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| F 000 | INITIAL COMMENTS<br><br>Recert was scheduled for 9/17/18 and was postponed due to hurricane florence BW<br><br>Survey team returned to facility on 11/13/18 to gather additional information and to decide whether the team had substandard quality of care and whether an extended survey was required. Team exited on 11/14/18 and scope and severity of F760 was changed from an E to a G. There was no substandard quality of care, and thus an extended survey was not required. A pharmacist interview was conducted on 11/19/18 to strengthen the citation at F760. DB | F 000 | | |
| F 565 SS=E | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their | F 565 | | 12/7/18 |

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

Electronically Signed | 11/30/2018

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| F 565 | Continued From page 1<br>response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, and record review the facility failed to resolve concerns expressed by residents during resident council meetings. During a resident group meeting 4 of 5 residents who participated expressed on-going issues with call bell response and receiving cold food at meals which had been discussed during resident council meetings. The facility also failed to resolve an individual grievance brought up in a resident council meeting about the disrespectful attitude of second and third shift nursing assistants (NAs) which contributed to 4 of 5 residents present in a group meeting reporting that this issue was still an on-going problem. Findings included:<br><br>1. a. Minutes from the 11/29/17 resident council meeting documented, "Sometimes staff take a while to answer call lights. Residents state it seems like 15 - 20 minutes. 11 - 7 also takes a while to answer lights."<br><br>Minutes from the 01/28/18 resident council meeting documented, "Staff takes a while to | F 565 | Current residents are potentially at risk for this issue.<br><br>The Activities Director has been reeducated to write concerns from Resident Council Meetings on concern forms for the facility to address. These forms will be utilized for general as well as specific concerns. The resident specific concern will have direct follow up with the resident and the resolution will also be shared in the next meeting. The Activity Director will bring the general concern resolutions back to the next Resident Council Meeting to review the resolutions for them and follow up with the group with any further related issues.<br><br>The Administrator will review the Resident Council Meeting minutes and the concern forms generated from them with the Activities Director after each meeting. The concerns will be logged in the concern log for trending. The | |

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| F 565 | Continued From page 2<br>answer lights."<br><br>Minutes from the March 2018 resident council meeting (undated) documented, "Call lights on 3 - 11 residents state it seems like 15 minutes. Food could be a little warmer in the dining room. When food is received on the back of the 100 hall it's cold."<br><br>Minutes from the 04/30/18 resident council meeting documented problems with, "Call lights."<br><br>Minutes from the 05/28/18 resident council meeting documented, "Call bells on 3 - 11 ring a while. Resident food still is cold on the 100 hall mainly the back of the 100 at breakfast time."<br><br>Minutes from the 07/29/18 resident council meeting documented, "Residents state that when the food cart comes out staff is not right there to pass out the food, by the time they receive their food it's cold."<br><br>Minutes from the 08/27/18 resident council meeting documented, "Call bells are a problem again on 3 PM - 11 PM. Food is cold when residents received their breakfast on the back of the 100 hall."<br><br>Minutes from the 09/30/18 resident council meeting documented, "Residents feel like when kitchen brings out food staff does not pass it out right away."<br><br>1. b. On 10/23/18 at 2:08 PM five residents participated in a group meeting, and review of their minimum data set (MDS) assessments revealed that all five were documented as having intact cognition. 4 of 5 residents stated that there | F 565 | Administrator and Activities Director will review the concerns from the two previous Resident Council meetings to identify any issues that are reoccurring. Any reoccurring issues will be brought to the QAPI committee for the development of a new plan to improve performance.<br><br>This monitoring will be documented by the Activities Director for the next three Resident Council Meeting minutes. The Activities Director will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period. | |

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were some core issues that were shared during group meetings which did not seem to get resolved. They explained that staff performance in these areas would get better for a couple of weeks and then return to a problematic level again. They reported that call bell response was unacceptable on second and third shifts, and even though this problem had been discussed multiple times in group meetings it kept reoccurring. 3 of 5 residents stated that the problems started when the administrative staff left the building on second shift. They reported on multiple occasions, after waiting 20 minutes or more for their call bells to be answered, they had gone to the nurse's station to find the nursing assistants (NAs) huddled together having personal conversations and/or using their personal phones.

During the meeting 4 of 5 residents stated there was an on-going problem with cold food being received by residents who preferred to eat meals in their rooms. They reported that cold food had been discussed in resident council meetings multiple times, but the issue was not getting resolved. They commented that the NA staff was not passing the trays out quickly enough. They reported they had seen NAs sitting at the nurse's station, or the NAs were nowhere to be seen when the meal carts arrived on the halls. 2 of 5 residents stated that it was hard to have an appetite when the food was cold upon arrival.

On 10/25/18 at 10:18 AM the Dietary Manager (DM) stated he attended resident council meetings when he could. He reported he was aware residents had ongoing concerns about cold food, and had in-serviced his dietary staff about how to ensure foods were hot enough when they

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left the kitchen. He commented he completed monthly test tray audits during which he found the overall tray delivery process to be acceptable. However, he stated he did not actually check a watch or clock to time the different elements of the delivery system such as when trays left the kitchen, arrived on the hall, and when the last meal tray was given out to a resident.

On 10/25/18 at 12:10 PM the Activities Director (AD), and coordinator of the resident council program, stated call bell response and cold food seemed to be recurrent problems that were brought up during the resident council meetings. According to the AD, she encouraged residents to anticipate their needs and ring the call bells before their needs rose to an emergent level. However, the AD stated that residents were frustrated because some NAs on second and third shifts would turn the call bell lights off, promise to return, but never show back up. The AD also commented that she educated residents that sometimes call bell waits of up to 15 minutes could not be avoided due to the volume of call bells going off. She also reported she encouraged the residents to ask the NAs to warm their food up if it arrived cold, but some residents stated they did not want to bother the NAs or they did not like food that had been microwaved. The AD stated she gave a report about resident council concerns in the morning meetings the days following the resident council sessions.

On 10/25/18 at 12:27 PM the Director of Nursing (DON) stated the facility was aware of ongoing resident concerns about cold food and call bell response. She reported staff were informed about these concerns during "huddles" at change of shift as out-going staff shared with in-coming

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staff. However, she stated the facility had not held formal in-servicing during which interventions to address these problems were developed. The DON commented the facility had completed periodic call bell audits, and she provided copies which documented the call bell responses for random rooms had been monitored on 12/25/17, 12/26/17, 03/18/18, 03/27/18. 04/10/18, 05/14/18, and 09/13/18. According to the DON, there were two unit managers, and one of those unit managers was available to work when needed on all three shifts, although she was not sure how much time had been worked outside of the 8:00 AM - 6:00 PM range in the past.

On 10/26/18 at 11:45 AM the Administrator stated part of the issue with ongoing complaints about call bell response was the subjective nature of what people considering acceptable response times. She reported the facility tried to "drill down" to pinpoint the day, time, and resident/staff members involved in specific incidents. She also commented that residents had been asked to anticipate their needs in advance and not wait until the last minute to ring for assistance. The Administrator reported that a large amount of residents did not consider a wait time of 20 minutes to be acceptable call bell response. She stated cold food was brought up by residents sporadically, food temperature was subjective, and some of the sporadic nature of food concerns was probably related to the residents who were able to attend the meetings, with some having a lot stronger opinions about food. According to the Administrator, the facility could do a better job documenting discussions and education provided in small huddles.

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2. a. On 10/23/18 at 2:08 PM five residents participated in a group meeting, and review of their minimum data set (MDS) assessments revealed that all five were documented as having intact cognition. 4 of 5 of these residents stated there was an ongoing problem in the building on second and third shifts which seemed to start once the administrative staff left in the early evenings. They reported that the NAs on second and third shift treated them like they "were an imposition." They explained when they asked for assistance, the NAs would sigh and roll their eyes. 1 of 5 residents stated after a NA finally answered her call bell, and brought her fresh ice water, the NA slammed the cup down on the table. 2 of 5 residents stated on second and third shift when a NA finally showed up to answer their call bell, the NA stated. "What do you want now?" 3 of 5 residents stated if they complained to anyone about the attitude of the second and third shift NAs, these NAs would give them subtle "pay back." They explained the NAs would greet and carry on conversation with roommates but ignore them, would bring roommates fresh ice water but not offer to do the same for them, would take away a roommate's meal tray but leave theirs in the room, and other subtle "snubs." They stated the amount of staff noise late on second shift and during third shift was disrespectful, and when residents asked the staff to be quieter, the staff just stared at the residents and continued as before. These three residents commented it was stressful enough having to adapt to a new environment in the nursing home without having to deal with attitude from the NA staff on second and third shifts.

On 10/25/18 at 12:27 PM the Director of Nursing (DON) stated the facility was unaware of ongoing

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| F 565 | Continued From page 7<br>attitude from the NAs on second and third shifts. She reported that the only dignity issue discussed in morning meetings and documented in resident council minutes and in the grievance log was reoccurring complaints about call bell response. She commented that if the facility had been made aware of this problem they could have included it in discussions during "huddles" at change of shift as out-going staff shared with in-coming staff. According to the DON, there were two unit managers, and one of those unit managers was available to work on all three shifts when problems arose, although she was not sure how much time this unit manager had worked outside of the 8:00 AM - 6:00 PM range in the past.<br><br>2. b. On 10/25/18 at 12:10 PM the Activities Director (AD), and coordinator of the resident council program, stated she recalled a resident complaining about NA attitude back around April 2018 during a resident council meeting. She reported she could not remember who the resident was, but that the resident was stating some NAs on second and third shifts were not treating residents with dignity, and had a very poor attitude. She explained that she entered and documented this resident's concern in the facility's grievance log because it appeared to be isolated to a single resident. However, when the AD reviewed the facility's grievance log, she reported she could not find where she entered this concern about dignity into the system. | F 565 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, | F 580 | | 12/7/18 |

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consistent with his or her authority, the resident representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in

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| F 580 | Continued From page 9<br>§483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on physician interview, staff interview, and record review the facility failed to notify the physician on the day a fall occurred which involved the head making contact with pavement for 1 of 4 residents (Resident #45) reviewed for falls. Resident #45 later developed a subdural hematoma. Findings included:<br><br>Record review revealed Resident #45 was admitted to the facility on 09/10/18, and was discharged to the hospital on 10/17/18 without return to the facility. The resident's documented diagnoses included multiple cancers with metastasis, chronic kidney disease, atrial fibrillation, and hypertension.<br><br>Nurse #19 wrote a late entry nursing note on 10/18/16 at 9:06 AM for 10/14/18 9:00 PM. The note documented, "Resident...reported 'wheelchair went off of edge of sidewalk...' Brought into building by staff member at approximately (7:00 PM) this evening. (Family member) in attendance. Alert, (oriented) x 1, reported headache 3/10 (3 out of 10 on pain scale). Noted quarter sized abrasion/ecchymosis (bruising) left anterior-lateral forehead; 0.8 (centimeter) laceration left nose, presumably from glasses. Given ice pack. Neuro checks: (pupils equal, round, and reactive to light). No other injuries noted. Moves all extremities well....Reported pain relieved to head by (8:00 | F 580 | Resident #45 is no longer at the facility.<br><br>Residents who have an incident are at risk for this issue.<br><br>Resident incidents since October 22, 2018 have been audited to verify that there was documentation of the notification of the MD after the incident. Any identified deficiency has been addressed.<br><br>Licensed Nurses have been reeducated concerning the expectation that the MD will be notified of any changes, including incidents with any injury, and that the notification will be documented in the resident□s medical record.<br><br>The Director of Nursing or designee will review each incident at the following morning clinical meeting and verify the notification of the MD was completed and documented. This verification will be done for every morning meeting for 4 weeks and then weekly for 8 weeks.<br><br>The Director of Nursing will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the | |

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PM). Currently, denied complaints. Stated 'I am ok, do not need to go to hospital....' Assisted to bed, positioned for comfort. Will continue to monitor...."

A 10/15/18 11:17 AM physician progress note documented, "Nursing staff reports patient fell over the weekend. Patient reports he was outside in his wheelchair. His wheel slipped off the curb and he fell out of his wheelchair. He has slight bruising over his left eye and on his forehead. He didn't lose consciousness. He denies any pain with eye movement...."

On 10/25/18 at 11:31 AM, during a telephone interview, Nurse #19 stated he was told by a facility nurse and someone from administration that Resident #45 was found outside where he rolled off the sidewalk in his wheelchair. Nurse #19 commented a family member arrived during his post-fall assessment of the resident, and she was informed of the fall and how it happened. However, the nurse reported he did not follow the facility policy which was to contact the physician, informing the physician of what happened, the resident's injuries, and his nursing assessment so the physician could decide about how to proceed. He commented sometimes post-fall the physician wanted continued vital signs and neuro-checks done, and other times the physician wanted the resident sent to the emergency room (ER).

On 10/25/18 at 1:53 PM the Director of Nursing (DON) stated anytime there was a fall with injury the physician was supposed to be notified and involved in resident's after-care. She reported the physician was supposed to make the decision about whether to send the resident to the ER following head trauma. She explained even

monitoring period.

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| F 580 | Continued From page 11<br>though Resident #45 was interviewable, and stated he did not want to go to the hospital, the physician should have made the final decision about whether to send the resident to the ER because the resident hit his head on pavement and a hematoma was present.<br><br>On 10/25/18 at 3:27 PM the DON stated in-servicing was begun on 10/19/18 about incident/risk management reporting. She commented the emphasis of the training was to remind the nursing staff about all the components that should be included in documentation concerning falls and about who to notify following falls. She reported so far about 1/4 of the nursing staff have been in-serviced (there were nine signatures on the sign-in sheet). The in-service handout documented, "MD (physician) must be notified of any fall."<br><br>On 10/25/18 at 4:38 PM Physician #1, who cared for Resident #45, stated the facility usually called her after residents experienced any falls, with or without injury. She reported if there was a post-fall injury her expectation was that she should always be notified. She commented it was up to the physician to decide whether or not to send the resident out to the hospital. She commented when falls resulted in a hematoma she needed information about the size of the hematoma, details about other injuries, information about pain and vitals, and neuro-checks from the assessing nurse in order to make her decision about sending the resident to the emergency room versus continuing to take vital signs and neuro-checks in the facility. | F 580 | | |
| F 600 SS=G | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1) | F 600 | | 12/7/18 |

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| F 600 | Continued From page 12<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, family interview, staff interviews, Physician Assistant interview, Physician interview and record review the facility neglected to care for residents by omitting the administration of medication for 6 of 33 residents reviewed for medication administration (Residents #118, #4, #216, #140, #36, and #50). Resident #118 was given Morphine Sulfate Immediate release 15 mg (Milligrams) in error instead of MS Contin 75 mg Extended Release as ordered at 8:00 PM on 10/20/18 and his pain level rose from a "6" (moderate pain) to a "10" (extreme pain) when he was assessed at 6:21 AM on 10/21/18. The facility also neglected to provide toe nail care for 1 of 3 dependent residents (Resident #27) reviewed for Activity of Daily Living (ADL) care which resulted in the resident's toe nails having grown over the toes a half inch on each toe.<br><br>Findings included: | F 600 | Residents #4,#36, and #50 were assessed and found no current detrimental effects from the medication omissions. Residents #118, #216, & #140 are no longer in the facility.<br><br>Resident #27 had toe nails trimmed on the day the issue was identified.<br><br>Current Residents are at risk for these issues.<br><br>The medication administration records for current residents were reviewed to identify any other medication documentation omissions. If identified, the resident was assessed and the MD was notified. Current residents were assessed for the condition of their toe nails. No further issues were identified. | |

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| F 600 | Continued From page 13<br><br>1. Resident #118 was admitted to the facility on 10/17/18 with diagnoses that included cancer of the prostate that had spread (metastatic). A care plan dated 10/18/18 included a goal to maintain the residents comfort with palliative care services. Interventions included to administer pain/symptom relief medications as prescribed by the physician, provide palliative care, and assess for verbal and nonverbal signs and symptoms relating to pain: grimacing, guarding, crying, moaning, and increased anxiety. The resident was a new admission and had not had a Minimum Data Set Assessment completed at the time of the survey.<br><br>Resident #118 was ordered MS Contin 75 mg by mouth every 12 hours for pain. This medication was ordered by the physician on 10/17/18. Review of the Controlled Medication Utilization records showed that the medication had not been removed from stock and given to the resident on 10/20/18 at 8:00 PM but was initialed on the eMAR (electronic medication administration record) as given by Nurse #11 who documented the resident's pain level as "6" on a pain scale of 0-10 with 0 being no pain and 10 being extreme pain. Review of the nursing progress notes revealed that on 10/21/8 at 6:21 AM the resident had reported his pain level was "10" (prior to this the highest pain level recorded had been a "7"). Review of the Controlled Medication Utilization record showed that Nurse #11 had given the resident Morphine Sulfate Immediate Release 15 mg on 10/20/18 at 8:00 PM and on 10/21/18 at 6:21 AM.<br><br>An attempt to contact Nurse #11 on 10/26/18 at 12:47 PM was unsuccessful. A second message | F 600 | Licensed nurses were reeducated concerning the expectation that medication is given as ordered and the documentation of the medication administration is accurate. This education included the requirement to document why a medication was not given in the nurses notes and to notify the MD.<br><br>Licensed nurses were reeducated concerning the expectation that the toe nails be evaluated during the skin checks and any toe nails that were difficult to trim/needed podiatry referral would be referred to the Director of Nursing for follow up.<br><br>Ongoing, the Director of Nursing or designee will review controlled medication count sheets and compare them to the medication administration record. This review will be documented for 5 random residents a week for 12 weeks.<br><br>The Director of Nursing or designee will check the toe nails of randomly selected residents on an ongoing basis. This will be documented for 5 random residents a week for 12 weeks.<br><br>The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee meeting for review and recommendations for the duration of the monitoring period. | |

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was left on 11/14/18 and she returned the call at 10:02 AM. She stated that she had no idea why she had given the resident an alternate dose instead of his scheduled medication. She stated that she had made a medication error.

In an interview conducted with the facility consultant pharmacist on 11/19/18 at 2:08 PM she stated that Morphine Sulfate 15 mg Immediate Release had an onset of approximately 15 to 30 minutes after administration and was effective for 3 to 6 hours. She said MS Contin 75 mg Extended Release had an onset in approximately the same amount of time as the Morphine Sulfate Immediate Release but was a higher dose and was effective for a longer period of time-12 hours. She stated that the Morphine Sulfate 15 mg Immediate Release that was given would have been less effective because it was a lower than the scheduled dose of MS Contin 75 mg that was omitted and lasted less time in the body after administration.

According to Lexi-Comp, a comprehensive medication data base, although the duration of action for morphine is patient dependent, the estimated duration of action for pain relief from immediate-release formulations of morphine is 3 to 5 hours. The duration of action for pain relief from extended-release morphine depends on the product formulation but is estimated to be 8 to 24 hours.

The resident had been asleep when interviews were attempted on 10/24/18, 10/25/18 and 11/13/18. He passed away the evening of 11/13/18.

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2. Resident #4 was ordered Modafinil 100 mg (Milligrams) via Gastrostomy Tube one time a day for lethargy at 6:00 AM. This medication was ordered by the physician on 07/17/18. Modafinil is a stimulant used to increase alertness. Review of the Controlled Medication Utilization records showed that this medication had not been removed from controlled stock and given to the resident on the following dates:

a. 07/26/18 at 6:00 AM Nurse #3 did not remove the medication from controlled stock to administer
b. 07/29/18 at 6:00 AM Nurse #4 did not remove the medication from controlled stock to administer
c. 08/01/18 at 6:00 AM Nurse #3 did not remove the medication from controlled stock to administer
d. 08/10/18 through 08/16/18 the medication was not available for administration at the facility
e. 08/17/18 at 6:00 AM Nurse #4 did not remove the medication from controlled stock to administer
f. 08/18/18 at 6:00 AM Nurse #4 did not remove the medication from controlled stock to administer
g. 08/21/18 at 6:00 AM Nurse #3 did not remove the medication from controlled stock to administer
h. 08/26/18 at 6:00 AM Nurse # 5 did not remove the medication from controlled stock to administer
i. 08/27/18 at 6:00 AM Nurse # 6 did not remove the medication from controlled stock to administer
j. 08/28/18 at 6:00 AM Nurse #6 did not remove the medication from controlled stock to administer

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| F 600 | Continued From page 16<br>k. 08/30/18 at 6:00 AM Nurse #7 did not remove the medication from controlled stock to administer<br>l. 09/22/18 at 6:00 AM Nurse #8 did not remove the medication from controlled stock to administer<br>m. 09/24/18 at 6:00 AM Nurse #8 did not remove the medication from controlled stock to administer<br>n. 10/05/18 at 6:00 AM Nurse #9 did not remove the medication from controlled stock to administer<br>0. 10/06/18 at 6:00 AM Nurse #10 did not remove the medication from controlled stock to administer<br>p. 10/08/18 at 6:00 AM Nurse #9 did not remove the medication from controlled stock to administer<br>q. 10/10/18 at 6:00 AM Nurse #9 did not remove the medication from controlled stock to administer<br>r. 10/11/18 at 6:00 AM Nurse #10 did not remove the medication from controlled stock to administer<br><br>In an interview conducted on 10/24/18 at 4:30 PM with the Physician's Assistant she stated that she did not know why she had not provided the pharmacy with a hard script to refill the Modafinil 100 mg for Resident #4 between 08/10/18 and 08/16/18 because the order had not been discontinued. She said that the medication had been ordered to increase the resident's level of alertness after suffering a stroke.<br><br>In an interview conducted on 10/25/18 at 10:05 AM with the Pharmacy Director she stated that the Modafinil for Resident #4 had not been refilled between 08/10/18 and 08/16/18 because the | F 600 | | |

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physician had not provided a hard script (which was required when refilling a controlled substance) to refill the medication until 08/17/17.

In an interview conducted on 10/26/18 at 12:40 PM with Nurse #6 she stated that she had missed giving doses to Resident #4 because she couldn't find it in the medication cart and had not realized that it was a controlled substance and located in the locked drawer on the cart. She had signed the eMar as administered to the resident on 08/27/18 and 08/28/18 at 6:00 AM.

In an interview conducted on 10/26/18 at 12:57 PM with Nurse #10 she said that if she had not signed a medication out on the narcotic sheet and the count was correct then she had missed giving the medication to Resident #4 but had signed the eMar as administered to the resident 10/06/18 and 10/11/18 at 6:00 AM.

An attempt to contact Nurse #4 on 10/26/18 at 12:08 PM was unsuccessful. His phone would not accept a message. He was no longer employed at the facility.

An attempt to contact Nurse #3 on 10/26/18 at 12:29 PM was unsuccessful. Her phone would not accept a message. She was no longer employed at the facility.

An attempt to contact Nurse #5 on 10/26/18 at 12:46 PM was unsuccessful. Her phone would not accept a message.

An attempt to contact Nurse #7 on 10/26/18 at 12:34 PM was unsuccessful. A message was left but she did not return the call.

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An attempt to contact Nurse #8 on 10/26/18 at 12:37 PM was unsuccessful. A message was left but she did not return the call.

An attempt to contact Nurse #11 on 10/26/18 at 12:47 PM was unsuccessful. A message was left but she did not return the call.

Attempts to contact Nurse #9 on 10/26/18 at 11:42 AM and 12:03 PM were unsuccessful. The first attempt was busy and the second attempt went straight to voice mail but would not accept a message because it was full.

In an interview conducted with Physician #3 on 11/14/18 at 12:29 PM she stated that because the resident received all but two doses of the Modafinil 100mg in July 2018 and had remained lethargic that it could not be determined if when he had received the medication in September 2018 that his increased alertness was due to the medication. She said that because of the time lapse between July and September the resident's increased alertness could have been due to the natural healing of the brain after a severe stroke which was common.

3. Resident #216 was ordered Lyrica 150 mg one capsule by mouth three times daily for pain. This medication was ordered by the physician on 10/19/18. Review of the Controlled Medication Utilization records showed that the medication had not been removed from stock and given to the resident on 10/22/18 at 10:00 PM but was initialed on the eMAR as given by Nurse #5. Record review revealed that Resident #216 had received Oxycodone-Acetaminophen 5-325mg for pain on 10/23/18 at 2:52 AM.

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An attempt to contact Nurse #5 on 10/26/18 at 12:46 PM was unsuccessful. Her phone would not accept a message.

Resident #216 was discharged to home on 11/02/18. She was contacted by phone on 11/14/18 and revealed that she was pleased with the care she received at the facility. She stated that she felt her pain was controlled.

4. Resident #140 was ordered Oxycodone HCL Extended Release Abuse Deterrent give one tablet by mouth two times a day for pain. This medication was ordered by the physician on 10/14/18. Review of the Controlled Medication Utilization records showed that the medication had not been removed from stock and given to the resident on 10/15/18, 10/16/18, 10/17/18 or 10/18/18 at 8:00 AM but was initialed on the eMAR as given by Medication Aide (MA) #1. On 10/15/18 MA#1 documented the resident's pain level as "9", on 10/16/18 as "5", on 10/17/18 as "7" and on 10/18/18 as "2" on a pain scale of 0-10 with 0 being no pain and 10 being extreme pain.

In an interview conducted on 10/26/18 at 11:16 AM with Medication Aide #1 she stated that if she had signed off on the eMAR that she gave the medication but had not signed it out of the locked drawer on the cart then she must have missed giving the doses to the resident.

Three unsuccessful attempts to contact Resident #4 were made on 11/13/18 who had been discharged to home on 10/27/18. Messages were left but she did not return the calls.

In an interview with the Director of Therapy on 11/13/18 at 1:38 PM she reported that Resident

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#4 had not missed any therapy sessions due to uncontrolled pain. She said the resident did so well that she went straight to outpatient therapy when she was discharged.

5. Resident #36 was ordered Lyrica 50 mg one capsule by mouth one time a day for nerve pain. This medication was ordered by the physician on 9/7/17. Review of the Controlled Medication Utilization records showed that the medication had not been removed from stock and given to the resident on 10/21/18 at 9:00 AM but was initialed on the eMAR as given by Nurse 12.

In an interview conducted with Nurse #12 on 10/23/18 at 6:07 PM she stated that she had signed off the medication on the eMAR but had not given it to the resident or removed it from the controlled medication drawer.

In an interview conducted with Resident #36 on 11/13/18 at 10:30 AM she stated that she could not remember any days when she had worse or different pain. She stated that she always had some discomfort in her neck but that the pain medication helped.

6. Resident #50 was ordered Tramadol 50 mg by mouth two times a day for pain. This medication was ordered by the physician on 10/06/18. Review of the Controlled Medication Utilization records showed that the medication had not been removed from stock and given to the resident on 10/15/18 at 8:00 AM but was initialed on the eMAR as given by Nurse #13.

In an interview conducted on 10/25/18 at 4:04 PM with Nurse #13 she stated that she had signed the eMAR as having given the medication to

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Resident #50 but forgot to go back and give it. She said that she had not taken it out of the controlled substance locked drawer when she passed his other medications and intended to go back and give it later but forgot.

In an interview conducted with Resident #50 on 11/14/18 at 11:30 AM he stated that he could not recall any days when his pain level was greater than normal. He stated that he received 8 or 9 pills every morning and they were generally effective. He said that there had been no days on which he noticed his pain level to be worse or different.

In an interview with the Director of Nursing on 10/26/18 at 7:56 AM she stated that she expected all medications to be given to residents as ordered by the physician.

7. Resident #27 was admitted to the facility on 06/20/13. The resident ' s diagnoses included, in part, muscle weakness, depression, and altered mental status.

A review of a mycotic (infected with fungus) nail evaluation from the podiatrist dated 09/20/17 revealed Resident #27 ' s toe nails were callused. The evaluation stated the toe nails were trimmed, filed, and cut and to follow up with podiatry in 3 months or sooner if necessary.

The Minimum Data Set (MDS) dated 09/20/18 quarterly assessment revealed Resident #27 was severely cognitively impaired and required total dependence with one to two person physical assistance with all activities of daily living (ADLs).

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A care plan updated on 09/26/18 revealed a plan of care for requiring assistance with ADLs related to impaired mobility. Interventions included, in part, to assist resident with all ADLs as needed or requested and monitor for any decline.

An observation of Resident #27 on 10/22/18 at 10:00 AM revealed an alert resident lying in bed. The resident ' s toenails were noted to have grown 1/2 inch over the toe and into the skin for each toe. Resident #27 was non-verbal and did not express any pain to her feet.

An interview with Nursing Assistant (NA) #8 on 10/24/18 at 9:00 AM revealed the NA worked at the facility for over a year and usually worked on the hall Resident #27 resided on. NA #8 stated she knew Resident #27 well. NA #8 stated Resident #27 was completely dependent, did not get out of bed and would get a full bed bath daily. NA #8 reported she washed the resident ' s fingernails and toenails and would cut them if it were okay with the nurse or let the nurse know they needed to be cut. NA #8 stated Resident #27 ' s fingernails were long, but she did clean them and washed her hands and nails during care. NA #8 stated she washed Resident #27 ' s feet as well and stated that her toenails looked fine.

An observation of Resident #27 ' s feet was conducted with NA #8 on 10/24/18 at 9:10 AM. NA #8 reported the resident ' s toe nails were very long and noted they were growing over her toes and into her skin. NA #8 stated she had not noticed the toe nails being that long when she did care and she would tell the nurse to see what she should do.

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| F 600 | Continued From page 23<br>An interview was conducted with Nurse #18 on 10/24/18 at 10:00 AM. Nurse #18 revealed she was aware of the length and condition of Resident #27 ' s toe nails and stated that a podiatrist had seen her about a year ago. Nurse #18 stated the last she had known the Director of Nursing (DON) was cutting her fingernails and toenails. Nurse #18 stated she was aware of the excessive length of the toenails and stated they definitely needed to be trimmed. Nurse #18 reported she was not sure the last time they were trimmed, but given the length of them, it had to be awhile.<br><br>An interview was conducted with the facility ' s "Scheduler" who made the appointments with the podiatrist, on 10/24/18 at 11:15 AM. The Scheduler revealed the last time Resident #27 was on the list to be seen by the podiatrist was 11/27/17. The Scheduler reported she did not have any information or paperwork to support Resident #27 had been seen on 11/27/17.<br><br>An interview was conducted with the DON on 10/25/18 at 9:15 AM. The DON reported she had previously cut Resident #27 ' s fingernails but she did not have any knowledge about her toe nails needing to be cut. The DON stated her expectation of the staff was to ensure that both fingernail and toenail care was being provided with each bath and if the nails were long, the staff should be filing and trimming them. The DON confirmed the toenails for Resident #27 were very long and had been neglected. | F 600 | | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care | F 655 | | 12/7/18 |

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| F 655 | Continued From page 24 | F 655 | | |

Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting

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| F 655 | Continued From page 25<br>on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, and staff interviews, the facility failed to develop and implement a baseline care plan for falls for 1 of 4 residents (Resident #4) reviewed for falls.<br><br>Findings included:<br><br>Resident #4 was admitted to the facility on 7/17/18. His active diagnoses included: Muscle Weakness, Dysphagia, Aphasia, Lack of Coordination, Hypertension, Hemiplegia, CVA, Convulsions, Urine Retention, and Nontraumatic Intracerebral Hemorrhage.<br><br>A review of the most recent Minimum Data Set (MDS) dated 7/24/18, coded as an Admission Assessment, indicated the resident was cognitively intact, non-verbal with adequate vision and hearing. The MDS also indicated that Resident #4 exhibited no behaviors and no rejection of care.<br><br>The CAA (Care Area Assessment) completed on 7/24/18 triggered a risk for falls.<br><br>A review of Resident #4's admission falls risk assessment completed on 7/17/18 and on 7/24/18 documented resident as being at high risk for falls.<br><br>A record review revealed there was no baseline care plan completed within forty-eight hours of admission. | F 655 | Resident # 4 now has a fall care plan.<br><br>Residents admitted to the facility are at risk for this issue.<br><br>Current resident care plans have been audited to ensure there is a fall focus for each resident.<br><br>Licensed nurses have been reeducated concerning the expectation that the fall focus care plan be initiated upon admission.<br><br>The Director of Nursing or designee will review the initial care plans for new admissions to ensure they contain a fall focus. This will be documented during each morning clinical meeting for 4 weeks and then weekly for 8 weeks.<br><br>The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee meeting for review and recommendations for the duration of the monitoring period. | |

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| F 655 | Continued From page 26<br>A review of the nursing progress notes dated 8/6/18@ 08:25 AM showed documentation that Resident #4 fell out of bed at 0300 AM. Neurologic checks were within normal limits and his vital signs were stable. His physical assessment revealed that he had a cut on his forehead and on his right hairline, with a swollen area on his right eye brow. Resident #4 was transported to the emergency Department for evaluation.<br><br>An interview with the MDS (Minimum Data Set) and Care Plan Coordinator was conducted on 10/24/18. She stated the care plan related to falls with goals and interventions was not initiated until 8/6/18 which was the day of the fall. She stated after the IDT (Inter-disciplinary team) meetings are held, she updates the care plan. The MDS nurse confirmed that the care plan for Resident #4's falls was not initiated until 8/6/18. She stated that the comprehensive care plan dated 7/24/18 was the first care plan that was implemented.<br><br>An interview was conducted on 10/25/18 with the Director of Nursing. She stated Resident #4 is at high risk for falls. She stated that the fall risk with goals and interventions should have been initiated on the care plan.<br><br>An interview was conducted on 10/25/18 with the facility Administrator. She stated the MDS nurse should have initiated a fall risk with goals and interventions on the residents' care plan. | F 655 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and | F 656 | | 12/7/18 |

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| F 656 | Continued From page 27 | F 656 | | |

implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(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.

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| F 656 | Continued From page 28<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, after more than 2 months, the facility failed to implement an intervention in a resident's care plan that was put in place after a fall with injury for 1of 3 residents (Resident #37) reviewed for accidents.<br><br>Findings included:<br><br>Resident #37 was admitted to the facility on 05/07/14. Diagnoses included, in part, a fib, dementia without behaviors, history of falls, fracture of right humerus and osteoarthritis.<br><br>A review of the accident and incident report dated 07/25/18 revealed a visitor came inside and reported there was a resident on the ground. A therapist was the first to reach Resident #37 and additional staff alerted nurses to respond. The report indicated Resident #37 was lying face down in front of the curb to the left of the front entrance and was complaining of pain to her left shoulder, neck and face. The resident ' s left side of face and forehead was bleeding. The facility physician was on site and ordered Emergency Medical Services (EMS) to be notified immediately. The report revealed the Interdisciplinary Team (IDT) discussed the fall and determined the intervention was to complete blood work and a medication review to assess for change of condition, and as an environmental safety precaution, paint a bright color on the curb to make the curb more visible.<br><br>A review of Resident #37's updated care plan dated 07/27/18 revealed the resident was at risk for falls related to decreased mobility and | F 656 | Resident #37 is no longer at the facility.<br><br>Residents who are at risk for falls are potentially at risk for this issue.<br><br>Each resident□'s care planned fall risk interventions have been verified as being in place as care planned.<br><br>The Maintenance Director has been reeducated that interventions decided on by the interdisciplinary team requiring his department'□s assistance must be completed by a time agreed to by the team.<br><br>During the morning meeting, the Administrator will document interventions when they require maintenance and the time frame agreed upon. The Maintenance Director will report the completion of the intervention to the Administrator.<br><br>The interventions and completion dates will be documented for monitoring each morning meeting for 4 weeks and then weekly for 8 weeks.<br><br>The Administrator or Maintenance Director will report the findings of the monitoring to the monthly QAPI committee meeting for review and recommendations for the duration of the monitoring period. | |

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| F 656 | Continued From page 29 | F 656 | | |

functions, and impaired safety awareness with a history of falls with fracture. The care plan indicated an intervention was put in place to perform lab work and paint the outside curb.

The Minimum Data Set (MDS) quarterly assessment dated 10/01/18 revealed the resident was cognitively impaired. Resident #37 required extensive assistance with two person physical assist with transfers. Resident #37 had no impairments, used a wheelchair and received an anticoagulant (blood thinner) medication for 7 days. There was one fall with injury indicated on the MDS for this assessment.

An interview was conducted with the Maintenance Manager (MM) on 10/25/18 at 1:35 PM. The MM stated about two weeks ago, he was asked to paint the curbing to the right and left of the facility ' s front porch. The MM reported he was told to use red paint to caution residents about the drop off created by the curbing. The MM reported it was important because a resident had a fall when the wheelchair went over the curb.

An interview was conducted with the Director of Nursing (DON) on 10/25/18 at 2:25 PM. The DON reported the curb was painted red, however it was not painted in July after Resident #37 had a fall. The DON stated it was done a couple of weeks ago during the month of October, 2018. The DON reported she did not know why the painting of the curb was not done in July, 2018, when the intervention was put in place for Resident #37 to prevent her or any other resident from falling over the curb.

An interview with the DON on 10/26/18 at 4:10 PM revealed her expectation of the facility staff

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| F 656 | Continued From page 30<br>was to follow the implemented interventions in care plans as they were updated. | F 656 | | |
| F 658 SS=E | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, staff interviews and a Physician Assistant interview, the facility failed to: 1) follow the facility's system for obtaining medications for residents by borrowing medications from three residents (#118, #119, #2) and administering those medications to two other residents (#216, #58) as documented on 4 of 31 controlled medication utilization records; 2) the facility failed to maintain infection control during 1 of 25 medication administration pass opportunities by not washing hands properly prior to administering eye drops; 3) the facility failed to administer scheduled medication per physician orders for 1 of 33 sampled residents (#4) reviewed for medication administration; and 4) the facility failed to obtain physician's orders to insert, discontinue, and reinsert a larger size of an indwelling urinary catheter for 1 of 1 residents (#52) observed for urinary catheters.<br><br>Findings included:<br><br>1. a. Record review of the Controlled Medication Utilization Record for Lyrica 100 mg (milligrams) capsules belonging to Resident #119 revealed | F 658 | 1. Residents #119 and #2 did not miss any medications due to this issue. Resident #118 is no longer at the facility. Residents #216 and #58 were assessed and there were no unaddressed issues related to this.<br><br>2. No specific resident was identified for this issue.<br><br>3.Resident #4 has been assessed and there is identified issue from the failure to administer the scheduled medication per order.<br><br>4. Resident #52 now has complete orders for the Foley catheter.<br><br>1.Resident with medications are at risk for borrowing issue. Records were reviewed to identify and other issue of borrowing. An audit was performed to identify any other instances of this issue. Any issues were reported to the MD and the effected resident and /or resident representative. | 12/7/18 |

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| F 658 | Continued From page 31<br>that Nurse #1 borrowed one dose of this medication for Resident #216 on 10/19/18 at 4:30 PM.<br><br>b. Record review of the Controlled Medication Utilization Record for Morphine Sulfate ER 15 mg belonging to Resident #118 revealed that Nurse #1 borrowed two doses of this medication for Resident #216 on 10/19/18 at 4:30 PM.<br><br>In an interview conducted by telephone with Nurse #1 on 10/26/18 at 11:30 AM she stated that she had borrowed a Lyrica 100 mg capsule from Resident #119 and (2) doses of Morphine Sulfate ER 15 mg from Resident #118 and gave them to Resident #216 because Resident #216 was used to getting the medications, was a new admission, and was upset that her medications had not arrived at the facility. Nurse #1 stated that she had not checked the stock of back up medications for availability and had not notified the physician or the pharmacy that the medications ordered were not available.<br><br>Review of the Items Table List Report for back up medications revealed that (5) Lyrica 50 mg tablets were available for use on 10/19/18. Morphine Sulfate was not stocked in back up in pill form.<br><br>c. Record review of the Controlled Medication Utilization Record for Morphine Sulfate ER 15 mg belonging to Resident #118 revealed that Nurse #6 borrowed (2) doses of this medication for Resident #216 on 10/19/18 at 9:38 PM.<br><br>In an interview conducted with Nurse #6 on 10/24/18 at 12:53 PM she stated that she had borrowed the medication from Resident #118 and gave it to Resident #216 because Resident #216 | F 658 | 2. Residents with eye drops are at risk of infection related to the observed lack of handwashing. No resident receiving eye drops has acquired any new infection since the exit date for the survey.<br><br>3.Residents receiving medications are at risk for a medication not being administered. The medication administration records were reviewed from October 22, 2018 forward to identify and holes in the documentation and notify the MD and resident representative of any issues.<br><br>4. Residents with Foley catheters are at risk for this issue. A full audit of residents with Foley catheters was performed and any missing orders were completed.<br><br>1.Licensed nurses have been reeducated that no medication may be borrowed and any medication supply need can be met by either contacting the pharmacy or utilizing the onsite medication Omnicell device utilized for back up medications. This reeducation also included that the physician must be notified if a medication is unavailable for further orders.<br>They were also instructed that if a controlled medication is taken out by accident, it must be wasted according to policy.<br><br>2. Licensed nurses have been reeducated concerning the expectation that hand hygiene must be performed prior to putting on gloves for administering | |

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| F 658 | Continued From page 32<br>was in dire pain and the medication was not available in the back up stock. She stated that she had not called the pharmacy because the resident was a new admission. She also reported that she had not notified the physician that the medication ordered was not available.<br><br>d. Record review of the Controlled Medication Utilization Record for Ativan 0.5 mg belonging to Resident #2 revealed that Nurse #14 borrowed one dose of this medication for Resident #58 on 10/14/18 at 9:00 PM.<br><br>In an interview conducted with Nurse #14 on 10/23/18 at 11:15 AM she stated that after she popped the Ativan 0.5 mg pill out of the bubble pack belonging to Resident #2 she realized that the medication did not belong to the resident she was medicating (Resident #58) but said that since it was the same medication and the same dose instead of wasting it she borrowed it from Resident #2 and gave it to Resident #58.<br><br>Record review of the Controlled Medication Utilization Record for Resident #58 revealed that she had Ativan 0.5 mg available for use on 10/14/18 at 9:00 PM.<br><br>In an interview conducted with the Director of Nursing on 10/26/18 at 12:22 PM she stated that borrowing of medications between residents was not allowed and she did not expect staff to borrow medications. She reported that the facility had a stock of back up medications for the staff to use. She said the facility also had a 24 hour back up pharmacy to utilize if a medication was not available.<br><br>2. Review of the facility Infection Control Policy | F 658 | eye drops.<br><br>3.Licensed nurses have been reeducated that all medications must be administered according to physician orders.<br><br>4. Licensed nurses have been reeducated to obtain orders for any Foley catheter either newly ordered or in a newly admitted resident. They have been reeducated that they may not insert a Foley without a complete order.<br><br>1. Ongoing, the Director of Nursing or designee will review controlled medication count sheets to verify that no medication has been borrowed for another resident. This review will be documented for 5 random residents a week for 12 weeks.<br><br>2.Ongoing, the Director of Nursing or designee will observe eye drop administration to verify proper hand washing. This observation will be documented for 2 random residents a week for 12 weeks.<br><br>3. The Director of Nursing or designee will review the medication administration completion report available in the electronic medical record during each morning clinical meeting to verify medication is given as ordered. This will be documented at each morning clinical meeting for 4 weeks and then weekly for 8 weeks.<br><br>4. The Director of Nursing or designee will review the new Foley orders written in | |

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| F 658 | Continued From page 33<br>effective May 2105 read: "1. Hand washing procedure, as described in the facility's Infection Control Policy, shall be followed."<br><br>Review of the Medication Administration Skills Checklist read in Section E - Eye Drops and Ointments, Step #6: "washes hands" prior to the administration of the eye drops in Step #10.<br><br>On 10/24/18 at 8:20 AM Nurse #1 was observed administering eye drops to a resident. She did not wash her hands prior to administering the eye drops. After Nurse #1 left the room she stated that she should have washed her hands prior to giving the eye drops.<br><br>In an interview with the Director of Nursing on 10/24/18 at 9:00 AM she stated that she expected all nurses to wash their hands prior to administering eye drops. She reported that the proper administration of eye drops was taught in orientation and during annual trainings which included proper hand washing.<br><br>3. Resident #4 was admitted to the facility on 7/17/18. His active diagnoses included: Muscle Weakness, Dysphagia, Aphasia, Lack of Coordination, Hypertension, Hemiplegia, CVA, Convulsions, Urine Retention, and Nontraumatic Intracerebral Hemorrhage.<br><br>A review of the most recent Minimum Data Set (MDS) dated 7/24/18, coded as an Admission Assessment, indicated the resident was cognitively intact, non-verbal with adequate vision and hearing. The MDS also indicated that Resident #4 exhibited no behaviors and no rejection of care. | F 658 | the morning clinical meeting. The monitoring will be documented at each morning clinical meeting for 4 weeks and then weekly for 8 weeks.<br><br>The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee meeting for review and recommendations for the duration of the monitoring period. | |

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A review of the physicians' orders dated 8/10/18 documented an order written for Levetiracetam Solution (Keppra) 100mg/ml (milligram/milliliters) to give 10 ml via gastrostomy tube two times a day for seizures.

A review of the Medication Administration Record (MAR) from July 2018-October 2018 showed dates on 9/1, and 9/9 that Keppra (Levetiracetam) 10 ml (100mg/ml) via gastrostomy tube was not signed off on the MAR.

An attempt was made on 10/23/18 at 04:57 PM to contact the nurse (Nurse #3) who was assigned to Resident #4 on 9/1, and 9/9. It was unsuccessful, no voicemail was set up. A second attempt was made on 10/24/18 at 08:59 AM and it was unsuccessful.

A review of the physician orders from 7/17/18 through 10/24/18 documented that no seizure activity occurred during that time.

An interview was conducted on 10/23/18 at 1:23 PM with the facility Physician Assistant. She stated she is familiar with Resident #4. She stated it is her expectation that all medications are administered per orders.

An interview was conducted on 10/23/18 with the DON (Director of Nursing). She stated the nurse on duty those dates (Nurse #3) is no longer employed at the facility. The DON made an attempt to contact Nurse #3 without success.The DON stated it is her expectation that all medications are administered per physician orders.

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An interview was conducted on 10/26/18 with the Administrator. She stated that it is her expectation that the nurses are administering all medications per physician orders and signing them off on the MAR.

4. Resident #52 was admitted to the facility on 06/28/18. Diagnoses included, in part, Stage IV pressure ulcer to the sacrum and a Stage III pressure ulcer to the left hip.

A review of the Foley Catheter Justification assessment dated 06/28/18 revealed Resident #52 was incontinent and had open sacral or perineal wounds and a urinary catheter was used to assist in healing.

A review of the physician ' s orders since admission from 06/28/18 through 10/24/18 revealed there were no orders for Resident #52 to have an indwelling urinary catheter.

The Minimum Data Set (MDS) quarterly assessment dated 10/01/18 revealed the resident was moderately cognitively impaired. Resident #52 was noted to have impairments to both sides on the lower extremities, had an indwelling urinary catheter and was always incontinent of bowel. Resident #52 had two Stage III pressure ulcers one to the left hip and one to the left foot which were present upon admission and a Stage IV pressure ulcer to the sacrum which was also present upon admission and an unstageable pressure ulcer (facility acquired) to the right foot.

A review of the care plans updated on 10/12/18 revealed Resident #52 had a plan of care in place for an indwelling urinary catheter related to skin breakdown. All interventions and goals were

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appropriate and measurable.

An observation of Resident #52 on 10/22/18 at 1:30 PM revealed an indwelling urinary catheter was in place.

An interview was conducted with Nurse #18 on 10/24/18 at 10:15 AM. Nurse #18 reported Resident #52 had an indwelling urinary catheter and indicated the size of the catheter was an 18 French (size number and type of the catheter) with 10 milliliter (ml) saline balloon (an inflation of the balloon with saline secures the urinary once inserted.) Nurse #18 stated Resident #52 was admitted to the facility with a 16 French, but it was leaking so it was changed to an 18 French catheter. Nurse #18 could not recall when the catheter was changed to an 18 French. Nurse #18 confirmed there was no actual order for the indwelling urinary catheter upon admission and only the batch (a series of orders) orders were in place on how to care for the urinary catheter. Nurse #18 reported there was also no order for the 16 French indwelling urinary catheter to be discontinued, and no order for the 18 French indwelling urinary catheter to be inserted.

An interview was conducted with Nurse #6 (Unit Manager) on 10/24/18 at 10:40 AM. Nurse #6 confirmed there were no orders for Resident #52 to have a 16 French catheter, to discontinue the 16 French catheter, or to insert the 18 French catheter. Nurse #6 stated it was an oversite and there should have been written orders to obtain the 16 French indwelling urinary catheter upon admission as well as physician orders to discontinue the 16 French urinary catheter and insert an 18 French urinary catheter.

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| F 658 | Continued From page 37<br>An observation of the indwelling urinary catheter for Resident #52 was conducted on 10/24/18 at 10:50 AM. Resident #52 was noted to have an 18 French indwelling urinary catheter in place.<br><br>An interview was conducted with the Director of Nursing (DON) on 10/24/18 at 10:00 AM. The DON revealed her expectation of the nursing staff was to ensure that if a resident was admitted with an indwelling urinary catheter, the nurses should obtain an order from the physician indicating the size of the catheter as well as the balloon amount. The DON also stated the nurses should have also made sure an order was written to discontinue the 16 French urinary catheter and a new order was written to insert a different size catheter. | F 658 | | |
| F 677 SS=E | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§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;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to provide toe nail care to 1 of 3 dependent residents (Resident #27) reviewed for Activity of Daily Living (ADL) care which resulted in excessively long toe nails that had grown over the toes by a half inch on each toe.<br><br>Findings included:<br><br>Resident #27 was admitted to the facility on 06/20/13. Diagnoses included, in part, muscle | F 677 | Resident #27 had toe nails trimmed on the day the issue was identified.<br><br>Licensed nurses were reeducated concerning the expectation that the toe nails be evaluated during the skin checks and any toe nails that were difficult to trim/ needed podiatry referral would be referred to the Director of Nursing for follow up.<br><br>The Director of Nursing or designee will check the toe nails of randomly selected | 12/7/18 |

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| F 677 | Continued From page 38<br>weakness, depression, and altered mental status.<br><br>The Minimum Data Set (MDS) dated 09/20/18 quarterly assessment revealed Resident #27 was severely cognitively impaired. Resident #27 required total dependence with one to two person physical assistance with all activities of daily living (ADLs).<br><br>A care plan updated on 09/26/18 revealed a plan of care was in place for requiring assistance with ADLs related to impaired mobility. Interventions included to assist resident with all ADLs as needed or requested and monitor for any decline.<br><br>An observation of Resident #27 on 10/22/18 at 10:00 AM revealed an alert resident lying in bed. The resident ' s toenails were noted to be excessively long and growing 1/2 inch over the toe and into the skin for each toe. Resident #27 was non-verbal and did not express any pain to her feet.<br><br>An interview with Nursing Assistant (NA) #8 on 10/24/18 at 9:00 AM revealed the NA worked at the facility for over a year and usually worked on the hall Resident #27 resided on. NA #8 stated she knew Resident #27 well. NA #8 reported when she performed ADL care on Resident #27, her process was to get all her supplies together, enter the resident ' s room, introduce herself and let her know that she was going to be completing her bed bath. NA #8 stated Resident #27 was completely dependent, did not get out of bed and would get a full bed bath daily. NA #8 stated she would wash the resident ' s face first and then the rest of the body with warm soapy water then change out the water out and get new wash clothes and cleanse the peri areas. NA #8 stated | F 677 | residents on an ongoing basis. This will be documented for 5 random residents a week for 12 weeks.<br><br>The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee meeting for review and recommendations for the duration of the monitoring period. | |

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she would do the resident ' s hair and teeth last. NA #8 reported she washed the fingernails and toenails and would cut them if it were okay with the nurse or let the nurse know they needed to be cut. NA #8 stated Resident #27"s fingernails were long, but she did clean them and washed her hands and nails during care. NA #8 stated she washed Resident #27 ' s feet as well and stated that her toenails looked fine.

An observation of Resident #27 ' s feet was conducted with NA #8 on 10/24/18 at 9:10 AM. NA #8 reported the resident ' s toe nails on both of her feet were very long and noted they were growing over her toe and into her skin. NA #8 stated she had not noticed the toe nails being that long when she did care and she would tell the nurse to see what she should do.

An interview was conducted with Nurse #18 on 10/24/18 at 10:00 AM. Nurse #18 revealed she was aware of the length and condition of Resident #27 ' s toe nails and stated that a podiatrist had seen her about a year ago. Nurse #18 stated the last she had known, the Director of Nursing (DON) was cutting her fingernails and toenails. Nurse #18 stated she was aware of the excessive length of the toenails and stated they definitely needed to be trimmed. Nurse #18 reported she was not sure the last time they were trimmed, but given the length of them, it had to be awhile. Nurse #18 stated nursing was responsible for cutting residents toenails unless the resident was being specifically followed by podiatry.

An interview was conducted with the facility's "Scheduler", who made the appointments for residents with the podiatrist, on 10/24/18 at 11:15

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| F 677 | Continued From page 40<br>AM. The Scheduler revealed the last time Resident #27 was on the list to be seen by the podiatrist was 11/27/17. The Scheduler reported she did not have any information or paperwork to support Resident #27 had been seen on 11/27/17.<br><br>An interview was conducted with the DON on 10/25/18 at 9:15 AM. The DON reported she had previously cut Resident #27 ' s fingernails but she did not have any knowledge about her toe nails needing to be cut. The DON stated her expectation of the staff was to ensure that both fingernail and toenail care was being provided with each bath and if the nails were long, the staff should be filing and trimming them. | F 677 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, Medical Director interview, family interview, staff interview, and record review the facility failed to implement measures to identify an outside curb as a hazard which resulted in 1 of 3 residents (Resident #45) reviewed for falls falling from his wheelchair when it got caught on the curbing. Resident #45 hit his head on pavement, and sustained a subdural hematoma from this fall. Findings included: | F 689 | Resident #45 is no longer at the facility.<br><br>Residents who are at risk for falls are potentially at risk for this issue.<br><br>Each resident's care planned fall risk interventions have been verified as being in place as care planned. | 12/7/18 |

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| F 689 | Continued From page 41<br><br>Review of an incident report documented on 07/25/18 Resident #37 fell from her wheelchair after one of its wheels got caught on curbing outside the building, resulting in a fractured humerus and a laceration above the eye requiring seven sutures. The interdisciplinary (IDT) committee developed interventions to keep this resident and other residents from falling in the future as a result of the drop created by the curbing. Painting the curb was documented as an intervention on Resident #37's accident/incident report and on her care plan. However, in an interview with the Maintenance Manager (MM) on 10/25/18 at 1:35 PM he stated he did not paint the curbing until after Resident #45's 10/14/18 fall off the curbing because the IDT committee could not make up its mind what color to paint the curbing until then.<br><br>Record review revealed Resident #45 was admitted to the facility on 09/10/18. The resident's documented diagnoses included multiple cancers with metastasis and chronic kidney disease.<br><br>As part of Resident #45's 09/10/18 Admission/Readmission Nursing Assessment a Fall Evaluation was conducted, and the resident was determined to be at high risk for falls.<br><br>On 09/11/18 the resident's care plan identified, "Resident is at risk for falls" as a problem. Interventions for this problem included, "Implement preventative fall interventions/devices. Maintain call light within reach. Educate resident to use call light. Maintain needed items within reach. PT/OT/SLP (physical therapy, occupational therapy, speech | F 689 | The Maintenance Director has been reeducated that interventions decided on by the Interdisciplinary team requiring his department's assistance must be completed by a time agreed to by the team.<br><br>During the morning meeting, the Administrator will document interventions when they require maintenance and the time frame agreed upon. The Maintenance Director will report the completion of the intervention to the Administrator.<br><br>The interventions and completion dates will be documented for monitoring each morning meeting for 4 weeks and then weekly for 8 weeks.<br><br>The Administrator will report the findings of the monitoring to the monthly QAPI committee meeting for review and recommendations for the duration of the monitoring period. | |

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language pathology) evaluation. Resident/family education regarding preventative fall interventions/devices and safety devices."

Resident #45's 09/17/18 admission minimum data set (MDS) documented his cognition was moderately impaired, he exhibited no behaviors including rejection of care, he required limited assistance from a staff member with bed mobility/transfers/locomotion on and off the unit, he had no falls six months prior to his nursing home admission, and he experienced no falls since being admitted to the nursing home.

Nurse #19 wrote a late entry nursing note on 10/18/16 at 9:06 AM for 10/14/18 9:00 PM. The note documented, "Resident found lying in grass outside of building, reported 'wheelchair went off of edge of sidewalk and I fell into the grass.' Brought into building by staff member at approximately (7:00 PM) this evening. (Family member) in attendance. Alert, (oriented) x 1, reported headache 3/10 (3 out of 10 on pain scale). Noted quarter sized abrasion/ecchymosis (bruising) left anterior-lateral forehead; 0.8 (centimeter) laceration left nose, presumably from glasses. Given ice pack. Neuro checks: (pupils equal, round, and reactive to light). No other injuries noted. Moves all extremities well. Given ice pack for forehead. Face washed with soap and water. Bleeding left nose stopped. Further (neurological) checks resulted in orientation returning to (oriented) x 3. Reported pain relieved to head by (8:00 PM). Currently, denied complaints. Stated 'I am ok, do not need to go to hospital....' Assisted to bed, positioned for comfort. Will continue to monitor...."

A 10/15/18 11:17 AM physician progress note

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documented, "Nursing staff reports patient fell over the weekend. Patient reports he was outside in his wheelchair. His wheel slipped off the curb and he fell out of his wheelchair. He has slight bruising over his left eye and on his forehead. He didn't lose consciousness. He denies any pain with eye movement...."

A 10/17/18 1:25 PM nursing note documented, "Resident presented with slurred speech, left sided weakness, weak left side hand grasp, and left side facial drooping at (1:05 PM). (Vital Signs) 162/96, pulse 71, (oxygen saturation) 97%, 18 respirations, (blood sugar) 116.... (Physician Assistant) notified and assessed resident. Orders to send to (emergency room) for evaluation. Left with (emergency medical services) at (1:25 PM)."

A 10/17/18 2:05 PM Emergency Department Encounter note documented in the Physical Exam section, "hematoma over left forehead, normocephalic (head and all major organs of the head in normal condition)."

CT (computed tomography) results captured in the 10/17/18 hospital History and Physical documented, "A subdural hemorrhage is seen over the left frontal lobe region. This measures about 10 (millimeters) in thickness."

A 10/17/18 2:54 PM physician progress note documented, "Nursing staff reports patient is having slurred speech and weakness. Patient's left side of his face was drooping when he smiled and his left hand was unable to squeeze my fingers. After several minutes his face no longer had a drooping look and he was able to squeeze my fingers with both hands. He continued to slur

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his speech and was difficult to understand. (Physical Therapy) also reports that his left side of his chest looks larger today and he has swelling in his lower extremities. He was having difficulty walking in (Physical Therapy) today. Patient denies any (chest pain) or (shortness of breath). He nods his head yes when asked if he would like to go to the hospital.... Possible (transient ischemic attack), sent to hospital for head (computed tomography).

On 10/25/18 at 9:24 AM, during a telephone interview, Nursing Assistant (NA) #1 stated on 10/14/18 she was coming out of the lobby restroom when a person approached her stating that a resident had fallen in the parking lot of the building. The NA reported when she got outside Resident #45 was laying on the pavement in the parking lot in the circle drive area in front of the building. She commented his standard wheelchair was still on the sidewalk with the brakes locked. She stated the resident was kind of laying on his side with his face held up off the pavement. She commented there was a red bump/raised area above one of the resident's eyes. She reported there was a small amount of blood coming from somewhere. She remarked the resident stated he was waiting on a family member to arrive at the facility The NA commented a nurse (Nurse #20) and an administrative person (Business office Manager) came out of the building and took the resident back inside the facility. She stated the resident could not explain what caused him to end up on the pavement. The NA reported Resident #45 told her that his head was hurting.

On 10/25/18 at 10:03 AM, during a telephone interview, Nurse #20 stated she was informed

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there was an empty wheelchair caught on the curbing. She reported she went out to the circular drive in front of the facility entrance, and found the resident laying of his left side on the blacktop pavement. She stated that this was to the right of the front porch/patio (in the center of the building) as you exited the building. She commented she assisted the resident to his wheelchair, and explained that the resident's wheelchair was half on the pavement and half on the sidewalk. According to Nurse #20, Resident #45 had no range of motion issues, and did not have complaints about pain. She stated a hematoma had started to form above the left eye, and there was a small laceration to the resident's left nare (nostril). She reported the resident was taken back into the building where the resident's primary hall nurse completed a full assessment.

On 10/25/18 at 11:31 AM, during a telephone interview, Nurse #19 stated he was told by a facility nurse and someone from administration that Resident #45 was found outside where he rolled off the sidewalk in his wheelchair and fell forward into the grass. Nurse #19 reported the resident had a bruise and elevated abrasion to his left temple/forehead, and had a laceration to his left nare consistent with injury from his glasses. He commented there was bleeding from the resident's nose laceration which was minimal and easy to stop, and the resident's neuro-checks and vitals were okay. According to Nurse #19, when Resident #45 first returned to the building after his fall on 10/14/18 he was disoriented, but within 30 minutes returned to his baseline of alert and oriented x 3. The nurse stated a family member arrived during his assessment, and was informed of the fall and how it happened. According to the nurse, he decided not to send

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Resident #45 out because the resident fell in the grass, his neuro-checks and vitals were within normal limits, and the resident stated he did not want to go out to the hospital. However, the nurse stated he did not discuss with the resident why it might be important to go to the hospital after falling and hitting his head or what the repercussions might be if he did not go the hospital. Nurse #19 reported Resident #45 did have a "bump" to his left forehead which could have been anything from a contusion to a sign of possible brain injury. The nurse stated he told the resident he would keep any eye on him, and he asked the resident to report to him if he experienced any changes to his health status. He commented Resident #45 got around the building in a standard wheelchair using his feet and hands. He stated the resident had no safety awareness issues, so as the nurse he had no concerns about the resident going in and out of the building independently.

On 10/25/18 at 1:45 PM the Director of Nursing (DON) stated the facility had two courtyards, but the residents liked to sit on the front porch/patio. As a result she reported sometimes there were a lot of resident outside on the patio getting fresh air.

On 10/25/18 at 2:12 PM an observation revealed, when exiting the building, the curbing to the right (where Resident #45 fell) and left (where Resident #37 fell) of the front porch/patio was painted red. There was a drop of two to three inches from the top of the curb to the pavement in the drive which circled in front of the porch.

On 10/25/18 at 2:34 PM a family member of Resident #45 stated during a telephone

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conversation that the resident expired on 10/23/18 in hospice, after being discharged from the hospital. (A death certificate documented Resident #45 passed away on 10/23/18, and the immediate cause of death was bladder cancer). The family member stated she arrived in the facility on 10/14/18 after the resident was brought back into the building following his fall. She reported she heard that her father had stated he did not want to go to the hospital. She commented the resident stated he was outside waiting for her to arrive, saw a car drive up that looked very similar to hers, went out on the sidewalk to meet her, realized it was not her, and turned around to go back when one of his wheels got caught on the curb. She reported the resident told her that he had gotten the wheel of his wheelchair caught on the curb earlier the same week, but someone, she thought a staff member, had lifted the wheel off the curb.

On 10/25/18 at 3:27 PM the DON stated in-servicing was begun on 10/19/18 about incident/risk management reporting. She commented the emphasis of the training was to remind the nursing staff about all the components that should be included in documentation concerning falls. She reported so far about 1/4 of the nursing staff have been in-serviced (there were nine signatures on the sign-in sheet).

On 10/25/18 5:22 PM the DON stated the IDT committee debated about the effectiveness of painting the curbing as a fall intervention for Resident #37, but this interventions was documented as an intervention on the accident/incident report and the resident's care plan anyway so she expected that the intervention be carried out.

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| F 689 | Continued From page 48<br><br>On 10/26/18 at 11:22 AM the Business Office Manager stated she was just driving up to the building on 10/14/18 when she saw Nurse #20 and NA #1 running out the front door of the facility. She reported when she looked closer she saw Resident #45 laying on the pavement in the circular drive in front of the front patio/porch. She commented his wheelchair had tipped over, and there was blood on his face. She stated the resident was helped back into his wheelchair and taken into the building where a nurse on duty could assess him.<br><br>On 10/26/18 at 11:52 AM, during a telephone interview, the facility's Medical Director stated Resident #45 had a very small hematoma, had a neurosurgery consult in the hospital, and his family did not want to pursue surgery. She explained while in the hospital it was discovered the rate of Resident #45's cancer metastasis had increased, and the family wanted the resident placed on hospice because of the cancer. According to the Medical Director, the resident's fall and hematoma were incidental, and the cause of death, as listed on the death certificate, was metastatic bladder cancer. | F 689 | | |
| F 760 SS=G | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, resident interviews, Physician Assistant interview, Physician interview and record review the facility failed to administer | F 760 | Residents #4, #36 and #50 were assessed and found no current detrimental effects from the medication | 12/7/18 |

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| F 760 | Continued From page 49<br>medications as ordered by the physician for 6 of 33 residents (Residents #118, #4, #216, #140, #36 and #50) whose electronic Medication Administration Records and Controlled Medication Utilization records were reviewed. Resident #118 was given Morphine Sulfate Immediate release 15 mg (Milligrams) in error instead of MS Contin 75 mg Extended Release as ordered at 8:00 PM on 10/20/18 and his pain level rose from a "6" (moderate pain) to a "10" (extreme pain) when he was assessed at 6:21 AM on 10/21/18.<br><br>Findings included:<br><br>1. Resident #118 was admitted to the facility on 10/17/18 with diagnoses that included cancer of the prostate that had spread (metastatic). A care plan dated 10/18/18 included a goal to maintain the residents comfort with palliative care services. Interventions included to administer pain/symptom relief medications as prescribed by the physician, provide palliative care, and assess for verbal and nonverbal signs and symptoms relating to pain: grimacing, guarding, crying, moaning, and increased anxiety. The resident was a new admission and had not had a Minimum Data Set Assessment completed at the time of the survey.<br><br>Resident #118 was ordered MS Contin 75 mg by mouth every 12 hours for pain. This medication was ordered by the physician on 10/17/18. Review of the Controlled Medication Utilization records showed that the medication had not been removed from stock and given to the resident on 10/20/18 at 8:00 PM but was initialed on the eMAR (electronic medication administration record) as given by Nurse #11 who documented | F 760 | omissions. Resident #118, #140 and #216 no longer at the facility.<br><br>Licensed nurses were reeducated concerning the expectation that medication is given as ordered and the documentation of the medication administration is accurate. This education included the requirement to document why a medication was not given in the nurses notes and to notify both the resident representative and MD.<br><br>Ongoing, the Director of Nursing or designee will review controlled medication count sheets and compare them to the medication administration record. The review will be documented for 5 random residents a week for 12 weeks.<br><br>The Director of Nursing will report the findings of the monitoring to the monthly QAPI meeting for review and recommendations for the duration of the monitoring period. | |

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the resident's pain level as "6" on a pain scale of 0-10 with 0 being no pain and 10 being extreme pain. Review of the nursing progress notes revealed that on 10/21/8 at 6:21 AM the resident had reported his pain level was "10" (prior to this the highest pain level recorded had been a "7"). Review of the Controlled Medication Utilization record showed that Nurse #11 had given the resident Morphine Sulfate Immediate Release 15 mg on 10/20/18 at 8:00 PM and on 10/21/18 at 6:21 AM.

An attempt to contact Nurse #11 on 10/26/18 at 12:47 PM was unsuccessful. A second message was left on 11/14/18 and she returned the call at 10:02 AM. She stated that she had no idea why she had given the resident an alternate dose instead of his scheduled medication. She stated that she had just started working at the facility on October 1, 2018. She commented that she only worked with the resident one time and was not that familiar with him. She stated that she had made a medication error.

In an interview conducted with the facility consultant pharmacist on 11/19/18 at 2:08 PM she stated that Morphine Sulfate 15 mg Immediate Release had an onset of approximately 15 to 30 minutes after administration and was effective for 3 to 6 hours. She said MS Contin 75 mg Extended Release had an onset in approximately the same amount of time as the Morphine Sulfate Immediate Release but was a higher dose and was effective for a longer period of time-12 hours. She stated that the Morphine Sulfate 15 mg Immediate Release that was given would have been less effective because it was a lower than the scheduled dose of MS Contin 75 mg that was

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omitted and lasted less time in the body after administration.

According to Lexi-Comp, a comprehensive medication data base, although the duration of action for morphine is patient dependent, the estimated duration of action for pain relief from immediate-release formulations of morphine is 3 to 5 hours. The duration of action for pain relief from extended-release morphine depends on the product formulation but is estimated to be 8 to 24 hours.

The resident had been asleep when interviews were attempted on 10/24/18, 10/25/18 and 11/13/18. He passed away the evening of 11/13/18.

2. Resident #4 was ordered Modafinil 100 mg via Gastrostomy Tube one time a day for lethargy at 6:00 AM. This medication was ordered by the physician on 07/17/18. Modafinil is a stimulant used to increase alertness. Review of the Controlled Medication Utilization records showed that this medication had not been removed from controlled stock and given to the resident on the following dates:

a. 07/26/18 at 6:00 AM Nurse #3 did not remove the medication from controlled stock to administer
b. 07/29/18 at 6:00 AM Nurse #4 did not remove the medication from controlled stock to administer
c. 08/01/18 at 6:00 AM Nurse #3 did not remove the medication from controlled stock to administer
d. 08/10/18 through 08/16/18 the medication was not available for administration at the facility

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| F 760 | Continued From page 52<br>e. 08/17/18 at 6:00 AM Nurse #4 did not remove the medication from controlled stock to administer<br>f. 08/18/18 at 6:00 AM Nurse #4 did not remove the medication from controlled stock to administer<br>g. 08/21/18 at 6:00 AM Nurse #3 did not remove the medication from controlled stock to administer<br>h. 08/26/18 at 6:00 AM Nurse # 5 did not remove the medication from controlled stock to administer<br>i. 08/27/18 at 6:00 AM Nurse # 6 did not remove the medication from controlled stock to administer<br>j. 08/28/18 at 6:00 AM Nurse #6 did not remove the medication from controlled stock to administer<br>k. 08/30/18 at 6:00 AM Nurse #7 did not remove the medication from controlled stock to administer<br>l. 09/22/18 at 6:00 AM Nurse #8 did not remove the medication from controlled stock to administer<br>m. 09/24/18 at 6:00 AM Nurse #8 did not remove the medication from controlled stock to administer<br>n. 10/05/18 at 6:00 AM Nurse #9 did not remove the medication from controlled stock to administer<br>0. 10/06/18 at 6:00 AM Nurse #10 did not remove the medication from controlled stock to administer<br>p. 10/08/18 at 6:00 AM Nurse #9 did not remove the medication from controlled stock to administer<br>q. 10/10/18 at 6:00 AM Nurse #9 did not remove the medication from controlled stock to administer | F 760 | | |

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r. 10/11/18 at 6:00 AM Nurse #10 did not remove the medication from controlled stock to administer

In an interview conducted on 10/24/18 at 4:30 PM with the Physician's Assistant she stated that she did not know why she had not provided the pharmacy with a hard script to refill the Modafinil 100 mg for Resident #4 between 08/10/18 and 08/16/18 because the order had not been discontinued. She said that the medication had been ordered to increase the resident's level of alertness after suffering a stroke.

In an interview conducted on 10/25/18 at 10:05 AM with the Pharmacy Director she stated that the Modafinil for Resident #4 had not been refilled between 08/10/18 and 08/16/18 because the physician had not provided a hard script (which was required when refilling a controlled substance) to refill the medication until 08/17/17.

In an interview conducted on 10/26/18 at 12:40 PM with Nurse #6 she stated that she had missed giving doses to Resident #4 because she couldn't find it in the medication cart and had not realized that it was a controlled substance and located in the locked drawer on the cart. She had signed the eMar as administered to the resident on 08/27/18 and 08/28/18 at 6:00 AM.

In an interview conducted on 10/26/18 at 12:57 PM with Nurse #10 she said that if she had not signed a medication out on the narcotic sheet and the count was correct then she had missed giving the medication to Resident #4 but had signed the eMar as administered to the resident 10/06/18 and 10/11/18 at 6:00 AM.

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An attempt to contact Nurse #4 on 10/26/18 at 12:08 PM was unsuccessful. His phone would not accept a message. He was no longer employed at the facility.

An attempt to contact Nurse #3 on 10/26/18 at 12:29 PM was unsuccessful. Her phone would not accept a message. She was no longer employed at the facility.

An attempt to contact Nurse #5 on 10/26/18 at 12:46 PM was unsuccessful. Her phone would not accept a message.

An attempt to contact Nurse #7 on 10/26/18 at 12:34 PM was unsuccessful. A message was left but she did not return the call.

An attempt to contact Nurse #8 on 10/26/18 at 12:37 PM was unsuccessful. A message was left but she did not return the call.

An attempt to contact Nurse #11 on 10/26/18 at 12:47 PM was unsuccessful. A message was left but she did not return the call.

Attempts to contact Nurse #9 on 10/26/18 at 11:42 AM and 12:03 PM were unsuccessful. The first attempt was busy and the second attempt went straight to voice mail but would not accept a message because it was full.

In an interview conducted with Physician #3 on 11/14/18 at 12:29 PM she stated that because the resident received all but two doses of the Modafinil 100mg in July 2018 and had remained lethargic that it could not be determined if when he had received the medication in September 2018 that his increased alertness was due to the

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medication. She said that because of the time lapse between July and September the resident's increased alertness could have been due to the natural healing of the brain after a severe stroke which was common.

3. Resident #216 was ordered Lyrica 150 mg one capsule by mouth three times daily for pain. This medication was ordered by the physician on 10/19/18. Review of the Controlled Medication Utilization records showed that the medication had not been removed from stock and given to the resident on 10/22/18 at 10:00 PM but was initialed on the eMAR as given by Nurse #5. Record review revealed that Resident #216 had received Oxycodone-Acetaminophen 5-325mg for pain on 10/23/18 at 2:52 AM.

An attempt to contact Nurse #5 on 10/26/18 at 12:46 PM was unsuccessful. Her phone would not accept a message.

Resident #216 was discharged to home on 11/02/18. She was contacted by phone on 11/14/18 and revealed that she was pleased with the care she received at the facility. She stated that she felt her pain was controlled.

4. Resident #140 was ordered Oxycodone HCL Extended Release Abuse Deterrent give one tablet by mouth two times a day for pain. This medication was ordered by the physician on 10/14/18. Review of the Controlled Medication Utilization records showed that the medication had not been removed from stock and given to the resident on 10/15/18, 10/16/18, 10/17/18 or 10/18/18 at 8:00 AM but was initialed on the eMAR as given by Medication Aide (MA) #1. On 10/15/18 MA#1 documented the resident's pain

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| F 760 | Continued From page 56 | F 760 | | |

level as "9", on 10/16/18 as "5", on 10/17/18 as "7" and on 10/18/18 as "2" on a pain scale of 0-10 with 0 being no pain and 10 being extreme pain.

In an interview conducted on 10/26/18 at 11:16 AM with Medication Aide #1 she stated that if she had signed off on the eMAR that she gave the medication but had not signed it out of the locked drawer on the cart then she must have missed giving the doses to the resident.

Three unsuccessful attempts to contact Resident #4 were made on 11/13/18 who had been discharged to home on 10/27/18. Messages were left but she did not return the calls.

In an interview with the Director of Therapy on 11/13/18 at 1:38 PM she reported that Resident #4 had not missed any therapy sessions due to uncontrolled pain. She said the resident did so well that she went straight to outpatient therapy when she was discharged.

5. Resident #36 was ordered Lyrica 50 mg one capsule by mouth one time a day for nerve pain. This medication was ordered by the physician on 9/7/17. Review of the Controlled Medication Utilization records showed that the medication had not been removed from stock and given to the resident on 10/21/18 at 9:00 AM but was initialed on the eMAR as given by Nurse 12.

In an interview conducted with Nurse #12 on 10/23/18 at 6:07 PM she stated that she had signed off the medication on the eMAR but had not given it to the resident or removed it from the controlled medication drawer.

In an interview conducted with Resident #36 on

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| F 760 | Continued From page 57<br>11/13/18 at 10:30 AM she stated that she could not remember any days when she had worse or different pain. She stated that she always had some discomfort in her neck but that the pain medication helped.<br><br>6. Resident #50 was ordered Tramadol 50 mg by mouth two times a day for pain. This medication was ordered by the physician on 10/06/18. Review of the Controlled Medication Utilization records showed that the medication had not been removed from stock and given to the resident on 10/15/18 at 8:00 AM but was initialed on the eMAR as given by Nurse #13.<br><br>In an interview conducted on 10/25/18 at 4:04 PM with Nurse #13 she stated that she had signed the eMAR as having given the medication to Resident #50 but forgot to go back and give it. She said that she had not taken it out of the controlled substance locked drawer when she passed his other medications and intended to go back and give it later but forgot.<br><br>In an interview conducted with Resident #50 on 11/14/18 at 11:30 AM he stated that he could not recall any days when his pain level was greater than normal. He stated that he received 8 or 9 pills every morning and they were generally effective. He said that there had been no days on which he noticed his pain level to be worse or different.<br><br>In an interview with the Director of Nursing on 10/26/18 at 7:56 AM she stated that she expected all medications to be given to residents as ordered by the physician. | F 760 | | |
| F 761 | Label/Store Drugs and Biologicals | F 761 | | 12/7/18 |

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| F 761 SS=E | Continued From page 58<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, Pharmacist interview, staff interviews and record review the facility failed to: 1) label medications that were pre-poured into medication cups on 1 of 4 medication carts observed; 2) dispose of expired and/or incorrectly labeled insulin medications on 1 of 4 medication carts observed; and 3) ensure medication labels on medication bubble packs matched the current physician orders and medication administration records for 3 of 31 | F 761 | 1. Prepoured medications were disposed of.<br><br>2. Expired and/or incorrectly labeled insulin medication were disposed of.<br><br>3.Medication bubble packs identified were labeled to check the medication administration records prior to administration to follow current order. | |

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| F 761 | Continued From page 59<br>medications reviewed.<br><br>Findings included:<br><br>1) On 10/24/18 at 7:45 AM Nurse #1 was observed to have pre-poured medications for five residents into white medication cups that were viewed in the top drawer of the 100 Hall medication cart. The observation revealed each cup contained multiple unlabeled medications with no identification on the cups. Nurse #1 stated that she had pre-poured medications for the residents in rooms 101, 109D, 109W, 110D, and 110W. She said that she had been trying to take a short cut because she often had trouble locating those residents when it was time to give them their medications.<br><br>In an interview conducted on 10/24/18 at 7:56 AM with the Director of Nursing she stated that the facility did not allow staff to pre-pour medications. She removed the unlabeled medications from the cart and disposed of them. She said that she did not expect nurses to pre-pour medications.<br><br>2) An observation made on 10/26/18 at 7:30 AM of the front 100 Hall medication cart revealed the following expired and incorrectly labeled insulin medications:<br><br>a. One expired Humalog Insulin Kwikpen labeled, "Opened 8/16/18- Expires 9/16/18", was on the cart. There was no resident name on the Kwikpen.<br><br>b. One Novolog Insulin Flexpen for Resident #29 had no open date or expiration date on the label. The Flexpen had been opened. | F 761 | Current residents are at risk for this issue. All medication storage areas and carts were examined and any out of date of unlabeled medications were removed.<br><br>Current medication bubble packs were compared to the medication administration record to verify that it matched and if there had been a change, the change order alert sticker was added to the bubble pack.<br><br>Licensed nursing were reeducated concerning the appropriate labeling and storage of medications. This included the expectation that no medication would be poured unless they were to be given immediately; and that any insulin opened would have a date written on it to ensure it was disposed of when the timeframe for that open medication had expired.<br><br>Licensed nurses were reeducated concerning the need to label any bubble pack that did not match the current order listed in the medication administration record.<br><br>The Director of Nursing or designee will inspect the medication storage areas on an ongoing basis. The monitoring will be documented weekly for 12 weeks for the 4 medication carts and the 2 medication rooms.<br><br>The Director of Nursing or designee will verify that the bubble pack matches the medication administration record and | |

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| F 761 | Continued From page 60<br>c. One Novolog Insulin Flexpen for Resident #1 had no open date or expiration date on the label. The Flexpen had been opened.<br><br>d. One Humalog Insulin Kwikpen for Resident #39 had no open date or expiration date on the label. The Kwikpen had been opened.<br><br>In interview conducted on 10/26/18 at 7:30 AM with Nurse #13 she stated that she was passing medications on the front 100 Hall medication cart. She stated that she was not aware that an expired pen of insulin was on the cart. She said that she didn't have a routine method for checking the cart for expired medications but did it whenever time permitted. She also stated that she could not verify when the incorrectly labeled insulin pens that contained no open or expiration dates had been opened or when they expired but that they had been opened with doses used.<br><br>In an interview conducted on 10/26/18 at 7:56 AM with the Director of Nursing she stated that she expected all insulins to be labeled with an open and expiration date. She also said she would not expect to find any expired medications on a medication cart. She reported that she expected the nursing staff to remove any expired medications from the carts on the day the medications expired. She said that the consultant pharmacist also inspected one cart a month on a rotating basis as a part of the monthly pharmacy review. She removed the expired and incorrectly labeled medications from the 100 Hall medication cart and disposed of them.<br><br>3) A review of pharmacy labels on medication bubble packs on 10/25/18 revealed that the following pharmacy labels did not match the | F 761 | ensure that there is notification on the bubble pack if they do not match. This will be documented for 5 random residents weekly for 12 weeks.<br><br>The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee meeting for review and recommendations for the duration of the monitoring period. | |

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| F 761 | Continued From page 61 | F 761 | | |

current physician's orders on the Medication Administration Records for the following items:

a. Resident #118 had a medication bubble pack on the medication cart with a pharmacy label that read: "Morphine Sulfate ER 60 mg (milligram) Tablet ER; Take 1 tab by mouth every 12 hours with 15 mg tablet for 75 mg total-Dx: pain" and "Morphine Sulfate ER 15 mg Tablet ER; Take 1 tab by mouth every 12 hours with 60 mg tablet for 75 mg total-Dx pain." The order on the Medication Administration Record read, "MS Contin tablet extended Release 15 mg (Morphine Sulfate ER) Give 5 tablets by mouth every 12 hours for pain, Start date 10/17/18." Although the labeling was incorrect, the resident did receive the correct dosage.

b. Resident #7 had a medication bubble pack on the medication cart with a pharmacy label that read: "Morphine Sulfate S/F,A/F 10 mg/5 ml give 2.5 ml (5mg) by mouth every day Dx: pain dressing change." The order on the Medication Administration Record read: "Morphine Sulfate Solution 10 mg/5 ml Give 5 mg by mouth as needed for pain, daily dressing change (start date 7/31/18). Although the labeling was incorrect, the resident did receive the correct dosage.

c. Resident #9 had a medication bubble pack on the medication cart with a pharmacy label that read: "Oxycodone Immediate 5 mg tablet give 1 tab by mouth every 6 hours for pain." The order on the Medication Administration Record read: "Oxycodone HCL tablet 5 mg give 1 table by mouth every 6 hours as needed for pain (start date 6/27/18). Although the labeling was incorrect, the resident did receive the correct dosage.

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| F 761 | Continued From page 62<br><br>In an interview with the Director of the facility consultant pharmacy on 10/25/18 at 10:05 AM she stated that the medication bubble pack labels on the medication carts were to match the physician's order on the Medication Administration Records. She said it was the facility's responsibility to update the eMAR (electronic medication administration record) alerting the pharmacy that an order for a medication had been changed. She stated that the pharmacy would then send a label to the facility that read: "Direction change-refer to MAR." She said that this label was to alert the staff that an order change had occurred. She revealed that if the facility was out of direction change labels supplied by the pharmacy that staff could hand write the direction on the label but that nothing on the original label could be over written.<br><br>In an interview with the Director of Nursing on 10/26/18 at 12:22 PM she stated that she expected the labels on the medication bubble packs to match the current physician's orders on the Medication Administration Records. | F 761 | | |
| F 770 SS=D | Laboratory Services<br>CFR(s): 483.50(a)(1)(i)<br><br>§483.50(a) Laboratory Services.<br>§483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.<br>(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.<br>This REQUIREMENT is not met as evidenced | F 770 | | 12/7/18 |

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| F 770 | Continued From page 63<br>by:<br>Based on record review, staff interviews, and Consultant Pharmacist interview, the facility failed to obtain lab work per physician orders for 1 of 7 residents. (Resident#4)<br><br>Findings included:<br><br>Resident #4 was admitted to the facility on 7/17/18. His active diagnoses included: Muscle Weakness, Dysphagia, Aphasia, Lack of Coordination, Hypertension, Hemiplegia, CVA, Convulsions, Urine Retention, and Nontraumatic Intracerebral Hemorrhage.<br><br>A review of the most recent Minimum Data Set (MDS) dated 7/24/18, coded as an Admission Assessment, indicated the resident was cognitively intact, non-verbal with adequate vision and hearing. The MDS also indicated that Resident #4 exhibited no behaviors and no rejection of care.<br><br>A review of the physician orders dated 9/10/18 showed an order written for a Keppra (Levetiracetam) Level, CBC (Complete Blood Cell Count), and CMP (Comprehensive Metabolic Panel), to be drawn on 9/11/18.<br><br>A review of the progress notes showed no labs were obtained for this resident on 9/11/18. The labs were not drawn until 9/19/18 which included CMP, and CBC, but did not show that the Keppra (Levetiracetam) level was drawn.<br><br>An interview was conducted with Nurse # 16. She stated that the 3rd shift nurse takes off the orders and the lab orders with the requisition is placed in the lab book for the lab agency to draw. | F 770 | The lab ordered for Resident #4 was obtained and results were reported to the MD and RP.<br><br>Current residents who have labs ordered are at risk for this issue.<br><br>An audit was performed for all labs ordered for the month of October to present to ensure that they were drawn, the physician had reviewed the results, and the resident and resident representative were notified. Any issues identified have been addressed.<br><br>Licensed nurses have been reeducated concerning the processing of lab orders. This includes receiving the order and entering it into PCC and transcribing the order into the lab book and onto the tracking record. A night nurse will review the lab book and prepare for the next days lab draws.<br><br>The Unit Managers or nurse designee will review the lab book each morning to identify what labs were to be drawn that morning, and determine if they were drawn. The labs for the previous day will be identified and the results obtained to ensure that they will be reviewed by the physician. After the physician review, resident and or resident representative will be notified and any new orders will be acted upon.<br><br>The Director of Nursing or designee will review lab orders in the morning clinical | |

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| F 770 | Continued From page 64<br><br>A review of the Lab requisition book showed no order had been recorded in the book to draw the Keppra (Levetiracetam) level on 9/11/18.<br><br>A phone interview was conducted on 10/24/18 at 04:05 PM with the facility Consultant Pharmacist, who stated there is no standard as to when to check Keppra levels, it is up to the physician. She stated that Keppra does not have a narrow therapeutic level, but the level is typically checked after a dosage increase.<br><br>A review of the physician orders dated 8/10/18 documented an order in place for Keppra (Levetiracetam) to be increased from 500mg to 1000mg BID on 8/10/18.<br><br>A review of the Medication Administration Record (MAR) showed the Keppra (Levetiracetam) dosage was increased to 1000mg (100mg/ml) on 8/10/18.<br><br>An interview was conducted on 10/25/18 with the DON (Director of Nursing) who verified that the Keppra level ordered by the physician on 9/11/18 was not drawn. She stated it's her expectation that the nurses are following the procedure regarding putting the lab orders in, and ensuring the orders are followed through.<br><br>An interview was conducted on 10/25/18 with the facility Administrator. She stated it's her expectation that when labs are ordered by the physician that the procedures for getting the orders to the lab are followed by the staff. | F 770 | meeting. The lab will be verified to be in the lab book. The tracking record in the lab book will be reviewed to ensure that all labs have been received and follow up as occurred.<br><br>This process will be documented during every morning meeting for 4 weeks and the then weekly for 8 weeks.<br><br>The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee meeting for review and recommendations for the duration of the monitoring period | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) | F 812 | | 12/7/18 |

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| F 812 | Continued From page 65<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to air dry kitchenware before stacking it in storage, and failed to ensure that kitchenware was free of stains, dried food particles, and cracks/chips. The facility also failed to label and date opened food items in multiple storage areas. Findings included:<br><br>1. At 10:20 AM on 10/24/18 12 of 18 eight-ounce cups were stacked on top of one another with moisture trapped inside of them. These cups were stacked in a rack on shelving above the dish machine.<br><br>At 10:18 AM on 10/25/18 the Dietary Manager (DM) stated that kitchenware items were not supposed to be stacked on top of one another | F 812 | All issues identified were corrected at that time.<br><br>Current residents are at risk for these issues.<br><br>The kitchen was inspected by the corporate dietician for any further issues with nothing new found.<br><br>Dietary staff have been reeducated concerning the requirement that anything opened or prepared and stored must have a date of opening written/attached to the product. This education also included the requirement that no dishes be stacked prior to complete air drying. Also | |

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| F 812 | Continued From page 66<br>until they were completely dry. He reported that moisture trapped between pieces of kitchenware could lead to bacterial formation which had the potential of making residents sick.<br><br>At 11:12 AM on 10/25/18 the AM Cook stated all kitchenware was to be air dried before it was stacked in storage. She reported if this policy was not followed bacteria and mold could grow in the trapped moisture.<br><br>2. At 10:40 AM on 10/24/18 the AM Cook stated that the facility currently had seven or eight residents who received their meals in sectional plates.<br><br>At 10:56 AM on 10/24/18 6 of 9 sectional plates had dark brown stains on them, 2 of 9 sectional plates had dried food particles on them, and 1 of 9 sectional plates had chipped dividing walls.<br><br>At 10:18 AM on 10/25/18 the Dietary Manager (DM) stated kitchenware was to be de-stained using a bleach-based solution as necessary. He reported kitchenware should be clean before placing it in storage, and chipped and cracked kitchenware was supposed to be disposed of. He explained that kitchenware that was compromised with chips and cracks could pose a choking hazard for residents if the residents swallowing any of the materials which were sloughing off. According to the DM, the kitchenware was a reflection of the dedication and quality of service provided by the dietary staff.<br><br>At 11:12 AM on 10/25/18 the AM Cook stated kitchenware which was stained was not appealing to the residents who had to eat off of it. She | F 812 | reeducated that kitchenware must be free of stains, dried food particles, and cracks or chips.<br><br>The kitchen will be inspected at least daily for any unlabeled/opened foods or dishes stacked while still wet and dishes free from stains, chips/cracks, or food particles. The Dietary Manager or designee will document this monitoring daily for 2 weeks, 5 days a week for 2 weeks, and then weekly for 8 weeks.<br><br>The Dietary Manager will report the findings of the monitoring to the monthly QAPI committee meeting for review and recommendations for the duration of the monitoring period. | |

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| AZALEA HEALTH & REHAB CENTER | 3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412 |

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| F 812 | Continued From page 67 | F 812 | | |

reported the dietary staff was instructed to inform the DM when they disposed of kitchenware compromised by chips and cracks so he could reorder the right quantity of replacement items. She commented it was more difficult to clean chipped and cracked kitchenware. According to the AM cook, residents could develop foodborne illness if dried food particles were not removed from kitchenware during the dish washing process and fresh food was placed on the kitchenware and served to the residents.

3. During initial tour of the kitchen and food storage areas, beginning at 10:55 AM on 10/22/18, opened food items including a 16-ounce box of corn starch, a 3-pound 8.8 ounce carton of instant mashed potatoes, and a 32-ounce bag of brown sugar were found stored in the kitchen above food preparation surfaces without labeling and dating. In the dry storage room a 5-pound box of cornbread mix, 2 bags of ziti noodles, 1 bag of tri-color rotini noodles, and a bag of elbow macaroni noodles were found opened but without labeling and dating. In the walk-in refrigerator an opened gallon of Italian dressing, an opened gallon of mayonnaise, an opened gallon or ranch dressing, and parts of tomatoes, cucumbers, bell peppers, red onions, and yellow onions which were left over from salad preparation were found without labeling and dating. A bag of green peas found in the walk-in freezer was opened but without labeling and dating.

During a follow-up tour of the kitchen, beginning at 9:42 AM on 10/24/18, a bag of oatmeal raisin cookies above a food preparation counter was not labeled and dated. In addition, a bag of chicken in the walk-in freezer was opened but

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| F 812 | Continued From page 68<br>without labeling and dating.<br><br>At 10:18 AM on 10/25/18 the Dietary Manager (DM) stated there were reminders posted throughout the kitchen for staff to place labels and dates on food items which were opened or stored as leftovers. He also reported that food items removed from their original packaging were supposed to be placed in storage containers and labeled and dated. He commented that he and the cooks checked behind the staff to make sure this policy was being followed.<br><br>At 11:12 AM on 10/25/18 the AM Cook stated labeling and dating opened food items and leftovers was important to the first-in, first out (FIFO) philosophy of food service which guaranteed that the freshest foods were served to the residents. | F 812 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete; | F 842 | | 12/7/18 |

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| F 842 | Continued From page 69<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments; | F 842 | | |

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| F 842 | Continued From page 70<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review the facility failed to accurately document details about a fall involving trauma to the head in a post-fall nursing progress note for 1 of 4 residents (Resident #45) who were reviewed for falls. Resident #45 fell from his wheelchair onto the parking lot pavement when one of his wheelchair wheels caught on the curbing. Findings included:<br><br>Record review revealed Resident #45 was admitted to the facility on 09/10/18, and was discharged to the hospital on 10/17/18 without return to the facility. The resident's documented diagnoses included multiple cancers with metastasis, chronic kidney disease, atrial fibrillation, and hypertension.<br><br>Nurse #19 wrote a late entry nursing note on 10/18/16 at 9:06 AM for 10/14/18 9:00 PM. The note documented, "Resident found lying in grass outside of building, reported 'wheelchair went off of edge of sidewalk and I fell into the grass.' Brought into building by staff member at approximately (7:00 PM) this evening. (Family member) in attendance. Alert, (oriented) x 1, reported headache 3/10 (3 out of 10 on pain scale). Noted quarter sized abrasion/ecchymosis (bruising) left anterior-lateral forehead; 0.8 | F 842 | Resident #45 is not longer at the facility.<br><br>Current residents are at risk for the issue.<br><br>The progress notes for the month of October, 2018 have been reviewed for accuracy. No further inaccurate information was found in any other progress note.<br><br>Licensed nurses have been reeducated concerning the expectation that all information put into the resident's progress notes be factually accurate.<br><br>The Director of Nursing or designee will review the new progress notes written the previous day/days for accuracy in the morning clinical meeting for 4 weeks and then weekly for 8 weeks.<br><br>The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee meeting for review and recommendations for the duration of the monitoring period. | |

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| F 842 | Continued From page 71 | F 842 | | |

(centimeter) laceration left nose, presumably from glasses.

On 10/25/18 at 9:24 AM, during a telephone interview, Nursing Assistant (NA) #1 stated on 10/14/18 she found Resident #45 laying on the pavement in the parking lot in the circle drive area in front of the building.

On 10/25/18 at 10:03 AM, during a telephone interview, Nurse #20 stated on 10/14/18 there was an empty wheelchair caught on the curbing. She reported she went out to the circular drive in front of the facility entrance, and found Resident #45 lying of his left side on the blacktop pavement.

On 10/26/18 at 11:22 AM the Business Office Manager stated she was just driving up to the building on 10/14/18 when she saw Nurse #20 and NA #1 running out the front door of the facility. She reported when she looked closer she saw Resident #45 laying on the pavement in the circular drive in front of the front patio/porch.

On 10/25/18 at 11:31 AM, during a telephone interview, Nurse #19 stated he thought he remembered being told by a facility nurse and someone from administration that Resident #45 was found outside where he rolled off the sidewalk in his wheelchair and fell forward into the grass. According to the nurse, he decided not to send Resident #45 out to the emergency room because the resident fell in the grass which softened his fall, his neuro-checks and vitals were within normal limits, and the resident stated he did not want to go out to the hospital.

On 10/25/18 at 3:27 PM the Director of Nursing

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| F 842 | Continued From page 72<br>(DON) stated in-servicing was begun on 10/19/18 about incident/risk management reporting. She commented the emphasis of the training was to remind the nursing staff about all the components that should be included in documentation concerning falls and to emphasize the importance of documenting accurate information. She reported so far about 1/4 of the nursing staff have been in-serviced (there were nine signatures on the sign-in sheet). | F 842 | | |