAPI Committee will begin identifying other areas of quality concern through the QI review process, for example: review of rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), review of resident council minutes, review of resident concern logs, review of pharmacy reports, review of audits related to the plan of correction and review of regional facility consultant recommendations. The Facility QAPI Committee will meet at a minimum of monthly and Executive QAPI committee meeting a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiencies. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The executive QAPI committee will	

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F 865	Continued From page 163 7. F 657 - Review/revise Care Plan - Based on record review and staff interview, the facility failed to review and revise plans of care to reflect the current status of the resident for 2 of 25 residents (Residents #13 and #58) reviewed. During the recertification survey of 6/9/17, the facility was cited F 657 for failure to revise the care plan for wandering and falls and for failure to involve alert and oriented residents in the care planning process. 8. F675 - Quality of Life - Based on staff and resident interviews and record review, the facility failed to provide psychological services as ordered for 1 (Resident #68) of 6 residents reviewed for unnecessary medications. During the recertification survey of 6/9/17, the facility was cited F 675 for failure to obtain psychiatric consult as ordered. 9. F 677 - ADL care - Based on record review, observation and staff interview, the facility failed to provide incontinent care (Resident #69) and nail care (Resident #9) for 2 of 8 sampled residents reviewed for activities of daily living (ADL). During the recertification survey of 6/9/17, the facility failed to provide showers as scheduled. 10. F689 - Accident - Based on observations, record reviews, and interviews with family, staff, police, and the Nurse Practitioner (NP), the facility failed to implement fall risk interventions for Resident #13 for two falls, one of which she sustained a nasal fracture. The facility also failed to provide adequate supervision for a cognitively	F 865	continue to meet at a minimum of Quarterly, and QAPI committee monthly with oversight by a corporate staff member. The Executive QAPI Committee, including the Medical Director, will review quarterly compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QAPI Committee will validate the facility□s progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The title of the person responsible for implementing the acceptable plan of correction The administrator is responsible for implementation of the acceptable plan of correction.	

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F 865	Continued From page 164	F 865		

impaired male resident (Resident #45) to prevent him from exposing his genital region to a cognitively impaired female resident (Resident #13). The facility additionally failed to monitor Resident #16 ' s wander guard (a device used to monitor exit seeking behaviors for cognitively impaired residents) and failed to thoroughly analyze falls to determine causative factors and implement appropriate interventions to prevent further falls (Residents #22, #50, and #69). This was for 6 of 7 residents reviewed for accidents.

During the recertification survey of 6/9/17, the facility failed to prevent cognitively impaired resident from exiting the facility unsupervised.

11. F 757/758 - Unnecessary medications - Based on record review and Pharmacists, Nurse Practitioner and staff interviews, the facility administered an antipsychotic medication to a resident without a physician ' s order (Resident #39) and failed to ensure that as needed (PRN) psychotropic medications are time limited in duration for 6 of 6 sampled residents reviewed for unnecessary medications (Residents #13, #58, #38, #22, #39 and #52).

During the recertification sur vey of 6/9/17, the facility was cited F757/758 for failure to administer medications as ordered, failure to monitor weights and blood pressure, and failure to complete an AIMS assessments.

12. F 883 - Influenza and Pneumococcal Immunizations - Based on record review and staff interview, the facility failed to provide education regarding the benefits and potential side effects of the influenza immunization before offering the immunization with documentation in the resident '

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F 865	Continued From page 165 s medical records (Resident # 37) and failed to offer the influenza immunization during the influenza season (October-March) (Resident #52) for 2 of 5 sampled residents reviewed. During the recertification survey of 6/9/17, the facility was cited F 883 for failure to administer pneumococcal vaccine as ordered 13. F 756 - Drug Regimen Review - Based on record review and Pharmacy Consultant and staff interview, the Pharmacy Consultant failed to identify and to report drug irregularities to the physician for 1 of 6 sampled residents reviewed for unnecessary medications (Residents #39). During the recertification survey of 6/9/17, the facility was cited F 756 for failure to request an AIMS assessment for a resident on antipsychotic medication. On 4/26/18 at 7:25 PM, the Administrator was interviewed regarding the facility ' s QAA program. The Administrator stated that the facility had a QAA program consisted of all the department heads including the Administrator, Director of Nursing and the Medical Director. She indicated that the committee had met quarterly. She revealed that she was new to the facility as Administrator and she had read the statement of deficiencies from the previous surveys. The Administrator stated that the reasons for the repeat deficiencies were staff not following the system in place and they were not consistently monitoring the implemented interventions in place.	F 865		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		5/24/18

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F 883	Continued From page 166 §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 (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	F 883		

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F 883	Continued From page 167 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 record review and staff interview, the facility failed to provide education regarding the benefits and potential side effects of the influenza immunization with documentation in the medical records before offering the immunization (Resident # 37) and failed to offer the influenza immunization during the influenza season (October-March) (Resident #52) for 2 of 5 sampled residents reviewed. Findings included: The facility's policy/procedure on immunization dated 10/18/17 was reviewed. The policy indicated that before offering the influenza immunization, the resident or resident's legal representative will be provided education regarding the benefits and potential side effects of the immunization with documentation in the medical record. The policy also indicated that residents will be offered the influenza immunization annually from early October to March.	F 883	F883 Influenza The plan of correcting the specific deficiency The position of Richmond Pines Nursing and Rehabilitation center regarding the process that led to this deficiency was the staff failure to follow established policy and procedure related immunizations to include documenting and/or providing education and offering the influenza vaccine during the influenza season. On 5/18/18, the quality improvement (QI)/Infection Control nurse provided Resident #37 education, including risk versus benefits related to the influenza vaccine, for the influenza vaccine the resident received on 10/17/17. Resident #52 will not be offered the	

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RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

(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 883	Continued From page 168 1. Resident #37 was admitted to the facility on 12/21/15 with multiple diagnoses including chronic obstructive pulmonary disease (COPD). The annual Minimum Data Set (MDS) assessment dated 2/9/18 indicated that Resident # 37's cognition was intact. Resident #37's immunization record was reviewed. The records revealed that Resident #37 had received influenza immunization on 10/17/17. The records did not indicate that education was provided to Resident #37 regarding the benefits and the potential side effects of the influenza immunization. On 4/26/18 at 6:20 PM, the Quality Assurance/Infection Control(QA/IC) Nurse was interviewed. She stated that she mailed the education regarding the benefits and potential side effects of the influenza immunization to the resident's representative (RP) but did not document it. She also indicated that she could not find documentation that the education was provided to Resident #37. On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that she expected the resident and or the resident's legal representative to be provided with education regarding the benefits and potential side effects prior to offering the influenza immunization and to document in the resident's medical records that education was provided. 2. Resident #52 was admitted to the facility on 6/10/15 with multiple diagnoses including dementia with behaviors. The quarterly Minimum	F 883	influenza vaccine due to the flu season ended at the end of March, per the Centers of Disease Control (CDC) guidelines. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/18/18, the QI nurse began auditing 100% of resident records to ensure they received education related to the influenza vaccine, if the resident was residing in the facility during the flu season and received the vaccine. The QI nurse immediately addressed any questions or concerns with the resident and/or resident representative. The audit was 100% completed by 5/24/18. Four residents were found without education documented in the electronic health record. The QI nurse contacted the resident representative and education was provided then documented in the electronic health record. Residents not offered the influenza vaccine during the 2017-2018 flu season will not be offered the vaccine due to the flu season ended at the end of March 2018, per the CDC guidelines. On 5/18/18, the QI and SF nurses began in-servicing all registered nurses (RNs) and licensed practical nurses (LPNs), including part time (PT), as needed (PRN), and agency. To protect other residents in similar situations, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 883	Continued From page 169 Data Set (MDS) assessment dated 4/15/18 indicated that Resident #52 had memory and decision making problems. Resident #52's immunization record was reviewed. The records indicated that Resident #52 did not receive influenza immunization during the immunization season (October - March). On 4/26/18 at 6:20 PM, the Quality Assurance/Infection Control (QA/IC) Nurse was interviewed. She stated that she could not find documentation in the medical records that Resident #52 was offered influenza immunization during the immunization season. On 4/26/18 at 7:20 PM, the Administrator was interviewed. She stated that her expectation was for the influenza immunization to be offered to all residents during the immunization season and to document in the resident's medical records the administration or the refusal.	F 883	in-service covers the facility's policy/procedure related to immunizations to include providing and documenting education related to risk versus benefits prior to offering the influenza vaccine. The in-service will be completed by 5/24/18. After 5/24/18, no licensed nurse, including PT, PRN, and agency will be allowed to work without completing the in-service. This in-service will be added to the orientation for all newly hired nurses including PT, PRN, and agency. On 5/18/18, the QI and SF nurses began in-servicing all RN's and LPN's, including part time, PRN, and agency, related to offering the influenza vaccine during flu season (October-March) per the CDC guidelines. The in-service will be completed by 5/24/18. After 5/24/18, no licensed nurse, including PT, PRN, and agency will be allowed to work without the in-service. This in-service will be added to the orientation for all newly hired nurses including PT, PRN, and agency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements On 5/18/18, the QI nurse and SF nurse began auditing resident records to ensure if the resident receives a vaccine, education was provided and documented in the resident electronic health record. This audit will aide in protecting residents in similar situations. The audit is	

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F 883	Continued From page 170	F 883	documented on the Vaccine Audit Tool. 5 resident records will be audited weekly x 4 weeks, the biweekly x 8 weeks to monitor and ensure the system remains in place and the problem does not recur. The QI nurse will present findings from the Vaccine Audit at the monthly QI committee. The monthly QI committee will review the results of the Vaccine Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The QI nurse will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The director of nursing is responsible for implementing the acceptable plan of correction.	